STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	09/02/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation, interview, and record review, the facility failed to perform life saving measures to include Cardio-pulmonary resuscitation (CPR) for one sampled resident (Resident #1) when staff found the resident without a pulse or respirations. The resident indicated that he/she wanted to be resuscitated in the event his/her heart and/or respirations stopped when he/she was admitted to the facility. On [DATE] staff found the resident in the facility courtyard, unresponsive with no sign of life. Staff did not initiate CPR or any other life saving measures. Staff did not call 911. The resident died in the facility on [DATE]. The facility census was 97. The administrator was notified on [DATE] at 4:11 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor on-site. Review of the Resident Rights policy, dated [DATE], showed: - The resident has the right to a safe, clean, comfortable and homelike environment including to receiving treatments and supports for daily living safely. - The resident has the right to participate in his/her person-centered plan of care and to receive services outlined in the plan of care. Review of the Medical Emergency Response policy, dated [DATE], showed: - The employee who is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate and summon for assistance. - CPR will continue unless the resident has a Do Not Resuscitate (DNR) order or there are obvious signs of death such as rigor mortis or dependent lividity. - If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of Emergency Medical Services (EMS). - The nurse will assess the resident and designate a staff member to notify the physician and call 911 as needed. 1. Review of Resident #1's medical record showed the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- admitted [DATE]. - Physicians Order Sheet (POS) showed an order, dated [DATE], the resident was a full code, (indicating the resident wanted CPR if his/her heart/respirations stopped). Review of the resident's care plan, dated [DATE], included the following: - The resident was a full code status. - Advanced directive and resident wishes will be honored. - Advanced directives completed and placed in the front of the chart to ensure timely access. - Resident had completed the following advance directive, full code. Review of Resident #1's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated [DATE], showed: - Diagnoses included: Diabetes Mellitus type 2 (a disease in which the body is unable to process blood sugar properly), chronic obstructive pulmonary disease (COPD, a chronic disease of the lungs in which they do not work properly), pigmentary retinal dystrophy (a disorder of the eye that causes blindness), above the knee right leg amputation, and stroke that affected the resident's right upper extremity causing paralysis. - Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit. Review of the resident's progress note dated [DATE] at 4:19 P.M., showed the following: - The charge nurse was looking for the resident during rounds at 3:20 P.M. and was unable to find him/her even though he/she was seen by staff at around 2:15 P.M. and 3:00 P.M. - The charge nurse asked others to help look for the resident and when others were asked, they mentioned he/she may be in the courtyard as he/she was earlier in the day. - Staff went outside to the courtyard and found the resident at approximately 3:35 P.M. laying on the ground on his/her left and the wheelchair was upright and the brakes locked. - Staff went to the resident, calling his/her name and he/she did not answer. - The resident was assessed for life and it was noted he/she had no pulse nor breaths. - The resident was stiff in the arms and purple in color on his/her left side and blue facial color. - Resident was brought inside at that time and taken to his/her room. - The resident had obvious signs of prolonged death by lividity and discoloration of the face and stiffened hands. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:55 A.M., Licensed Practical Nurse (LPN) A said: - Therapy staff reported to him/her at 3:15 P.M. he/she was not able to find the resident. - He/she began looking for the resident, went to the front desk and paged over the intercom system a code white. - Certified Nursing Assistant (CNA) C found the resident lying in the courtyard on his/her side. - The resident's wheelchair was upright with three wheels on the cement sidewalk and the right front wheel off into the dirt and gravel. - LPN A, LPN C, Director of Nursing (DON), and CNA D arrived in the courtyard as CNA C approached the resident. - The resident was lying in the overgrown vegetation half on his/her right side and half on his/her face. - LPN A called the resident's name, the resident did not respond. - The DON turned the resident over. - LPN A and the DON checked for a pulse and was not able to find one and did not see the resident breathing. - The resident skin was fire hot and red with a blue face. - He/she did not see lividity of the resident's body. - The DON assumed control of the event. - The DON was aware the resident was a full code. - The DON told LPN A that the resident was obviously dead and there was no need to start CPR. - The DON, LPN A, or LPN C did not start CPR and did not call 911. - LPN A told the DON that the resident was a full code, the DON told LPN A that the resident was obviously dead, there is no need to start CPR. - The DON, CNA D, and LPN C picked the resident up and placed him/her back in his/her wheelchair. - LPN B arrived as the DON was pushing the resident into the facility and the DON told LPN B to pick up the resident's left leg and assist them down the hall into the resident's room. During an interview on [DATE] at 12:00 P.M., CNA C said: - He/she heard an overhead page for a code white and started looking for a missing resident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/she entered the courtyard, saw the resident lying there. - LPN A, LPN C, CNA D, and the DON arrived at the same time. - He/she saw the resident's face was blue. - He/she returned to his/her hall and resumed his/her duties. During an interview on [DATE] at 10:15 A.M. LPN C said: - He/she heard a code white announced over the intercom system and started looking for the missing resident. - He/she followed LPN A, CNA D, and the DON outside into the courtyard. - He/she saw the resident's wheelchair sitting upright with both back wheel and the front left wheel on the cement sidewalk and the right front wheel off of the sidewalk into the dirt and gravel. - He/she saw the resident lying mostly face down lying in the tall grass. - The DON took control of the event and rolled the resident over. - The resident's face and neck were blue in color. - He/she did not see lividity of the resident's body. - His/her skin was hot like fire. - The resident was a full code. LPN A, LPN C, or the DON did not initiate CPR or call 911. - The DON told LPN C and CNA D to help him/her get the resident in the wheelchair. - The resident was placed in the wheelchair and he/she was covered with a blanket. - LPN B, CNA D, and the DON transferred the resident to his/her bed. - He/she questioned the DON if he/she should call 911 and the physician. The DON said the resident is dead and we are not going to do CPR, if we call 911, they are going to say the resident is dead and why did you call? - LPN C exited the resident's room. - He/she should have initiated CPR and called 911. During an interview on [DATE] at 3:06 P.M., CNA D said: - He/she started searching the facility when it was announced on the overhead intercom system that the resident was missing. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/she entered the courtyard after the DON, LPN A, LPN B, and LPN C and saw the resident lying in the foliage, dirt, and gravel. - The DON took charge of the event and said that the resident was dead. - The DON did not initiate CPR. - The DON instructed him/her, LPN B, and LPN C to help him/her pick up the resident and place him/her into the wheelchair. - The resident's skin was very hot and pale and he/she had a blue face. - The DON, CNA D, and LPN B transferred the resident to his/her bed. - The DON instructed CNA D to clean the resident's body with cold water; the resident's skin was very hot. - The DON asked for ice to be brought to the resident's room and the staffing coordinator obtained tea pitchers of ice and poured into the sink of cold water. - CNA D and the DON continued to clean the resident with the ice water. - While the resident's body was being cleaned, the Administrator came into the room, then he/she left the room. During an interview on [DATE] at 3:49 P.M., LPN B said: - He/she was in his/her office when he/she heard the announcement overhead that the resident was missing. - He/she started looking for the resident, he/she received a call on his/her cell phone that the resident was found in the courtyard. - He/she arrived in the courtyard and saw the DON and LPN C next to the resident's body checking for vital signs. - The DON was in control of the event. - The DON, CNA D, and LPN C picked up the resident and put him/her in the wheelchair. - The DON instructed CNA D, LPN B, and LPN C to transfer the resident to the bed with him/her. - The resident's skin was very hot, like fire. - The DON instructed the resident's body to be cleaned with cold rags. - The resident's body was soft and limp. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- LPN C asked the DON Isn't the resident a full code? - The DON did not respond. - He/she made a statement to the DON, Isn't the resident a full code? - The DON said that the resident was dead and he/she was not going to initiate CPR or call 911. During an interview on [DATE] at 8:37 A.M., the DON said: - On [DATE] at 3:30 P.M., LPN A went to the front desk and paged overhead a code white, meaning there was a missing resident. - He began looking for the resident. - The resident was last seen at 2:00 P.M. in the lobby area near 100 hall. - The administrative assistant said that the resident was outside in the courtyard. - The DON and LPN C went into the courtyard, saw the resident lying on his/her side and rolled forward with his/her face in the foliage and dirt. They called the resident's name. - The resident did not respond. - The DON rolled the resident over. - The resident's face was blue, the resident had no pulse, and no respiration. - He did not initiate CPR or call 911. - He should have initiated CPR and called 911. - He was in charge of the event and made the choice not to initiate CPR or call 911. - He said that the resident had signs of lividity (the settling of blood after death in gravity-dependent portions of the body, including in the organs) and that is why he/she did not initiate CPR or call 911. - He defined lividity as a blue or purple coloration of an extremity that is lying down. - The resident's body was hot, arms and legs were movable. - He was in charge of the situation and gave the staff directions. - The DON, LPN C, and CNA D picked the resident up off the ground and began wheeling him/her inside the facility. - The DON, LPN C, and CNA D picked the resident up and put him/her in bed. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He asked for ice to be brought from the kitchen and the staffing coordinator brought in a pitcher of ice. - He requested the ice to clean the resident. - He notified the physician and the resident's family of the resident's death. During an interview on [DATE] at 11:21 A.M. the Administrator said: - She was in her office when she heard an overhead page stating there was a missing resident. - She began looking for the resident. - LPN B told her that the resident had been found in the courtyard and was deceased . - She arrived to the resident's room, the DON was giving direction to the staff and was in charge of the situation. - She did not see the resident's body. - She expected the DON and nursing staff to perform CPR and call 911 for the resident who was a full code and had no respirations and no pulse. During an interview on [DATE] at 11:40 A.M., the Primary Care Physician (PCP) said: - The DON left a message for the physician and reported the resident had been found in the courtyard deceased on [DATE]. - He/she did not expect the resident to die of natural causes. - He/she expected the nursing staff to initiate CPR and call 911 for the resident, who was a full code and had no respirations and no pulse. During an interview on [DATE] at 4:14 P.M. Family Member A said: - He/she was notified the resident was found outside in the courtyard dead in his/her wheelchair. - He/she did not understand why the facility staff brought the resident in from outside and did not perform CPR. - He/she expected the facility staff to initiate CPR and call 911 because that is what the resident wanted to happen when his/her heart stopped and the resident stopped breathing. - He/she expected the facility staff to send the resident to the hospital. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation. MO206164 MO206169

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation, interview, and record review, the facility failed to provide protective oversight for one resident (Resident #1). The resident had a right above the knee amputation and was a right hemiplegic (inability to use the right upper extremity due to a prior stroke). The resident used a wheelchair for mobility and also had poor eyesight. On the morning of [DATE], the resident wanted to leave the facility. At 3:25 P.M., staff were unable to locate the resident. Staff searched for the resident and located him/her without signs of life at 3:36 P.M. in the enclosed courtyard. The resident's wheelchair, had one wheel off the sidewalk and the resident was lying on the ground in heavy foliage. The resident had skin tears to his/her upper and lower extremities as well as the groin. The resident had grass and dirt on his/her body. The resident was very hot to touch. The facility census was 97. The administrator was notified on [DATE] at 4:11 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor on-site. Review of the Elopements and Wandering Resident policy, dated [DATE], showed: - Wandering is defined as repetitive locomotion that may be goal-directed such as the resident is searching for an exit. - Elopement is defined as when a resident leaves the premises or a safe area without authorization. - Adequate supervision will be provided to help prevent accidents or elopements. - Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Review of the Accidents and Supervision policy, dated [DATE], showed: - The resident environment will remain as free of accident hazards as is possible. - Each resident will receive adequate supervision and assistive devices to prevent accidents. - Accident is defined as: Any unexpected or unintentional incident, which results in injury to a resident. - Environment is defined as: Any area in the facility that is frequented by or accessible to residents including outdoor patios. - Risk is defined as: External factor, facility characteristic such as physical environment, or characteristic of an individual resident that influences the likelihood of an accident. - Supervision is defined as: Intervention and means of mitigating risk of an accident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The facility shall make a reasonable effort to identify the hazards and risk factors for each resident. - The facility will provide adequate supervision to prevent accidents. 1. Review of Resident #1's Activities of Daily Living (ADL's) care plan, dated [DATE], showed: - He/she had an amputation (surgically removed) of the right lower leg between the knee and the hip. - He/she required one staff to transfer, use the toilet, and turn while in bed. Review of the wandering risk assessment, dated [DATE], showed the facility staff documented the resident recently lost a loved one, was recently admitted to the facility from another facility, and was wheelchair bound. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated [DATE], showed: - Diagnoses included: Diabetes Mellitus type 2 (a disease in which the body is unable to process blood sugar properly), chronic obstructive pulmonary disease (COPD) a chronic disease of the lungs in which they do not work properly), pigmentary retinal dystrophy (a disorder of the eye that causes blindness), above the knee right leg amputation, and stroke that affected the resident's right upper extremity causing paralysis. - BIMS score of 15, indicating no cognitive deficit. - He/she required assistance of one staff member for bed mobility, to transfer, use the toilet, and get dressed. Review of the local weather for the afternoon of [DATE] showed: - The temperature was 92 degrees Fahrenheit with a heat index of 96. Review of the resident's progress note dated [DATE] at 4:19 P.M., showed the following: - The charge nurse was looking for the resident during rounds at 3:20 P.M. and was unable to find him/her even though he/she was seen by staff at around 2:15 P.M. and 3:00 P.M. - The charge nurse asked others to help look for the resident and when others were asked, they mentioned he/she may be in the courtyard as he/she was earlier in the day. - Staff went outside to the courtyard and found the resident at approximately 3:35 P.M. laying on the ground on his/her left and the wheelchair was upright and the brakes locked. - Staff went to the resident, calling his/her name and he/she did not answer. - The resident was assessed for life and it was noted he/she had no pulse nor breaths. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident was stiff in the arms and purple in color on his/her left side and blue facial color. - Resident was brought inside at that time and taken to his/her room. - The resident had obvious signs of prolonged death by lividity and discoloration of the face and stiffened hands. - The doctor was called and informed of residents passing and also resident's next of kin. During an interview on [DATE] at 11:00 A.M., the administrative assistant said: - The key to the courtyard was kept in the door. - Between 10:45 A.M. and 11:30 A.M., the resident approached the front desk and asked to talk to the Administrator about getting his/her money and leaving the facility. - The Administrator talked to the resident, the resident was yelling and cussing at the Administrator saying that he/she wanted his/her money and to leave. - The resident then went to the front door and was pushing on it. - The Administrator pulled the resident from the front door and turned him/her around and pushed him/her further into the lobby and returned back into his/her office. - The resident wheeled to the courtyard door and was feeling for the key with one hand. - The resident found the key, unlocked the door, and was trying to pull the door open with one hand. - He/she told the Director of Nursing (DON) that the resident was trying to let him/herself out of the courtyard door. - The DON helped the resident open the door and helped the resident outside of the door. - The DON then came back inside and told him/her to not forget that the resident was outside. - The resident seemed upset and confused that morning. - He/she left for a late lunch at 2:00 P.M. and returned to his/her duties at 2:30 P.M. and at 3:15 P.M., Licensed Practical Nurse (LPN) A used the front desk phone to page on the overhead intercom system a code white, meaning a missing resident. - He/she then realized that he/she did not see the resident come back inside from the morning. During an interview on [DATE] at 4:50 P.M., the Administrator said: - The key was always kept in the courtyard door lock. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident was able to turn the lock and pull the door open by him/herself. - The resident spoke to him/her about wanting his/her money and wanted to leave the facility that morning. - On that morning the resident pushed on the front doors and he/she redirected the resident away from the front doors and pointed him/her to the 100 hall where he/she resided. During an interview on [DATE] at 12:53 P.M., Certified Nursing Assistant (CNA) A said: - He/she saw the resident sitting at the receptionist desk in the front lobby on [DATE] at 2:00 P.M. when he/she clocked out and left for the day. During an interview on [DATE] at 11:57 A.M., CNA B said: - He/she saw the resident sitting in his/her wheelchair at the end of the 100 hall, near the front lobby on [DATE] at 2:05 P.M. - He/she was leaving for the day. During an interview on [DATE] at 10:55 A.M., LPN A said: - The staff do not know when or how the resident got outside on [DATE]. - Therapy staff reported to him/her at 3:15 P.M., he/she was not able to find the resident. - He/she began looking for the resident, went to the front desk and paged over the intercom system a code white. - The staff spread out and looked for the resident. - CNA C found the resident lying in the courtyard on his/her side. - The resident's wheelchair was upright with three wheels on the cement sidewalk and the right front wheel off into the dirt and gravel. - LPN A, LPN C, the DON, and CNA D arrived in the courtyard as CNA C approached the resident. - The resident was lying in the overgrown vegetation half on his/her right side and half on his/her face. - LPN A called the resident's name, the resident did not respond. - The DON turned the resident over. - LPN A and the DON checked for a pulse and was not able to find one and did not see the resident breathing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident's skin was fire hot and red with a blue face. - The DON assumed control of the event. - The DON, CNA D, and LPN C picked the resident up and placed him/her back in his/her wheelchair. - LPN B arrived as the DON was pushing the resident into the facility and the DON told LPN B to pick up the resident's left leg and assist them down the hall into the resident's room. During an interview on [DATE] at 12:00 P.M., CNA C said: - He/she heard an overhead page for a code white and started looking for a missing resident on [DATE]. - He/she entered the courtyard, saw the resident lying there. - LPN A, LPN C, CNA D and the DON arrived at the same time. - He/she saw the resident's face was blue. - He/she returned to his/her hall and resumed his/her duties. During an interview on [DATE] at 10:15 A.M., LPN C said: - He/she heard a code white announced over the intercom system and then started looking for the missing resident between 3:00 P.M. and 3:15 P.M. - He/she followed LPN A, CNA D, and the DON outside into the courtyard. - He/she saw the resident's wheelchair sitting upright with both back wheels and the front left wheel on the cement sidewalk and the right front wheel off of the sidewalk into the dirt and gravel. - He/she saw the resident lying mostly face down lying in the tall grass. - The DON took control of the event and rolled the resident over. - The resident's face and neck were blue in color, there was no blood on the resident, but the resident had skin tears to both of his/her arms and left side of his/her groin. - The resident had bruising to his/her right leg stump, and abdomen. - His/her skin was hot like fire. - He/she cared for the resident earlier in the week and did not note any injuries to the resident at that time. - The DON told LPN C and CNA D to help him get the resident into the wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident was placed in the wheelchair and he/she was covered with a blanket. - LPN B held the resident's left leg up as the DON pushed the resident to his/her room. - LPN B, CNA D and the DON transferred the resident to his/her bed. - LPN C exited the resident's room. During an interview on [DATE] at 306 P.M. CNA D said: - He/she started searching the facility when it was announced on the overhead intercom system that the resident was missing. - He/she entered the courtyard after the DON, LPN A, LPN B, and LPN C and saw the resident lying in the foliage, dirt and gravel. - The DON took charge of the event and said that the resident was dead. - The DON instructed him/her, LPN B and LPN C to help him pick up the resident and place him/her into the wheelchair. - The resident's skin was very hot and pale with a blue face. - The courtyard was horribly hot and the sun was beating down, making it very uncomfortable. - The DON and CNA D pushed the resident to his/her room with LPN B holding the resident's leg up as he/she was being pushed. - The DON, CNA D, and LPN B transferred the resident to his/her bed. - The DON instructed CNA D to clean the resident's body with cold water because the resident's skin was so hot. - He/she cleaned grass and dirt off of the resident's body. - The resident had soiled him/herself and had grass, dirt and gravel in his/her brief. - The DON asked for ice to be brought to the resident's room and the staffing coordinator obtained tea pitchers of ice and poured into the sink of cold water. - CNA D and the DON continued to clean the resident with the ice water. - While the resident's body was being cleaned, the Administrator came into the room. During an interview on [DATE] at 3:49 P.M. LPN B said: - He/she was in his/her office when he/she heard the announcement overhead that the resident was missing about 3:30 P.M. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/she started looking for the resident, he/she received a call on his/her cell phone that the resident was found in the courtyard. - He/she arrived in the courtyard and saw the DON and LPN C next to the resident's body checking for vital signs. - The resident was lying in the foliage and dirt on his/her back. - The DON was in control of the event. - The DON, CNA D, and LPN C picked up the resident and put him/her in the wheelchair. - The DON instructed him/her to pick up the resident's leg and hold it up as the DON and LPN C pushed the resident to his/her room. - The DON instructed CNA D, LPN B, and LPN C to transfer the resident to the bed with him. - The resident's skin was very hot, like fire. - The resident appeared as if he/she had been all over the ground, he/she had dirt and grass all over his/her body. - The resident had skin tears on both arms and his/her left groin. - He/she had purple bruises to the left side of his/her abdomen, left leg, right leg stump, and both arms. - The DON instructed the resident's body to be cleaned with cold rags. During an interview on [DATE] at 8:37 A.M. the DON said: - On [DATE] at 3:30 P.M. LPN A went to the front desk and paged overhead a code white, meaning there was a missing resident. - He began looking of the resident. - The resident was last seen at 2:00 P.M. in the lobby area near 100 hall. - The resident would wander up and down the hall and hung out at the receptionist desk often. - The administrative assistant said that the resident was outside in the courtyard. - The DON and LPN C went into the courtyard, saw the resident lying on his/her side and rolled forward with his/her face in the foliage and dirt. He called the resident's name. - The resident did not respond. - The DON rolled the resident over. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident had black stuff on his/her face and LPN C wiped the resident's face. - The residents face was blue, the resident had no pulse, and no respiration. - He/she had purple bruises to his/her left side. - The resident's body was hot, arms and legs were movable. - The resident had skin tears to both of his/her arms and groin area. - He/she was in charge of the situation and gave the staff directions. - The DON, LPN C, and CNA D, picked the resident up off of the ground and put him/her back into the wheelchair. They began wheeling him/her inside the facility. - LPN B arrived and he directed LPN B to pick up the resident leg as the DON rolled his/her wheelchair to his/her room. - The DON, LPN C and CNA D picked the resident up and put him/her in bed. - He asked for ice to be brought from the kitchen and the staffing coordinator brought in a pitcher of ice. - He requested the ice to clean the resident. - The resident had grass and dirt all over his/her body. - He notified the physician and the resident's family of the resident's death. Review of surveillance video of the front door, dated [DATE], showed: - 10:06 A.M., the resident was at the front door using his/her left hand pushing vigorously on the door handle. The Administrator was on her cell phone and pulled the resident from the door, turning the resident around with the resident's back to the door. The resident can be seen talking to the Administrator and appears agitated and had an angry look on his/her face. - 10:35 A.M., a reflection in the front door, that is directly across from the courtyard door, that showed a wheelchair being pushed by a person, the courtyard door opens, the wheelchair was pushed through the door and the courtyard door closes with the walking individual remaining inside the facility. - 2:00 P.M., Certified Nurse Aide (CNA) A was seen walking out the front door. - 2:03 P.M., CNA B was seen walking out of the front door. - 3:30 P.M., CNA C was seen hurriedly running out the front door with the Administrator following him/her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 3:36 P.M., LPN B and the Administrator seen running back inside the front door. - 3:38 P.M., A reflection of the courtyard door opening and two pairs of legs going into the courtyard. - 4:21 P.M., A reflection of the courtyard door opening and a pair of legs pushing a wheelchair with a person that appears to be slumped forward coming inside from the courtyard. During an interview on [DATE] at 11:40 A.M., the Primary Care Physician (PCP) said: - The DON left a message for the physician and reported the resident had been found in the courtyard deceased on [DATE]. - He/she did not expect the resident to die of natural causes. - He/she has the expectation that resident safety will be observed at all times and by all staff. At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation. MO206164 MO206169

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44993 Based on observation and interview, the facility failed to maintain a safe environment when the facility maintenance supervisor occluded the walkway around the courtyard with dead vegetation, making the sidewalk impassable. The facility census was 97. The facility did not provide a policy that addressed maintenance of the courtyard. Review of the Resident Rights policy, dated 8/2/22, showed: - The resident has the right to a safe, clean, comfortable, and homelike environment. 1. Observation on 8/30/22 at 11:00 A.M., showed: - The courtyard foliage was overgrown. - The sidewalk at the back of the courtyard was completely covered in dead foliage that appeared to have been cut and laid out on the sidewalk. The sidewalk was not passable. During an interview on 9/1/22 at 9:37 A.M., the Maintenance Supervisor said: - He/she was responsible to keep the courtyard clean. - The Administrator asked him/her to pull the weeds from the courtyard in late July 2022 - He/she laid the vegetation across the sidewalk at that time. - He/she thought that residents would not attempt to cross the sidewalk, and instead turn around and go the other direction. - The sidewalk was not safe with the dead vegetation across it. During an interview on 8/31/22 at 4:50 P.M. the Administrator said: - She had asked the Maintenance Supervisor to clean the weeds from the courtyard. - The weeds had been there at least two weeks. - The courtyard was not safe with the dead vegetation blocking the sidewalk. - She expected the weeds to be removed to make the area safe for resident use. MO206164 MO206169