STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265349	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Center for Rehab and Healthcare	2001 Jefferson Parkway Harrisonville, MO 64701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #44) rights remained intact when he/she had to move to a different room out of 17 sampled residents. The facility census was 67 residents. Review of the facility's policy titled Resident Rights dated 6/10/25 showed Information about resident rights and responsibilities would be given to the resident both orally and in writing.1. Review of Resident #44's admission Record showed he/she admitted to the facility with diagnoses that included:-Unspecified 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, judgement, and impulses), Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance.-Anxiety (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).Review of the resident's care plan dated 1/7/26 showed:-The resident had dementia.-On 1/6/26 the room move was discussed with the resident and the resident agreed.-On 1/7/26 the staff were assisting the resident with the room move when the resident became upset and said that he/she wanted to leave the facility.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/8/26 showed:-The resident had severely impaired cognition.-The resident did not have any wandering behavior.During an interview on 1/21/26 at 1:57 P.M. the resident said:-He/She did not agree to the room move.-He/She was very upset about the move and became tearful.-He/She did not understand why he/she had been moved to the locked unit.-He/She felt trapped when he/she was in the locked unit.-He/She was unable to answer whether he/she had received written notice of the room change.Review of the resident's Electronic Medical Record (EMR) on 1/27/26 showed:-The resident did not have a Guardian or Durable Power of Attorney (DPOA- a legal document giving someone authority to make financial, legal, or medical decisions for you that remains valid even when you become incapacitated).-The resident was his/her own responsible party.-No signed agreement had been uploaded related to the resident's room move.During an interview on 1/29/26 at 11:44 A.M. Certified Nursing Assistant (CNA) A and CNA B said:-The resident had moved rooms recently, but they did not realize that the resident had been moved to the memory care unit before moving into his/her current room.-All residents needed to be informed in writing when a room move occurred.-They were unsure if the resident had received a written notice.-If the resident did not receive a written notice, then he/she should have been provided with a written notice.-All parties needed to agree before a room change could be completed.During an interview on 1/29/26 at 11:55 A.M. Agency Licensed Practical Nurse (LPN) A said:-All residents needed to be informed in writing when a room move occurred.-He/She was unsure if the resident had received a written notice.-The resident should have been provided a written notice related to his/her room move.-He/She had been the nurse who assisted the resident the day of his/her original move.-The resident was upset about the room move.-The resident was refusing to move rooms once (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they started walking down the hall with the resident.During an interview on 1/29/26 at 12:24 P.M. LPN A said:-He/She was unfamiliar with the resident and was not aware that the resident had been originally moved to the memory care unit.-All residents were to be informed in writing when a room move occurred.-The resident should have received a written notice of the room move.-The facility needed to follow all policies and regulations related to resident's rights.During an interview on 1/29/26 at 1:34 P.M. the Director of Nursing said:-The resident had not been notified in writing about the room move.-He/She was not sure why the resident had not received a written notification.-He/She was unaware of the regulation.-The resident should have been notified in writing related to his/her room move.2713401

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two sampled residents (Resident #44 and #75) physician's orders were followed out of 17 sampled residents. The facility census was 67 residents. A policy related to following physician orders was requested and not received prior to exit on 1/20/26.1. Review of Resident #44's admission Record showed he/she was admitted to the facility with the following diagnoses:-Retention of Urine (the inability to completely empty your bladder), Unspecified.-Neuromuscular Dysfunction of Bladder (occurs when nerve damage disrupts the brain-bladder communication, causing problems with storage or emptying), Unspecified.Review of the resident's Order Summary Report dated December 2025 showed:-The resident had an order for a Urinary Analysis (UA- a test of your urine that checks and screens for diagnoses such as a UTI), ordered on 12/16/25.--The status of the order showed it had been completed.-The resident had an order for a UA to be completed between 12/21/25 through 12/28/25.--The status of the order showed it had been completed.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility for care planning) dated 1/8/26 showed:-The resident had severely impaired cognition.-The resident did not have a Urinary Tract Infection (UTI-an infection caused by bacteria that enters and multiplies within any part of the urinary system).Review of the resident's care plan dated 1/19/26 showed:-The resident required an Indwelling Catheter (a thin, flexible tube left inside the body, most commonly in the bladder, to continuously drain urine into an external bag when a person cannot urinate on their own) due to his/her diagnosis of Neuromuscular Dysfunction of Bladder with an intervention for staff to monitor/record/report to the resident's physician signs and symptoms of a UTI.-On 12/22/25 the resident had a fixation with his/her private area causing complications with his/her catheter.-The resident would refuse catheter care at times. Review of the resident's Electronic Medical Record (EMR) on 1/23/26 showed:-No notes in place related to collecting the UA that was ordered on 12/16/25 and 12/21/25.-No results were found related to the results of any UA completed in December 2025.2. Review of Resident #75's admission Record showed he/she admitted to the facility on [DATE] with the following diagnoses:-Enterocolitis (inflammation of both the small intestine and the colon) due to Clostridium Difficile (C. diff- a bacteria that causes severe, contagious diarrhea and colon inflammation).-Morbid Obesity due to Excessive Calories.Review of the resident's Un-witnessed Fall report dated 1/20/26 showed:-The resident had been using the commode and tried to stand.-He/She lost his/her balance and fell to the floor.-An X-ray (a photographic or digital image of the internal composition of the body) had been ordered.-The X-ray was unable to be obtained due to the resident's abdomen size.-The resident's physician had been notified and had ordered a Computed Tomography (CT) scan (a noninvasive, diagnostic imaging that combines a series of X-rays with computer technology to create detailed, cross-sectional, 3D images of bones, soft tissues, and blood vessels).-The order had been faxed to the local hospital.Review of the resident's Order Summary Report dated January 2026 showed an order for the resident to have a CT scan of Back and Right Side due to a fall, which was ordered on 1/23/26.During an interview on 1/28/26 at 11:22 A.M. the resident said:-He/She was unaware that a CT scan had been ordered after his/her fall.-He/She had not been given a date in which the CT scan had been scheduled.During an interview on 1/29/26 at 10:25 A.M. a hospital scheduler from the local hospital said:-He/She was the manager of scheduling procedures at the hospital.-He/She did not see a CT order for the resident until 1/27/26.-The CT scan had not been scheduled yet because the facility sent in an invalid order.-Once the order was corrected, then the CT scan could get scheduled.3. During an interview on 1/28/26 at 1:03 P.M. the Administrator said:-To his/her knowledge, Resident #44 would not let (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff collect the urine for the UA to be completed.-He/She expected staff to document a progress note if the UA had been attempted/refused and that staff were unable to collect a sample.During an interview on 1/29/26 at 11:49 A.M. Certified Nursing Assistant (CNA) A and CNA B said:-All physician orders should be followed.-All physician orders should be followed as written.-CNAs and nurses could collect UAs depending on the order.-If they were unable to collect a sample for a UA to be completed, then they would let the nurse know.During an interview on 1/29/26 at 12:07 P.M. Agency Licensed Practical Nurse (LPN) A said:-All physician orders should be followed.-All physician orders should be followed as written.-If a licensed staff member could not collect a UA, then a note needed to be documented somewhere in the resident's EMR.-Sometimes the UA orders could be seen on the Treatment Administration Record (TAR) and nurses could document on the TAR whether the sample had been collected.-When he/she received an order for a CT scan, he/she would call the location that the CT scan was to be completed and document who he/she spoke to.-He/She would also inform the resident about when the procedure was scheduled for.-If the CT order needed to be faxed, then he/she would wait for a fax confirmation number and put a note in the resident's EMR.-He/She was unsure of when the CT scan had been ordered and when the order was sent to the local hospital.-If the order was placed on 1/23/26, then the facility should have the CT scan scheduled by that point in time.During an interview on 1/29/26 at 12:30 P.M. LPN A said:-All physician orders should be followed.-All physician orders should be followed as written.-Staff should follow all facility policies related to following physician orders and sample collection.-If staff were unable to collect a UA, then a note should have been documented in Resident #44's EMR.-If he/she needed to send an order for a CT scan, then he/she would confirm the location that the order needed to be sent to.-He/She would then send the order and wait for confirmation that the order had been received.-He/She would then document a progress note with the order confirmation number.-Resident #75's CT scan order should have been sent on the day it was ordered.During an interview on 1/29/26 at 1:41 P.M. the Director of Nursing (DON) said:-All physician orders should be followed.-All physician orders should be followed as written.-When a UA was ordered, the order would show on the nurse Medication Administration Record (MAR).-He/She expected the nurses to document in the MAR or in a progress note if a UA could not be collected.-He/She was unsure why staff did not document a note that indicated that a UA could not be completed as ordered.-There should have been a note documented in Resident #44's EMR to indicate that a UA could not be collected.-He/She was unsure when Resident #75's CT scan order was sent.-He/She did not have any documentation to confirm that Resident #75's order had been sent prior to 1/27/26.-He/She would have expected staff to get confirmation that the order was received and document a progress note.2713401