STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265303	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Carondelet LLC	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an appropriate discharge plan, when the facility issued a Notice of Medicare (a federal health insurance program) Non-Coverage (NOMNC - a mandatory document provided to beneficiaries by skilled nursing facilities when their covered services are ending) to one sampled resident (Resident #1) out of seven sampled residents. The facility census was 134 residents.Review of the facility's Discharge policy, dated April 2023, showed:-A resident's discharge potential was assessed by Social Services upon admission.-When the Interdisciplinary Team (IDT - a group of facility staff, including nursing, medicine, therapy, and social work, work together with the resident to develop and implement a person-centered discharge plan) meet to discuss the discharge, the physician was contacted.-Social Services met with the resident to set up outside services and equipment.-A discharge form was completed by the IDT that explained the resident's care needs when at home. A policy regarding Discharge Planning was requested but not received. 1. Review of Resident #1's face sheet, undated, showed:-The resident was admitted to the facility on [DATE].-The resident was diagnosed with:--Hemiplegia (severe muscle weakness, stiffness, or total loss of movement on one side of the body).--Aphasia (a language disorder caused by brain damage, usually from a stroke or injury, that impaired a person's ability to speak, understand, read, or write).--Unsteadiness on feet. Review of the resident's initial Minimum Data Set (MDS - a health status screening and assessment tool used for all residents of long-term care nursing facilities) dated 3/1/26, showed the resident was cognitively intact. Review of the resident's Care Plan (a written, step-by-step outline of a person's specific medical, personal, and social needs who cannot live independently), dated 3/1/26, showed:-The resident wished to remain at the facility for long term care.--Evaluate the resident's motivation to return to the community quarterly, annually and as needed.-Identify, discuss and address limitations, risk, benefits and needs for maximum independence. -The resident had impaired cognitive function.-The resident had a deficit and limitations in her Activities of Daily Living (ADL - necessary and routine tasks required for personal care, health, and independent living).-The resident was at risk for falls. Review of the facility's Progress Notes, created by the Director of Care Transitions (DCT), dated 3/4/26, showed:-The Initial Care Management meeting was held.-The resident's plan for living arrangements have not changed.-There were no environmental barriers impacting the discharge plan.-There were no remaining medical education needs for the resident.-Stairs were a functional barrier at discharge.-Bathing was an ADL barrier for the resident. Review of the facility's NOMNC, signed by the resident on 3/5/26, showed:-The resident's Medicare Coverage was ending on 3/7/26.-The following information was to be completed by the provider and was given to the resident blank:--Notice delivered by (name and title).--Call date/time.--Spoke with: name, phone number, relation to resident.--Date NOMNC mailed to representative.--Provider signature, title, and date. During an interview on 4/10/26 at 10:04 A.M., the resident said:-He/She had issues with staff not giving him/her medications.-All the medication issues were resolved. -He/She talked to the DCT who talked to the nurses.-He/She got frustrated and yelled at the staff.-He/She did not want to be kicked out of (continued on next page)

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

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility without cause or for displaying anger on account of the staff lied and said he/she cussed them. -He/She recognized their need to be in a safe place, to have shelter, food, showers and care.-The Administrator and the DCT helped him/her get his/her medication and staff issues resolved. -The Administrator and DCT said he/she could not stay at the facility and find somewhere else to go.-The DCT was working on transferring him/her to another facility. -He/She was unsure about going to that facility as she needed to research it.-He/She was unsure if they were trying to put him/her Long-Term Care (LTC) or in an Assisted Living Facility (ALF).-He/She did not want to move again.-He/She liked it in the facility. -He/She did not receive a discharge notice but was told he/she had to leave.-He/She told the Administrator he/she did not want to move. During an interview on 4/10/26 at 10:58 A.M., the DCT said: -The resident received a NOMNC.-Medicare was paying for the resident's stay and he/she was past his/her last covered day.-He/She also had Medicaid (a federal and state program that provided free or low-cost health coverage to those with limited income and resources).-He/She sent a referral to another facility. -Due to the resident's behaviors, that facility will not accept the resident. -The resident was not given a letter of discharge.-He/She and the Administrator discussed LTC, patient liability, semi private room, and the differences between that and therapy with the resident.-The resident had the right to go back to the community.-The resident accepted going to the other facility and he/she wanted to look it up on line and said he/she was ok with it.-He/She was sending out referrals to other facilities. -There is no plan for the resident to stay here.-Right now, the goal is to move forward with a transfer.-A discharge notice had not been issued. During an interview on 4/10/26 at 12:25 P.M., the Administrator said:-He/She was actively looking for placement for the resident.-The resident was not appropriate to be safe towards staff and other residents.-The DCT continued to send out referrals.-The resident had to accept the referrals.-The resident accepted the referral to the other facility. -The resident had stated he/she did not want to be here.-The resident did not need long term care according to the resident's level of care (LOC - defined the intensity, frequency, and type of medical or support services a person needed based on their health status).-The resident was independent with most of his/her cares.-He/She did not want to do a 30-day discharge for the resident.-The resident has not made any payment. -If the resident did not accept placement, he/she will get a 30-day discharge based on offering him/her safe placement and he/she declined.-Documentation was kept on the risk management side, not in electronic progress notes. During a follow up interview on 4/10/26 at 2:10 P.M., the DCT said:-He/She had the resident's consent to send out referrals to other facilities.-He/She did not ask the resident what his/her preferences were for other transfers. -The resident stated he/she wanted to go back to an LTC facility.-The resident is not dis-included from proper discharge planning.-He/She had conversations in passing with the resident but did not always make a note about it. During a follow up interview on 4/10/26 at 2:10 P.M., the Administrator said:-We were planning to discharge the resident.-The resident can go back to the motel he/she was living in for six months prior to being hospitalized and admitted to this facility.-Care plan says she initially planned to stay long term care.-The Care Plan has not been updated.-The resident received education on the discharge planning process.-He/She would expect to have the care plan updated with discharge planning.-Sending the resident to a hotel would not be a safe discharge. -He/She will not send the resident to a hotel if he/she did not wish to go to a hotel. Complaint #2969722

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medical related social services by not planning for and referring one resident (Resident #1) out of three sampled residents, to potential community services necessary for the resident to have a successful and appropriate discharge back to the community. The facility census was 134 residents. Review of the facility's Discharges policy, dated April 2023, showed:-A resident's discharge potential was assessed by Social Services upon admission.-When the Interdisciplinary Team (IDT - a group of facility staff, including nursing, medicine, therapy, and social work, work together with the resident to develop and implement a person-centered discharge plan) meet to discuss the discharge. -Social Services met with the resident to set up outside services and equipment.-A discharge form was completed by the IDT that explained the resident's care needs when at home. 1. Review of Resident# 1's face sheet, undated, showed:-The resident was admitted to the facility on [DATE].-The resident was diagnosed with the following diagnoses:--Hemiplegia (severe muscle weakness, stiffness, or total loss of movement on one side of the body).--Aphasia (a language disorder caused by brain damage, usually from a stroke or injury, that impaired a person's ability to speak, understand, read, or write).--Unsteadiness on feet. Review of the resident's initial Minimum Data Set (MDS - a health status screening and assessment tool used for all residents of long-term care nursing facilities) dated 3/1/26, showed the resident was cognitively intact. Review of the resident's Care Plan (a written, step-by-step outline of a person's specific medical, personal, and social needs who cannot live independently), dated 3/1/26, showed:-The resident wished to remain at the facility for long term care.--Evaluate the resident's motivation to return to the community quarterly, annually and as needed.-Identify, discuss and address limitations, risk, benefits and needs for maximum independence. -The resident had impaired cognitive function.-The resident had a deficit and limitations in her Activities of Daily Living (ADL - necessary and routine tasks required for personal care, health, and independent living).-The resident was at risk for falls. Review of the facility's Progress Notes, created by the Director of Care Transitions (DCT), dated 3/4/26, showed:-The Initial Care Management meeting was held.-The resident's plan for living arrangements had not changed.-There were no environmental barriers impacting the discharge plan.-There were no remaining medical education needs for the resident.-Stairs were a functional barrier at discharge.-Bathing was an ADL barrier for the resident.-NOTE: there was no documentation of:--Referrals to needed services from outside entities.--Assisting the resident with identifying community placement options. During an interview on 4/10/26 at 10:04 A.M., the resident said:-He/She recognized their need to be in a safe place, to have shelter, food, showers and care.-The Administrator and DCT said he/she could not stay at the facility and he/she needed to find somewhere else to go.-The DCT was working on transferring him/her to another facility. -He/She was unsure about going to that facility as he/she needed to research it.-He/She was unsure if they were trying to put him/her in a Long-Term Care (LTC) facility, housing, or in an Assisted Living Facility (ALF).-He/She had not received any information from the facility regarding getting assistance from outside agencies. During an interview on 4/10/26 at 10:58 A.M., the DCT said: -The resident received a Notice of Medicare Non-Coverage (NOMNC).-Medicare was paying for the resident's stay and he/she was past his/her last covered day.-He/She also had Medicaid (a federal and state program that provided free or low-cost health coverage to those with limited income and resources).-He/She sent a referral to another facility. -Due to the resident's behavior, that facility did not accept the resident. -The resident was not given a letter of discharge.-He/She and the Administrator discussed LTC, patient liability, semi private room, and the differences between that and therapy with the resident.-He/She did not give any other referrals to available community resources to the resident.-The resident had the right to go back to the community.-He/She was (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sending out referrals to other facilities. -Right now, the goal is to move forward with a transfer.-A discharge notice had not been issued. During an interview on 4/10/26 at 12:25 P.M., the Administrator said:-He/She was actively looking for placement for the resident at other facilities.-The DCT continued to send out referrals.-The resident had to accept the referrals.-The resident accepted the referral to the other facility. -The resident had stated he/she did not want to be here.-The resident did not need LTC according to the resident's level of care (LOC - defined the intensity, frequency, and type of medical or support services a person needed based on their health status) and could live in the community.-There were no other referrals to outside agencies as some of them require the resident to be in LTC for at least three months.-He/She had no plans for the resident to remain at the facility that long.-If the resident did not accept placement he/she will be issued a 30-day discharge based on offering him/her safe placement and he/she declined. During a follow up interview on 4/10/26 at 2:10 P.M., the DCT said:-He/She had the resident's consent to send out referrals to other facilities.-He/She did not ask the resident what his/her preferences were for other transfers. -The resident stated he/she wanted to go back to an LTC facility.-The resident was not dis-included from proper discharge planning.-He/She had conversations in passing with the resident but did not always make a note about it. Complaint #2969722