

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2026
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Carondelet LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  621 Carondelet Drive Kansas City, MO 64114	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure multiple shower refusals were reviewed and documented for a potential reason for the shower refusals, and failed to review and document preferences for bathing or shower days and preferred shower times, for one sampled resident (Resident's #19), who refused 5 out of 5 showers since his/her admission; and failed to ensure one sampled resident (Resident #12) who required staff assistance with activities of daily living (ADL's) had the call light placed within his/her reach out of 21 sampled residents. The facility resident census of 105 residents. The facility's Bathing/Shower Program policy was requested and not received at time of exit.</p> <p>Review of the facility's Call Light-Ability to Use policy last revised/reviewed in January 2024, showed:-The call light system is provided as a tool for residents to communicate with staff.-Residents will be evaluated for ability to use call light on admission, quarterly and annually.-If residents are determined to be physically unable to use call lights, alternative call buttons (touch, whistle, etc.) will be provided.-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.</p> <p>1. Review of Resident #19's admission Record showed he/she was admitted on [DATE] with a diagnosis of adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability) and need for assistance with personal cares.</p> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/3/25 showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.</p> <p>Review of the facility's binder that indicated the resident's assigned shower days and time schedule dated 7/21/25 showed:-Residents were assigned their showers by room number.-The resident's room was assigned for a shower during the evening/night shift on Monday and Thursday.-A note on the binder indicated the Certified Nursing Assistant's (CNA's) were to report any skin changes and refusal of showers to the charge nurse. If a resident refused a shower, the CNA would document on the resident's shower sheet the resident had refused a shower. The shower sheet was to be signed by the resident or guest for any refusal of shower for assigned shower times and day.</p> <p>Review of the resident's Care Plan for ADL's dated 12/4/25 showed:-He/She had ADL self-care performance deficits, needed assistance with cares, required assistance with shower or bathing. -The resident had delirium (a sudden, serious change in mental state, causing confusion, disorientation, and reduced awareness, with symptoms like difficulty focusing, memory problems, hallucinations, agitation, or drowsiness, often fluctuating over hours or days, and typically linked to an underlying medical issue, infection, medication, or substance withdrawal).-The resident had delusions (a fixed, false</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 265303	If continuation sheet Page 1 of 6

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/26 at 12:00 P.M., the resident said:-He/she had received a shower on Tuesday when his/her daughter was at the facility. -He/she was not aware he/she was assigned certain shower days and time. -He/she had wash cloths and towels available in his/her room to provide sponge baths at the bathroom sink.</p> <p>Review of the resident's Health Status Note dated 1/13/26 at 1:17 P.M. showed:-Staff called and spoke with the family regarding the resident ongoing refusal of showers and challenges with bathing.-The resident was referred to Social Services and Psychiatric Services.</p> <p>Review of the resident's Social Services note dated 1/14/26 at 5:56 P.M., showed: -Social Services called to talk to the resident's family member about setting up a care plan meeting. -The family member said he/she had been helping the resident with showers. -The family member preferred to help the resident with showers. -He/she didn't want the resident to refuse showers from care staff. -The family member would talk to the resident about allowing staff to provide care also.</p> <p>During an interview on 1/15/26 at 12:14 P.M., CNA C said:-If the resident refused a shower he/she would offer again later that shift, then notify the charge nurse the resident had refused.-He/She would have the resident sign the shower sheet.-The resident was assigned to the evening night shift for showers.</p> <p>During an interview on 1/16/26 at 9:11 A.M., CNA D said: -The resident was scheduled for nights shift showers. -Day shift showers did not populate as an option for the resident on the resident care task.-The resident's family member would give the resident baths also. -If the resident refused a shower or care, he/she would let the charge nurse know and the nurse would follow-up with the resident on why refused.</p> <p>During an interview on 1/16/26 at 9:31 A.M., Licensed Practical Nurse (LPN) B said:-For a shower refusal, the staff would try to offer a shower later that shift after first refusal, then if refused second time would then ask the resident why and would have the resident sign that he/she had refused the shower.-Nurse would let management know so they could follow-up with family members to encourage the resident to shower. -Nursing management would be responsible for changing the resident's shower days. -It was discussed during morning clinical meeting that the resident preferred a different time or days. -The resident was able to and provided some of his/her own personal body care at the bathroom sink, provided own sponge bath.-The night nurse would be responsible to document the resident refusal of a shower and any follow-up action taken. -He/she had not seen the resident unclean in the morning shift change.</p> <p>During an interview on 1/16/26 at 12:04 P.M., CNO said: -The resident had a history of refusal of cares by staff to include night/evening showers.-The resident's shower days and times were assigned by their room number.-Shower sheets were to be reviewed by the charge nurse every shift. -The resident care plan meeting reviewed the resident's preference on showering and then determined if there was a need to change the shower schedule.-The resident's shower should be documented by the assigned CNA as given or refused. -If a resident refused a shower he/she would expect the CNA to document on the shower sheet refused and have the resident sign that he/she had refused the shower that day. -If staff noted ongoing refusal of showers, then he/she would expect the CNA to notify the charge nurse to address with the resident and discuss the refusal of the showers with care team during the morning clinical meetings. -The resident's family member expressed concern related to the resident refusing staff assistance with his/her showers. The family indicated they would like to provide the resident shower when they visited. -He/she would expect shower/bathing provided by a family member be</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>documented on the resident's shower sheet and/or in the nursing progress notes. -The clinical administrative staff were more focused on the resident's mental health changes and physical changes, then they were going to address the resident's refusal of care and his/her care preferences.</p> <p>2. Review of Resident #12's admission Face Sheet showed he/she was admitted to the facility with diagnoses that included:-Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Muscle weakness.-Need for assistance with personal care.-Difficulty walking.</p> <p>Review of the resident's Quarterly MDS dated [DATE] showed the resident:-Was able to express ideas and wants.-Had the ability to understand others.-Was moderately cognitively impaired.-Required either moderate or maximal assistance with self-care.-Required either moderate or maximal assistance with transfers, mobility, and walking up to 10 feet.-Had a diagnosis of Dementia.-Had a history of falls.</p> <p>Observation on 1/11/26 at 2:22 P.M., showed:-The resident was in bed.-The resident's call light was behind his/her nightstand and not within reach.</p> <p>Observation on 1/12/26 at 3:34 P.M., showed:-The resident was in bed.-The resident's call light was draped over the back of his/her nightstand and not within reach.</p> <p>During an interview on 1/12/26 at 3:24 P.M., the resident said:-Staff kept him/her in bed most of the time due to frequent falls.-The night shift staff purposefully placed his/her out of reach during the shift.-He/She was not able to get up on his/her own to go to the bathroom because he/she could not walk very far and had to wait until staff came into the room to check on him/her.</p> <p>Observation on 1/13/26 at 9:32 A.M., showed:-The resident was in his/her wheelchair in his/her room.-The resident's call light was behind his/her nightstand and not within reach.</p> <p>Observation on 1/13/26 at 10:03 A.M., showed the Assistant Chief Nursing Officer (ACNO):-Completed wound care and incontinent care on the resident.-The resident chose to stay in bed when asked.-The call light was not placed within reach.</p> <p>Observation on 1/14/26 at 8:17 A.M., showed:-The resident was in his/her wheelchair in his/her room.-The resident's call light was behind his/her nightstand and not within reach.</p> <p>Review of the resident's care plan last updated on 1/14/26 showed:-He/She had a communication problem related to difficulty understanding and expressing self at times.--Staff were to ensure/provide a safe environment by having the call light within reach.-He/She had an ADL self-care performance deficit and limited physical mobility related to Dementia, limited range of motion, and generalized weakness.--Staff were to encourage the resident to use the call light for assistance.--Staff were to educate the resident on the need to call for assistance when transferring, ensure the resident's call light was within reach and encourage him/her to use it.</p> <p>Observation on 1/14/26 at 11:41 A.M., showed:-The resident was in bed sleeping in his/her room.-The resident's call light was behind his/her nightstand and not within reach.</p> <p>During an interview on 1/16/26 at 10:12 A.M., CNA E said:-The resident required assistance from</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>staff with cares and transfers.-He/She knew what the resident's assistance needs were based on information at the nurse's station and by asking the nurse.-He/She knew when the resident needed assistance by doing rounds and when the resident used the call light because he/she can use it.-He/She made sure the call light was within reach by making sure it was close by the resident and telling him/her that it was there.-Call lights were checked every time they entered the room and during rounds.-All nursing and other staff were responsible for making sure that call lights were within reach after cares had been provided.-Call lights should be placed within reach by being hooked to the bed or linens.-If a call light was found to be out of reach, he/she should place it within the resident's reach as soon as possible.-Staff should ensure call lights were within reach before leaving the room.-He/She identified the resident's call light was behind his/her nightstand.-The call light should not have been behind the nightstand.</p> <p>During an interview on 1/16/26 at 11:11 A.M., LPN C said:-The resident required assistance from staff with cares and transfers.-He/She knew what assistance was needed for the resident by looking at the resident's Electronic Health Record (EHR) under therapy, task, and MDS tabs and under the progress notes.-He/She would know if the resident was in need of assistance because he/she usually yelled out or using the call light.-The CNA's would check under interventions in the resident's EHR or ask the nurse to find out what assistance a resident needed.-Call lights should be checked when going in and coming out of the resident's room.-Everyone was responsible for making sure that call lights were within reach at all times.-All nursing staff was responsible for implementing the resident's interventions.-Call lights should be within reach before leaving the room by attaching it to the linens or bed rail in a position where the resident could reach it.-He/She attended an in-service one week ago that included the topics of call light placement.-Risks for not having the call light within reach at all times were fall and injury.</p> <p>During an interview on 1/16/26 at 12:05 P.M., the CNO said:-He/She would expect the resident's call light to always be within reach.-All nursing staff were responsible for making sure that call lights were within reach.-Staff should check that call lights were within reach before leaving a resident's room.-If staff saw a call light was not within reach, he/she would expect staff to place it within reach by securing it to the linens or wrap it around the bed rail.-He/She would expect the resident's care plan to be followed and interventions implemented.-Staff could find information about the resident's assistance needs and intervention information in the Kardex (a quick reference tool in the resident chart that has summarizes resident data a such as medications, care plans and critical information), care plan, during wound rounds and orders.-He/She would expect residents who are dependent on staff for all care and transfers to have their call light within reach at all times. -Staff received training on call light accessibility every month during an in-service, during new employee orientation and as needed.</p> <p>Complaint # 2703939</p>		

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F 0921  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain the inner area of the climate control units in resident rooms A9, A1, B11, D3, free from debris; failed to ensure the restroom ceiling vent covers in the restrooms of resident rooms A14, C8, C3, and D11, were firmly attached to the ceiling; failed to ensure the hand rail in the restroom of resident room A5, was firmly attached to the wall; and failed to ensure the wall guard in C12 was firmly attached to the wall. This practice potentially affected at least 15 residents who resided in or used those areas. The facility census was 105 residents. 1. Observation on 1/13/26 between 11:02 A.M. and 2:41 P.M., with the Facility Maintenance Director of the climate control units, showed:-The presence of an ointment bottle, a fork and a small medication cup were inside the climate control unit in resident room A9, with the grate cover for the climate control unit missing.-There was a heavy buildup of dust and cobwebs in the climate control unit in resident room A1.-There was a heavy buildup of dust and cobwebs in the climate control unit in resident room B11.-There was a large amount of dust and debris inside of the climate control unit in resident room D3.During an interview on 1/14/26 at 11:10 A.M., the Facility Maintenance Director said the climate control units should be checked once per month for debris buildup.2. Observation on 1/13/26 between 10:56 A.M. and 2:25 P.M., with the Facility Maintenance Director of the restroom ceiling vents, showed:-The ceiling vent in the restroom of resident room A14 was loose and not firmly attached to the ceiling.-The ceiling vent in the restroom of resident room C8 was loose and not firmly attached to the ceiling.-The ceiling vent in the restroom of resident room D11 was loose and not firmly attached to the ceiling.During an interview on 1/14/26 at 11:08 A.M. the Facility Maintenance Director said he/she had checked those vents in the past.3. Observation on 1/11/26 at 3:15 P.M.; 1/13/26 at 9:20 A.M., and on 1/13/26 at 12:51 P.M., showed a handrail that was not firmly attached to the wall of the restroom in resident room A5.4. Observation on 1/14/26 at 11:31 A.M. showed the wall guard in resident room C12 was peeling away from the wall with some of the screws protruding from the guard as it was detached from the wall.During an interview on 1/14/26 at 11:31 A.M., the Facility Maintenance Director said:-He/She was unaware of the loose wall guard in resident room C12.-He/She thought the facility staff (nurses and housekeepers) were really good about placing those items in The Equipment Lifecycle System (TELS(R))-Platform connects your teams to the data that matters - work orders, assets, compliance, and capital planning - all in one place).2685006</p>		