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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265579 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/09/2025 |
| NAME OF PROVIDER OR SUPPLIER Monterey Park Rehabilitation & Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4600 Little Blue Parkway Independence, MO 64057 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 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. (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were treated in a dignified manner when one staff member (Dietary Manager) spoke in a harsh tone and showed aggression to one sampled resident (Resident #2). The facility census was 97 residents. On 7/9/25 the facility Administration was notified of the past noncompliance which occurred on 6/18/25. Facility staff had subsequently been educated on all facility medication administration policies. All resident bed assignments were audited. The deficiency was corrected on 7/7/25. A facility policy for dignity and respect was requested but not provided. 1. Review of Resident #2's admission Record, showed:-The resident was admitted to the facility on [DATE].-The resident had a diagnosis of need for assistance with personal cares.-The resident had a diagnosis of dysphagia (difficulty in swallowing).-The resident had a diagnosis of cognitive communication deficit (a person has difficulty communicating because of injury to the brain that controls the ability to think).-The resident had a diagnosis of major depressive disorder (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts).Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/21/24, showed:-The resident was cognitively intact.-It was important to the resident to be able to make his/her own decision.-The resident required set up and clean up assistance for meals.During an interview on 7/9/25 at 11:00 A.M., the Director of Rehab said:-He/She was a witness to an incident that occurred between the resident and the previous dietary manager on 6/18/25.-The previous dietary manager was holding a resident council meeting on 6/18/25 and during the meeting the resident was expressing some concerns about his/her food.-The residents' concerns were valid and needed to be voiced to the dietary manager.-The resident started enplaning to the previous dietary manager how he/she did not like fish and was requesting an alternative be offered to her/him when fish was being served at the facility.-The dietary manager became very belligerent slammed his/her hands down very hard on the table and stated, what do you want me to do about it. -The resident began to cry after the previous dietary manager slammed his/her hands down and yelled at the resident.-During the entire resident council meeting the dietary manager was expressing frustration with the residents when they would express concerns about their meals.-The previous dietary manager no longer worked at the facility.During an interview on 7/9/25 at 11:15 A.M., the resident said:-He/She was attending a resident council meeting on 6/18/25 when the previous dietary manager got mad at him/her for expressing his/her concerns.-The previous dietary manager aggressively smacked the table with both of his/her hands and began to yell at me.-The dietary manager yelled, what do you want me to do about it when the resident expressed concerns about not liking fish and desired an alternative meal when fish was being served at the facility.-He/She was very upset and embarrassed and began to cry after the incident with the previous dietary manager.-He/She was consoled by other staff members and residents who were present at the meeting.-The previous dietary manager was pulled out of the meeting by the Administrator and separated from the residents.-The previous dietary manager was let go from the facility and no longer worked there.-He/She was pleased with how the facility handled the situation after it occurred. -He/She felt belittled when the incident occurred but felt better after the previous employer no longer worked at the facility.-He/She felt safe at the facility.During an interview on 7/9/25 at 11:34 A.M., the Business Office Manager said:-He/She was a witness to an incident that occurred between the resident and the previous dietary manager on 6/18/25.-He/She felt so uncomfortable about the way the previous dietary manager responded to the resident, that he/she left the meeting to get the administrator involved.-The resident was expressing concerns to the previous dietary manager about food when the previous dietary manager slammed both hands face down on the table hard and yelled at the resident.-He/She could tell that the resident was visibly upset about the way that the previous dietary manager handled the situation.-He/She saw the resident began to cry after the previous dietary manager yelled at the resident.-He/She left the meeting immediately and reported the incident to the administrator.-The administrator removed the previous dietary manager from the resident council meeting.-He/She witnessed the previous dietary manger being rude and disrespectful to other residents in the past.-The social services director filed a grievance on the resident's behalf.During an interview on 7/9/25 at 11:48 A.M., the Social Services Director said:-He/She filled out a grievance on the resident's behalf after the incident that occurred between the resident and the</p> | | |