

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31100</p> <p>Based on interview and record review, the facility failed to ensure residents are free from sexual abuse, when two residents (Residents #1 and #2) who are alert and oriented and independent with care, reported that the nurse would touch and rub their genitals using the excuse of providing incontinent care and treatments. The residents reported that the actions of the nurse made them feel very uncomfortable and they felt violated. The facility census was 109.</p> <p>The Administrator was notified on 1/5/22 at 4:00 P.M. of an Immediate Jeopardy (IJ) which began on 1/2/22. The IJ was removed on 1/6/22 as confirmed by surveyor onsite verification.</p> <p>1. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed:</p> <ul style="list-style-type: none"> <li>- The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation.</li> <li>- Defined abuse as willful infliction of injury and included sexual abuse.</li> <li>- Willful was defined as acting deliberately.</li> <li>- Sexual abuse was defined as non-consensual sexual contact of any kind with a resident.</li> </ul> <p>2. Review of Resident #1's care plan, dated 4/27/20, showed:</p> <ul style="list-style-type: none"> <li>- The resident self-toileted.</li> <li>- The resident was resistive to cares and staff should allow the resident to make decisions regarding cares.</li> <li>- Diagnoses included diabetes, lung disease, and schizophrenia (a severe mental health disorder affecting mood, behavior, and thinking).</li> </ul> <p>Review of the resident's physician order sheet, dated 11/17/21, showed an order for Nystatin powder (used to treat yeast infections) apply to affected area daily.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/7/21, showed:</p> <ul style="list-style-type: none"> <li>- Cognitively intact;</li> <li>- No help from staff required for cares;</li> <li>- Always continent of bowel and bladder;</li> </ul> <p>- Diagnoses included diabetes, heart failure, anxiety, depression, schizophrenia, lung disease with respiratory failure.</p> <p>During an interview on 1/4/22 at 10:00 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>- He/she had a perineal (peri) yeast rash.</li> <li>- Staff treated his/her yeast rash daily with powder and occasionally twice a day at his/her request.</li> <li>- The other night Licensed Practical Nurse (LPN) A came in to provide the yeast treatment even though he/she did not request the treatment.</li> <li>- LPN A told the resident that he/she was in good shape for [AGE] years.</li> <li>- Without wearing gloves, LPN A applied the yeast treatment and then started washing the resident's penis.</li> <li>- The resident said he/she did not have a rash on the penis.</li> <li>- LPN A kept coming back during the night and washed my penis.</li> <li>- LPN A fondled my penis.</li> <li>- LPN A made the resident feel uncomfortable.</li> <li>- The resident thought LPN A washed my penis five or six times.</li> <li>- Guys don't tell.</li> </ul> <p>3. Review of Resident #2's admission MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>- Moderate cognitive impairment;</li> <li>- Independent for cares;</li> <li>- Always continent of bowel and bladder;</li> <li>- Diagnoses included a stroke, depression, and lung disease;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Received antidepressant medications.</li> </ul> <p>Review of the resident's care plan, dated 10/15/21, showed:</p> <ul style="list-style-type: none"> <li>- The resident self-toileted.</li> <li>- Diagnoses included a stroke, lung disease, and kidney disease.</li> </ul> <p>During an interview on 1/4/22 at 10:10 A.M. the resident said:</p> <ul style="list-style-type: none"> <li>- He/she did not need staff assistance using the restroom.</li> <li>- LPN A woke him/her up five or six times in the middle of the night and washed my penis.</li> <li>- LPN A did not wear gloves when he/she washed my penis.</li> <li>- It made him/her uncomfortable when LPN A washed my penis.</li> <li>- He/She told LPN A not to wash my penis, but LPN A continued to wash him/her.</li> <li>- LPN A made him/her very uncomfortable.</li> </ul> <p>4. During an interview on 1/4/22 at 8:25 A.M., the Administrator (ADM) and the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>- They immediately spoke with LPN A who said both residents were dependent and required peri care,</li> <li>- Resident #1 had a treatment for a yeast infection in his/her skin folds.</li> <li>- Resident #1 requested the treatment and LPN A provided the treatment.</li> <li>- LPN A wore gloves to apply the treatment.</li> <li>- They felt LPN A behaved in an inappropriate manner.</li> <li>- They notified LPN A that he/she was suspended from the facility.</li> <li>- They notified the staffing agency that LPN A was not to return to their facility pending investigation.</li> <li>- After interviewing staff and residents they told the staffing agency that LPN A could not come back to the facility.</li> <li>- They contacted the police.</li> </ul> <p>During an interview on 1/4/22 at 9:00 A.M., the Social Services Designee (SSD) said:</p> <ul style="list-style-type: none"> <li>- He/she interviewed Resident #1 and Resident #2 and all the male residents in the facility.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Resident #1 told him/her that he/she felt LPN A treated him/her in an inappropriate manner and made him/her very uncomfortable.</li> <li>- Resident #2 told the SSD that LPN B gave him/her pericare multiple times during the night.</li> <li>- Resident #2 said he/she did not require pericare.</li> <li>- Resident #2 said LPN A made him/her very uncomfortable.</li> </ul> <p>During an interview on 1/4/22 at 9:45 A.M., LPN B said:</p> <ul style="list-style-type: none"> <li>- Residents #1 and #2 told him/her that LPN A cleaned their genitals multiple times during the night.</li> <li>- Resident #1 said that LPN A came in the middle of the night and washed their privates.</li> <li>- Resident #1 said he/she felt assaulted by LPN A.</li> <li>- Resident #2 was crying and said he/she did not like the way LPN A treated him/her.</li> <li>- Resident #1 said that LPN A was counting on the residents not reporting the assault.</li> <li>- LPN B immediately texted the ADM and the DON.</li> </ul> <p>During an interview on 1/6/22 at 10:45 A.M., LPN A said:</p> <ul style="list-style-type: none"> <li>- He/she performed peri care to keep the residents from becoming irritated.</li> <li>- Resident #1 and Resident #2 requested peri care due to perineal irritation.</li> <li>- He/she provided clean clothing to the residents.</li> <li>- He/she did not comment on the age of any resident.</li> <li>- He/she only provided care to keep residents clean.</li> <li>- He/she checked Resident #1 for a yeast infection and felt the medication was not working so he/she repeated the treatment several times during the night.</li> <li>- He/she did not fondle any residents' penis.</li> </ul> <p>Review of the facility investigation of the incident, dated 1/10/22 by the Administrator (ADM), showed:</p> <ul style="list-style-type: none"> <li>- The incident allegedly occurred on 1/1/22 through 1/2/22 on the night shift.</li> <li>- Resident #1 and Resident #2 were roommates.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Both residents reported LPN A provided peri care multiple times during the night.</li> <li>- The facility substantiated the allegation of abuse due to LPN A providing peri care for two independent residents.</li> <li>- Facility staff inserviced staff on reporting abuse and neglect.</li> <li>- On 1/3/22 at 8:38 A.M. the ADM was called by the DON who said Resident #1 and Resident #2 told the DON that LPN A kept wanting to wash his/her genitals due to a rash.</li> <li>- Resident #1 said he/she had trouble sleeping, because LPN A kept washing his/her genitals.</li> <li>- Resident #2 said LPN A washed his/her genitals five to six times during the night.</li> <li>- Both residents said LPN A did not wear gloves when he/she provided care.</li> <li>- Resident #1 said He/she was trying to make me excited.</li> <li>- LPN A told Resident #1 just turned 60, huh? You don't look it.</li> <li>- Resident #1 said he/she normally received the treatment during the day and never administered like that.</li> <li>- Resident #2 said LPN A used powder and got underwear out of the drawer and put on clean underwear.</li> <li>- Resident #2 said LPN A washed and washed his/her peri area.</li> <li>- Resident #1 said usually don't tell. It's not easy on us.</li> <li>- Resident #1 said he/she was worried about residents that could not speak up.</li> <li>- The DON and ADM assured the resident that LPN A would not return to the facility.</li> <li>- The ADM called the police and made a report.</li> <li>- The DON called the social worker.</li> </ul> <p>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.</p> <p>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).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>MO195392, MO195442</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>31100</p> <p>Based on interview and record review, the facility failed to ensure the proper background checks were completed prior to allowing one Agency staff member, Licensed Practical Nurse (LPN) A, to work in the facility. The facility census was 109.</p> <p>1. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed:</p> <ul style="list-style-type: none"> <li>- The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation.</li> <li>- Defined abuse as willful infliction of injury and included sexual abuse.</li> <li>- Willful was defined as acting deliberately.</li> <li>- Sexual abuse was defined as non-consensual sexual contact of any kind with a resident.</li> </ul> <p>-Review showed the policy did not mention background checks.</p> <p>Review of Licensed Practical Nurse (LPN) A's pre-employment screens performed by the staffing agency showed:</p> <ul style="list-style-type: none"> <li>- On 12/9/21 the facility contacted the exclusions search and found LPN A was not currently excluded from working in long term care (LTC).</li> <li>- LPN A was registered with the state of Missouri Family Care Safety Registry (FCSR), a registry that does criminal background checks (CBC), sex offender registry.</li> <li>- The request to the FCSR, dated 11/15/21, showed this was not a background screening and background screening could be obtained from the registry.</li> </ul> <p>During an interview on 1/4/21 at 2:00 P.M., the Administrator (ADM) said:</p> <ul style="list-style-type: none"> <li>- LPN A was employed by a staffing agency.</li> <li>- The staffing agency performed all the background checks.</li> </ul> <p>During an interview on 1/11/21 at 4:00 P.M., the Staffing Agency (SA) A said:</p> <ul style="list-style-type: none"> <li>- The staffing agency used a third party to perform background checks on all their employees.</li> <li>- He/she would check to ensure that all the background checks were performed.</li> <li>-They did not have a background screen on LPN A.</li> </ul> <p>MO195383, MO195392</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34003</p> <p>Based on interview and record review, the facility failed failed to report to the state survey agency according to the law when one resident (Resident #5) reported an allegation of abuse to a staff member that a staff member had made derogatory comments about his/her genitals. The facility census was 109.</p> <p>1. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed:</p> <ul style="list-style-type: none"> <li>- The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation;</li> <li>-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;</li> <li>-Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm;</li> <li>-Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability;</li> <li>-The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented as written;</li> <li>-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur;</li> <li>-The facility will have written procedures that include: <ul style="list-style-type: none"> <li>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other agencies (e.g. law enforcement when applicable) within specified timeframe's; <ul style="list-style-type: none"> <li>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or</li> <li>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury;</li> </ul> </li> <li>-The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.</li> </ul> </li> </ul> <p>During telephone interview on 1/8/22 at 10:00 A.M., the Social Services Director said:</p> <p>(continued on next page)</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was notified by a staff member on 1/7/22 that Resident #5 said that a staff member had made derogatory comments about his/her genitalia;</p> <p>-The resident said the staff member said, you have small balls;</p> <p>-He/she notified the Director of Nursing (DON) and made a report to the state survey agency.</p> <p>Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/20/21, showed:</p> <p>-The resident was alert with difficulty making decisions;</p> <p>-Required extensive assistance of two staff for Activities of Daily Living (ADL's);</p> <p>-Incontinent of bowel and bladder.</p> <p>-Diagnoses of stroke, hypertension, diabetes, hemiparesis (weakness or inability to move on one side of the body), dementia, seizure disorder, and anxiety.</p> <p>During an interview on 1/8/22 at 11:34 P.M., the resident said:</p> <p>-A couple of days ago a staff member was helping him/her after he/she was incontinent;</p> <p>-After the staff member was finished, the staff member made a comment about his/her genitalia that he/she found very derogatory. The staff member said you have small balls. The staff member pulled the blankets over his/her body and patted his/her genitalia and said see you later, small balls;</p> <p>-He/she found the comments very degrading and humiliating;</p> <p>-He/she can identify the staff member, but does not know the staff member's name;</p> <p>-He/she told a staff member about these comments on 1/7/22. He/she could not remember which staff member.</p> <p>During an interview on 1/8/22 at 1:00 P.M., the DON said:</p> <p>-She was aware of the allegation of abuse that the resident made toward a staff member;</p> <p>-She thinks she had identified the staff member per the residents description;</p> <p>-That staff member will no longer work at the facility.</p> <p>During an interview on 1/9/22 and again on 1/13/22 at 3:00 P.M., the Administrator said:</p> <p>-The DON identified the staff member, who worked for an agency and this staff member will not be allowed to work in the facility again.</p> <p>-She had not notified the state survey agency of the allegation of abuse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	MO195605

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>34003</p> <p>Based on interview and record review, the facility failed to investigate an allegation of staff to resident abuse, when one resident (Resident #5) reported to staff that a staff member made derogatory comments about his/her genitals. The facility census was 109.</p> <p>1. Review of the facility policy, dated 2021, on abuse, neglect, and exploitation showed:</p> <ul style="list-style-type: none"> <li>- The facility would provide protection for the health, welfare and the rights of each resident to prohibit and prevent abuse, neglect, and exploitation.</li> <li>-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;</li> <li>-Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm;</li> <li>-Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability;</li> <li>-The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented as written;</li> <li>-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur;</li> <li>-Written procedures for investigations include: <ul style="list-style-type: none"> <li>1. Identifying staff responsible for the investigation;</li> <li>2. exercising caution in handling evidence that could be used in a criminal investigation;</li> <li>3. Investigating different types of alleged violations;</li> <li>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;</li> <li>5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and;</li> <li>6. Providing complete and thorough documentation of the investigation;</li> </ul> </li> </ul> <p>During telephone interview on 1/8/22 at 10:00 A.M. the Social Services Director said:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was notified by a staff member on 1/7/22 that Resident #5 said that a staff member had made derogatory comments about his/her genitalia;</p> <p>-The resident said that the staff member said: you have small balls;</p> <p>-He/she notified the Director of Nursing (DON) and made a report to the state survey agency.</p> <p>Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/20/21 showed:</p> <p>-The resident was alert with difficulty making decisions;</p> <p>-Required extensive assistance of two staff for Activities of Daily Living (ADL's);</p> <p>-Incontinent of bowel and bladder.</p> <p>-Diagnoses of stroke, hypertension, diabetes, hemiparesis (weakness or inability to move on one side of the body), dementia, seizure disorder and anxiety.</p> <p>During an interview on 1/8/22 at 11:34 P.M., the resident said:</p> <p>-A couple of days ago a staff member was helping him/her after he/she was incontinent;</p> <p>-After the staff member was finished, the staff member made a comment about his/her genitalia that he/she found very derogatory. The staff member said you have small balls. The staff member pulled the blankets over his/her body and patted his/her genitalia and said see you later, small balls;</p> <p>-He/she found the comments very degrading and humiliating;</p> <p>-He/she can identify the staff member, but does not know the staff member's name;</p> <p>-He/she told a staff member about these comments on 1/7/22;</p> <p>-He/she does not know the staff members name.</p> <p>During an interview on 1/8/22 at 1:00 P.M. the DON said:</p> <p>-She was aware of the allegation that the resident made toward a staff member;</p> <p>-She thinks she had identified the staff member per the residents description;</p> <p>-She had not began a formal investigation.</p> <p>During an interview on 1/9/22 and again on 1/13/22 the Administrator said:</p> <p>-She had not made a formal investigation into the resident's allegation.</p> <p>MO195605</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003 42093</p> <p>Based on observation, interview, and record review, the facility failed to administer haldol (antipsychotic medication used to treat certain mental disorders) and lorazepam (also known as Ativan, a sedative that can be used for anxiety) as ordered by the physician as needed for one resident (Resident #9), failed to administer enteral feedings (tube feeding, a way to deliver nutrition directly to the stomach or small intestine) as ordered by the physician to one resident (Resident #8), and failed to notify the physician of one resident (Resident #4) of an abnormal urinalysis. The facility failed to assess and monitor one resident (Resident #7) for a change of condition. Facility census was 109.</p> <p>1. Review of facility policy, Consulting Physician/Provider Orders, not dated, did not address following physician orders.</p> <p>Review of Resident #9's admission minimum data set (MDS, a federally mandated assessment completed by facility staff), dated 1/11/22, showed:</p> <ul style="list-style-type: none"> <li>-Brief interview for mental status (BIMS) score of 6. This indicates moderate cognitive impairment.</li> <li>-Diagnosis include: cancer and lung disease.</li> <li>-On hospice.</li> <li>-Received antipsychotic medication two days out of the last seven days.</li> <li>-Received anti-anxiety medication four days out of the last seven days.</li> <li>-Received opioids six days out of the last seven days.</li> </ul> <p>Review of the physician orders, dated January 2022, showed:</p> <ul style="list-style-type: none"> <li>-Haloperidol 0.5 milligrams (mg) every hour as needed for anxiety.</li> <li>-Lorazepam 0.5 milliliters (ml) every two hours as needed for pain.</li> </ul> <p>During an interview on 1/14/22 at 3:15 P.M. Hospice Staff Member A said:</p> <ul style="list-style-type: none"> <li>-On 1/11/22 he/she asked the resident's nurse if haldol or lorazepam had been administered. The nurse said he/she could not access it due to not having the narcotic key because the previous nurse did not give him/her the narcotic key before they left.</li> </ul> <p>Review of the medication administration record showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Haloperidol 0.5 mg every hour as needed for anxiety: no documented administered doses on 1/11/22, 1/12/22, 1/13/22, or 1/14/22.</p> <p>-Lorazepam 0.5 ml every two hours as needed for pain: no documented administered doses on 1/11/22, 1/12/22, 1/13/22, or 1/14/22.</p> <p>Review of nurse's notes showed:</p> <p>-On 1/11/22: Could not administer Ativan due to key not handed over by previous shift. Staffing coordinator notified.</p> <p>-On 1/12/22: Resident went to the hospital due to having hallucinations and making suicidal statements. Resident broke his/her pain pump.</p> <p>-On 1/14/22 at 1:27 A.M.: Resident having hallucinations and hearing voices. Resident asked for as needed (PRN) dose for haldol and Ativan. Medications given per order.</p> <p>During an interview on 1/19/22 at 2:00 P.M., Agency Nurse B said:</p> <p>-He/she had never not had the narcotic key when working.</p> <p>-Medications are documented on the MAR.</p> <p>During an interview on 1/20/22 at 10:12 A.M., the Director of Nursing (DON) said:</p> <p>-Physician orders should be followed. If not completed, it should be documented as to why.</p> <p>-Nurse's can access any medication needed through the medication cubex.</p> <p>-Medications should be documented if administered on the MAR.</p> <p>During an interview on 1/20/22 at 11:03 A.M., the Staffing Coordinator said:</p> <p>-He/she was notified when the agency nurse did not have the narcotic key and a resident was needing his/her lorazepam. The key was locked in the medication room.</p> <p>-Agency staffing may not have known there was a Pyxis (automated medication dispensing system) to access lorazepam in when the narcotic key was not available.</p> <p>-The Pyxis allows medications to always be accessible to staff.</p> <p>2. Review of facility policy, Care and Treatment of Feeding Tubes, not dated, showed:</p> <p>-It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush.</p> <p>-Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders.</p> <p>-Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders.</p> <p>-The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors.</p> <p>Review of Resident #8's quarterly MDS, dated [DATE], showed:</p> <p>-BIMS score of 15. This indicates no cognitive impairment.</p> <p>-Diagnosis include: diabetes and fracture.</p> <p>-Had a feeding tube.</p> <p>Review of the care plan, dated 12/27/21 showed:</p> <p>-Resident required tube feedings. Resident was dependent with tube feedings and water flushes. See physician orders.</p> <p>Review of physician orders, dated January 2022, showed:</p> <p>-On 1/8/22: Every six hours bolus until able to use pump. 240 ml with water flushes 60 ml after.</p> <p>Review of nurse's note, dated 1/7/22, showed the resident refused bolus due to nausea.</p> <p>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed:</p> <p>-Bolus order was not documented as given on 1/12/22 at 1:00 P.M., 1/12/22 at 7:00 P.M. or 1/13/22 at 1:00 A.M.</p> <p>During an interview on 1/28/22 at 3:00 P.M., the resident and family member A said:</p> <p>-He/she had missed feedings.</p> <p>-One time the nurse tried to say he/she was asleep when it was administered, but that was a lie because the resident was awake and on the phone when the nurse claimed to have administered it.</p> <p>During an interview on 1/19/22 at 2:00 P.M., Agency Nurse B said:</p> <p>-Medications are documented on the MAR.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/20/22 at 10:00 A.M. the Central Supply person said:</p> <ul style="list-style-type: none"> <li>-The resident did not have a feeding pump yet;</li> <li>-He/she was working with sister facilities to see if the facility can borrow a feeding pump until one can be delivered from their vendor.</li> </ul> <p>During an interview on 1/20/22 at 10:12 A.M., the DON said:</p> <ul style="list-style-type: none"> <li>-Physician orders should be followed. If not completed, it should be documented as to why.</li> <li>-Medications should be documented if administered on the MAR.</li> <li>-The facility was having difficulty getting a feeding pump from their vendor. Central supply was contacting sister facilities for a feeding pump.</li> </ul> <p>3. Review of Resident #4's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Alert and oriented and able to answer questions;</li> <li>-Dependent upon two staff members for cares;</li> <li>-Diagnoses of neurogenic bladder (a condition in which problems with the nervous system affect the bladder and urination), hypertension, Multiple Sclerosis ( MS is a potentially disabling disease of the brain and spinal cord (central nervous system), arthritis, Parkinson's disease (is a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination).</li> </ul> <p>Review of a telephone order, dated 12/9/21, showed:</p> <ul style="list-style-type: none"> <li>-UA with C&amp;S (urinalysis with culture and sensitivity).</li> </ul> <p>Review of the nurses notes, dated 12/11/21, showed:</p> <ul style="list-style-type: none"> <li>-From 12/9/21, new orders: UA with C&amp;S, macrobid (a common medication used to treat or prevent uncomplicated urinary tract infections (UIT)) 100 mg (milligrams) for UTI/PPX (prophylaxis), no stop date at this time.</li> </ul> <p>Review of the nurses note, dated 12/12/21, showed:</p> <ul style="list-style-type: none"> <li>-Resident continued on antibiotic for daily suppression and treatment of UTI. UA with C&amp;S to be collected tomorrow to go out on Tuesday.</li> </ul> <p>Review of the nurses note, dated 12/13/21, showed:</p> <ul style="list-style-type: none"> <li>- UA collected and in the fridge.</li> </ul> <p>Review of the medical record showed no documentation of the UA with C&amp;S results being received or of physician notification.</p> <p>(continued on next page)</p>



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/13/22 at 2:08 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-She cannot find any documentation in the resident's medical record of the urinalysis being received. She would need to check the laboratory for the results;</li> <li>-She logged onto the outside laboratory's electronic medical record and found the results of the UA that was collected on 12/14/21;</li> <li>-The UA showed: the urine color was a dark yellow, turbid in clarity, 2 plus leukocytes (white blood cells (WBC), 2 plus blood, WBC count of 30-50 (normal being 0-3), RBC (red blood cells) 10-20 (normal being 0-3), many bacteria, and moderate triple phosphate (The formation of magnesium ammonium phosphate crystals (triple phosphate crystals) is caused by a combination of factors including decreased urine volume combined with bacteria) and mucus;</li> <li>-She could not find the results of the culture and sensitivity.</li> <li>-She could not find documentation of the physician being notified of the abnormal UA.</li> </ul> <p>During an interview on 1/13/22 at 2:24 P.M., Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> <li>-He/she remembered the resident had an order UA with C&amp;S;</li> <li>-The results should have been uploaded in the computer;</li> <li>-He/she cannot find any documentation that the UA with C&amp;S was received and the physician was notified of the results;</li> <li>-He/she looked in the contracted laboratory electronic medical record and found the results;</li> <li>-The C&amp;S was in the laboratory's electronic medical record and did not have a high enough colony count to warrant the physician being called;</li> <li>-He/she would have faxed the physician the results of the UA with C&amp;S;</li> <li>-He/she could not find any fax communication to the physician where the physician was notified.</li> </ul> <p>During an interview on 12/13/22 at 5:00 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-She would expect the nurses to print out the laboratory results and medical records to upload the results in the residents electronic medical record;</li> <li>-She would expect the physician to be notified of the results of the lab.</li> </ul> <p>4. Review of the undated facility policy for Notification of Changes showed:</p> <ul style="list-style-type: none"> <li>-The purpose of this policy is to ensure the facility promptly informs the resident, consults with the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification;</p> <p>-Circumstances requiring notification include:</p> <p>-Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include:</p> <p>-Life-threatening conditions or clinical complication;</p> <p>-A transfer or discharge of the resident from the facility.</p> <p>Review of facility policy, Transfers and Discharges, not dated, showed:</p> <p>-Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified): Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis; Notify resident and/or resident representative; Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements. Document assessment findings and other relevant information regarding the transfer in the medical record.</p> <p>Review of Resident #7's admission minimum data set (MDS, a federally mandated assessment completed by facility staff), dated 11/24/21, showed:</p> <p>-Brief interview for mental status (BIMS) score 10. This indicates moderate cognitive impairment.</p> <p>-Diagnosis included: coronary artery disease (plaque buildup causes arteries to narrow, limiting blood flow to the heart), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), anemia (condition in which the blood doesn't have enough healthy red blood cells), renal failure, stroke, and depression.</p> <p>-Had no teeth.</p> <p>-Required one staff assist to eat.</p> <p>Review of the Physician's Order Sheet (POS), dated January 2022, showed an order for COVID-19 Respiratory Assessment every 12 hours;</p> <p>-Review of the January COVID-19 assessments showed respiratory status, and vital signs to be documented:</p> <p>--There were no assessments completed for 1/1/22, 1/2/22, 1/3/22, 1/5/22, 1/6/22 and 1/8/22.</p> <p>Review of the facility's resident roster for COVID-19 testing showed the resident tested positive for COVID-19 on 1/11/22.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/11/22 at 12:05 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-Resident #7 was tested via a rapid test in the facility and was COVID-19 positive;</li> <li>-The resident will be moved to the COVID-19 unit.</li> </ul> <p>During an interview on 1/11/22 at 1:44 P.M., Minimum Data Set (MDS)/Registered Nurse (RN) A said:</p> <ul style="list-style-type: none"> <li>-Resident #7 tested positive for COVID-19 on 1/11/22, the resident required assistance of staff for activities of daily living (ADL's);</li> <li>-There was one staff member on the COVID-19 unit. There was no dedicated nurse;</li> <li>-The nurses go back at least one time per shift to give medication and complete assessments on the residents to look for any worsening symptoms related to COVID-19, like respiratory concerns. These assessments are documented in the resident's electronic medical record.</li> </ul> <p>During an observation on 1/12/22 at 4:30 P.M., on the facility's COVID-19 hall showed:</p> <ul style="list-style-type: none"> <li>-Resident #7 was in a room by him/herself;</li> <li>-The resident lay in a bed that was placed in the low position with no call light within reach.</li> </ul> <p>During an interview on 1/12/22 at 4:30 P.M., Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> <li>-A nurse will come back and pass medication and assess the residents, but usually only comes back one time per shift.</li> </ul> <p>Review of the medical record from 1/10/22 through 1/18/22 showed:</p> <ul style="list-style-type: none"> <li>-No COVID-19 assessments completed;</li> <li>-No documentation of any signs or symptoms of COVID-19 or other resident condition documentation;</li> <li>-No documentation of vital signs.</li> </ul> <p>Review of the resident's physician orders, dated January 2022, showed:</p> <ul style="list-style-type: none"> <li>-On 1/18/22 send to emergency room for evaluation and treatment.</li> </ul> <p>Review of the resident's nurse's notes on 1/18/22 showed no documentation regarding resident condition, no documentation of any vital signs or assessment of the resident, or the reason for transfer to the hospital.</p> <p>During an interview on 1/18/22 at 2:22 P.M., Family Member B said:</p> <ul style="list-style-type: none"> <li>-He/she had not been able to see the resident since the resident had tested positive for COVID-19 on 1/11/22;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On Monday 1/17/22, he/she visited the resident on the COVID unit. The resident did not appear to be well. He/she asked for the resident to be sent to the hospital, but staff reported he/she was not sick enough to send.</p> <p>-Today (1/18/22), the resident was staring out, not focusing, had swelling on the right side of his/her face, and he/she demanded for resident to be sent to the hospital.</p> <p>Review of the resident's assessments dated 1/11/22 through 1/18/22 showed no documentation of the resident's change of condition.</p> <p>Review of the resident's medical record, dated 1/17/22 and 1/18/22, showed no documentation of any assessment or vital signs.</p> <p>During an interview on 1/19/22 at 10:30 A.M., Agency Nurse A said:</p> <p>-This was his/her first shift at the facility in over a month;</p> <p>-He/she did not take care of the resident on 1/18/22;</p> <p>-There was not a nurse scheduled to work on the COVID-19 unit only a CNA or CMT;</p> <p>-If the CNA or CMT notices a change in a resident's condition, they should notify the nurse so the nurse can complete an assessment;</p> <p>-The assessment should be documented in the resident's progress notes.</p> <p>-A progress note or nurse's note should be completed if a resident transfers or discharges.</p> <p>During an interview on 1/18/22 at 2:30 P.M., Agency Nurse C said:</p> <p>-He/she will go to the COVID-19 unit one time a shift and complete an assessment on the residents who are on the unit;</p> <p>-The assessment consists of respiratory status and signs and symptoms of COVID-19;</p> <p>-There was not a nurse assigned to work the COVID-19 unit. A CNA or CMT works the unit and they notify the nurse if a resident needs something.</p> <p>During an interview on 1/19/22 at 10:59 A.M., Social Services said:</p> <p>-Yesterday (1/18/22) the resident's family member said the resident wasn't doing okay. The resident had some swelling in his/her face and wanted the resident to be sent to the emergency room . The family member said the resident would not drink from the straw for him/her. The resident was sent to the hospital yesterday.</p> <p>During an interview on 1/19/22 at 11:20 A.M. the MDS Coordinator said:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The nurse should have done an assessment when Family Member A reported a change of condition in the resident;</p> <p>-Nurses should document an assessment and vital signs in the medical record when a resident has a change of condition;</p> <p>-There was no documentation on 1/17/22 or 1/18/22 of any vital signs or assessment or physician notification;</p> <p>-The nurse should complete the SBAR UDA under the assessment tab when a resident has a change of condition and was transferred out.</p> <p>During an interview on 1/20/22 at 10:12 A.M., the Director of Nursing said:</p> <p>-On 1/17/22 Family Member A reported to him/her that he/she felt the resident had a change of condition;</p> <p>-The nurses should have completed an assessment on the resident if there was a change of condition;</p> <p>-When a resident was transferred to the emergency room , nursing should document a progress note and assessment of the resident condition.</p> <p>-She would expect the nurses to have completed an assessment on the resident when they were notified by Family Member A of a change of condition;</p> <p>-She would expect the nurses to have completed the COVID-19 assessments as ordered by the physician.</p> <p>MO196004</p> <p>MO195904</p> <p>MO195765</p> <p>MO196108</p> <p>/</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on record review and interview, the failed to properly document a discharge to home for one resident (Resident #6). The facility census was 109.</p> <p>1. Review of facility policy, Transfers and Discharges, not dated, showed:</p> <ul style="list-style-type: none"> <li>-For a community discharge, a discharge summary and plan of care should be prepared for the resident. Document in the medical record that written discharge instructions were given to the resident and if applicable, the resident's representative.</li> <li>-In case of discharge, notice requirements and procedures for facility-initiated discharges shall be followed.</li> <li>- Anticipated Transfers or Discharges - initiated by the resident: Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care; A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results; A final summary of the resident's status; Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter); A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment; Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team.</li> </ul> <p>Review of Resident #6's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-BIMS score 14. This indicated no cognitive impairment.</li> <li>-Diagnosis include: atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), renal failure, obstructive uropathy (a condition in which the flow of urine is blocked), multi-drug resistant organism (MDRO), urinary tract infection (UTI) in the last thirty days, diabetes, psychotic disorder, depression, post-traumatic stress disorder (PTSD), and lung disease.</li> <li>-Indwelling catheter (catheter that drains urine from the bladder to a bag outside the body).</li> </ul> <p>Review of physician orders, dated January 2022, showed:</p> <ul style="list-style-type: none"> <li>-1/18/22: May be discharged home with medications.</li> </ul> <p>Review of the electronic medical record showed:</p> <ul style="list-style-type: none"> <li>-Resident was discharged from the charting system on 1/18/22.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No documentation regarding discharge.</p> <p>During an interview on 1/19/22 at 10:30 A.M., Agency Nurse A said a progress note or nurse's note should be completed if a resident transfers or discharges.</p> <p>During an interview on 1/20/22 at 10:12 A.M., the Director of Nursing said:</p> <p>-When a resident discharges home, there should be a documented note about the discharge and any paperwork, resident condition, and education provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42093</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received treatment as ordered for two residents (Resident #7 and #8). The facility census was 109.</p> <p>Review of facility policy, Consulting Physician/Provider Orders, not dated, did not address following physician orders.</p> <p>The facility did not provide a policy for pressure ulcers.</p> <p>1. Review of Resident #7's admission minimum data set (MDS, a federally mandated assessment completed by facility staff), dated 11/24/21, showed:</p> <ul style="list-style-type: none"> <li>-Brief interview for mental status (BIMS) score 10. This indicates moderate cognitive impairment.</li> <li>-At risk for pressure ulcers.</li> <li>-No present pressure ulcers.</li> <li>-Had moisture associated skin damage (MASD)</li> </ul> <p>-Diagnosis include: coronary artery disease (plaque buildup causes arteries to narrow, limiting blood flow to the heart), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), anemia (condition in which the blood doesn't have enough healthy red blood cells), renal failure, stroke, and depression.</p> <p>Review of the resident's admission assessment on 11/17/21 showed only skin issue as redness to the left iliac crest (area where arching bones sit on either side of the pelvis).</p> <p>Review of the resident's care plan, dated 11/30/21, showed:</p> <ul style="list-style-type: none"> <li>-Resident had the potential/actual impairment to skin integrity. Follow protocols for treatment, and keep from excessive moisture.</li> </ul> <p>Review of the resident's physician orders, dated January 2022, showed:</p> <ul style="list-style-type: none"> <li>-12/6/21: Cleanse area to right buttock with wound cleanser, pat dry then cover with border dressing daily.</li> </ul> <p>Review of the resident's nurses notes showed:</p> <ul style="list-style-type: none"> <li>-On 12/4/21: Resident had a open area on right buttock, 0.3 centimeter (cm) by 0.2 cm by 0.1 cm. Clean with wound cleanser, applied triple antibiotic ointment (TAO) and covered with bandage. Wound bed has red granulated tissue (primary type of tissue that fills in a wound that is healing by secondary intention), no drainage present, no odor present, and no redness.</li> </ul> <p>(continued on next page)</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 12/6/21: New skin issue to right buttock, 1 cm by 0.2 cm. Could be from moisture due to incontinence. Staff educated to reposition every two hours, provide peri-care every two hours, and new orders received. All notifications completed.</p> <p>Review of the resident's Treatment Administration Record (TAR) showed:</p> <p>-Cleanse area to right buttock with wound cleanser, pat dry, then cover with border dressing.</p> <p>-Staff did not document the treatment as completed on 12/9/21, 12/12/21, 12/16/21, 1/3/22, 1/10/22, 1/12/22, and 1/15/22. On 1/13/22 and 1/14/22 documentation reflected a #9 which directs staff to see progress note. Review showed there were no progress notes found.</p> <p>2. Review of Resident #8's quarterly MDS, dated [DATE], showed:</p> <p>-BIMS score of 15. This indicated no cognitive impairment.</p> <p>-Diagnosis include: diabetes and fracture.</p> <p>-Had a stage three pressure ulcer (injury extends into the tissue beneath the skin forming a small crater; fat may show).</p> <p>Review of the resident's care plan, dated 12/27/21, showed:</p> <p>-Resident had a stage three pressure ulcer.</p> <p>-Resident had a long history of pressure ulcers.</p> <p>-Administer treatments as ordered and monitor for effectiveness.</p> <p>-Monitor/document/report as needed (PRN) any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage.</p> <p>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.</p> <p>-12/2/2021. Stage three pressure ulcer to left proximal (nearer to the center) lateral (away from the midline) buttock had deteriorated. Wound was debrided (procedure for treating a wound, it involves thoroughly cleaning the wound and removing all thickened skin, infected skin, and dead tissue, and debris from the dressing) by wound care professional (WCP) on 11/29/2021. Continue treatment as per orders.</p> <p>-12/9/21. Stage three pressure ulcer to left proximal lateral buttock was improved. Wound was debrided by WCP on 12/6/21. Continue treatment as per orders.</p> <p>-On 12/15/21. Stage three pressure ulcer to left proximal lateral buttock had remained unchanged. Wound was debrided by WCP on 12/13/2021. Continue treatment as per orders.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-12/23/21. Stage three pressure ulcer left proximal lateral buttock has deteriorated. Wound was debrided by WCP on 12/20/2021. Continue treatment as per orders.</p> <p>Review of the resident's care plan, dated 12/27/21, showed:</p> <p>-Resident had a stage three pressure ulcer.</p> <p>-Resident had a long history of pressure ulcers.</p> <p>-Administer treatments as ordered and monitor for effectiveness.</p> <p>-Monitor/document/report as needed (PRN) any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage.</p> <p>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.</p> <p>-12/2/2021. Stage three pressure ulcer to Left proximal (nearer to the center) lateral (away from the midline) buttock had deteriorated. Wound was debrided (procedure for treating a wound, it involves thoroughly cleaning the wound and removing all thickened skin, infected skin, and dead tissue, and debris from the dressing) by wound care professional (WCP) on 11/29/2021. Continue treatment as per orders.</p> <p>-12/9/21. Stage three pressure ulcer to left proximal lateral buttock was improved. Wound was debrided by WCP on 12/6/21. Continue treatment as per orders.</p> <p>-On 12/15/21. Stage three pressure ulcer to Left Proximal lateral buttock had remained unchanged. Wound was debrided by WCP on 12/13/2021. Continue treatment as per orders.</p> <p>-12/23/21. Stage three pressure ulcer left proximal lateral buttock has deteriorated. Wound was debrided by WCP on 12/20/2021. Continue treatment as per orders.</p> <p>Review of the resident's physician orders, dated January 2022, showed:</p> <p>-12/4/21: Cleanse wound to left buttock with normal saline (sterile water), pat dry, apply santyl (ointment that removes dead tissue from wounds so they can start to heal) to wound bed, apply gentamycin (antibiotic) to calcium alginate (used to absorb wound exudate and form a gel-like covering over the wound, helping to maintain a moist wound healing environment, promote the healing process and minimize bleeding) and place on wound, cover with dry dressing daily.</p> <p>Review of the resident's nurse's notes showed:</p> <p>-On 12/12/21: Cleanse wound order not done. Will pass on to night shift.</p> <p>Review the resident's of the TAR showed:</p> <p>-The resident's wound treatment order not documented as completed on 1/6/22, 1/12/22, and 1/17/22.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/18/22 at 3:00 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>-He/she had skin issues on his/her bottom.</li> <li>-The skin issues started three months ago.</li> <li>-Staff put patches on, but unsure if the areas are getting better.</li> </ul> <p>3. During an interview on 1/19/22 at 10:30 A.M., Agency Nurse A said nurses were responsible for completing wound treatments.</p> <p>During an interview on 1/19/22 at 10:40 A.M. Agency Nurse C said nurses were responsible completing wound treatments.</p> <p>During an interview on 1/19/22 at 11:20 A.M. the MDS Coordinator said wound care was completed by the nurse and documented on the TAR.</p> <p>During an interview on 1/19/22 at 1:00 P.M., Agency Nurse B said wound treatments are documented on the TAR.</p> <p>During an interview on 1/20/22 at 10:12 A.M., the Director of Nursing said:</p> <ul style="list-style-type: none"> <li>-Wound treatments should be documented on the TAR and a progress note if applicable (if there were changes or problems).</li> <li>-Physician orders should be followed. If not completed, it should be documented as to why.</li> </ul> <p>MO196004</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31100</p> <p>Based on observation, interview, and record review, the facility failed to have sufficient staff to provide bi-weekly showers for four residents (Residents #4, #5, #6, and #7); and failed to have sufficient staff to ensure residents medication was administered timely for five residents (Resident #10, #11, #12, #13 and #3). The facility failed to ensure facility had enough staff to answer the facility phone. This affected one resident (Resident #3), The facility census was 109.</p> <p>1. The facility did not provide a policy on resident showers.</p> <p>2. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/16/21, showed:</p> <ul style="list-style-type: none"> <li>- Cognitively intact;</li> <li>- Did not reject cares;</li> <li>- Totally dependent upon staff for transfers, bed mobility, dressings, toileting, and bathing;</li> <li>- Always incontinent of bowel;</li> <li>- Diagnoses included bladder dysfunction, cerebral palsy (brain disorder resulting in motor dysfunction), paralysis, multiple sclerosis (a disease of the nerves), anxiety, depression, bipolar disease (profound mood swings), and schizophrenia (a severe mental illness affecting behavior, mood, and brain function).</li> </ul> <p>Review of the resident's care plan, dated 10/18/21, showed:</p> <ul style="list-style-type: none"> <li>- The resident had a self care deficit due to multiple sclerosis.</li> <li>- The resident was totally dependent upon two staff to provide showers.</li> <li>- Staff must offer the resident showers per resident preference and as needed.</li> </ul> <p>Review of the resident's shower sheets for December 2021 showed the resident received a shower on 12/14/21 and 12/21/21 and was supposed to receive two showers. The resident missed a week for a total of 10 showers, but only received two showers.</p> <p>Observation on of the resident on 1/5/22 at 10:30 A.M., showed the resident's hair appeared greasy and the resident had facial hair.</p> <p>During an interview on 1/5/22 at 10:30 A.M., the resident said:</p> <ul style="list-style-type: none"> <li>- He/she felt dirty.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Staff had not given him/her a shower in over a week,</li> <li>- He/she would like a shower at least twice a week.</li> </ul> <p>3. Review of Resident #5's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Moderate cognitive impairment;</li> <li>- Total dependence upon staff for transfers and dressing;</li> <li>- Required two person assistance for eating, toileting, and hygiene;</li> <li>- Frequently incontinent of bowel and bladder;</li> </ul> <p>- Diagnoses included a stroke, diabetes, difficulty speaking, dementia, paralysis, seizure disorder, anxiety, and lung disease.</p> <p>Review of the resident's care plan, dated 10/21/21, showed:</p> <ul style="list-style-type: none"> <li>- The resident was totally dependent upon staff for bathing.</li> <li>- Staff should shower the resident per resident preference and as needed.</li> </ul> <p>Review of the resident's shower sheets for December 2021 showed the resident received a shower on 12/23/21 when the resident was supposed to receive 10 showers. The resident missed nine showers.</p> <p>Observation on 1/5/22 at 12:00 P.M., showed:</p> <ul style="list-style-type: none"> <li>- The resident was lying in bed.</li> <li>- The resident was wearing a gown stained with food.</li> <li>- The resident's facial hair appeared unkempt.</li> </ul> <p>During an interview on 1/5/22 at 12:00 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>- Staff did not give him/her a shower.</li> </ul> <p>4. Review of Resident #6's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Cognitively intact;</li> <li>- Required the assistance of two staff members for transfers, toileting, and personal hygiene;</li> <li>- Total dependence upon staff for bathing;</li> <li>- Always incontinent of bowel;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Diagnoses included heart disease, kidney failure, urinary tract infection within the last 30 days, diabetes, depression, and psychotic disorder,</p> <p>Review of the resident's care plan, dated 11/30/21, showed:</p> <ul style="list-style-type: none"> <li>- The resident needed assistance with bathing due to fatigue and limited mobility;</li> <li>- The resident required the assistance of two staff for bathing;</li> <li>- Staff should shower the resident bi-weekly and as needed.</li> </ul> <p>Review of the resident's shower sheets for December 2021 showed the resident did not receive any showers during December 2021.</p> <p>Observation of the resident on 1/5/22 at 12:25 P.M., showed the resident neatly with combed greasy hair.</p> <p>During an interview on 1/5/22 at 12:25 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>- He/She could not remember the last time she received a shower.</li> <li>- He/She would like a daily shower.</li> <li>- When he/she is up in his/her wheelchair, he/she brushed his/her hair, washed his/her face, and brushed his/her teeth.</li> </ul> <p>5. Review of Resident #7's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Moderate cognitive impairment;</li> <li>- Required assist of two staff for dressing, eating, and hygiene;</li> <li>- Totally dependent upon staff for toileting;</li> <li>- Occasionally incontinent of bladder;</li> <li>- Had a colostomy (a surgically created opening into the bowel for drainage of feces);</li> <li>- Diagnoses included heart disease, kidney failure, arthritis, a stroke, and depression.</li> </ul> <p>Review of the resident's shower sheets for December 2021 showed the resident did not receive a shower during December 2021.</p> <p>Review of the resident's care plan, dated 1/30/21, showed:</p> <ul style="list-style-type: none"> <li>- The resident had self-care deficits due to a stroke with paralysis.</li> <li>- Did not address bathing the resident.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 1/5/22 at 12:30 P.M., showed the resident with facial hair and greasy hair.</p> <p>During an interview on 1/5/22 at 12:30 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>- He/she could not remember the last time he/she received a shower.</li> <li>- A family member came in daily and helped him/her with hair care and teeth brushing.</li> <li>- He/she did not feel clean.</li> <li>- He/she would like a shower at least twice a week.</li> </ul> <p>During an interview on 1/5/22 at 12:40 P.M. the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>- Staff should offer each resident the opportunity to receive a shower twice a week or as desired and needed.</li> <li>- He/she did not have enough staff to ensure residents were offered biweekly showers.</li> </ul> <p>6. The facility did not provide a policy on answering the phone.</p> <p>Observation on 1/5/22 at 7:00 A.M., showed:</p> <ul style="list-style-type: none"> <li>- The investigator called the facility five times and let the phone ring for five minutes each time.</li> <li>- The phone was never answered.</li> </ul> <p>Review of Resident #3's admission MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Moderate cognitive impairment;</li> <li>- Required extensive staff assistance for transfers, toileting, and hygiene;</li> <li>- Diagnoses included a blood clot in the leg, diabetes, difficulty talking, anxiety, bipolar (severe mood swings, schizophrenia (severe mental illness affecting mood, behavior, and thinking), and respiratory failure.</li> </ul> <p>During an interview on 1/5/22 at 12:35 P.M., the resident said:</p> <ul style="list-style-type: none"> <li>- He/she could not afford a cell phone.</li> <li>- His/her parent tried to call the resident several times a day.</li> <li>- His/her parent said the phone would ring and ring and staff did not answer the phone.</li> <li>- He/she would like to talk to his/her parent at least daily.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Staff had to bring the phone to the room.</li> <li>- Staff did not have time to answer the phone.</li> </ul> <p>During an interview on 1/5/22 at 12:40 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>- The facility had a receptionist to answer the phone from 8:30 A.M. to 5:00 P.M.</li> <li>- The receptionist transferred the calls to the nurse's station.</li> <li>- Frequently staff did not have time to answer the phone calls.</li> <li>- He/she frequently called the facility after the receptionist left.</li> <li>- Staff rarely had time to answer her calls.</li> </ul> <p>During an interview on 1/5/22 at 12:45 P.M. the receptionist said:</p> <ul style="list-style-type: none"> <li>- He/she worked the desk from 8:30 A.M. to 5:00 P.M.</li> <li>- He/she answered the phone and transferred calls to the nurses station.</li> <li>- Frequently staff did not answer the phone.</li> </ul> <p>7. Review of the facility policy for Medication Administration, dated 9/21, showed:</p> <ul style="list-style-type: none"> <li>-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infections.</li> <li>-Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.</li> </ul> <p>8. During an interview on 1/13/22 at 9:22 A.M. Licensed Practical Nurse (LPN) B said:</p> <ul style="list-style-type: none"> <li>-He/she was the only nurse for the 100 hall;</li> <li>-There was one Certified Medication Technician (CMT) for rooms 118 to 133 on the 100 hall;</li> <li>-There was no CMT for rooms 101 to 115, he/she was expected to pass all of the medications for rooms 101 to 115 and administer insulin, narcotics, resident assessments, and physician notification for all the residents on the 100 hall</li> <li>-There are 55 residents on the 100 hall;</li> <li>-The morning medications had not been passed yet for rooms 101 to 115. The medications should have been passed by now.</li> </ul> <p>(continued on next page)</p>



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Review of Resident #10 Medication Administration Record (MAR), dated January 2022 at 10:30 A.M., showed the following the medications not documented as given at the 8:00 A.M. medication pass on 1/13/22:</p> <ul style="list-style-type: none"> <li>-Ready Care/Med Pass 2.0 (a high calorie supplement) in the morning for supplement documented as not given;</li> <li>-Bumetanide tablet (a type of medicine called a diuretic. It's used to treat heart failure and the build up of fluid in your body) 2 milligrams (mg) one tablet two times a day (BID) documented as not given;</li> <li>-Potassium tablet 40 meq (milli equivalent) two times a day documented as not given.</li> </ul> <p>10. Review of Resident #11 MAR, dated January 2022 at 10:30 A.M., showed the following the medications not documented as given at the 8:00 A.M. medication pass on 1/13/22:</p> <ul style="list-style-type: none"> <li>-Lorazepam (used to treat anxiety and sleeping problems that are related to anxiety) 0.5 mg, three (TID) a day documented as not given.</li> </ul> <p>11. Review of Resident #12 MAR, dated January 2022 at 10:40 A.M., showed the following the medications not documented as given at the 8:00 A.M. medication pass on 1/13/22:</p> <ul style="list-style-type: none"> <li>-Lorazepam 1 mg BID, not documented as given.</li> <li>-Gabapentin (relieve nerve pain) 100 mg TID, not documented as given.</li> </ul> <p>12. Review of Resident #13's MAR, dated January 2022 at 10:45 A.M., showed the following the medications not documented as given at the 8:00 A.M. medication pass on 1/13/22:</p> <ul style="list-style-type: none"> <li>-Apixaban tablet (used to prevent serious blood clots from forming due to a certain irregular heartbeat (atrial fibrillation) BID, not documented as given.</li> </ul> <p>13. Review of Resident #3's MAR, dated January 2022 at 10:50 A.M., showed the following the medications not documented as given at the 8:00 A.M. medication pass on 1/13/22:</p> <ul style="list-style-type: none"> <li>-Doxycycline Hyclate (used to treat a wide variety of bacterial infections) TID at 8:00 A.M. and 5:00 P.M., not documented as given at 8:00 A.M.;</li> <li>-Eliquis (a type of blood thinner) 5 mg BID at 8:00 A.M. and 5:00 P.M., not documented as given at 8:00 A.M.;</li> <li>-Lorazepam 0.5 mg TID, not documented as given;</li> <li>-Hydroxyzine HCl ( used to treat itching caused by allergies) 25 mg every six hours to be given at 1:00 A.M., 7:00 A.M. 2:00 P.M. and 9:00 P.M., not documented as given at 7:00 A.M.</li> </ul> <p>During an interview on 1/13/22 at 11:00 A.M., LPN B said:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The CMT that was scheduled to work rooms 118 to 133 was going to help with passing the morning medication;</p> <p>-He/she had not had time to begin passing the morning medications for rooms 101 to 115 yet.</p> <p>Observation on 1/13/22 at 11:45 A.M., showed CMT B passing medications for rooms 101 to 115 for medication that were scheduled at 8:00 A.M. and AM medication pass.</p> <p>During an interview on 1/13/22 at 11:45 A.M., CMT B said:</p> <p>-He/she just finished the medication pass for rooms 118 to 133 and had began the morning medication pass for room [ROOM NUMBER] to 115;</p> <p>-He/she should be passing the noon medication for rooms 118 to 133, but there was no CMT for rooms 101 to 115 and these residents need their medication.</p> <p>Review of the daily staffing sheet for 1/13/22 showed:</p> <p>-One nurse for the top (rooms 101 to 115) 100 hall, a CMT with a line crossed through the name, one CMT with a line through their names and two CNA's with a line through their names, one nurse for the bottom (Rooms 118 to 133) 100 hall with a line crossed through it, one CMT and two aides with a line crossed through the names.</p> <p>During an interview on 1/13/22 at 11:00 A.M., the DON said:</p> <p>-The facility utilizes agency staff to fill nursing positions.</p> <p>-They are having difficulty filling nursing positions;</p> <p>-The Administrator was trying to fill the vacant positions with the staffing agency.</p> <p>-She was aware there was only one nurse working the 100 hall.</p> <p>-A line through the name on the staffing sheets mean that the staff member did not work;</p> <p>-She was aware medications were not given this morning due to only one nurse working the floor;</p> <p>-She was trying to get nurses to come in, but has not had anyone willing to come in to work.</p> <p>During an interview on 1/13/22 at 12:00 P.M., the Administrator said:</p> <p>-She was having difficulty with getting agency staff to fill the voids in the schedule;</p> <p>-The staff with their names crossed off the schedule are agency staff and they did not show up this morning;</p> <p>-She was informed that the staffing agency would not be sending any more staff to the facility due to lack of payment;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She notified the facility's corporate office that the agency would not fill any open positions due to not receiving payment;</p> <p>-She was told that a partial payment was made to the agency;</p> <p>-She called the agency to verify the payment and that a partial payment was received;</p> <p>-The facility only had one agency that they can call, they had contracts with two other agencies, but those agencies will not fill any vacant positions due to non-payment;</p> <p>-She had a call out to the staffing agency to get someone to come to help;</p> <p>-She had some nurses coming in at 2:00 P.M., but not until then.</p> <p>MO195244</p> <p>MO195121</p> <p>MO195658</p> <p>34003</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34003</p> <p>Based on observation and interview, the facility failed to prepare and serve food under sanitary condition when staff prepared and served the supper meal while standing in sewer water that had seeped up from the drains in the kitchen from a sewer blockage. The facility census was 109.</p> <p>The facility did not provide a policy for kitchen sanitation.</p> <p>During an interview on 1/11/22 at 1:50 P.M. Cook A said:</p> <ul style="list-style-type: none"> <li>-He/she was the cook on 1/8/21, he/she prepared the noon and supper meals;</li> <li>-Before the noon meal service, he/she noticed water was coming up from the drains in the kitchen;</li> <li>-The floor was a little wet around each drain;</li> <li>-There was a very foul odor which smelled like sewer;</li> <li>-He/she notified the Dietary Manager and the Maintenance Director;</li> </ul> <p>-Around 4:00 P.M., an outside agency came into the kitchen and put an eel (a drain auger (a.k.a. the plumber's snake) down the toilet in the bathroom in the kitchen. At this time, he/she was preparing the supper meal. As the agency was putting the eel in the toilet, more and more water was coming up out of the drains. There was now water covering the entire kitchen floor with a very foul odor of sewer. It took several hours for the agency to clear the blockage in the sewer. He/she continued to prepare and serve the supper meal while standing in the water. He/she felt that he/she needed to get the food out to feed the residents.</p> <p>During an interview on 1/11/22 at 1:50 P.M. the Dietary Manager said:</p> <ul style="list-style-type: none"> <li>-She was aware of the water backing up in the kitchen, and instructed Cook A to notify the Maintenance Director;</li> <li>-She was not aware of the supper meal being prepared and served while Cook A had to stand in the water.</li> </ul> <p>During an interview on 1/12/22 at 4:03 P.M. the Maintenance Director said:</p> <ul style="list-style-type: none"> <li>-He was called by Cook A on 1/8/22 and was notified of the water backing up in the drains;</li> <li>-He called the outside agency to come and check on the sewer;</li> <li>-The outside agency said the main sewer line, which runs under the kitchen was blocked;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He was not aware the water covered the entire kitchen floor and Cook A had to stand in the water and prepare and serve the supper meal.</p> <p>During an interview on 1/12/22 at 12:53 P.M. the Administrator said:</p> <p>-She was aware the sewer was backing up on 1/8/22;</p> <p>-The maintenance director called someone to take care of the issue;</p> <p>-She was not aware the evening meal was prepared and served while Cook A was standing in the water;</p> <p>-She would have expected to be notified of the standing water, so an alternative to the evening meal could have been served.</p> <p>MO195658</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection control program during a Coronavirus disease 2019 pandemic (COVID-19) during an outbreak, when the facility allowed a staff person who was symptomatic for COVID-19 and known to have a positive COVID-19 test the day of the scheduled shift to have direct contact with residents who were not COVID positive. Additionally, the facility failed to store and dispose of potentially infectious material in a safe and sanitary method, and failed to administer the two step TB testing for three residents (Resident #7, Resident #14, and Resident #15). The facility census was 109.</p> <p>The Administrator was notified on 1/11/22 at 12:37 P.M. of an Immediate Jeopardy (IJ) which began on 1/11/22. The IJ was removed on 1/13/22 as confirmed by surveyor onsite verification.</p> <p>1. Review of the undated facility policy for Novel Coronavirus Prevention and Response showed:</p> <p>-This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus;</p> <p>-Staff will Think COVID-19 when a resident or employee exhibits the following clinical features and epidemiological risk:</p> <p>-Fever or cough/shortness of breath and has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset</p> <p>-Fever and cough/shortness of breath and a history of travel from affected geographic areas, within 14 day so symptom onset</p> <p>-Fever with severe acute lower respiratory illness (e.g. pneumonia, Acute respiratory distress syndrome (ARDS) is a life-threatening lung injury that allows fluid to leak into the lungs) without an alternative explanatory diagnosis such as influenza and no identified source of exposure;</p> <p>-Considerations/priorities for testing:</p> <p>a. Use clinical judgement on case-by-case basis to determine if a resident has signs and symptoms compatible with COVID-19;</p> <p>b. Test for other causes of of respiratory illness, such as influenza or other respiratory panels;</p> <p>c. Testing for COVID-19 will occur for staff or residents with signs and symptoms of COVID-19, outbreaks within the facility and routinely following the frequency guidance according to the facility's level of community transmission;</p> <p>-Interventions to prevent the introduction of respiratory germs into the facility:</p> <p>- Enforce sick leave policies that allow employees to stay home if they have symptoms of respiratory infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- Assess visitors and healthcare personnel, regardless of vaccination status, for symptoms of COVID-19, a positive viral test for COVID-19 or who meets criteria for quarantine or exclusion from work. The can include, but is not limited to:</p> <p>-Individual screening on arrival at the facility;</p> <p>-Implementation of electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of COVID-19 infection in the prior 10 days, and confirmation they have not been exposed to others with COVID-19 infection during the prior 14 days;</p> <p>-Restrict employee from work in accordance with current Centers for Disease Control (CDC) guidelines for healthcare personnel;</p> <p>-Monitor staff for fever or respiratory symptoms. Restrict from work.</p> <p>Review of the visitor/employee screening for COVID-19 showed no screening form completed prior to Registered Nurse (RN) A beginning his/her shift on 1/8/22.</p> <p>Observation on 1/8/22 at 12:00 P.M., showed RN A working in the facility on the 100 hall.</p> <p>During a telephone interview on 1/10/22 at 3:30 P.M., RN A said:</p> <p>-He/she worked at another facility and was tested for COVID-19 on 1/8/22 and had tested positive;</p> <p>-He/she reported to the staffing coordinator that he/she had tested positive for COVID-19 on the morning of 1/8/22 before he/she was to report to work;</p> <p>-He/she told the staffing coordinator that he/she did not feel well;</p> <p>-The staffing coordinator told him/her that he/she had to come to work or he/she would not be allowed to work in the facility again.</p> <p>During an interview on 1/10/22 at 6:40 P.M., the Administrator said:</p> <p>-She had talked with the Staffing Coordinator who denied telling RN A that if he/she did not report to work, he/she would not be able to work in the facility again.</p> <p>During an interview on 1/10/22 at 7:00 P.M., the Staffing Coordinator said:</p> <p>-RN A was scheduled to work on 1/8/22 from 6:00 A.M. to 6:00 P.M.;</p> <p>-RN A came into work on 1/8/22 somewhere between 8:30 A.M. and 8:40 A.M. due to he/she was working at another facility;</p> <p>-He/she did tell him/her that he/she had tested positive for COVID-19 at the other facility, but then tested again and was negative;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-The facility was short of staff on 1/8/22, and since he/she had a negative test, he/she told the RN to come into work;</p> <p>-RN A never told him/her that he/she was not feeling well.</p> <p>-He/she had staff tell him/her that RN A was tired and had fallen asleep a few times, but he/she thought this was due to him/her working another job.</p> <p>During an interview on 1/10/22 at 7:45 P.M., the Director of Nursing (DON) said:</p> <p>-She was not informed RN A had tested positive at another place of employment;</p> <p>-There had been a lot of call in's on 1/8/22 and was told that RN A was here to save the day;</p> <p>-If he/she had been informed RN A had tested positive, RN A would not have been allowed to work;</p> <p>-She reviewed the staff screening forms for 1/8/22 and found no screening form for RN A.</p> <p>During an interview on 1/10/22 at 7:58 P.M. ,the Administrator said:</p> <p>-She considered RN A's positive COVID-19 test a false positive as he/she had tested negative after taking the first test.</p> <p>Review of the COVID-19 testing records for the residents on 1/10/22 showed two residents had tested positive for COVID-19 on 1/8/22, another resident had tested positive on 1/9/22 and an additional four resident tested positive for COVID-19 on 1/11/22 and an additional 11 residents tested positive for COVID-19 on 1/12/22.</p> <p>Review of the COVID-19 testing records showed RN A had provided care for two residents who had tested positive for COVID-19. One resident tested positive on 1/10/22 and the other resident tested positive on 1/11/22.</p> <p>During an interview on 1/19/22 at 9:35 A.M., the Medical Director said:</p> <p>-He would consider one COVID-19 positive test as the employee or the resident was infected with COVID-19;</p> <p>-A COVID-19 positive employee should not be allowed to work, especially if that employee was not feeling well.</p> <p>2. Review of the undated facility policy for Infection Prevention and Control Program showed:</p> <p>-Policy: This facility has established and maintains 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:</p> <p>-Environmental cleaning an disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility.</p> <p>(continued on next page)</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Observation on 1/12/22 at 9:45 A.M. and 4:02 P.M., showed:</p> <ul style="list-style-type: none"> <li>-An isolation cart set up outside of the double doors in the front entry;</li> <li>-A red bio-hazard bag tied to the handrail next to the cart;</li> <li>-The bio-hazard bag was full of soiled Personal Protective Equipment (PPE), gowns and gloves.</li> </ul> <p>Observation on 1/12/22 at 4:02 P.M., on the facility's COVID-19 isolation unit showed:</p> <ul style="list-style-type: none"> <li>-A red bio-hazard bag of soiled PPE tied to the hand rail out side of room [ROOM NUMBER]. In room [ROOM NUMBER] bathroom sat full red bio-hazard bags on the floor and several cardboard boxes with full red bio-hazard bags sitting in the boxes;</li> <li>-Two cardboard boxes with three full bio-hazard bags sitting inside of room [ROOM NUMBER] and room [ROOM NUMBER].</li> <li>-Trash, used gloves sitting on the floor in the room used for medication carts and the employee's break room.</li> </ul> <p>During an interview on 1/12/22 at 5:30 P.M., Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> <li>-He/she would place the full bio-hazard bags in the bathroom, he/she was unsure of who was suppose to pick up and dispose of it;</li> </ul> <p>During an interview on 1/12/22 at 5:45 P.M., the Administrator said:</p> <ul style="list-style-type: none"> <li>-Staff should place the red bio-hazard bags in the card board boxes, when they are full, staff should take to a designated room for bio-hazard material for pick up;</li> <li>-Staff should not be tying the red bio-hazard bags to the hand rails.</li> </ul> <p>3. The facility did not provide a policy for two step TB testing.</p> <p>4. Review of Resident #7's medical record showed:</p> <ul style="list-style-type: none"> <li>-admitted to the facility on [DATE] with one TB test administered on 11/29/21;</li> <li>-There was no second TB test given as documented.</li> </ul> <p>5. Review of Resident #14's medical record showed:</p> <ul style="list-style-type: none"> <li>-The resident was admitted on [DATE] with the first TB test administered on 10/29/21 with no documentation of the second TB test given.</li> </ul> <p>6. Review of Resident #15's medical record showed:</p> <ul style="list-style-type: none"> <li>-The resident was admitted on [DATE] with no documentation of the 2-step TB tests given.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/11/22 at 3:00 P.M., the DON said:</p> <ul style="list-style-type: none"> <li>-The facility had fallen behind on TB testing due to no Infection Preventionist (IP) to administer, track and monitor;</li> <li>-The nurses should administer the first TB test upon admission and enter the information in the electronic medical record.</li> <li>-The IP should track and monitor for when the second TB test should be given.</li> </ul> <p>NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level K. 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.</p> <p>At the time of exit, the severity of the deficiency was lowered to the E 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).</p> <p>MO195692</p> <p>MO195658</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>34003</p> <p>Based on record review and interview, the facility failed to establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The facility census was 109.</p> <p>Review of the undated facility policy for Infection Prevention and Control Program showed:</p> <ul style="list-style-type: none"> <li>-This facility has established and maintains 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 infection.</li> <li>-An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program;</li> <li>-Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.</li> </ul> <p>During an interview on 1/12/22 at 3:00 P.M. the Director of Nursing said:</p> <ul style="list-style-type: none"> <li>-The facility had been short of staff recently with the management nurses working the floor;</li> <li>-There had been no tracking for the use of antibiotics, no review of the use of antibiotics, and no reports generated for review of the use of antibiotics.</li> <li>-The Infection Preventionist would document, and track the use of antibiotics, but the facility did not have an Infection Preventionist.</li> </ul> <p>During an interview on 1/19/22 at 9:36 A.M., Physician A said:</p> <ul style="list-style-type: none"> <li>-He would expect the facility to monitor antibiotic usage and have a program established to monitor antibiotic use.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>34003</p> <p>Based on record review and interview, the facility failed to employ an infection preventionist (IP) on at least a part-time basis. The facility census was 109.</p> <p>Review of the undated facility policy for Infection Prevention and Control Program showed:</p> <ul style="list-style-type: none"> <li>-This facility has established and maintains 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 infection.</li> <li>-The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.</li> </ul> <p>During an interview on 1/12/22 at 4:00 P.M., the Director of Nursing said:</p> <ul style="list-style-type: none"> <li>-The facility does not have a person designated as the IP. The facility was in the process of hiring an individual for this position.</li> <li>-She had not completed the required training for the IP.</li> </ul> <p>During an interview on 1/13/21 at 3:00 P.M., the Administrator said:</p> <ul style="list-style-type: none"> <li>-The facility does not have a person designated as the IP;</li> <li>-The facility was in the process of hiring an IP.</li> </ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on record review and interview, the facility failed to ensure all residents were offered the flu and pneumonia vaccinations in a timely manner. This affected two residents (Resident #7 and #14). The facility census was 109.</p> <p>Review of the undated facility policy for Infection Prevention and Control Program showed:</p> <p>-This facility has established and maintains 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 infection.</p> <p>-Influenza and Pneumococcal Immunization:</p> <p>a. Residents will be offered the influenza vaccine each year between October 1 and March 31 unless contraindicated or received the vaccine elsewhere during that time;</p> <p>B. Residents will be offered the pneumococcal vaccines recommended by the CDC (Centers of Disease Control) upon admission, unless contraindicated or received the vaccines elsewhere;</p> <p>c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines;</p> <p>d. Residents will have the opportunity to refuse the immunizations;</p> <p>e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunization.</p> <p>1. Review of Resident #7's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 11/24/21, showed:</p> <p>-The resident was admitted to the facility 11/17/21 with diagnoses of coronary artery disease, hypertension, and stroke;</p> <p>-No influenza vaccine given or offered;</p> <p>-No pneumococcal vaccine given or offered.</p> <p>Review of the resident's medical record on 1/11/22 showed no influenza or pneumococcal vaccine offered or given.</p> <p>2. Review of Resident #14 admission MDS, dated [DATE], showed:</p> <p>-admitted on [DATE] with diagnoses of hypertension, pneumonia, septicemia (clinical name for blood poisoning by bacteria) and diabetes;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-No influenza vaccine given or offered;</p> <p>-No pneumococcal vaccine given or offered.</p> <p>Review of the resident's medical record on 1/11/22 showed no influenza or pneumococcal vaccine offered or given.</p> <p>During an interview on 1/11/22 at 3:00 P.M., the Director of Nursing said:</p> <p>-The facility had fallen behind on influenza and pneumonia vaccines, due to lack of staff;</p> <p>-The residents should be offered the vaccines upon admission.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Report COVID19 data to residents and families.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on interview and record review, the facility failed to inform five residents (Resident #6, Resident #7, Resident #16, Resident #17, and Resident #18) responsible parties after the residents tested positive for COVID-19 (a new disease, caused by a novel (or New) coronavirus that has not previously been seen in humans); and failed to consistently inform residents, their representatives, and families following the occurrence of confirmed Coronavirus disease 2019 (COVID-19 for one resident (Resident #18). The facility census was 109</p> <p>The facility did not provide a policy for notifying the residents, their representatives and families of confirmed infections of COVID-19.</p> <p>1. During an interview on 1/8/22 at 1:30 P.M., the Director of Nursing (DON) said:</p> <p>-The facility had a staff member test positive for COVID-19 on 12/24/21. The facility had began their outbreak testing for staff on 12/25/21. They had not tested any residents yet due to not having enough solution to perform a rapid COVID-19 test. They were just testing staff.</p> <p>2. Review Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 11/25/21, showed:</p> <p>-The resident was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart.), hypertension (HTN), urinary tract infection (UTI), and diabetes.</p> <p>Review of the resident's record showed Family Member (FM) E listed as responsible party for notification.</p> <p>Review of the Nurse's Note dated 1/9/2022 at 12:40 A.M., showed:</p> <p>-The resident arrived from local hospital at 11:30 P.M the resident was moved to room [ROOM NUMBER]A due to the diagnosis of COVID-19.</p> <p>During an interview on 1/10/22 at 4:30 P.M., the DON said:</p> <p>-The resident tested positive for COVID-19 at the hospital on 1/8/22.</p> <p>Review of the resident's record showed no documentation of the resident testing positive for COVID-19 on 1/8/22 or documentation for the resident's responsible party being notified of the facility's COVID-19 status.</p> <p>During an interview on 1/12/22 at 5:30 P.M., FM E said:</p> <p>-He/she received a phone call from Resident #6 on 1/10/22 notifying him/her that he/she had tested positive for COVID-19 on 1/8/22;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she had not been notified by the facility of a staff member testing positive for COVID-19 on 12/24/21.</p> <p>3. Review of Resident #7's admission MDS, dated [DATE], showed:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-Diagnoses of anemia (low red blood cells), coronary artery disease (CAD, plaque buildup in the wall of the arteries that supply blood to the heart), HTN, and stroke.</p> <p>Review of the medical record showed FM A as the responsible party for the resident.</p> <p>Review of the residents record showed no documentation of the resident testing positive for COVID-19 on 1/11/22 or documentation for the resident's responsible party being notified of the facility's COVID-19 status.</p> <p>Review of the facility's resident roster for COVID-19 testing showed the resident tested positive for COVID-19 on 1/11/22.</p> <p>During an interview on 1/12/22 at 11:51 A.M., FM A said:</p> <p>-He/she was not notified the resident had tested positive for COVID-19 on 1/11/22;</p> <p>-He/she was at the facility on 1/8/22 when the resident was sent to the hospital to be tested and was aware the resident tested negative on 1/8/22, but was concerned due to the resident being congested and not feeling well;</p> <p>-He/she had tried to talk with someone at the facility today, but no one will answer the phone.</p> <p>4. Review of Resident #16's quarterly MDS, dated [DATE], showed:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-Diagnoses of hip/knee replacement, HTN, anxiety and depression.</p> <p>Review of the medical record showed that FM C was listed as emergency contact.</p> <p>Review of the resident's medical record showed no documentation for the resident's emergency contact being notified of the facility's COVID-19 status or that the resident had tested positive for COVID-19 on 1/10/22.</p> <p>Review of the facility's resident roster for COVID-19 testing showed the resident tested positive for COVID-19 on 1/10/22.</p> <p>During an interview on 1/12/22 at 12:37 P.M., FM C said:</p> <p>-The resident had called him/her to let them know that the resident had tested positive for COVID-19;</p> <p>(continued on next page)</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she had not received a phone call from the facility regarding the facility COVID-19 status in months.</p> <p>5. Review of Resident #17's admission MDS dated [DATE] showed:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>-Diagnoses of diabetes, osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue), Schizophrenia (a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation), depression, and post traumatic stress disorder (PTSD, is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event).</p> <p>Review of the resident's medical record showed FM D as a contact for emergencies.</p> <p>Review of the facility's resident roster for COVID-19 testing showed the resident tested positive for COVID-19 on 1/10/22</p> <p>Review of the medical record showed no documentation for the resident's emergency contact being notified of the facility's COVID-19 status or that the resident had tested positive for COVID-19 on 1/9/22.</p> <p>During an interview on 1/12/22 at 5:45 P.M., FM D said:</p> <p>-He/she had not received a phone call from the facility notifying him/her of the status of COVID-19 in the facility;</p> <p>-He/she was notified on 1/10/22 that the resident had tested positive for COVID-19 on 1/9/22.</p> <p>6. Review of Resident #18's annual MDS dated [DATE] showed:</p> <p>-The resident was admitted to the facility on [DATE] with diagnoses of HTN, arthritis, stroke and dementia.</p> <p>Review of the resident's medical record showed FM F as Power of Attorney and emergency contact.</p> <p>Review of the resident's medical record showed no documentation for the resident's responsible party being notified of the facility's COVID-19 status.</p> <p>During an interview on 1/12/22 at 12:03 P.M., FM F said:</p> <p>-It was several months ago when he/she last heard from the facility of their COVID-19 status;</p> <p>-He/she had not been notified of the facility's recent COVID-19 outbreak or testing;</p> <p>During an interview on 1/13/22 at 2:00 P.M., the Social Services Director said:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she started at the facility on 12/23/21;</p> <p>-He/she was responsible for notifying the resident's families of the facility COVID-19 status;</p> <p>-He/she had not done this as of yet;</p> <p>-He/she should be notifying the families and documenting when this was done.</p> <p>During an interview on 1/13/22 at 4:00 P.M., the Administrator said:</p> <p>-Social Services was responsible for notifying the resident's responsible parties/families of the facility COVID-19 status;</p> <p>-She would expect them to notify the responsible parties/families within 24 hours;</p> <p>-The DON or nurses should notify the responsible parties/families when a resident tests positive for COVID-19.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Perform COVID19 testing on residents and staff.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on observation, interview, and record review, the facility failed to conduct COVID-19 (Coronavirus disease 2019 is defined as illness caused by a novel coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; formerly called 2019-nCoV) testing for residents and staff during a known COVID-19 outbreak. The facility failed to have supplies and a system to complete outbreak testing. The facility's outbreak began on 12/25/21. The facility completed one round of outbreak testing on 12/27/21. The facility failed to conduct further outbreak testing due to no antigen supplies on-hand and the facility did not implement other testing, including PCR (stands for polymerase chain reaction test. This is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the virus). This deficient practice had the potential to affect all residents. The facility census was 109.</p> <p>The Administrator was notified on 1/10/22 at 6:06 P.M. of an Immediate Jeopardy (IJ) which began on 1/10/22. The IJ was removed on 1/13/22 as confirmed by surveyor onsite verification.</p> <p>Review of the undated facility policy for Novel Coronavirus Prevention and Response showed:</p> <p>Policy: This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus.</p> <p>-Consideration/priorities for testing:</p> <ol style="list-style-type: none"> <li>a. Use clinical judgement on case-by-case basis to determine if a resident has signs and symptoms compatible with COVID-19</li> <li>b. Test for other caused of respiratory illness, such as influenza or other respiratory panels;</li> <li>c. Testing for COVID-19 will occur for staff or residents with signs and symptoms of COVID-19, outbreaks within the facility and routinely following the frequency guidance according to the facility's level of community transmission;</li> <li>d. Prioritize symptomatic residents [AGE] years of age and older and those with underlying conditions that may put them at higher risk for poor outcomes (e.g. diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease and chronic kidney disease).</li> </ol> <p>1. Review of the COVID-19 testing records for the residents showed two residents had tested positive for COVID-19 on 1/8/22, another resident had tested positive on 1/9/22, an additional four resident tested positive for COVID-19 on 1/11/22, and an additional 11 residents tested positive for COVID-19 on 1/12/22.</p> <p>During an interview on 1/8/22 at 11:34 A.M., Agency Licensed Practical Nurse (LPN) D said:</p> <p>-He/she had two residents who have signs and symptoms of COVID-19 and he/she does not know what to do, the facility does not have any testing supplies to do rapid testing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/8/22 at 12:30 P.M., the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-The facility did not have any solution to perform antigen (rapid) COVID-19 testing;</li> <li>-There was just enough solution to test any symptomatic staff members as they came into work;</li> <li>-They have not tested any residents since 12/25/21;</li> <li>-They receive a shipment of the antigen tests from the government a couple times a month, the solution that comes with each box of tests was not enough to complete the number of tests in each box;</li> <li>-She did not know how to order any other antigen tests; they were not out of tests, only a very low supply of solution, not enough solution to complete testing of the residents</li> <li>-She was not aware of any residents with any signs or symptoms of COVID-19;</li> <li>-If there are two residents with signs and/or symptoms of COVID-19 the facility would have to send the residents to the hospital for testing.</li> </ul> <p>During an interview on 1/10/22 at 10:17 P.M., the Administrator said:</p> <ul style="list-style-type: none"> <li>-The facility had a staff member test COVID-19 positive on 12/25/21, the facility had completed several round of antigen (rapid) tests for staff, but did not have enough solution for the tests to do more than one round of testing on the residents. The last round of testing for the residents was 12/27/21;</li> <li>-Two residents were sent to the hospital on 1/8/22 one of those residents are positive for COVID-19, and another resident on 1/9/22 who have tested positive for COVID-19.</li> <li>-The facility had not tested any other residents due to no solution, if any other residents have signs or symptoms, they would have to be sent to the hospital for testing.</li> <li>-The facility had PCR tests available, but does not have a lab that the tests can be sent to.</li> <li>-On 1/10/22, another resident had to be sent to the hospital to be tested , he/she just came back and he/she was positive for COVID-19.</li> <li>-The facility census was 109, they would need a lot of solution to complete the outbreak testing.</li> <li>-The facility had enough tests to complete about 15 resident tests today;</li> <li>-The facility was screening all residents and staff for signs and/or symptoms for COVID-19.</li> </ul> <p>During an interview on 1/10/22 at 6:30 P.M., the Regional Director of Operations said:</p> <ul style="list-style-type: none"> <li>-The facility had enough PCR tests kits in the facility to complete several rounds of testing on the residents, but he was not aware of any lab for the processing of the PCR tests. He had reached out to the corporation for a lab for the processing of the tests.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2022
NAME OF PROVIDER OR SUPPLIER  Liberty Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Observation on 1/10/22 at 7:30 P.M., showed two large boxes of PCR tests and eight boxes of antigen tests with no solution available to process the tests.</p> <p>Observation and interview on 1/11/22 at 12:05 P.M., showed the DON and Corporate Nurse performing antigen tests on the residents;</p> <ul style="list-style-type: none"> <li>-The facility had received a donation of solution for the antigen tests for the facility to start facility wide testing;</li> <li>-The facility had a contract with an outside lab to begin PCR testing this week for residents and staff;</li> <li>-The DON said that they have completed about one third of the residents and have identified an additional two positive residents;</li> <li>-They had not tested any staff members.</li> </ul> <p>During an interview on 1/19/22 at 9:30 P.M., the Medical Director said:</p> <ul style="list-style-type: none"> <li>-He was made aware on 1/10/22 when the surveyor was in the facility, that the facility did not have solution to perform antigen testing on all residents.</li> <li>-He was told the facility did have PCR tests, but did not have a lab to send the tests to for processing;</li> <li>-He would have expected the facility to have a contract with a lab to complete PCR tests, and to have enough testing supplies to do outbreak testing on all residents and staff.</li> <li>-He would expect the facility to follow the Centers for Disease Control (CDC) guidelines for testing.</li> </ul> <p>NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy at an L level. 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.</p> <p>At the time of exit, the severity of the deficiency was lowered to the F 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).</p> <p>MO195692</p>