

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Overland Park LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11901 Rosewood Street Overland Park, KS 66209	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation in the facility's one kitchen to prevent the spread of food borne illness. Findings included:- Initial tour of the kitchen on 07/27/2026 at 08:09 AM with Dietary Staff BB revealed the following areas of concern:Two small skillets and two small pots had black staining to the interior and exterior of the cookware.The small freezer at the entrance into the kitchen from the dining room had an open box of chocolate ice cream cups and an open box of vanilla ice cream with no open date.A small cart had a plastic bag of thawing, frozen, diced turkey dated 07/19.The pantry had one devil's food cake mix dated 06/05, an opened half full bag of devil's food cake mix opened 06/12, one yellow cake mix dated 07/02, one bag of fudge brownie mix dated June 2, four bags of fudge brownie mix dated 07/17 three bags of basic muffin mix dated 07/10, a large storage bin labeled flour and dated 05/12 and a large storage bin labeled sugar and dated 05/22, five bags of dry crispy cereal dated with 07/17, seven bags of frosted dry cereal dated 07/21, six bags of pancake/waffle mix dated 07/10, twelve containers of dry oatmeal dated 07/24, one open container of dry oatmeal dated 07/27, a large container of peanut butter with an open date of 06/02/1, five large containers of peanut butter dated 06/19, five large containers of salad dressing dated 07/07, two cartons of pineapple juice with an expiration date of 07/01/2026.The large cooler had an open carton of liquid egg on the bottom shelf dated 07/27, sitting below a turkey loaf wrapped in unsealed, partially open plastic wrap that was dripping liquid on the third rack above the open liquid egg and a partial crate of eggs on the bottom shelf.The food items had no documentation of the year listed with the dates marked on them.On 07/29/2026 at 12:03 PM, Dietary Staff BB reported that potentially hazardous foods should be stored separately to prevent cross-contamination and to prevent illness. Dietary Staff BB also reported that food should be dated with the month, day, and year.The facility's policy Dietary Food Storage, dated December 2020, with revision dates of 11/2021, 10/2022, and 04/2023 documented food and non-food supplies will be purchased, received, and stored under sanitary, safe, and secure conditions as required to meet federal, state, and local laws.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R)121's call light was within his reach to enable him to call for staff assistance. Findings included:- R121's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), left leg above the knee amputation (surgical removal of a body part), and right leg above the knee amputation. R121 was admitted on [DATE], and no Minimum Data Set (MDS) assessment had been completed at the time of the survey. R121's Baseline Care Plan dated 07/26/2026 documented that he was a fall risk and to anticipate and meet his needs. The plan documented that he did not have cognitive impairment. R121's Daily Skilled Note on 07/24/2026 documented that he had cognition to person, place, time, and situation, but required supervision for safety. Observed on 07/27/2026 at 09:45 AM, R121 laid in bed on a low air loss mattress with his breakfast tray on his table over the bed and a pencil and paper on the tray to fill out his menu. R121's call light was on the floor out of his reach. Observation on 07/28/2026 at 07:58 AM, R121 laid in his bed with the call light on the floor out of his reach. His oxygen tubing lay on his bed. During an interview on 07/27/2026 at 09:45 AM, R121 stated that he could not reach his call light because it was on the floor, so he could not call for help to fill out the menu as he could not write it. He stated that he could activate his call light when he could reach it. During an interview on 07/28/2026 at 07:58 AM, R121 stated he could not reach his call light to ask for help to put on his nasal cannula as he thought he was supposed to be wearing it. He stated that he had not had breakfast and was leaving at 09:00 AM for an appointment but could not use his call light to ask about breakfast. During an interview on 07/29/2026 at 07:36 AM, Licensed Nurse (LN) G stated that R121 was able to use his call light and that he should have it on his bedside within his reach. During an interview on 07/29/2026 at 07:42 AM, Certified Nursing Aide (CNA) O stated that R121 was able to use his call light and should always have it within his reach. During an interview on 07/29/2026 at 12:44 PM, Administrative Nurse D stated that she expected that R121's call light should always be within his reach. She said if a resident was impaired or cognitively impaired, then the call light should be clipped on them and always within their reach. Policy for Call Light -Ability to Use dated 11/2018 revised 09/1019, 08/2020, 08/2021, 10/2022, 04/2023, 01/2024 documented that the call light system is provided as a tool for residents to communicate with staff and staff members will ensure that call lights are within reach of a resident who is able to cognitively use a call light each time they leave the room.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the Office of the Long Term Care Ombudsman was notified when Resident (R) 3 was transferred to the hospital. The facility failed to ensure R3, R4. and R8 and their representatives were provided with a bed hold policy that included their daily rate to hold the bed. The facility failed to ensure R3 and their representatives were provided with a written notification of transfer that included a statement of the right to appeal and the state ombudsman information, upon their transfer to the hospital as soon as practicable upon their transfer to the hospital. Findings included:- 1. R3's EMR documented a Discharge Minimum Data Set (MDS), dated 08/02/2025, for an unplanned discharge to an acute hospital with a return anticipated. R3's Entry MDS, dated 08/02/2025, documented a re-entry to the facility from an acute hospital.R3's Discharge MDS, dated 08/20/2025, documented an unplanned discharge to an acute hospital with a return anticipated.R3's Entry MDS, dated 08/26/2025, documented a re-entry to the facility from an acute hospital. R3's Discharge MDS, dated 03/05/2026, documented an unplanned discharge to an acute hospital with a return anticipated.R3's Entry MDS, dated 03/10/2026, documented a re-entry to the facility from an acute hospital. The facility lacked proof or documentation that R3 or his representative had been provided the bed hold information or the notice of transfer in writing for his transfers to the hospital on [DATE], 08/20/2025, and 03/05/2025. The facility lacked proof or documentation that the LTC ombudsman had been notified of R3's 03/05/2026 transfer to the hospital. The facility's Bed Hold Notice form documented the bed hold information, including the appeal rights and the LTC ombudsman information as well as the private and semi-private daily rates to hold the bed. The form also had an area for staff to document where the resident was transferred to, the reason for transfer, and the date of the transfer. On 07/29/2026 at 09:19 AM, Administrative Staff A stated that the nurses completed a bed hold assessment in the EMR that shows the information about the bed hold, and the representative was called to ask about the bed hold, but the actual paper form that was completed by staff was not scanned into the residents record. Administrative Staff A stated that the social worker submitted the transfers and discharges to the state ombudsman monthly and could not state why R3's transfer to the hospital had been omitted from the list.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observations, interviews, and record reviews, the facility failed to ensure appropriate care and services were provided to promote wound healing (R)72 when staff failed to follow the physician's treatment order for leg wraps. Findings included:- R72's Electronic Health Record (EHR) documented diagnoses that included chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminishing lung capacity and difficulty or discomfort in breathing), elevated white blood cell count, kidney failure, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), heart failure (HF-a condition with low heart output and the body becomes congested with fluid), lymphedema (swelling caused by an accumulation of protein-rich fluid), history of thrombosis (a clot that develops within a blood vessel) and embolism (an obstruction in a blood vessel due to a blood clot or other foreign matters that gets stuck while traveling through the bloodstream).R72's 07/20/2026 Quarterly Minimum Data Set (MDS) documented R72 had received an application of ointments or medications other than to the feet and documented R72 had a Brief Interview for Mental Status score of 15, which indicated intact cognitive function.R72's Care Plan documented R72 had actual impairment to her skin integrity and further documented staff should evaluate and treat per physician order.R72's Registered Dietitian Progress Note dated 07/12/2026 documented diagnoses including lymphedema, heart failure, and depression. R72 had a significant weight gain of 12 pounds (five percent) in 30 days, seventeen pounds and six ounces in 90 days. R72's physician's order dated 04/26/2026 documented nursing staff was to apply ace wrap for compression lightly to bilateral lower extremity up to the knee, every Wednesday and Saturday, and to change wrap on shower days scheduled on Wednesday and Saturday.R72's EHR documented a pulmonary follow up appointment on 07/23/2026 at 11:55 AM that documented R72 presented with swollen bilateral leg. The note documented that R72's legs were currently wrapped but had not been wrapped for several days prior.R72's electronic Medication Administration Report (MAR) documented hydrocodone-acetaminophen for pain was requested by R72 on 07/01/2026 with a reported pain level of 5, 07/04/2026 with a reported pain level of 5, 07/09/2026 with a reported pain level of 6, on 07/15/2026 with a reported pain level of 6, 07/19/2026 with a reported pain level of 5, 07/20/26 with a reported pain level of 4, and 07/23/2026 with a reported pain level of 6. R72's MAR dated July 2026 showed the order for ace wrap to bilateral lower extremity each day shift on Wednesday and Saturday. The MAR documented that the ace wraps were applied by nursing staff each Wednesday and Saturday between July 1, 2026, and July 25, 2026.R72's EHR lacked evidence that the resident refused the wraps.Observation on 07/27/26 at 09:13 AM showed R72 lying in bed. She reported she has leg wraps that were supposed to be done on Wednesday and Saturday, and this does not always get done. She stated she was there for help, and not receiving the help caused her to feel depressed and frustrated. R72's legs were visibly swollen, and she did not have ace wraps on her right or left leg.Observation on 07/28/2026 at 04:53 PM showed R72 sitting in her recliner with the footrest partially extended. R72 stated the wraps were still not on her legs. R72 reported the last time her wraps were on was last Saturday, 7/25/2026. R72's legs were visibly swollen, and she did not have ace wraps on her right or left leg.Observation on 07/29/2026 at 09:05 AM showed R72 lying in bed with breakfast on a tray on the bedside table over the bed. R72 reported the nurses had still not put the wraps on her legs, and she said she hoped that they would put them on after her shower that day. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R72 reports it was hit or miss if the nurses put her leg wraps on. She used to ask them to please put them on but stopped asking because it did not do any good. On 07/29/2026 at 12:21 PM, Certified Nurse Aide (CNA) PP reported R72 had leg wraps, but the wraps were not on her legs about 60% of the time when CNA PP assisted R72 with her shower. On 07/29/2026 at 12:25 PM, Licensed Nurse (LN) J stated staff was to unwrap R72's legs before her shower. LN J stated she had never had to do that because the wraps were not on the resident's legs. LN J stated there was an order to wrap R72's legs with ace wraps after her shower, but it only got done about 25% of the time. On 07/29/2026 at 12:53 PM, Administrative Nurse D stated all nursing staff should follow and provide all treatments as ordered.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, record review, and interview, the facility failed to provide an environment free from accident hazards for Resident (R) 121 when staff transferred R121 using the full body lift (Hoyer) and did not maintain direct contact to provide safety and stabilization during the transfer. Findings included:- R121's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), left leg above the knee amputation (surgical removal of a body part), and right leg above the knee amputation. R121 admitted on [DATE], and no Minimum Data Set (MDS) assessment had been completed at the time of the survey. R121's Baseline Care Plan, dated 07/26/2026, documented that he was a fall risk and to anticipate and meet his needs. The plan documented that he did not have cognitive impairment and he was a maximum assist for transfers. R121's Daily Skilled Note on 07/24/2026 documented that he had cognition to person, place, time, and situation, but required supervision for safety. Observed on 07/28/2026 at 09:07 AM, Certified Nurse Aide (CNA) M and CNA N placed the Hoyer lift sheet under the R121 and attached the lift sheet correctly to the Hoyer lift over. CNA M used the control on the Hoyer to lift to raise R121 into the air over the bed while CNA N held the Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) urine collection bag in his hands and walked around the bed to the same side the Hoyer lift was on next to R121 as he was transferred from the bed to his wheelchair while suspended in the air. While R121 was lifted and transferred from the bed to the chair, and lowered into the chair, CNA M operated the lift while CNA N stood by holding the urine collection bag, he did not provide contact to R121 while he was transferred. While R121 was suspended in the air over the chair, there was a knock on the door and a staff member informed CNA M and CNA N that the call light was on. CNA M removed his hands from the Hoyer lift and turned the call light off while CNA N stood next to R121 holding his catheter bag. As R121 was lowered into his wheelchair, CNA N placed one hand on R121 to adjust him in the chair. On 07/28/2026 at 11:17 AM, CNA M stated that she would get a second person to help with the transfer when a Hoyer lift was used, as it required two staff members. She would place a clean lift sheet under the resident and use one staff member to operate the lift, and the other staff member was to keep their hands on the resident and guide them. CNA M said the resident should never be left suspended in the air without someone having hands on them during the transfer process. On 07/28/2026 at 11:33 AM, CNA N stated that the proper way to use a Hoyer lift was to place a clean lift sheet under the resident and to have one person hold R121's foley bag below the waist while one person guided the lift. He stated that one person should have had a hand on R121 while he was transferred. On 07/28/2026 at 11:41 AM, Licensed Nurse (LN)G stated that for Hoyer lift transfers there should have been two staff members for safety. One staff should have held the foley catheter bag and kept a hand on R121 to guide him for safety and reassurance, and the other staff member was to operate the lift. On 07/29/2026 at 12:44 PM, Administrative Nurse D stated that her expectation was that two staff members were to use the Hoyer lift correctly for patient safety by keeping their hand on the resident during the transfer and to never walk away during a transfer. The facility policy Hoyer Lift (Mechanical Lift), dated 03/2025, documented Resident's that required a Hoyer lift would be transferred and use approved mechanical lifting equipment by trained staff in accordance with the resident's care plan, manufacturer guidelines, and all applicable state and federal guidelines.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to provide adequate infection control practices related to utilization of Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high-contact care), Personal Protective Equipment (PPE), or proper hand hygiene, while providing direct care to Resident (R) 120 and R29. Additionally, the facility failed to implement adequate infection control practices related to sanitary storage of respiratory equipment for R41. Findings included:- 1. Observed on 07/27/2026 at 09:26 AM, R120 had EBP signage on his door that required staff to wear gloves and gown PPE when providing cares related to a wound on his backside and right lower leg, as reported by R120. Certified Nurse Aide (CNA) OO assisted R120 off the toilet and only wore gloves. R120 also reported that staff would only wear gloves when they provided care. Observed on 07/27/2026 at 04:34 PM, Certified Medication Aide (CMA) R answered R120's call light and assisted him to the bathroom while wearing only gloves. R120 stood up with gait belt assistance, and his pants and wheelchair cushion were wet. The dressing on R120's sacrum (large triangular bone/area between the two hip bones), dated 07/26/26, was peeling away from his skin. CMA R assisted R120 onto the toilet and removed his wet pants and then cleaned off the wheelchair cushion. CMA R then opened the closet door and removed a clean pair of pants for R120 without changing gloves or performing hand hygiene, then applied a new incontinence brief and the clean pants to his lower legs. On 07/27/2026 at 04:52 PM, CNA P reported that EBP was required for residents who had a wound, feeding tube (tube for introducing high-calorie fluids into the stomach), or a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). She then said that EBP meant that staff needed to wear a gown and gloves PPE. On 07/28/2026 at 01:55 PM, Licensed Nurse (LN) H reported the staff are required to wear the appropriate personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) when a resident was on EBP when they were completing hands on care. On 07/28/2026 at 04:30 PM, CMA R reported that she did not notice that R120 had an EBP sign on his door frame when she assisted him with his toileting. CMA R reported she should have removed her gloves and performed hand hygiene before she started to gather the items she needed from his closet. On 07/29/2026 at 10:32 AM, Administrative Nurse K expected all staff to wear PPE when a resident required EBP. 2. 07/28/2026 at 09:37 AM CNA Q knocked on R29's room no hand hygiene performed. CNA Q just applied gloves, no gown was applied EBP sign and PPE was located outside R29's door. CNA Q then opened the closet in 29's room and removed a pad, wipes, and a brief as she was doing that R29 called out for help and had emesis twice. CNA Q cleaned R29's face, then CNA Q started to remove R29's brief. At 9:41 AM LN I knocked on R29s door to ask a question, CNA Q told LN I that R29 was throwing up. On 07/28/2026 at 9:51 AM LN I entered R29's room, CNA Q had a gown and gloves on while providing incontinent care to R29. CNA Q she cleansed bowel movement off R29's buttocks as R29 was sliding off the bed and CNA Q asked LN I to assist her. CNA Q removed her gloves and applied new gloves no hand hygiene performed. CNA Q continued to cleanse off R29's buttocks. CNA Q removed her gloves no hand hygiene performed, applied new gloves, and applied R29s brief. CNA Q and LN I adjusted R29's brief and gown and boosted her back up in bed. On 07/28/2026 at 04:05 PM, CNA Q reported she had forgotten to put on her gown when she started cares for R29 and did not know she had to wash her hands after she removed her gloves during care she said she thought she only had to do that at the end of all cares. On 07/28/2026 at 04:12 PM, LN I reported she noticed that CNA Q was not wearing a gown and reported she told CNA Q to apply a gown when providing hands on care to all the residents that have EBP. On 07/29/2026 at 10:32 AM, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Nurse K expected all staff to wear PPE when a resident required EBP. Administrative Nurse K expected all staff to complete hand hygiene when they removed gloves before applying new gloves. 3. On 07/27/2026 at 11:23 AM, R41 was not in his room LN H reported that R41 was in therapy. Observed in R41's room a nebulizer mask attached to the machine laying in the drawer with clear fluid in the chamber and the call touch pad laid directly in the mask. On 07/27/2026 at 04:56 PM, R41 was in his bed watching television. R41's nebulizer mask remained in the drawer lying directly on items and clear fluid in the chamber. On 07/28/2026 at 07:54 AM, R41 was seated upright in his bed, he did the ok sign with his fingers. R41's nebulizer mask remained in the top drawer lying on items and had clear liquid in the chamber. On 07/28/2026 1:39 PM, LN H pulled R41s the nebulizer mask out of his drawer and squeezed the vial of albuterol (a medication that works by relaxing the muscles in the airways, leading to increased airflow to the lungs) into the chamber. R41 applied the mask to administer the breathing treatment. On 07/28/2026 at 01:55 PM, LN H reported there was a bag that the mask should be placed in when the treatment was finished. On 07/29/2026 at 10:32 AM, Administrative Nurse K expected the nebulizer equipment to be rinsed out after use, air dry, and placed in a bag when not in use. The facility's policy Enhanced Barrier Precautions dated 3/2024, documented on the recommendation and approval of the facility's Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities. Standard Precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. EBP will be used for any residents in this facility who meet the stated criteria wherever the resident resides in the facility. Residents with the following conditions require EBP for all cares including wounds any skin opening requiring a dressing, Foley catheter (a tube inserted into the bladder to drain urine into a collection bag), and feeding tube. Contact precautions would be continued for infected or colonized residents in situations deemed necessary by the Infection Preventionist, the Infection Prevention Committee, the facility's Medical Director, and The State, and local health department, including but not limited to: C. difficile The facility's policy Hand Hygiene dated 04/2023 documented indications for handwashing was before and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident and after removing gloves. The facility's policy Respiratory Supplies dated May 2023 did not sanitary storage of nebulizer masks.		

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on the record review and interview, the facility failed to conduct a thorough facility-wide assessment to determine the nursing staff resources necessary to care for residents competently during both day-to-day operations and emergencies. Findings Included:- An inspection of the Facility Assessment dated 03/22/2026 provided by the facility revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked the staffing levels required for each daily shift and on weekends. On 07/29/2026 at 12:45 PM, Administrative Nurse D stated that the facility assessment should reflect the number of total hours for each nursing staff. Administrative Nurse D could not state for certain whether the facility assessment broke down each required nursing staff per shift. On 07/29/2026 at 01:09 PM, Administrative Staff A stated the Facility Assessment was reviewed annually, and information was included per the new guidelines. She was not aware that the staffing plan needed to be broken down for each category of nursing staff each shift and for each unit, including on the weekends. Administrative Staff stated she would make sure to review the facility assessment and revise it to reflect the needed information. The facility's Facility Assessment policy dated 08/01/2024 documented The Facility Assessment will address but is not limited to: the facility's resident population including, but not limited to: both the number of residents and the facility's resident capacity; the care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral needs, cognitive disabilities, overall acuity, and any other pertinent facts that are present within the population, consistent with and informed by individual resident assessments as required by regulation; staff competencies and skill set that are necessary to provide the level and types of care needed for the resident population; the physical environment, equipment, services and other physical plant considerations that are necessary to care for this population; any ethnic, cultural or religious factors that may potentially affect the care provided by the facility including but not limited to activities and food and nutrition services. The facility's resources, including but not limited to: All buildings and/or other physical structures and vehicles; equipment (medical and non-medical); services provided, including but not limited to physical, occupational, speech skilled therapy, pharmacy consulting and dispensing services, behavioral health services, specific rehabilitation therapies such as respiratory therapy services; all personnel, including managers, nursing, and other direct care staff, both employees and those who provide services under contract, and volunteers, as well as those staff members' education and/or training and any competencies related to resident care; contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and during emergencies; and health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations. A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in Federal regulations.		