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	06/25/2026

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 ongoing person-centered discharge plan, when the facility issued a 30-day discharge letter to one sampled resident (Resident #2), discharging the resident to a homeless shelter who required medication and care oversight out of five sampled residents. The facility census was 111 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 on 6/25/26, was informed by the Administrator that the facility does not have a Discharge Planning Policy, only the Discharges Policy. 1. Review of Resident #2's undated admission Record showed he/she was admitted to the facility on [DATE] with the following diagnosis:Hemiparesis (severe muscle weakness, stiffness, or total loss of movement on one side of the body) affecting the right dominant side.-Hemiplegia (a form of paralysis that affects one entire side of the body) affecting the right dominant side.-Contracture (permanent tightening or shortening of muscle, tendons, skin, or other soft tissue that causes joints to become stiff and restricts normal movement) of right upper arm.-Aphasia (a neurological disorder caused by brain damage that impairs a person's ability to speak, write, and understand language).-Syncope (fainting or passing out due to a sudden, temporary drop in blood flow to the brain) and Collapse (when a person falls down for no obvious reason).-Unsteadiness on feet. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff) dated 5/26/26, showed the resident was cognitively intact. Review of the resident's Care Plan dated 3/1/26, showed he/she:-May need help reading instructions, pamphlets or other written materials.-Had impaired cognitive function.-Had a deficit and limitations in his/her Activities of Daily Living (ADL - necessary and routine task required for personal care, health, and independent living).-Limitation in physical mobility due to weakness and uses a wheelchair for mobility.-Was at risk for falls.-Wishes to remain at the facility for long term care (LTC).--Care Plan meeting on 4/10/26, to discuss discharge goals (wishes to remain LTC), goals of care and treatment preference.--Evaluate his/her motivation to return to the community quarterly, annually and as needed.--Identify, discuss and address limitations, risk, benefits, and needs for maximum independence. Review of the resident's Care Management note dated 6/2/26 at 12:08 P.M., showed:-The resident's plan for living arrangements had not changed.-Upon discharge the resident plans to remain LTC at the facility.-Significant change in mood since last review.-Alternate discharge placement not discussed. Review of the resident's Social Service Note dated 6/8/26 at 1:05 P.M., showed:-Director of Care Transitions (DCT)/Social Services and the Administrator met with the resident.-During the meeting the resident was given formal notice of 30-day discharge.-The resident was educated on the 30-day discharge notice and his/her right to (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	appeal.-The resident expressed that he/she would like referrals sent out to locate an alternative location. Review of the Notice of Discharge Letter dated 6/8/26 showed:-Hand delivered to the resident.-After careful evaluation and consultation with the attending physician, the facility concluded that the safety of individuals at the facility was endangered by the resident and the resident's health had improved sufficiently so the resident no longer needs services provided by the facility.-The reason the safety of individuals in the facility was endangered by the resident barricading doors and refusing to allow staff to enter his/her room to provide care.-Additionally, the resident does not meet the level of care required for LTC facility and his/her needs can be met in the community.-The effective date of the discharge was 7/8/26.-The location to which he/she will be discharged was to the homeless shelter unless he/she had planned to move elsewhere. Review of the resident's Progress Note dated 6/8/26 at 3:26 P.M., showed:-Staff were working on finding the resident placement where he/she was able to be more independent per his/her wishes.-The resident wants to administer all his/her medications and complain when he/she was not able to take medications on his/her own except controlled substances, which makes it unreasonable for him/her to be under this level of care since he/she was wanting independence and continued to refuse care. During an interview on 6/24/26 at 1:08 P.M., Ombudsman A said it was not a safe discharge or considered a permanent location when the facility discharges a resident to a homeless shelter or a motel. During an interview on 6/24/26 at 2:35 P.M., the resident said he/she:-Had appealed the discharge letter and the hearing was set for 7/8/26.-He/she wanted to discharge from the facility to another facility and was willing to move anywhere. He/she needed a change.-Did not want to discharge to his/her parents' home.-Social Services was sending out referrals to other facilities.-Waiting to see if one of the facilities would take him/her. During an interview on 6/24/26 at 3:03 P.M., the Administrator said:-The facility had been trying to find placement for the resident, but no other facilities would accept the resident because of his/her behaviors.-He/She gave the discharge letter to the resident with the Social Services Director (SSD). -The resident's Preadmission Screening and Resident Review (PASRR - used to help ensure individuals with serious mental disorder and/or developmental disabilities are not inappropriately placed in nursing homes for long term care and receive the services they need in their residential setting) was done when the resident admitted to the facility.-A new PASRR has not been done to show the resident's improvements.-Placed a call to the resident's parents to see if the resident could discharge them to their home.-Parents said no, they were done with the resident because of his/her behaviors.-Part of the reason for the discharge was the resident's behavior and the other was the resident no longer meets LTC needs.-The resident can care for him/herself.-According to regulations he/she can discharge a resident to a homeless shelter.-He/she wrote the discharge letter and was responsible for the discharge decision. During an interview on 6/25/26 at 12:43 P.M., SSD said:-IDT meet weekly to go over the resident's care and discuss different interventions to get the resident to let staff care for him/her.-The IDT had discussed discharging the resident to another facility.-The resident wants to stay in an LTC.-He/She meets with the resident weekly to go over the referrals that have been sent out and the referrals response.-The other facilities were not taking the resident because of the residents' behaviors. During an interview on 6/30/26 at 10:33 A.M., the Nurse Practitioner (NP) said:-He/She sees the resident twice a week for care.-The resident needs medication management and was not compliant with schedule II medications.-The resident wants to self-administer all medications.-The resident was not compliant with staff caring for the resident and does most care him/herself.-The resident does have behavior problems toward others.-He/She does not agree with the resident discharging to a homeless shelter.-He/She was not included in the discharge planning meeting and was told after the discharge letter was given to the resident.-The resident was independent with some things but still needs assistance and protective oversight like setting up his/her medications in a pill box for self-administration.-The resident can walk some but not for long periods of time, will use wheelchair when tired or weak.-The resident does have limited use of his/her right dominant side due to a stroke.-He/She was not onboard with this discharge and does not approve of this discharge. 3039039