STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265579	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Park Rehabilitation & Health Care Center	4600 Little Blue Parkway Independence, MO 64057

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the staff member working in the kitchen failed to wash their hands, providing a risk of cross contamination between objects and food. This practice potentially affected all residents who ate the food from the kitchen. The facility census was 98 residents.Review of the facility's undated Handwashing Policy and Procedure showed:-Hand washing was the most important component for preventing the spread of infection. Proper hand washing technique was to be used at all times that hand washing is indicated.-Hand washing was to be done:--When hands were visibly soiled.--Before and after eating or handling food.--After toileting or after personal grooming (combing hair).--Before starting work.--After smoking.--After coughing, sneezing, or blowing your nose.--After handling uncooked animal products such as raw meat, or fish.1. Observation on 9/25/25 from 9:30 A.M. to 12:00 P.M. during the lunch meal preparation showed:-Dietary [NAME] A grabbed the ready to eat pies in a way that his/her ungloved hand full length of his/her thumbs were touching the top of the pies when he/she moved them. -Dietary [NAME] A touched the gray garbage can lid on the large trash can without gloves on then picked up a loaf of bread, went to the three-compartment sink and then to the dishwasher without washing his/her hands. -When Dietary [NAME] A was working on the preparation line handling hamburger buns, he/she was wearing gloves but pulled up his/her pants and then went back to preparing hamburger buns without washing hands and changing gloves. During interview on 9/26/25 at 9:00 A.M. the Dietary Director said he/she was aware of staff not always washing their hands and having the risk of cross contamination and since he/she started three weeks ago he/she had already created a schedule of education topics including handwashing.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's emergency contact in a timely manner for one sampled resident (Resident #54) when on 9/11/25 at 8:10 A.M., he/she had weakened knees that buckled resulting in staff lowering him/her to ground. out 21 sampled residents. The facility resident census of 98 residents. A policy related to Notification of Change was requested not received at time of exit. 1. Review of Resident #54's admission Record form showed the resident was admitted on [DATE] with diagnoses of:-History of falls. -Cerebral Infraction (stroke happens when there is a loss of blood flow to part of the brain). -Cognitive Communication Deficit (condition where a person has difficulty with communication because of a disruption in brain function that affects thinking abilities). -The resident was his/her own person, and a family member was his/her first emergency contact. Review of the resident's Health Status Note dated 9/11/25 at 8:10 A.M, showed:-This nurse was notified by Certified Nursing Assistant (CNA) G/shower aide, that the resident was lowered to the floor in the shower room. -Upon entering, the resident was found on the floor, lying on his/her back, with both legs extended and arms to his/her sides. -The resident denied hitting his/her head. -The resident had no issue with range of motion (ROM) of his/her extremities, denied any complaints of pain.-The resident had no skin issues noted, and the resident denied pain at that time. -This nurse and staff assisted the resident up from floor into his/her wheelchair. -The nurses had notified all appropriate parties.-Note: Did not indicate who was notified. Review of the resident's Fall Investigation/Incident report dated 9/11/25 at 8:10 A.M. showed.-The resident had allegedly fallen in the shower room on 9/11/25 at 8:10 A.M. during a transfer.-Documented the resident's family member was notified on 9/11/25 at 1:26 P.M.-The resident's physician was notified of the resident incident on 9/11/25 at 2:14 P.M.Review of the resident's medical record dated 9/11/25 showed he/she did not have documentation in the progress notes that the resident's family member and emergency contact was notified immediately after the resident's fall and/or lowered to the ground. Review of the resident's late entry Health Status Note dated 9/11/2025 at 2:55 P.M., showed:-The writer was notified by the charge nurse that resident was at an appointment to oncology when a family member had called the facility stating that resident had complaints of pain in his/her knee from a prior fall that morning (9/11/25).-At the time of the fall, the resident had no complaints of pain. The resident had reported knee pain during his/her doctor appointment. -The family member decided to take the resident over to the emergency room (ER) for evaluation and treatment.Review of the resident's Fall Investigation follow-up note written by Director of Nursing (DON) dated 9/15/25 showed: -On 9/11/25 at around 8:30 A.M., the resident had a witnessed fall without injury at the time of the fall. Upon assessment by the charge nurse, no injury was noted. -On 9/11/25 while the resident was out of the facility for a doctor appointment with a family member, the resident was noted to have his/her right knee swollen. The resident had told the family member he/she had fallen on his/her knee that morning. The resident's family member took the resident to ER for a full examination. The family member reported the resident had a fracture of his/her right knee. -The resident's ER report received showed there was a closed fracture of the right tibial plateau (the top surface of the tibia (shin bone) that forms the weight-bearing part of the knee joint with the femur).-The facility was waiting on the ER x-ray and CT scan results. Review of the resident's Social Services Notes dated 9/15/25 at 4:39 P.M., showed:-The facility had informed the resident's family member that he/she was listed as the resident first emergency contact only.-The facility had no documentation stating the family member was his/her Durable Power of Attorney (DPOA).During an interview on 9/26/25 at 9:56 A.M., Licensed Practical Nurse (LPN) B said:-He/She was the nurse assigned that day and was notified by the shower aide (CNA F) that the resident had been lowered to the ground in the shower room. -He/She did not notify the resident family member immediately after the incident. -The resident (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had already notified his/her family member while they were at a doctor appointment that morning, before the nurse could contact the emergency contact/family member. During an interview on 9/26/25 at 11:30 A.M., Assistant Director of Nursing (ADON) B said: -The nurse assigned to the resident or the unit ADON would normally be responsible for any follow-up calls and notification family members related to the resident fall or incidents. -He/She would expect staff to document emergency contact/family notification in the resident's medical record. During an interview on 9/26/25 at 12:49 P.M., Social Services Designee (SSD) said:-The resident's family member was listed as emergency contact -The resident was listed as own responsible person at that time. -The charge nurse would be responsible for contacting the resident's family member or emergency contact with any change in condition or incidents involving the resident. During an interview on 9/26/25 at 1:27 P.M., Acting Director of Nursing (DON)/ Regional Nurse said:-The resident's family member was contacted later that same day and was noted on the fall investigation report. -The charge nurse would be responsible to notify the resident's family member/emergency contact or DPOA in timely manner of any new incident/fall or resident change of conditions. Complaint # 2619401

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain one mechanical lift in resident room [ROOM NUMBER], free from a buildup of grime and particles. This practice affected one resident who was dependent on the use of a mechanical lift. The facility census was 98 residents.Review of the facility's Undated guidelines for inspecting the mechanical lifts, entitled Inspecting Mobile lifts, showed: -Inspect all surfaces on lifts to ensure they are in good repair.-Clean as necessary and notify housekeeping.-Check battery if applicable.-Inspect the control panel.-Inspect the electrical cords.1. Observations on 9/23/25 at 11:52 A.M. and on 9/25/25 at 12:58 P.M., showed a buildup of grime on the base of the mechanical lift in the resident's room. During an interview on 9/25/25 at 12:53 P.M., Certified Nursing Assistant (CNA) A said the mechanical lift should be cleaned every shift and the facility staff who used the mechanical lift should clean the lift more often. During an interview on 9/25/25 at 1:00 P.M., CNA B said the mechanical lifts should be cleaned at night and disinfected after every use. During an interview on 9/25/25 at 1:14 P.M., the North Unit Assistant Director of Nursing (ADON) said the lift should be cleaned weekly. During an interview on 9/26/25 at 1:10 P.M., the North Unit ADON said that housekeeping staff was supposed to clean the lifts after the maintenance staff checked the lifts. During an interview on 9/25/25 at 1:20 P.M., the North Unit Side ADON the lift should be cleaned by housekeeping, and the aides should inform housekeeping when the lift needs cleaning.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review the facility failed to ensure the call light was within reach for one sampled resident (Resident #18) out of 21 sampled residents. The facility census was 98 residents. A call light policy was requested and not provided at the time of exit. 1. Review of Resident #18's Significant Change Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 7/30/25 showed:-The resident was moderately cognitively impaired. -Required staff assistance with his/her activities of daily living. Review of the resident's care plan dated 9/24/25 showed:-The resident was at risk for falls related to unsteady gait and cognitive impairment with poor safety awareness.-The resident had limited physical mobility.-The resident would have interventions in place to reduce the risk for falls and/or injury r/t falls through the next review period that included:--Display a Call Don't Fall sign.--Educate resident to ask staff for assistance.--Educate resident to use the call light to ask for assistance.--Be educated to ensure the call light was clipped where the resident could easily reach it.Observation on 9/22/25 at 10:11 A.M. showed:-The resident's call light was draped across a pillow that was sitting on top of a chair in the resident's room at least 2 feet away from the resident. -A Call Don't Fall sign was posted on the wall above the resident's bed.Observation on 9/23/25 at 8:24 A.M. showed: -The resident's call light was draped across a pillow that was sitting on top of a chair in the resident's room at least 2 feet away from the resident. -A Call Don't Fall sign was posted on the wall above the resident's bed.Observation on 9/24/25 at 9:01A.M. showed:-The resident's call light was on the floor under a chair in the resident's room which was at least 2 feet away from the resident. -A Call Don't Fall sign was posted on the wall above the resident's bed.Observation on 9/24/25 at 1:39 P.M. showed:-The resident's call light was draped over a pillow that was sitting on top of a chair in the resident's room which was at least 2 feet away from the resident. -A Call Don't Fall sign was posted on the wall above the resident's bed.Observation on 9/25/25 at 10:26 A.M. showed:-The resident's call light was draped over a pillow that was sitting on top of a chair in the resident's room which was at least 2 feet away from the resident. -A Call Don't Fall sign was on the resident's bedside table which was positioned across the resident while he/she was lying in bed.Observation on 9/25/25 at 2:10 P.M. showed:-The resident's call light was draped over a pillow that was sitting on top of a chair in the resident's room which was at least 2 feet away from the resident. -A Call Don't Fall sign was on the resident's bedside table which was positioned across the resident while he/she was lying in bed.Observation on 9/26/25 at 9:16 A.M. showed:-The resident's call light was draped across the bedside table, which was near the middle of the room, 3 feet away from the resident. During an interview on 9/26/25 at 9:15 A.M. Certified Nursing Assistant (CNA) E said:-He/She knew to respond to the resident's needs by seeing if the call light was activated, regular room checks and asking the resident.-The call light should be attached to the person at all times.-The resident required total assistance.-The call light placement should be checked before leaving the resident's room.-At this time, the call light was located on the resident's beside table.--The bedside table was located 3 feet away from resident.-The call light should have been placed within the resident's reach if discovered to be out of reach. During an interview on 9/26/25 at 9:06 A.M. Licensed Practical Nurse (LPN) A said: -He/She identified that the resident was in need of assistance by the call light being activated, verbalization by the resident, the CNA or any other staff reporting it to her/him, walking by or asking the resident.-The resident was reminded to use the call light for assistance by the nursing staff, by having the call light close by, the staff verbalizing instructions, and/or displaying a Call Don't Fall sign in the room.-All call lights for all residents should be within arm's reach at all times.-All staff in the building were responsible for ensuring that call lights were within reach for all residents at all times.-Staff should ensure that call lights were within reach for residents before leaving the room. During an interview on 9/26/25 at 9:26 A.M. Assistant Director of Nursing (ADON) B said:-He/She (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would expect the call lights be within the residents reach at all times.-All staff including nursing, were responsible for ensuring the call lights were within reach at all times.-Staff should check that the call lights were within reach before leaving the resident's room.-If staff saw that the call light was not within reach for Resident #18, they should have moved it so it was clipped it to the resident's person within arm's reach. During an interview on 9/26/25 at 1:27 P.M. the Corporate Nurse said: -He/She would expect that call lights be within the residents reach at all times.-All staff were responsible for ensuring that the call lights were within reach at all times.-He/She would expect staff to check that the call lights were within reach before leaving the resident's room.-He/She would expect that if staff saw that a call light was not within reach, they should clip it to the resident's person placing it within arm's reach.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure infection control practices for proper placement of indwelling Foley catheter (a urinary bladder catheter inserted through urethra) tubing from dragging or touch the ground, for one sampled resident (Resident #10) who's at risk for Urinary Tack Infections (UTI - an infection of one or more structures in the urinary system) out of 21 sampled residents. The facility census was 98 residents. Review of the facility Indwelling Foley Catheter Care policy dated 12/2024 showed: -Ensure resident to keep the catheter and tubing free of kinks. -Check drainage tubing and bag to ensure that the catheter is draining properly. 1. Review of Resident #10 admission Record showed the resident admitted to the facility with a diagnosis of obstructive and reflux uropathy (is kidney scarring caused by urine flowing backward from the bladder into a ureter and toward a kidney).Review of the resident's Catheter Care Plan dated 5/6/25 showed:-The resident required a foley catheter due to diagnosis of obstructive and reflux uropathy.-Position catheter bag and tubing below the level of the bladder.Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/8/25, showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.-Required total assistant from staff for all cares and transfer.-admitted with indwelling catheter. Review of the resident's Physician Order Sheet (POS) dated 9/2025 showed: -Change catheter drainage bag as needed for leaking.-Foley catheter Care - wash catheter site with soap and water every shift.Observation of the resident on 9/23/25 at 11:32 A.M., showed:-He/She was sitting in a wheelchair.-His/Her catheter drainage bag was hooked underneath his/her wheelchair in a privacy bag. -The catheter tubing had creamy thick substance in tubing. -The tubing clipped to the resident pant leg at this time. Review the resident's lab progress note dated 9/25/25 at 8:30 A.M. showed: -The resident's provider was notified of the urinalysis (UA) and culture and sensitive (C&S) results.-Awaiting return call for further instructions at that time. Observation of the resident on 9/25/25 at 10:19 A.M., showed: -The resident sat in his/her wheelchair watching television in his/her room. -The resident catheter tubing was dragging on the ground under his/her wheelchair. -The tubing had thick cloudy substances in the tubing. Observation of the resident on 9/25/25 at 1:30 P.M., showed:-The resident sat in his/her wheelchair with catheter drainage bag under the resident's wheelchair. -The Certified Nursing Assistant (CNA) C was emptying the resident catheter drainage bag.-The catheter tubing remained on the ground under the resident wheelchair.-CNA C did not attempt to reposition the catheter tubing to ensure not touching or dragging on the ground. During an interview on 9/26/25 at 9:40 A.M, CNA H said:-The resident catheter tubing should not be touching the ground and check for kinks. -While sitting in wheelchair the resident catheter bag should be positioned not touch the ground. -He/She would clean the catheter tubing and reposition the tubing so it was not touching the ground. -He/she had recent skill check off and training related to catheter care and tubing placement. During an interview 9/26/25 at 9:58 A.M, CNA B said:-Catheter tubing is placed under the resident's wheelchair and staff were to ensure the tubing was not touching or dragging on the ground. -If found a catheter tubing on the ground, he/she would clean the tubing and reposition the tubing, so it was not touching the ground. During an interview on 9/26/25 at 11:17 A.M. Licensed Practical Nurse (LPN) C said: -The resident's catheter tubing should be place underneath the resident's wheelchair and positioned so it would not drag on the ground. -The resident was at risk for urinary tract infection due to catheter usage. -The nursing and CNA staff would be responsible for ensuring the placement of the resident's catheter bag tubing, so it was not touching the ground, During an interview on 9/26/25 at 11:17 A.M., Assistant Director of Nursing (ADON) B said: -He/She would expect CNA and nursing staff to ensure the resident's catheter tubing was positioned so it was not touching the ground. -He/She would expect care staff to clean the catheter tubing if it was on the ground and reposition the resident's catheter tubing to ensure it was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not touching the ground. During an interview on 9/26/25 at 1:27 P.M. Acting Director of Nursing (DON) said: -He/She would expect CNA and nursing staff to ensure the resident's foley catheter tubing was positioned under the resident's wheelchair so the tubing would not be touching or dragging on the ground.-If found tubing dragging on the ground, he/she would expect all care staff to have either replaced the drainage system or to clean the catheter tubing before repositioning the resident catheter tubing off the ground.