STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview and record review, the facility failed to provide protective oversight for one resident (Resident #1) when he/she became sexually aggressive to other residents. Resident #1 exposed and touched himself/herself sexually and verbalized sexual taunts. The facility became aware of the incident on 9/18/21 and failed to provide supervision and monitoring for Resident #1 and protective measures for all other residents. Facility census was 95. The Administrator was notified on 9/19/21 at 3:04 P.M. of an Immediate Jeopardy (IJ) which began on 9/18/21. The IJ was removed on 9/21/21. Review of the Behavior Management Policy, dated 10/15/15 and revised 6/2020, showed in part: -The goal of any behavior management process is to maintain function and improve the quality of life. The goal of the interdisciplinary team (IDT) is to promptly identify behavior management issues and develop an effective management program. -When a resident displays adverse behavioral symptoms (e.g. crying, yelling, hitting, biting, etc), Licensed Nursing staff will assess the behavioral symptoms to determine possible causal factors, contact the attending physician, and implement non-drug interventions to alleviate the behavioral symptoms. -Upon observing the adverse behavioral symptoms, staff will do the following as indicated: ensure the safety of the resident as well as all other residents. The charge nurse will assign a staff member(s) to monitor/shadow the resident as needed. Such monitoring is for the protection of the resident as well as all others and is not meant to restrict their movement or mobility. 1. Review of Resident #1's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 8/1/21, showed: - Brief Interview of Mental Status (BIMS) of 10. (Indicating some cognitive deficit); - Independent with Activities of Daily Living (ADLs i.e. eating, dressing, hygiene, transfers, locomotion) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Behaviors (i.e. public sexual acts, disrobing in public, throwing or smearing food or bodily waste) occurred 1-3 days of the 7 day assessment period. - Diagnosis of Vascular Dementia (a set of symptoms that can include memory loss and difficulties with thinking, problem-solving or language that is caused by poor blood flow in the brain) with behavioral symptoms. - Chronic Obstructive Pulmonary Disease (COPD a disease where the lungs are unable to exchange oxygen) and Primary Hypertenstion (high blood pressure). Review of the resident's current care plan for behaviors, initiated on 1/30/21 with revision on 9/19/21, showed: - Sexually inappropriate behaviors in common areas, to staff and other residents, voids (urinates) and defecates on the floor or spreads on the walls at times. - Goal was to have no evidence of behaviors by review date. Target date of 11/15/21. - Interventions include: medication as ordered, assist resident to develop more appropriate methods of coping and interacting. - Caregivers to provide opportunities for positive interaction and attention. Discuss behaviors and reinforce why it is inappropriate or unacceptable in the facility. Intervene as necessary to protect the rights and safety of others. Remove the resident from the situation and take to an alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Provide cares in pairs and male caregiver as needed. Provide privacy for resident. Review of the resident's Physician Order Sheets (POS), dated August 2021, showed the following medications discontinued on August 25th due to resident refusal: -Zoloft (antidepressant medication) 50 milligrams (mg) daily for impulsivity and outbursts ordered on 7/21/21; -Mirtazepine (antidepressant medication) 7.5 mg at bedtime for depression ordered 7/21/21; -Trazodone (antidepressant medication) 50 mg at bedtime for sleep ordered 2/25/21. Review of the resident's POS, dated September 2021, showed the resident had no medications ordered. Review of the resident's nurse progress notes showed: - On 7/8/21 at 3:48 P.M., Psychiatrist availability was to be checked and appointment scheduled. Social worker to follow up on 7/9/21 if no return call from Psychiatry clinic. -On 7/9/21 at 2:08 P.M., the resident was moved to a different room due to allegations of inappropriate sexual behaviors towards other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 7/21/21 at 10:44 A.M., the resident was sitting naked in room doorway exposing his/her private areas and inappropriately touching himself /herself when others looked at him/her. -On 7/22/21 at 10:08 A.M., the resident was making sexual comments and attempting to inappropriately touch staff. -On 7/26/21 at 2:33 P.M., the resident continued to make sexually inappropriate comments. The resident's spouse and Physician were notified. He/she was transferred to acute care hospital. The resident returned to the facility with no new orders and a diagnosis of Hypersexuality (excessive preoccupation with sexual fantasies, urges or behaviors that is difficult to control). -On 7/27/21 at 2:44 A.M., the resident made sexual comments to staff members. -On 8/23/21 at 9:42 A.M., the resident made sexual comments to staff and touched the staff member in the bikini area. -On 8/25/21 at 2:12 P.M., all the resident's medications was discontinued by the physician due to refusal to take them. -On 8/26/21 at 10:33 A.M., the resident began masturbating while receiving a shower from staff. -On 9/17/21 at 8:47 P.M., the resident asked the Certified Medication Technician (CMT) if he/she cums fast?, then began masturbating at the nurse's station. -On 9/19/21 at 1:11 P.M. showed: At 1600 (4:00 P.M., 9/18/21) the resident was in the hall in front of Resident #2 and #4's room, with only an adult brief on. The resident was educated by the nurse about appropriate clothing in general areas of the facility. The resident became belligerent and cursed at the nurse. The resident then returned to his/her room doorway. Resident #2 indicated that Resident #1 had exposed his/her privates to him/her. Resident #3 reported that Resident #1 had come up close enough he/she was unable to move. Once Resident #3 was able to maneuver away from Resident #1, he/she then followed Resident #3 closely and was making lewd sexual comments of pussy, pussy, pussy. Resident #1 was instructed to stay away from Residents #2 and #3 and was placed on 1:1 observation with a staff member. During an interview on 9/19/21 at 9:18 A.M., the Administrator said Resident #1 had exposed his/her private area to another resident as well as made sexual comments of pussy, pussy, pussy while following another resident to his/her room. Resident #1 resided on a hall by himself/herself, was on 20 minute checks, and was unable to leave his/her room without the Licensed Nurses seeing him/her due to their position at the desk. Review of the resident's medical record from 7/9/21 to 9/19/21 showed no Psychiatric evaluation, notes, or any interventions put in place after any of the above incidents prior to the 9/18 incident or after the 9/18 incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 9/19/21 at 1:00 P.M., showed Resident #1 sitting in his/her room. No staff were observed in the resident's room or one on one observation of the resident. One resident was in a room across the hall from Resident #1, one resident was to the right two doors away from Resident #1's room, and one resident was four rooms to the left of Resident #1. Resident #2's room was around the corner and three doors away from Resident #1's room. During an interview on 9/19/21 at 1:03 P.M., Licensed Practical Nurse (LPN) A said: -Resident #1 was not currently on 1:1 with a staff member or regular, documented checks. -He/she was not aware the Resident was to be on one on one observation with a staff member. Resident #1 was being checked frequently due to he/she keeps leaving his/her room and staff see him/her when he/she turns the corner. Resident #1 was not on the hall alone as there was a resident across from his/her room, one down the hall, and one past the double doors. Resident #1 was known to make sexual comments to staff and had left staff inappropriate notes. He/she was aware of an incident involving another resident from the shift prior. 2. Review of Resident #3 Quarterly MDS, dated [DATE], showed a BIMS of 15 (indicating no cognitive deficit). He/she was independent with ADLs. Diagnosis of Kidney Disease, Epilepsy (a brain disorder that causes seizures), and Hemiplegia (paralysis on one side of the body). During an interview on 9/19/21 at 1:10 P.M., Resident #3 said: -Resident #1 came up very closely behind him/her and he/she had difficulty getting away. Once he/she was able to walk down the hall Resident #1 followed him/her to his/her room while saying lewd sexual comments. Resident #1 makes him/her uneasy and uncomfortable. Resident #1 had come to his/her room multiple times and makes him/her uncomfortable. He/she had asked staff for something to be done with Resident #1. He/she filed charges with the Police department in regards to Resident #1. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed he/she had a BIMS of 4 (indicating severe cognitive deficit), needs supervision and assistance with ADLs, and diagnosis of Anemia, Breast Cancer, and Chronic Obstructive Pulmonary Disease. During an interview on 9/19/21 at 1:24 P.M., Resident #2 said yes when asked if another resident had come into his/her room and exposed themselves. He/she voiced he/she was not afraid. 4. During an interview on 9/19/21 at 1:34 P.M., Certified Nurse Aide (CNA) A said he/she was not given any direction on times of checks. He/she was not aware Resident #1 was to be 1:1. He/she just watched Resident #1 due to the incident last night in which the resident showed his/her private area to another resident. There was no documentation of staff checking on the resident. He/she said the intervention in place for the resident's sexual behavior was when behaviors occur he/she takes the resident to his/her room and tells him/her to stop. During an interview on 9/19/21 at 1:37 P.M., Certified Medication Technician (CMT) A said: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she is not aware of any scheduled time checks for Resident #1. Resident #1 had grabbed staff in private body areas multiple times. He/she had reported the incidents to Administration and nothing had been done. He/she kept the medication cart between him/her and the resident so the resident was not able to reach him/her. During an interview on 9/19/21 at 2:52 P.M., LPN B said: -He/she placed Resident #1 on 1:1 with a staff member after he/she was informed by Resident #2 that Resident #1 had exposed himself/herself to Resident #2 and followed Resident #3 making lewd comments on 9/18/21. He/she explained to Resident #1 that he/she could not show others private body parts or follow other residents making lewd comments. Resident #1 began cursing at LPN B stating he/she would do what he/she wanted. He/she notified the police for Resident #3. During an interview on 9/19/21 at 1:22 P.M., Administrator said: -Resident #1 was to transfer to another long term care facility with a secure unit. A bed was not available at that long term care facility at this time. He/she was aware of the sexual allegations. He/she told staff to monitor Resident #1 and place the resident on checks. -Administrator stated the resident was primarily in a hall by himself/herself and believed that 20 minute checks were sufficient. During an interview on 9/24/21 at 12:39 P.M., Physician A said his/her office was notified of the incident involving Resident #1 on 9/18/21. No orders were given. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO00191111