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	05/01/2026

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dependent residents who were unable to carry out Activities of Daily Living (ADLs-fundamental self-care tasks like bathing or eating) received the necessary services to maintain good personal hygiene by failing to ensure bathing was completed and documented according to the residents individual preference and facility policy for four sampled residents (Resident #2, #3, #4, and #5) out of six sampled resident's. The facility census was 62 residents.Review of the facility's Activities of Daily Living (ADLs) Policy revised 5/16/25, showed:-The facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs did not deteriorate unless deterioration was unavoidable.-Care and services would be provided for the following activities of daily living:--Bathing, dressing, grooming and oral care.--Transfer and ambulation.--Toileting.--Eating to include meals and snacks; and--Using speech, language or other functional communication systems.-A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's Resident Showers Policy revised 6/10/25, showed:-It was the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per in accordance with current standards of practice.-Residents would be provided with showers in accordance with the residents' preferences, care plan, and safety needs, as well as the facility's scheduled bathing protocol. 1. Review of Resident #2's admission Record showed he/she re admitted to the facility on [DATE] and had the following diagnoses:-Chronic Kidney Disease, stage 4 (severe- kidneys are moderately or severely damaged and are not properly filtering waste from the blood). -Dependance on renal dialysis (a treatment that filters waste and excess fluid from your blood when your kidneys are failing).-Type 2 diabetes mellitus with diabetic neuropathy (a chronic, progressive condition where high blood sugar (hyperglycemia) and high levels of fat (triglycerides) cause damage to peripheral nerves over time). -Peripheral vascular disease (a slow, progressive circulation disorder involving damage or blockage to blood vessels outside the heart and brain, primarily affecting arteries and sometimes veins in the legs and feet. It restricts blood flow, causing leg pain, cramping, and non-healing wounds). -Major Depressive Disorder (a serious mental health condition characterized by a persistent low mood, loss of interest in activities, and low energy). -Anxiety Disorder (a group of mental health conditions characterized by excessive, persistent, and uncontrollable fear, worry, or dread regarding everyday situations). Review of the resident's task list report dated 7/20/25 showed his/her scheduled bath days were on Monday, Wednesday and Friday and PRN (as needed) during the day shift. Review of the resident's bedside Kardex dated 7/20/25 showed he/she required partial to moderate assistance with washing, rinsing, and drying self. Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/11/26 showed:-He/She was cognitively intact. -He/She was able to make his/her needs known.-He/She required partial to moderate assistance with bathing.-He/She was occasionally incontinent with bowel and bladder. Review of the resident's Care Plan initiated on 3/23/26 (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed:-He/she requires additional assistance with ADL's. -He/She was at risk for impaired skin integrity related to occasional incontinence, impaired mobility related to his/her below the knee amputation, and decreased sensation due to diabetic neuropathy.-Staff were to provide partial to moderate assistance with washing, rinsing, and drying self.-Staff were to encourage the resident to change clothes daily. Review of the resident's Point of Care (POC) documentation dated 4/1/26-4/30/26 showed no baths or showers documented for the month of April. During an interview on 4/10/26 at 4:10 P.M., Social Worker A said:-The resident was observed on several occasions at his/her dialysis clinic wearing the same clothes multiple days in a row.-The resident received dialysis on Monday and Fridays each week.-The resident commonly arrived on Fridays in the same clothes he/she was wearing on Monday.-The resident's clothing was dirty at each visit and was observed being soiled with bodily fluids on numerous occasions. -The resident had a strong odor of urine when observed at his/her dialysis appointment.-The resident reported that the facility was not bathing him/her.-He/She contacted the facility to address the hygiene and bathing concerns, and nothing was done to fix the issue. -The resident was at a higher risk of infection due to receiving dialysis through a dialysis access port. Observation on 5/1/26 at 4:20 P.M., showed:-The resident was wearing unclean clothing that that had what appeared to be blood spots and other spills on both his/her shirt and jeans.-The resident was wearing a hat.-The resident's hair was long, unkept, and appeared to be greasy and dirty.-The resident had an odor of urine. During an interview on 5/1/26 at 4:20 P.M., the resident said:-He/she required assistance from facility staff for bathing and hygiene. -He/She wanted at least two showers per week. -He/she was not getting showers two times a week. -He/She was lucky to get one shower in a week.-He/She has gone several weeks without getting showered at all.-He/She recently went 6 weeks without getting a shower.-He/she did not remember when his/her last shower was. -He/She requested showers and did not get one on several occasions.-He/She was embarrassed by the lack of hygiene and the way he/she smelled.-He/She felt unclean and had a bad odor at times due to lack of showering. 2. Review of Resident #3's admission Record showed he/she re admitted to the facility on [DATE] and had the following diagnoses:-Dementia (a decline in mental ability-such as memory, reasoning, and behavior severe enough to interfere with daily life, caused by physical changes in the brain). -Cognitive communication deficit (a communication impairment resulting from underlying cognitive issues rather than primary language or speech muscle dysfunction). -Abnormalities of gait and mobility (unusual walking patterns, such as limping, shuffling, or instability, caused by pain, injury, neurological conditions, or muscular weakness).-Difficulty in walking.-Muscle weakness.-Need for assistance with personal care-Ulcer of the right foot (a chronic, non-healing open sore or lesion on the skin, often extending into deeper tissues). -Cellulitis of right lower limb (a serious bacterial infection of the deep dermis and subcutaneous tissue of the right leg, often caused by streptococci or staphylococci bacteria entering through skin breaks).-Tinea Unguium (a contagious fungal infection of the nail bed, plate, or matrix). Review of the resident's bedside Kardex dated 1/2/25 showed:-His/Her scheduled bath days were Tuesday, Thursday, Saturday, and PRN (as needed) during the day shift.-He/She required partial to moderate assistance to wash, rinse and dry herself. Review of the resident's annual MDS dated [DATE] showed:-He/She was cognitively intact. -He/She could not make needs known.-He/She required partial to moderate assistance with bathing.-He/She was frequently incontinent with urine and occasionally incontinent with bowel. Review of the resident's Care Plan initiated on 4/21/26 showed:-He/She was dependent on staff for meeting emotional, intellectual, physical, and social needs related to activity participation.-He/She had an ADL self-care performance deficit.-He/She was at risk for impairment to skin integrity.-He/She had bowel incontinence.-He/She had bladder incontinence. -Staff was to provide partial to moderate assistance to washing, rinsing and drying during bathing. Review of the resident's POC documentation dated 4/1/26-4/30/26 showed no baths or showers documented for the month of April. 3. Review of Resident #4's admission Record showed he/she re admitted to the facility on [DATE] and had the following diagnoses:-Dementia.-Depression (a mood disorder that causes a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	persistent feeling of sadness and loss of interest).-Anxiety Disorder.-Adult failure to thrive (a syndrome of progressive physical, functional, and cognitive decline, most common in frail older adults). Review of the resident's bedside Kardex dated 5/28/24 showed he/she was able to bathe and shower with setup and supervision. Review of the resident's Care Plan initiated on 6/4/24 showed:-He/She was at risk for impaired skin integrity related to a history of falls, physical conditionand dementia.-He/She had ADL self-care performance deficit related to activity intolerance.-Staff was to set up and supervise bathing. Review of the resident's task list report dated 7/1/25 showed his/her scheduled bath days were on Tuesday, Thursday, Saturday, and PRN (as needed) during the day shift. Review of the resident's annual MDS dated [DATE] showed:-He/She had moderate cognitive impairment. -He/She required partial to moderate assistance with bathing. Review of the resident's POC documentation dated 4/1/26-4/30/26 showed no baths or showers documented for the month of April. During an interview on 5/1/26 at 2:20 P.M., the resident said:-He/she required assistance from facility staff for bathing and hygiene. -He/She wanted more showers than he/she was getting.-He/She was not getting two showers per week on any week.-He/She showered daily before coming to the facility.-He/She liked to be clean.-He/She did not get a shower for over 4 weeks, prior to the one that he/she got yesterday. -He/She was embarrassed and felt dirty when not getting showered for a long period of time. -He/She requested showers often but was never given one when requested. 4. Review of Resident #5's admission Record showed he/she re admitted to the facility on [DATE] and had the following diagnoses:-Hemiplegia (partial or total paralysis) and Hemiparesis (weakness on one side of the body). -Anxiety disorder. -Depression.-Neuromuscular Dysfunction of the bladder (a person does not have bladder control because of brain, spinal cord, or nerve problems). -Muscle Weakness.-Cognitive communication deficit.-Diarrhea (passing loose, watery stools three or more times in a day). Review of the resident's bedside Kardex dated 9/11/25 showed his/her scheduled bath days were on Tuesday, Thursday, Saturday, and PRN (as needed) during the day shift. Review of the resident's Care Plan initiated on 11/5/25 showed:-He/She had ADL self-care performance deficit.-Staff was to provide sponge bath when a full bath or shower cannot be tolerated. Review of the resident's quarterly MDS dated [DATE] showed:-He/She was cognitively intact. -He/She could make needs known.-He/She required substantial to maximal assistance with bathing.-He/She had an indwelling urinary catheter (a flexible, sterile tube inserted through the into the bladder to drain urine continuously into a drainage bag). -He/She was frequently incontinent with bowels. Review of the resident's POC documentation dated 4/1/26-4/30/26 showed no baths or showers documented for the month of April. Observation on 5/1/26 at 3:30 P.M., showed:-The resident was laying in his/her bed eating snacks.-The resident had dirty clothes on that showed where food and drinks had spiled his/her clothing.-The resident's hair was unkept and greasy.-The resident had a foul body odor. During an interview on 5/1/26 at 3:30 P.M., the resident said:-He/she required assistance from facility staff for bathing and hygiene. -He/She wanted more showers than he/she was getting.-He/She was not getting two showers per week.-Some weeks, he/she was not showered once. -He/She wanted to have two or three showers per week.-He/She was supposed to get three showers a week. -He/She requested a shower today but did not get one.-He/She had not had a shower for almost two weeks.-His/Her last shower was on 4/20/26. -He/She only got 2 showers in the whole month of April. -It upsets him/her that he/she was not getting bathed. -He/She felt unclean and embarrassed due to not getting bathed. -Staff did not perform bed baths or sponge baths when his/her shower was missed. 5. During an interview on 5/1/26 at 1:00 P.M. Certified Nurse Assistant (CNA) A said:-There was one CNA who was responsible for giving baths and showers to all the residents in the facility.-When a CNA gave a resident a bath or shower, they were supposed to fill out a shower sheet and document the bath or shower in the resident's POC charting.-When a resident refused a bath or shower, the shower aide was supposed to fill out a shower sheet and write refused on it and tell the nurse on duty.-When a resident refused a bath or a shower, the bath aide was supposed to document the refusal in the resident's electronic (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record. -On an average day, the bath aide was able to give about 9 showers per day.-The bath aide worked 5 days per week and did not work on the weekends.-The bath aide gave about 45 baths and showers per week.-Each resident in the facility should get at least two showers or baths per week.-The residents were not getting a minimum of two baths or showers a week due to being short staffed.-The facility needed more than one bath aide because one could not keep up with the minimum standards or the facility policy of 2 bath or showers per week.-The residents are upset about not getting their baths and showers.-The bath aide often gets pulled to work the floor and that puts the showers and baths behind.-Some of the residents have gone weeks without getting bathed or showered due to not having the staff to help them. -There was only the one full-time bath aide that was giving the residents their baths and showers.-The evening staff did not help with baths or showers.-The weekend staff did not give baths or showers.-If the bath aide was not working or pulled from bathing to work the floor, the baths and showers were not being done.-The missed baths and showers were not rescheduled; they were just missed.-None of the residents in the facility were getting a minimum of two showers or baths per week. During an interview on 5/1/26 at 1:30 P.M. CAN B said:-The facility only had one bath aide for the entire facility. -The bath aide was the one responsible for bathing all the residents. -Residents should be getting a minimum of two baths per week.-Most residents would prefer to get three baths or showers per week.-The residents in the facility are not getting bathed at least twice per week.-The one bath aide can't keep up with the entire facility.-He/She did not give showers or baths to the residents.-He/She gave no showers or baths to any of the sampled residents in the month of April.-When a resident gets bathed, the CNA was supposed to fill out a bathing sheet and turn it into the charge nurse for the nurse to sign.-He/She was unsure who audited the bathing sheets.-CNA's were supposed to chart in the resident's POC charting any time a resident received a shower or bath.-If a resident refused a shower or bath, the CNA was supposed to chart the refusal on a bath sheet and in the POC charting. During an interview on 5/1/26 at 4:15 P.M., Licensed Practical Nurse (LPN) A said:-Residents should be getting a minimum of 2 showers per week.-The facility policy stated that if resident request more than two showers or baths, they should get more.-The Director of Nursing (DON) was the one who audited the showers and shower sheets.-She would expect that each resident in the facility to receive a minimum of 2 showers or baths per week, and more if requested.-He/She did not give baths or showers to the residents.-The bath aide was the one responsible for giving the residents their baths and showers.-The facility had one bath aide for the entire facility. -Baths and showers were not being assigned in the evenings and weekends as they used to be. -The one bath aide that worked Monday through Friday was the only aide giving the residents their scheduled baths and showers.-Sometimes, another aide would help if the bath aide was not working and a resident needed a PRN shower or bath. -It was hard for the one bath aide to keep up with bathing needs of the facility.-It would take more than one aide to be able to give all of the residents in the facility at least two showers or baths per week. -When a shower is given, it should be documented on the facility shower sheets by the CNA who is giving the shower.-The CNA then brings the shower sheets to the nurse who was on duty at the time of the shower to sign the sheets.-Both the CNA that gave the shower and nurse who worked the shift should have their names signed on the sheet.-If a resident refused bathing, the CNA should fill out the shower sheet and write on the sheet refused.-When bathing sheets are completed, they should be scanned into the resident's electronic medical record under the miscellaneous tab. -The baths and showers should be charted in the POC task sheet in the resident's electronic medical records when they are given and when the resident refused. -The one shower aide was pulled from giving showers and baths to work the floor when the facility is short staffed.-When the shower aide got pulled from giving showers and baths, the showers that were supposed to be given that day were all missing. -The facility had no alternative or back up plan when the bath aide was pulled to work the floor.-When the bath aide was pulled to work the floor or was not working, baths and showers were not getting done and were not rescheduled to get done. -With 62 residents in the facility,124 showers (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were needed to be given weekly, to meet minimum standards and facility policy of two showers per week. -It was not possible for the one bath aide to complete the showers that are needed. -No other staff are helping the bath aide with the showers and baths. During an interview on 5/1/26 at 5:00 P.M., DON said:-Residents should be offered 2 showers a week at minimum and more if asked.-They currently have one bath aide for the whole facility. -When a shower or bath is given, the CNA filled out a shower sheet on the day that the shower was given.-Once the shower sheet was filled out, the CNA gave the shower sheet to the charge nurse on duty that day or sometimes gave the sheet to him/her. -When a bath or shower was given to a resident or a resident refused a bath or shower, the CNA documented the resident's baths and showers in the resident's electronic medical record in the POC charting. -He/She was the one responsible for auditing the baths and showers.-He/She could not provide documentation or proof of auditing for any baths or showers. -The facility had no policy on documentation of showers.-He/She was not aware if the facility had a resident bathing schedule. -He/She was not sure how the bath aide made her bathing schedule for the week. -He/She was not sure if a schedule even existed, if the schedule was being followed. Complaint number: 2980493

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents' medical records were complete and accurate for four sampled residents (Resident #2, #3, #4, and #5) out of six sampled residents, when on 5/1/26 the Director of Nursing (DON) advised Certified Nurse Assistant (CNA) B and CNA C to retroactively complete and sign Skin Monitoring: Comprehensive CNA shower sheets for prior dates. The facility census was 62 residents. Review of the facility's Documentation in Medical Record Policy revised 6/6/25, showed:-Each resident's medical record would contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.-Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.-Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.-Documentation may be performed manually or as per the facility's specific electronic medical record software program.-Principles of documentation included, but were not limited to:--Documentation shall be factual, objective, and resident centered.--False information shall not be documented.--Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.-Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.-Documentation shall be timely and in chronological order.-When documentation occurred after the fact, outside acceptable time limits, the entry shall be clearly indicated as late entry. 1. Review of Resident #2's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/11/26 showed:-He/She was cognitively intact. -He/She was able to make his/her needs known.-He/She required partial to moderate assistance with bathing. Review of the resident's Skin Monitoring: CNA shower sheets that were provided by the DON on 5/1/26 at 12:00 P.M., showed:-On 4/6/26 and 4/9/26 CNA B documented a completed CNA visual assessment on the resident's skin during a shower and documented No new skin issues.-On 4/13/26 and 4/28/26 CNA B documented a completed CNA visual assessment on the resident's skin during a shower and documented Refused.-CNA B signed the shower sheet and dated the shower sheet 4/6/26, 4/9/26, 4/13/26, and 4/28/26. --The DON signed at the bottom of the shower sheet.--The date next to the DON's signature was left blank. During an interview on 5/1/26 at 1:30 P.M. CNA B said:-He/She did not give and or attempt to provide the resident a shower or assess the resident's skin on 4/6/26, 4/9/26, 4/13/26, 4/13/16, and 4/28/26.-He/She did not give the resident any showers or complete any skin assessments on the resident in the month of April. During an interview on 5/1/26 at 4:20 P.M., the resident said:-He/she required assistance from facility staff for bathing and hygiene. -He/she was not getting showers two times a week. -He/She recently went 6 weeks without getting a shower.-He/she did not remember when his/her last shower was but knew it had been at least 2 weeks since he/she had a shower. -He/She did not refuse any showers in the month of April. 2. Review of Resident #3's annual MDS dated [DATE] showed:-He/She was cognitively intact. -He/She could not make needs known.-He/She required partial to moderate assistance with bathing. Review of the resident's Skin Monitoring: CNA shower sheets that were provided by the DON on 5/1/26 at 12:00 P.M., showed:-On 4/2/26, there was a shower sheet completed that stated No issues, with no CNA signature or date.-On 4/4/26, 4/7/26, 4/9/26, 4/13/26, 4/16/26, 4/20/26, 4/24/26, 4/27/26, 4/30/26 CNA B documented a completed CNA visual assessment on the resident's skin during a shower.-CNA B signed the shower sheet and dated the shower sheet 4/4/26, 4/7/26, 4/9/26, 4/13/26, 4/16/26, 4/20/26, 4/24/26, 4/27/26, 4/30/26. --The DON signed at the bottom of the shower sheet.--The date (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	next to the DON's signature was left blank. During an interview on 5/1/26 at 1:30 P.M. CNA B said:-He/She did not give the resident a shower or assess the resident's skin on 4/2/26, 4/4/26, 4/7/26, 4/9/26, 4/13/26, 4/16/26, 4/20/26, 4/24/26, 4/27/26, 4/30/26.-He/She did not give the resident any showers or complete any skin assessments on the resident in the month of April. 3. Review of Resident #4's annual MDS dated [DATE] showed:-He/She had moderate cognitive impairment. -He/She required partial to moderate assistance with bathing. Review of the resident's Skin Monitoring: CNA shower sheets that were provided by the DON on 5/1/26 at 12:00 P.M., showed:-On 4/1/26, 4/10/26, 4/14/26, 4/24/26, 4/27/26 and 4/30/26 CNA B documented a completed CNA visual assessment on the resident's skin during a shower.-CNA B signed the shower sheet and dated the shower sheet 4/1/26, 4/10/26, 4/14/26, 4/24/26, 4/27/26 and 4/30/26. --The DON signed at the bottom of the shower sheet.--The date next to the DON's signature was left blank. During an interview on 5/1/26 at 1:30 P.M. CNA B said:-He/She did not give the resident a shower or assess the resident's skin on 4/1/26, 4/10/26, 4/14/26, 4/24/26, 4/27/26 and 4/30/26.-He/She did not give the resident any showers or complete any skin assessments on the resident in the month of April. During an interview on 5/1/26 at 2:20 P.M., the resident said:-He/she required assistance from facility staff for bathing and hygiene. -He/She was not getting two showers per week on any week.-He/She did not receive any showers for the entire month of April. 4. Review of Resident #5's quarterly MDS dated [DATE] showed:-He/She was cognitively intact. -He/She could make needs known.-He/She required substantial to maximal assistance with bathing. Review of the resident's Skin Monitoring: CNA shower sheets that were provided by the DON on 5/1/26 at 12:00 P.M., showed:-On 4/1/26, CNA B documented a completed CNA visual assessment on the resident's skin during a shower and documented 0 new skin issues.-On 4/3/26, 4/7/26, 4/16/26, 4/23/26 CNA B documented a completed CNA visual assessment on the resident's skin during a shower and documented No new skin issues.-On 4/11/26, CNA B documented a completed CNA visual assessment on the resident's skin during a shower and documented 0 skin.-On 4/28/26, CNA B documented a completed CNA visual assessment on the resident's skin during a shower.-CNA B signed the shower sheet and dated the shower sheet 4/1/26, 4/3/26, 4/7/26, 4/11/26, 4/16/26, 4/23/26 and 4/28/26. -The DON signed at the bottom of the shower sheet.-The date next to the DON's signature was left blank. During an interview on 5/1/26 at 1:30 P.M. CNA B said:-He/She did not give the resident a shower or assess the resident's skin on 4/1/26, 4/3/26, 4/7/26, 4/11/26, 4/16/26, 4/23/26 and on 4/28/26.-He/She did not give the resident any showers or complete any skin assessments on the resident in the month of April. During an interview on 5/1/26 at 3:30 P.M., the resident said:-He/She had not had a shower since 4/20/26. -He/She only received 2 showers in the whole month of April. 5. During an interview on 5/1/16 at 12:00 P.M., the DON said:-The shower sheets reflected the showers the four sampled residents received in the last 30 days.-He/She was sorry that it took so long to provide the documentation, he/she had a hard time finding the shower sheets. During an interview on 5/1/26 at 1:00 P.M. CNA A said:-When a CNA gave a resident a bath or shower, they were supposed to fill out a shower sheet and document the bath or shower in the resident's POC charting on the day that the shower was given.-When a resident refuses a bath or shower, the shower aide was supposed to fill out a shower sheet and write refused on it, document the refusal in the resident's POC charting, and tell the nurse on duty.-All documentation regarding showers and refusals of showers were supposed to be documented on the day the cares were given to the residents. -CNA B did not give any baths or showers to residents #2, #3, #4, or #5 in the month of April. During an interview on 5/1/26 at 1:30 P.M. CNA B said: -He/She was told to sign the Skin Monitoring: Comprehensive CNA shower sheets by the DON on 5/1/26.-The DON called him/her into the DON's office and advised him/her to document the CNA visual assessments, sign his/her name, and document a date on all of the shower sheets today. -When a resident was bathed, the CNA was supposed to fill out a bathing sheet and turn it into the charge nurse for the nurse to sign on the day that the cares were completed.-CNA's were supposed to chart in the resident's POC charting any time (continued on next page)

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	05/01/2026

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident received a shower or bath, on the day the cares were performed.-If a resident refused a shower or bath, the CNA was supposed to chart the refusal on a bath sheet and in the POC charting, on the day that the refusal occurred. During an interview on 5/1/26 at 1:00 P.M. CNA C said:-He/She was asked by the DON on 5/1/26 to complete resident's #2, #3, #4, and #5's shower sheets. -The DON had him/her look up all the dates that the resident's should have received their showers and place those dates on a blank shower sheet for CNA B to sign on 5/1/26.-None of the residents received the cares that the shower sheets had documented as being received in April.-All the shower sheets were created and documented on 5/1/26.-All shower sheets should be documented, signed, and completed by the CNA on the days that the service was given. -All of the resident's bathing should be documented in the resident's POC charting on the day that the bathing was completed. -Making up dates, false cares, and signing a bathing sheet when cares were not received by the resident was considered unethical and false documentation. During an interview on 5/1/26 at 4:15 P.M., Licensed Practical Nurse (LPN) A said:-The DON was the one who audited the showers and shower sheets.-When a shower was given, it should be documented on the facility shower sheets by the CNA who was giving the shower.-The CNA then brought the shower sheet to the nurse who was on duty at the time of the shower to sign the sheets.-Both the CNA that gave the shower and nurse who worked the shift should have their names signed on the sheet.-If a resident refused bathing, the CNA should fill out the shower sheet and write on the sheet refused.-When bathing sheets are completed, they should be scanned into the resident's electronic medical record under the miscellaneous tab. -The baths and showers should be charted in the POC task sheet in the resident's electronic medical records when they are given and when the resident refused. -He/She would expect all bathing sheets to be accurate and completed on the day that the CNA performed the cares for the residents. During an interview on 5/1/26 at 5:00 P.M., DON said:-When a shower or bath is given, the CNA filled out a shower sheet on the day that the shower was given.-Once the shower sheet was filled out, the CNA gave the shower sheet to the charge nurse on duty that day or sometimes gave the sheet to him/her. -When a bath or shower was given to a resident or a resident refused a bath or shower, the CNA documented the resident's baths and showers in the resident's electronic medical record in the POC charting. -He/She was the one responsible for auditing the baths and showers.-He/She could not provide documentation or proof of auditing for any baths or showers. -The facility had no policy on documentation of showers.-All of the shower sheets requested were signed and completed by CNA B on the day that CNA B gave the residents their showers. -The documentation for shower sheets should be completed on the day the shower was provided by the aide who provided the shower.

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	265349	A. Building B. Wing	05/01/2026

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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain the inside laundry wall on the parking lot side in good repair to prevent water from entering the laundry area and failed to prevent the growth of moldlike substance on the laundry wall. This practice affected one non-resident use area. The facility census was 62 residents.1. Observation with the Administrator and the Maintenance Person on 5/1/25 at 10:57 A.M., showed:-An area of the wall that was 8 feet (ft.) 7 inches (in.) high by 15 ft. wide that was covered in a moldlike substance.-One area behind a large stainless-steel sink with the presence of a moldlike substance on the wall that was 14 in. high by 4 ft. wide. During an interview on 5/125 at 11:03 A.M., Laundry Aide (LA) A said:-He/she has worked at the facility as a Laundry Aide for six years.-He/she has not seen any moldlike substances in the laundry area.-He/she has not seen standing water in the basement. During an interview on 5/1/26 at 11:26 A.M., the Maintenance Person said he/she noticed the moldlike substance on the wall and said he/she could mitigate the area by using cleaners. During an interview on 5/1/25 at 11:59 A.M., the Housekeeping Supervisor said: -Sometimes, water comes in through the window with the board on it, from the parking lot side, when it rains. -He/she has seen water standing in the laundry area after heavy rainstorms. -In the past, there may have been a leak on the wall behind the stainless-steel sink, but the moldlike substance remained even after the leak may have been fixed. During an interview on 5/1/26 at12:29 P.M., the Former Laundry Supervisor said water would come through the dumbwaiter (a small freight elevator or lift designed to transport food, dishes, laundry, or supplies between floors) area. During an interview on 5/1/26 at 2:53 P.M., the Administrator said he/she had the maintenance department clean the wall behind the washing machine with bleach and a mold killer, then paint the wall with a coating designed to block stubborn stains, seal odors, and ensure paint adhesion on surfaces like wood, drywall, and masonry. During an interview on 5/1/26 at 3:09 P.M., the Maintenance Person said:- The walls in the laundry sweat (a term used to explain when condensation, which occurs when warm, humid air touches cold surfaces, often caused by high indoor humidity, poor insulation, or inadequate ventilation).-He/she has not seen water gushing down through the walls. -He/she has not seen any water come through the windows. There was a pipe which leaked in the past, at the area behind the stainless-steel rinse sink. During a phone interview on 5/3/26 at 5:07 P.M., Former Laundry Aide (LA) B said:-He/she was at the facility in March 2026, when a rainstorm caused flooding.-Over by the back door, water came in through the bottom of the walls.-The only flooding that happens is when it rains. During a phone interview on 5/4/26 at 11:18 A.M., LA C said:-Water came into the laundry when it rained and-He/she didn't report any issues to management about the water in the basement. During written communication on 5/4/26 at 12:12 P.M., the Administrator communicated that the/she had only worked 8 days at the time of the investigation, and no one had brought any environmental concerns to him/her. During a phone interview on 5/4/26 at 1:36 P.M., the Maintenance Assistant said:-He/she has worked at the facility for 11 years-No one had brought the moldlike substance on the wall behind the washers to his/her attention in the past and he/she had not really paid attention to it in the past. -He/she has not heard of water coming in through the window. Complaint 2992609.