

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Blue Springs Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 930 NE Duncan Road Blue Springs, MO 64014	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two sampled residents (Resident # 8 and #9), out of 10 sampled residents, were free from abuse when on 8/31/25 Resident #7 pushed Resident #8 out of his/her wheelchair resulting in Resident #8 sustaining a laceration to his/her midforehead; and on 9/2/25 Resident #7 punched Resident #9 in the arm and began pulling on his/her arm causing immediate and residual arm pain and feelings of being attacked. The resident census was 92 residents. On 9/16/25 the Administrator was notified of the past noncompliance which occurred on 8/31/25. The facility had completed interventions for residents and training for all staff prior to state agency investigation. The deficiency was corrected on 9/6/25. Review of the facility Abuse Prevention and Prohibition Program dated 10/24/22 showed:-To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. -Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property.-The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property.-Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.-The Facility is committed to protecting residents from abuse by anyone, including but not limited to other residents.-The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.-Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring.-The Facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse.-Resident-to-resident altercations must be reported if the altercation is caused by a willful action that results in physical injury, mental anguish or pain.-The Administrator will submit initial and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies. 1. Review of Resident #7's admission Record showed the resident was admitted on [DATE] with diagnoses including patient's noncompliance with other medical treatment and regimen. Review of Resident #7's undated Care Plan showed:-The resident has the potential to demonstrate verbally abusive behaviors related to ineffective coping skills, mental / emotional illness, date Initiated: 01/23/2025.- When the resident becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 01/23/2025. Revision on: 06/27/2025. Review of Resident #8's admission Record showed the resident was admitted on [DATE] with diagnoses including bipolar disorder, anxiety disorder, and history of falling. Review of Resident #8's undated Care Plan showed the resident had a history of impulsive behavior and the ability to be disruptive. Review of Resident #9's admission Record showed the resident was admitted on [DATE] with diagnoses including bipolar disorder and post-traumatic stress disorder. Review of Resident #9's undated Care Plan showed the resident:-Had a mood problem related to depression.-Had a history of trauma related to sexual assault at age [AGE] years. Review of the undated facility Investigation for the 8/31/25 altercation showed:-On 8/31/25 at approximately 4:30 P.M. the charge nurse was alerted to Resident #8's room by staff.-Resident #8 accused Resident #7 of pushing him/her.-Resident #7 admitted to pushing Resident #8.-Resident #8 was moved out of the room and all parties were notified.-There were no injuries noted to Resident #7.-Resident #8 had a small laceration to the middle of his/her forehead and a small abrasion adjoined. -During the interview, Resident #8 disclosed he/she had been shoved out of his/her wheelchair onto the floor by Resident #7.-First aid was provided for Resident #8 and neurological checks were initiated.-Resident #8 was relocated for his/her protection and separation.-Law enforcement was contacted as this was the second resident assault in a week.-Law enforcement responded and charges were pending for Resident #7.-1:1 (one on one) supervision was in place for Resident #7.-Monitoring was continued for both residents.-Education for staff was initiated. Review of #7's Progress Notes dated 8/31/25 showed:-Alerted to resident room by staff.-Roommate (Resident #8) accused resident of pushing him/her, resident denied pushing or hitting Resident #8, did verbalize to other staff that he/she did push/hit the roommate -Resident #8 removed from the room and Resident #7 placed on 1:1 -All parties notified. Review</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</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 accurate accounting of narcotics for two sampled residents (Resident #4 and #5) when seven narcotic pain medications were unaccounted for out of 10 sampled residents. The facility census was 92 residents. The Administrator was notified of past noncompliance on 9/16/25 which occurred on 6/17/25. Staff training was completed, and the deficiency was corrected 7/8/25. Review of the facility Controlled Substances Policy dated 8/2020 showed:-Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with state and federal laws and regulations.-All controlled substances are stored and maintained in a locked cabinet or compartment. -Accurate inventory of all controlled medications is maintained at all times.-When a controlled substance is administered, the licensed nursing personnel administering the medications immediately enters the following information on the accountability record and the Medication Administration Record (MAR):--Date and time of administration on MAR and accountability record.--Amount administered on accountability record. --Remaining quantity on accountability record.--Signature of the nursing personnel administering dose on accountability record.--Initials of the nurse administering dose, completed after the medication has been administered on the MAR.-When a dose of controlled medication is removed from the container for administration but is refused by the resident or not given for any reason, the dose must be destroyed according to facility policy and the disposal documented on he accountability record on the line representing that dose.1.Review of Resident #4's admission Record showed the resident was admitted on [DATE] with diagnoses including dementia, and pain in his/her right leg. Review of the resident's Order Summary Report dated 6/18/25 showed:-Pain assessment before and after as needed (PRN) meds. -Hydrocodone-Acetaminophen (Norco) oral tablet 5-325 milligrams (mg), give one tablet by mouth two times a day for pain. Review of the resident's MAR dated 6/1/25 through 6/18/25 showed the resident was receiving Norco for pain twice daily. Review of the resident's Controlled Drug Administration Record dated 6/7/25 through 6/17/25 showed:-There were seven tablets of Norco 5-325 mg left after the last administration on 6/17/25 at 5:00 P.M.-There were six tablets of Norco 5-325 mg left with no documented administration on 6/18/25 at 12:00 A.M. 2.Review of Resident #5's admission Record showed the resident was admitted on [DATE] with diagnoses including senile dementia and adult failure to thrive. Review of the resident's Order Summary Report dated 6/18/25 showed:-Pain assessment before and after as needed (PRN) meds. -Hydrocodone-Acetaminophen (Norco) oral tablet 10-325 mg, give one tablet by every six hours for pain. Review of the resident's MAR dated 6/1/25 through 6/18/25 showed the resident was receiving Norco for pain. Review of the resident's Controlled Drug Reconciliation Record/Disposition Form dated 6/8/25 through 6/17/25 showed:-There were 52 tablets of Norco 10-325mg left after the last administration on 6/17/25 at 5:00 P.M.-There were 48 tablets of Norco 10-325 mg and no documented administration on 6/18/25 at 12:00 A.M. 3. Review of the undated facility investigation showed:-On 6/17/25 Licensed Practical Nurse (LPN) A was working as a medication nurse and was to work the floor at 10:00 P.M.-At approximately 6:00 P.M., LPN A and LPN B conducted a change of shift narcotic count for the north halls (100, 200, and 300 halls), which was without discrepancies.-At approximately 10:04 P.M., the Director of Nursing (DON) received a call because there was an off-going narcotic count between Registered Nurse (RN) A and LPN A, where RN A contacted the Assistant Director of Nursing (ADON) to let him/her know he/she was not accepting the controlled substance count.-There was a total of seven Norco tablets not accounted for, three tablets of 5-325 milligram(mg) Norco for Resident #4 and four tablets of 10-325 mg Norco for Resident #5.-The DON instructed the ADON to contact 911 so that law enforcement could become involved and intervene if need be in the misappropriation.-When law enforcement arrived at the facility, the officer was made aware of the missing narcotics that was noted during the change of shift controlled substance count.-The ADON began an audit of the medications and confirmed the missing narcotics.-Per practice once medications are discovered missing, an investigation is immediately launched and the two subjects counting were to stay together until released by the DON/designee. -LPN A denied knowing what happened to the missing narcotics. Review of the police report dated 6/23/25 showed:-Law enforcement was contacted on 6/17/25 at 11:15 P.M for stealing controlled substances.-Resident #4 and Resident #5 were listed as victims in which the narcotics were stolen from -ADON and RN A were listed as witnesses -Upon arrival at the facility, the officer was</p>		