

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Maywood Terrace Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 East Truman Rd Independence, MO 64052	
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 - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the care plan for Activities of Daily Living (ADL's) included the preference for bathing/showering was assessed and documented for one sampled resident (Resident #24); and failed to ensure bathing was completed and documented twice weekly by nursing staff for five sampled residents (Resident #32, #24, #3, #10, and #35) out of 13 sampled resident's. The facility census was 49 residents. Review of the facility's ADL's Policy and Procedure revised in April 2025 showed:-Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, to include appropriate support and assistance with personal hygiene to include bathing, dressing, grooming, and oral care).-If the resident refuses care and treatment the facility staff were to inform:-The resident and/or representative of the risks and benefits of the proposed care or treatment; and the resident has been offered alternative interventions to minimize further decline; and the refusal and details of the interventions refused are documented in the resident's clinical record.</p> <p>Review of the facility's blank Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review form showed:-Perform a visual assessment of the resident's skin when giving a shower. Report any abnormal looking skin (as described below) to the charge nurse immediately. Forward any problems to the Director of Nursing (DON) for review. Use this form to show the exact location and description of the abnormality. Using the body image chart below, describe and graph all abnormalities by number. -CNA signature and date shower and assessment was completed. -Document if toenails or fingernails needed trimmed.-If resident was shaved. -Charge nurse signature and charge nurse assessment and intervention.-Director of Nursing (DON) signature. -NOTE: If the resident refused their shower/bath, the charge nurse must be notified after two attempts, and the charge nurse should ask a third time. If the resident still refused, resident must sign below indicating refusal. If the resident was unable to sign, write unable to sign and have two staff members witness, including charge nurse.</p> <p>1. Review of Resident #32's admission Record showed he/she had the following diagnoses:-Acquired absence of right and left leg below the knee (amputation of lower extremities).-Stroke affecting right side of the body.</p> <p>Review of the resident's Electronic Medical Record (EMR) showed his/her scheduled bath days were on Tuesday and Friday during the day shift.</p> <p>Review of the resident's Care Plan initiated on 6/23/25 showed:-The resident had self-care performance deficit. -He/she required assistance from facility care staff for showering. (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
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form dated 2/13/26 showed:-A handwritten printed signature of the CNA that provided shower and was dated of 2/13/26.-Did not have documentation of the type of personal care provided and no charge nurse signature for review of the shower form. -NOTE: The facility was not able to provide additional documentation that showers were provided two times a week from 2/14/26 to 3/13/26.</p> <p>Review of the resident's EMR under task dated 2/13/26 to 3/13/26 showed the resident required assistance from staff for shower/bathing care dated 2/13/26.</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 3/10/26 showed.-He/She was cognitively intact. -He/she was able to make his/her needs known.-Required assistance of facility staff for ADL's including bathing.</p> <p>During an interview on 3/10/26 at 9:50 A.M., the resident said:-He/she required assistance from facility staff for all personal care. -He/she was not getting baths/showers two times a week. -He/she did not remember when his/her last shower was.</p> <p>2. Review of Resident #24's admission Face Sheet showed he/she was admitted with the following diagnoses: -Paraplegia (paralysis that affects your legs, but not your arms).-Neuromuscular Dysfunctional bladder (loss of bladder control caused by nerve damage from illnesses or injuries). -Suprapubic urinary catheter (a flexible tube inserted into the bladder through the abdominal wall).</p> <p>Review of the resident's initial MDS dated [DATE] showed the resident was admitted to the facility on [DATE].</p> <p>Review of the resident's Care Plan initiated on 2/13/26 showed: -The resident did not have patience for assistance.-There was no ADL care plan that included the type of assistance the resident required during baths/showers.-There was no care plan that included the resident's preference for baths/showers and personal cares.</p> <p>Review of the resident's admission MDS initiated on 2/20/26 showed:-He/She was cognitively intact. -Had difficulty communicating his/her needs.-NOTE: The facility had not submitted the resident's admission MDS as of 3/16/26.</p> <p>Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form dated 2/13/26 and 3/10/26 showed: -Had wrong resident first name listed and hand printed signature of the CNA completed the resident shower. -Did not have the type of personal care provided and no charge nurse signature for review of the resident's CNA skin monitoring and shower review form. -The resident had documentation of two showers out of eight scheduled opportunities.-NOTE: The facility did not have any additional documentation of any showers provided and completed or documentation that showers were refused from 2/14/26 to 3/9/26.</p> <p>During an interview on 3/10/26 at 11:15 A.M., the resident said:-He/she had concerns with not getting assistance with resident care and bathing.-Required assistance with transfers from the bed to the wheelchair. -He/she had difficulty with speech and in his/her expression of needs at times.</p> <p>3. Review of Resident #10's face sheet showed the resident was admitted on [DATE] with the following diagnoses:-Muscle weakness.-Unspecified lack of coordination.-Abnormal posture.-Need for (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 - Some</p>	<p>assistance with personal care.</p> <p>Review of the resident's annual MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had upper extremity impairment on one side and lower extremity impairment on both sides.-He/She required substantial/maximal assistance for bathing.</p> <p>Review of the resident's undated care plan showed the resident did not have a care plan for ADLs for the resident's cares.</p> <p>Review of the resident's paper bath sheets dated February 2026 to March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/26 the resident did not receive any baths out of three opportunities.</p> <p>Review of the resident's EMR showed:-The resident did not receive six baths out of nine opportunities. -Staff documented not applicable on 2/18/26, 2/20/26, 2/25/26, 2/28/26, 3/4/26 and 3/7/26.</p> <p>Observation on 3/9/26 at 10:21 A.M., showed the resident had an odor and was lying in the bed with hair uncombed and greasy.</p> <p>During an interview on 3/9/26 at 10:21 A.M. the resident said:-He/She did not get showers all the time when he/she was supposed to get them.-He/She would like to get showers in the evening, but the facility was short staffed and couldn't do it, so they always offered them in the morning.</p> <p>4. Review of Resident #35's face sheet showed the resident was admitted with the following diagnoses:-Morbid (severe) obesity.-Body Mass Index (BMI) 50.0-59.9, Adult.</p> <p>Review of the resident's admission MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had lower extremity impairment on one side.-He/She was dependent on staff for bathing.</p> <p>Review of the resident's undated care plan showed:-He/She had an ADL self-care performance deficit related to activity intolerance and impaired balance.-He/She was totally dependent on staff to provide showers.</p> <p>Review of the resident's paper bath sheets dated February 2026 to March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/25 the resident did not receive two baths out of three opportunities.</p> <p>Review of the resident's EMR showed:-The resident did not receive six baths out of nine opportunities. -Staff documented not applicable on 2/11/26, 2/14/26, 2/20/26, 2/25/26, 2/28/26 and 3/03/26.</p> <p>During an interview on 3/9/26 at 10:50 A.M., the resident said:-He/She was not getting baths on a regular basis.-There was not enough staff to make sure everyone got their baths.-The facility did not have a bath aide for a long time.-He/She preferred to have baths after he/she had received his/her scheduled pain medication because he/she was stiff and sore before then.-He/She often felt dirty and wished she/he could get bathed twice per week. (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 - Some</p>	<p>5. Review of Resident #3's face sheet showed the resident was admitted with the following diagnoses:-Morbid (severe) obesity due to excess calories.-Body Mass Index (BMI) 50.0-59.9, Adult.-Bilateral osteoarthritis (a degenerative disease of the bones and joints) of hip.-Reduced mobility.</p> <p>Review of the resident's annual MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had bilateral extremity impairment.-He/She required substantial/maximal assistance by staff for bathing.</p> <p>Review of the resident's undated care plan showed:-The resident's bath days were Tuesday and Friday on evening shift.-ADL/Functionality as a focus area but no interventions related to bathing.</p> <p>Review of the resident's paper bath sheets dated February 2026 and March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/26 the resident did not receive two baths out of three opportunities.</p> <p>Review of the resident's EMR showed:-The resident did not receive five baths out of nine opportunities. -Staff documented not applicable on 2/11/26, 2/18/26, 2/20/26, 2/28/26 and 3/4/26.</p> <p>During an interview on 3/9/26 at 11:28 A.M., the resident said:-He/She did not always get a shower twice per week. -He/She would like to receive a shower twice a week. -He/She preferred showers in the evening or at night, but the staff was too busy.-His/Her hair was messy and uncombed, and he/she did not like that.</p> <p>6. During an interview on 3/11/26 at 2:10 P.M., Administrator said: -Resident #32 and Resident #24 were scheduled for two baths a week.-He/She had transcribed information from the resident's EMR, under CNA task section onto Resident #32's and Resident #24's Skin Monitoring: Comprehensive CNA Shower Review forms. -Resident #32 and Resident #24 were missing documentation of showers/baths given or refused.-He/she would expect the assigned CNA's to complete shower sheets and also document care provided in the resident's EMR under the CNA task.</p> <p>During an interview on 3/13/26 at 11:15 A.M., CNA H said:-Residents should get showers two days per week on their bath days unless they refused.-Resident's bath times should be made according to their preference.-He/She could find the resident's preferences in the care plan, shower book or by asking the resident.-Each resident was assigned bath days and times.-If a resident asked for a different bath time, he/she would try to come back.-He/She was assigned five to six baths per shift.-If he/she was not able to get all the baths done, they would let the charge nurse know and try the next day.</p> <p>During an interview on 3/13/26 at 11:35 A.M., Licensed Practical Nurse (LPN) B said:-Residents could choose when they wanted to take baths.-He/She could find preferences on the clinical assessment that was done during admission and could be found under the assessments tab.-He/She was aware that Resident #35 would prefer showers after his/her pain medication had been given and not in the morning.-Residents should be care planned for ADLs which included bathing/showering.-If a resident did not get their showers, they would get it the next shift or the next day.-There was enough staff to get showers done when they showed up.</p> <p>During an interview on 3/13/26 at 11:58 A.M., CNA D said:-The facility had just hired a new shower aide, that would be assigned resident baths Monday through Friday. -Currently, the resident's (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 - Some</p>	<p>assigned CNA was responsible to ensure the resident's baths/showers were completed during day shift. -He/she would document on the resident's shower sheet and in the resident's EMR under CNA Task section for shower or bath that was provided or refused. -He/she was not aware Resident #32 had refused personal cares to include showers. -Resident #24 seemed to get frustrated easily during all personal cares but was not aware if he/she had any missed any showers.</p> <p>During an interview on 3/13/26 at 12:24 P.M., the DON said:-Residents could choose when they wanted to take their baths. -He/She recommended that staff let him/her, the Administrator or the charge nurse know if there was a problem with the scheduling of baths so they could reassess the schedule.-Resident bath schedules could be found in bath binder at the nurse's station.-Bath sheets should be filled out completely and were ultimately turned into him/her.-He/She tried to encourage showers at varying times with Resident #10, but he/she refused.-All residents should be care planned for ADLs that included bathing.-If a resident did not receive a bath due to staff call offs, they would try to figure out scheduling for the next day.-If a resident refused, staff was to try again later. Staff needed to be reeducated on how to document refusals.-The nursing staff and he/she were responsible for making sure that showers/baths were getting done.</p> <p>During an interview on 3/13/26 at 12:24 A.M., the Administrator said:-If a resident did not get their bath/shower on their scheduled day, then staff should let the charge nurse know immediately, he/she or the DON would try to reschedule with the resident.-He/She believed that some of the staff was possibly confusing not applicable with refusal when charting.-The facility was currently doing Performance Improvement Project (PIP) & (in long-term care is a structured, data-driven initiative used by nursing homes and care facilities to identify specific areas of concern) audits for showers.</p> <p>During an interview on 3/13/26 at 2:17 P.M., LPN B said:-He/She was not aware of Resident #32 refusing cares or showers.-Resident #24 had a history of refusal of care.-He/she would have the resident sign the shower form for any refusal of care/showers. -The assigned CNA would be expected to document in the resident's EMR under CNA task any care provided and any refusal of cares. -CNA's were to notify nursing staff of any refusal of cares. During an interview on 3/16/26 at 10:14 A.M., the MDS Coordinator said: -He/she was behind on completing MDS and care plan updates to include admission since 2/2026 since February when other nursing management staff no longer working at the facility. -admission MDS and comprehensive care plan should be completed within 7-14 days after admission. -Resident #24 admission MDS and Care areas had not been completed and submitted as of 3/16/26.</p> <p>During an interview on 3/16/26 at 12:58 P.M., the DON said:-The facility did not have an assigned shower aide at that time of review. -The CNA assigned to the resident would be responsible for providing and documenting showers/bath provided or refused. -He/She was still learning the resident's scheduled bath days and preferences. -Resident #24 had a history of refusal of care and he/she had to beg the resident to change clothes daily and let staff assist the resident with personal cares. -He/she had stayed late to ensure Resident #32 was given a shower if needed. -CNA staff were responsible for documenting showers/baths on the shower sheet and in the resident's EMR under CNA task.</p>		