STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265700	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilshire at Lakewood Rehab Center	600 N E Meadowview Drive Lees Summit, MO 64064

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease) that included specific assessments and contents, in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility; the facility failed to ensure appropriate barrier placement when checking one supplemental resident's (Resident #66) blood glucose (sugar) level, failed to ensure appropriate hand hygiene was completed for one supplemental resident (Resident #39), and failed to ensure appropriate infection control measures were taken prior to the use of an insulin (a hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose in the blood) pen for two supplemental residents (Resident #142 and #151) out of five supplemental residents. The facility census was 122 residents with a licensed capacity for 170 residents at the time of the survey.1. Observation on 9/16/25 between 8:47 A.M. and 9:27 A.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Dietary Manager (DM) showed there was a three-sink area, a chemical dish-washing machine, a hand-washing sink, an ice machine, and a steam table (also referred to as a hot food table, is specifically designed to hold food at steady, safe serving temperatures, and not designed to cook or warm foods from a raw state). Observation on 9/17/25 between 11:21 A.M. and 12:53 P.M. during the initial facility LSC walk-through inspection with the Director Plant Operations (DPO) showed:-The municipal water main supply entered the facility at the front of the building. -The building was equipped with a complete fire sprinkler system with sprinkler heads located throughout the facility. -There were housekeeping closets with floor mop sinks or ceramic service sinks (mop/service sinks are used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water), water heaters, water softeners, and hot/cold water piping throughout the facility.-There were numerous resident rooms with private and/or shared bathrooms and sinks throughout the eight resident hallways.-There were commercial clothes washers in the laundry area.-There were eight shower rooms in the facility. -There was a Beauty Shop with a sink. -There was a large unused fountain in the atrium (in architecture, it is a central, sky-lit space within a building, often covered by a glass roof, that can serve as a lobby or communal area).-There were two dining rooms with sinks.-Public restrooms were located on the front administrative office hall with additional restrooms in the west Employee Breakroom. Review of the facility's untitled, undated, and unreviewed Legionella paperwork, held together with a binder clip and provided by the Administrator, showed the following:-There was a 31-page (pg.) Centers for Disease Control (CDC) toolkit including a completed brief eight question assessment on page 2, with the rest consisting of educational (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	guidelines for creating a water management program with control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.-There was a 14-pg. CDC Legionella Environmental Assessment Form that was filled out up to the 19th question on page 5 and continued incomplete through the following 9 pages without notations on whether they were applicable or not.-Another similar 13-pg. CDC Legionella Environmental Assessment Form with some pages that were partially or completely filled out, and others that were left blank.-There was a 5-pg. facility-specific review of their own management plan that began and ended with the same facility layout map that only showed locations of water heaters, two sprinkler rooms, and utility shut-offs.-There was a Glossary, a 3-pg. explanation of Controlling Legionella in Decorative Fountains, and another 1-pg. assessment left blank.-A generic 8-pg. educational Communicable Disease Investigation Reference Manual from the Missouri Department of Health and Senior Services was included.-There was an additional 2 pages of CDC guidelines taken from a 241-page document.-A 2-pg. list of water test results from January 2024 through September 2025 was also provided. During an interview on 9/19/25 at 9:32 AM the Administrator said:-The water management program was created by using the assessments they follow.-He/She assumed they had all been finished.-He/She actually oversaw the program. During an interview on 9/19/25 at 10:37 AM the Director Plant Operations said:-Their water management program was based off a TELS (a computerized maintenance building management system and suite of services designed for Senior Living communities) review in June of this year.-If there were assessments that should have been completed by the Maintenance Director but were not, he/she actually did not catch that. Review of the facility's policy titled Subcutaneous Injection/ Insulin or Heparin dated 10/24/22 showed no mention of insulin pens within the policy. Review of the facility's policy titled Blood Glucose Monitoring dated 10/24/22 showed no policy for barrier use while checking a resident's blood glucose level. Review of the facility's policy titled Medication Administration dated 10/24/22 showed staff were to wash their hands before and after medication administration. 2. Review of Resident #66's admission Record showed he/she was admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Observation on 9/15/25 at 12:10 P.M. showed:-Licensed Practical Nurse (LPN) D entered the resident's room.-LPN D informed the resident that he/she was going to check the resident's blood sugar.-LPN D set the blood sugar supplies on the resident's sink area without a barrier in place.-LPN D checked the resident's blood sugar, gathered the supplies from the resident's sink area and left the resident's room. During an interview on 9/19/25 at 9:34 A.M. LPN D said:-He/She would not have done anything differently from how she performed the resident's blood sugar check.-He/She could not remember if he/she had used a barrier during the resident's blood sugar check.-He/She had never been taught that he/she needed to use a barrier when setting down blood sugar supplies in resident care areas. 3. Review of Resident #39's admission Record showed he/she admitted to the facility with the following diagnoses:-DM II.-Acute Kidney Failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/19/25 at 9:03 A.M. of the resident's medication administration completed by Certified Medication Technician (CMT) B showed:-He/She did not wash or sanitize his/her hands prior to taking all of the resident's medication out of the packets.-He/She entered the resident's room without washing or sanitizing his/her hands.-He/She exited the resident's room without washing or sanitizing his/her hands.-He/She began the next resident's medication administration without washing or sanitizing his/her hands. During an interview on 9/19/25 at 9:16 A.M. CMT B said he/she would not have done anything differently. During an interview on 9/23/25 at 12:18 P.M. CMT B said:-He/She was unsure if he/she had sanitized his/her hands before he/she passed Resident #39's medications.-He/She thought he/she had not sanitized his/her hands after he/she passed Resident #39's medications.-Hand hygiene should be performed before and after each resident during medication administration. 4. Review of Resident #142's admission Record showed he/she admitted to the facility with a diagnosis of DM II. Review of the resident's Order Summary Report dated September 2025 showed an order for Humalog (Insulin Lispro- short acting insulin) Solution 100 unit/milliliters (ml), inject per sliding scale: if 251-300 give 14 units. Observation on 9/19/25 at 11:45 A.M. of the resident's Humalog administration completed by LPN E showed:-LPN E went into the resident's room and checked the resident's blood sugar.-LPN E then exited the resident's room and prepared the resident's insulin via a pen injector.-LPN E placed the needle on the pen without sanitizing the hub of the pen.-LPN E then primed the insulin pen and dialed the insulin pen to 14 units.-LPN E walked into the resident's room and administered the resident's insulin. 5. Review of Resident #151's admission Record showed he/she admitted to the facility with a diagnosis of DM II. Review of the resident's Order Summary Report dated September 2025 showed an order for Insulin Lispro Injection Solution, inject as per sliding scale: if 250-299 inject six units. Observation on 9/19/25 at 12:04 P.M. of the resident's Insulin Lispro administration completed by LPN E showed:-LPN E went into the resident's room and checked the resident's blood sugar.-LPN E then exited the resident's room and prepared the resident's insulin via a pen injector.-LPN E placed the needle on the pen without sanitizing the hub of the pen.-LPN E then primed the insulin pen and dialed the insulin pen to six units.-LPN E walked into the resident's room and administered the resident's insulin. During an interview on 9/19/25 at 12:15 P.M. LPN E said he/she would not have done anything differently during Resident #142's and Resident #151's insulin administration. 6. During an interview on 9/22/25 at 2:12 P.M. the Director of Nursing (DON) said:-He/She expected staff to perform hand hygiene before and after each resident during medication administration.-CMT B had not performed correct hand hygiene during Resident #39's medication administration.-A barrier needed to be in place when setting any medical equipment down in a resident care area to include (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	blood sugar monitoring supplies.-Blood sugar monitoring was on a recent skills check-off that LPN D would have been a part of.-LPN D had not performed correct infection control measures during Resident #66's blood glucose check.-All insulin pens needed to be sanitized with the manufacturer's recommendation of sanitation prior to each use.-LPN E had not performed correct infection control measures during Resident #142's and Resident #151's insulin administration. During an interview on 9/23/25 at 12:18 P.M. CMT B said:-He/She was insulin administration certified.-When checking a resident's blood sugar, he/she would normally bring all of the supplies into the room and place a barrier down if he/she were setting down the supplies.-The staff person should have used a barrier when checking Resident #66's blood sugar.-Without a barrier in place, then the supplies could have been contaminated.-He/She was unsure if the hub of an insulin pen needed to be sanitized prior to use. During an interview on 9/23/25 at 12:35 P.M. the Assistant Director of Nursing (ADON) said:-Hand hygiene needed to be performed before and after each resident during medication administration. -CMT B had not performed appropriate hand hygiene during Resident #39's medication administration.-A barrier needed to be used when placing any medical equipment in resident care areas which included blood sugar monitoring equipment.-When a barrier is not in place then it puts residents at an increased risk of infection.-LPN D had not performed appropriate infection control measures during Resident #66's blood sugar check.-All insulin pens needed to be sanitized before each use.-LPN E had not performed appropriate infection control measures during Resident #142's and Resident #151's insulin administration.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards for one sample resident (Resident #5) when staff taped the resident's ileostomy (a surgical procedure that creates an opening in the abdominal wall through which the last part of the small intestine, called the ileum, is brought to the surface of the body) bag shut instead of using a clip and for one sampled resident (Resident #70) when staff failed to correct an order entry error related to weighing the resident daily and documenting the daily weights out of 31 sampled residents. The facility census was 122 residents.Review of the facility's policy titled Nutrition/Hydration Management dated 10/24/22 showed:-Residents were weighed upon admission and re-admission and then at least weekly for four weeks and then monthly if weight is stable.-Based on clinical judgement licensed nurses weigh residents as needed based on clinical presentation.Review of the facility's policy titled Ileostomy Care dated 10/24/22 showed:-When emptying the ostomy pouch staff were to drain the contents of the pouch into the toilet or bed pan, wipe the bottom of the pouch, and reapply the closure clamp.1. Review of Resident #5's admission Record showed he/she was admitted to the facility with a diagnosis of Ileostomy Status.Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/26/25 showed:-The resident was cognitively intact.-The resident did not have any type of ostomy present.Review of the resident's undated care plan showed the resident had an alteration in gastrointestinal status and had an ileostomy with no interventions in place related to the care or supplies the resident needed for his/her ileostomy care.During an interview on 9/15/25 at 2:19 P.M. the resident said:-He/She had an ileostomy.-The facility was not good about keeping the needed supplies in his/her room.During an interview on 9/22/25 at 11:09 A.M. the resident said:-He/She was upset because the staff that did his/her ostomy care had to tape up the bag because they could not find a clamp in his/her room.-He/She had been learning how to do his/her own ileostomy care and was frustrated that he/she could not empty his/her ileostomy bag because it was taped shut.Observation on 9/22/25 at 11:09 A.M. showed the resident's ileostomy bag had been taped shut. During an interview on 9/22/25 at 11:16 A.M. Licensed Practical Nurse (LPN) E said:-He/She could not find a clamp or closure device when doing the resident's ileotomy care earlier in the morning, so he/she had to tape it shut.-When the resident was first admitted to the facility, the staff had trouble keeping a good seal of the bag to the residents ostomy and staff had been blowing through supplies.-He/She was unsure of why the clamps to the ostomy pouches kept disappearing.-He/She had forgotten that he/she had taped the pouch shut and still needed to find a closure device for the resident's ileostomy pouch.During an interview on 9/22/25 at 2:12 P.M. the Director of Nursing (DON) said:-He/She had been made aware that LPN E had taped the resident's ileostomy pouch up because they could not find a closure device for the resident's pouch.-The facility had plenty of ostomy supplies.-All nursing staff had access to central supply, so finding extra supplies would not be difficult.During an interview on 9/23/25 at 12:35 P.M. the Assistant Director of Nursing (ADON) said:-There had been a lot of issues with the resident's ileostomy care when the resident first admitted to the facility.-When he/she had cared for the resident, he/she found it difficult to find the appropriate closure device for the resident.-Ostomy pouches should never be taped shut.-LPN E should have laid the pouch on a towel instead of taping the pouch shut.-After laying the pouch on a towel LPN E should have immediately gone to central supply to find a closure device for the resident.-By taping the ileostomy bag shut, LPN E hindered the resident's independence with performing his/her own ileostomy care.2. Review of Resident #70's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:-End Stage Renal Disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis (a medical procedure that replaces the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function of the kidneys by filtering water products and excess fluid from the blood through a machine). -Dependance of Renal Dialysis.Review of the resident's undated care plan showed the resident had renal insufficiency related to his/her diagnosis of ESRD and had dialysis treatments every Monday, Wednesday, and Friday.Review of the resident's Order Summary Report dated September 2025 showed:-An order for the resident to be weighed daily and staff were to call the facility doctor if the resident had a two or more-pound weight gain in 2 days or if the resident had a five-pound weight gain in a week.-The order was dated 8/11/25 but had a start date on 9/1/25.Review of the resident's weight's dated August 2025 and September 2025 showed:-The resident had only two weights documented in the Electronic Medical Record (EMR) for August 2025.-The resident did not have daily weight's put into the EMR eight times out of 21 opportunities.Review of the resident's dialysis communication forms dated August 2025, and September 2025 showed:-The facility had been faxed seven of the resident's communication forms on 9/19/25.-Only two dialysis communication forms were uploaded into the resident's EMR.-The resident was only getting weighed on his/her dialysis days in the month of August 2025.Review of the resident's Treatment Administration Record dated September 2025 showed:-Eight missing weights in the record.-Of the eight missing weights, staff marked drug refused six times.During an interview on 9/22/25 at 9:25 A.M. the Regional Nurse and the ADON said that they would expect staff to document in a progress note if the resident refused to be weighed and not use the drug refused option.During an interview on 9/22/25 at 12:46 P.M. the facility's Medical Director said:-Residents who received dialysis treatments were normally put on daily weights.-He/She was unsure of why the order had a start date of 9/1/25.-He/She thought the person who put in the order must have made an order entry error.-If the resident was refusing to be weighed, it needed to be documented.-The resident should have been getting weighed daily since admission to the facility.During an interview on 9/22/25 at 2:12 P.M. the DON said:-He/She was unsure of the resident's current weight order.-He/She assumed the resident's weight order was for the resident to be weighed three times a week, before and after dialysis.-He/She would expect a progress note to be made by staff every time the resident refused to be weighed.-The staff should have been clicking the progress note option on the TAR, this would automatically create a pop-up box for staff to type a note into the EMR.-It was not sufficient documentation for the staff to mark drug refused on the TAR.-The resident's weight order should have been clarified upon review of the orders.During an interview on 9/23/25 at 12:18 P.M. Certified Medication Technician (CMT) B said:-He/She was unsure of the resident's current weight order.-If the resident refused to be weighed it needed to be documented somewhere in the chart.-It was appropriate for staff to use the drug refused option on the TAR to indicate that the resident refused to be weighed.During an interview on 9/23/25 at 12:35 P.M. he ADON said:-The resident's current weight order was for the resident to be weighed before and after each dialysis treatment.-If the resident refused to be weighed it needed to be documented.-There was an option in the TAR for staff to be able to make a progress note.-He/She was unsure of why the resident's daily weight order had a start date of 9/1/25.-He/She assumed that it was an order entry error.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one sampled resident's (Resident #147) physician's order for no cardiopulmonary resuscitation (CPR - any medical intervention used to restore circulatory and/or respiratory function that has ceased) was followed when the resident was found not breathing and having no heart beat out of 31 sampled residents. The facility census was 122 residents.1. The Administrator was notified on [DATE] of past non-Compliance which occurred on [DATE]. The facility had completed an internal investigation and had in-serviced all staff on [DATE]. The past non-compliance was corrected on [DATE]. Review of the facility Cardiopulmonary Resuscitation (CPR) policy dated [DATE], showed:-CPR is instituted (started) in cases of recognized cardiac arrest (the heart has stopped) and/or pulmonary arrest (breathing has stopped) to sustain or support a resident's cardiac and/or breathing function until medical emergency personnel are available to take over the resuscitation efforts.-CPR is instituted on all residents except those designated as No Code or No CPR. Review of Resident #147's physician order dated [DATE] showed:-Do not resuscitate (DNR - a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest.Review of the resident's licensed nurse progress note dated [DATE] showed:-At approximately 4:00 A.M. on [DATE] the licensed nurse making rounds found the resident in his/her room not breathing and without a pulse.-The licensed nurse yelled Code Blue (an announcement that an adult is having a medical emergency, usually cardiac or respiratory arrest) and for help to come.-CPR was started.-911 was called.-Emergency Medical Services (EMS) arrived at the facility at approximately 4:20 A.M. Review of the resident's Fire Department Prehospital Care Report dated [DATE], showed:-Emergency Medical Services (EMS -a system of pre-hospital care and transport for patients with urgent medical needs) was dispatched to the facility at 4:22 A.M. on [DATE]/ 2024 for a resident having cardiac arrest and not breathing with CPR in progress. cardiac arrest-The resident's medical history was obtained from facility health care personnel.-The resident had cardiac arrest (his/her heart was not beating) and respiratory arrest (he/she was not breathing).-He/she had no advance directives.-On arrival, EMS found the resident unresponsive, lying on his/her back with his/her face and torso pointing up on his/her bed (NOTE: For chest compressions to be effective, they must be delivered with enough force to compress the chest by at least 2 inches (5 cm) for adults. When performed on a soft, flexible surface like a bed mattress, a significant amount of the force is absorbed by the surface, preventing adequate chest compression.)-Facility staff reported CPR had been started approximately 15 minutes before EMS arrival.-The resident was pale, with lividity (the bluish-purple discoloration of skin after death) starting to form on the dorsal (back) side of his/her arms, near his/her shoulders.-He/she was not breathing, rigor (stiffness that occurs shortly after death) was absent and he/she was warm to touch.-His/her eyes were non-reactive (the pupils did not change size in response to light - a sign of serious neurological damage in the brain stem that controls automatic body functions of breathing, heartbeat and blood pressure).-His/her breastbone was soft and flexible, in conjunction with CPR.-Facility staff reported the resident to be a full code (a healthcare directive indicating that all life-saving measures, such as CPR, should be used if a patient's heart stops beating or they stop breathing) and were in the process of contacting the resident's family upon EMS arrival.-Chest compressions were immediately taken over by EMS; pulse and breathing were found to be absent.-EMS moved the resident from his/her bed to the floor and continued chest compressions.-An oropharyngeal airway (ORA - a medical device used to maintain an open airway in persons who are unconscious or have difficulty breathing) was inserted and Bag-valve-mask (BVM - ventilation is a manual resuscitation technique that provides positive pressure ventilation to patients with inadequate (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or absent breathing) ventilation was initiated.-A nasal capnography was also placed (a non-invasive technique that monitors ventilation and airway integrity during procedures and critical care measures).-He/she was placed on a heart monitor and was found to be in asystole (the most serious form of cardiac arrest when the heart's electrical system fails entirely, which causes the heart to stop pumping and is usually irreversible); throughout EMS care, he/she never left asystole.-Possible Intravenous (IV) access was not found; intraosseous (IO - vascular access procedure used in emergencies to provide rapid, temporary access to the blood stream by inserting a needle into bone marrow allowing administration of fluids and medications). -The [NAME] device (a mechanical device that provides consistent and high-quality chest compressions during CPR) was placed.-Epinephrine (a medication used to increase blood flow to the heart and brain, which can increase the chances of a return of spontaneous circulation) three times with no change.-Normal saline (intravenous fluid with salt concentration of human blood) was administered.-An endotracheal tube (ET tube - a flexible, hollow plastic tube inserted into the windpipe through the mouth, serving to secure a definitive airway and facilitate breathing when a patient cannot do so sufficiently on their own, such as during critical illness).-Throughout EMS resuscitation the resident's lividity did not improve, and he/she remained pale through CPR.-After 25 minutes of Advanced Cardiovascular Life Support (ACLS - evidence-based clinical guidelines for the urgent treatment of life-threatening cardiovascular conditions, such as cardiac arrest; it incorporate advanced procedures, medications, airway management, and defibrillation, preparing healthcare providers to manage patients in critical medical emergencies) CPR, the resident's condition did not improve and no change in heat rhythm was found.-Facility staff had made contact with the resident's family who were comfortable terminating recessive efforts.-Per protocol, resuscitation was discontinued at 4:56 A.M. and the resident was left in the care of facility staff.During an interview on [DATE] at 12:33 P.M. the resident's physician said:-He/she believed the facility did everything correctly regarding CPR for the resident.-For CPR to have been successful, it had to have been started when the resident was found unresponsive warm.-The facility informed EMS of the resident's DNR and EMS said they could not stop resuscitation.-He/she felt EMS should have stopped resuscitation at that time.-In his/her view the facility staff were not wrong to have started CPR, but EMS should have stopped CPR once the resident's code status was communicated to EMS. During an interview on [DATE] at 9:59 A.M. Licensed Practical Nurse (LPN) A said:-He/she was the charge nurse on the resident's hall on the night shift on [DATE].-A Certified Nursing Assistant (CNA) had come to ask him/her about the resident's positioning in his/her bed - at that time the resident was alert and talking.-A few minutes later, he/she went to check on the resident and found him/her unresponsive, without a pulse, not breathing, but warm to touch.-He/she called a code (summoned staff for a life-threatening emergency) and started CPR.-EMS was called to come to the facility.-Facility staff confirmed that the resident was a DNR but by that time EMS had arrived and had taken over CPR.-Facility staff informed EMS that the resident was a DNR and EMS told facility staff they had to continue CPR and could not stop.-EMS worked on the resident for a while; their efforts were not successful, and they eventually stopped.-Afterward he/she was trained individually and with a group of facility staff to look in the facility electronic medical record (EMR) system to confirm a resident's code status before starting CPR.-He/She now knew to confirm code status in the EMR before starting CPR. During an interview on [DATE] 10:52 AM the resident's family member and Designated Power of Attorney (person named in writing as a decision-making agent in the when a person can no longer make decisions for themself) said:-He/she appreciated that the facility did CPR because he/she preferred they err on the side of caution when they found the resident not breathing and without a pulse.-He/she was not upset because the resident was in a better place now.Complaint 2619701

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265700	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilshire at Lakewood Rehab Center	600 N E Meadowview Drive Lees Summit, MO 64064

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff were adequately documenting supplement usage for one sampled resident (Resident #5) out of 31 sampled residents. The facility census was 122 residents.Review of the facility policy titled Nutrition/Hydration Management dated 10/24/22 showed:-A resident was assessed for nutrition/hydration status by nursing during the admission process.-A comprehensive care plan would be developed by the interdisciplinary team that addressed nutrition/hydration and an individualized nutrition/hydration management program based on individualized assessed needs. -The nutrition/hydration management program may address the following:--The factors contributing to actual or potential causes for inadequate nutrition or hydration status.--Specific modification in the resident's meal plan including food from outside of the facility and/or special food activities.--Use of supplemental vitamins and/or minerals.--Weight frequency.1. Review of Resident #5's admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Cerebral Infarction (ischemic stroke-occurs as a result of disrupted blood flow and restricted oxygen to the brain) Due to Unspecified Occlusion (blockage) or Stenosis (the narrowing of a passageway that prevents certain substance or structure from passing through as easily as it should) of Right Carotid Arteries.-Encounter for Surgical Aftercare Following Surgery on the Digestive System.-Unspecified Protein-Calorie Malnutrition.-Ulcerative Colitis (a chronic inflammatory bowel disease that affects the large intestine), Unspecified With Other Complication.-Diverticulosis (a condition where small, bulging pouches called diverticula form in the walls of the large intestine) of Large Intestine Without Perforation [NAME] a hole in) Or Abscess (a swollen area within body tissue) Without Bleeding.Review of the resident's admission Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff for care planning) dated 8/26/25 showed:-The resident was cognitively intact.-The resident had no known weight loss prior to admitting to the facility.Review of the resident's undated care plan showed:-The resident had a nutritional problem or potential nutritional problem related to a mechanically altered diet.-The following interventions were in place:--Monitor weight notifying Medical Doctor (MD)/Registered Dietitian (RD) of gain/loss per protocol.--Occupational Therapy (OT) to screen and provide adaptive equipment for feeding as needed.--Provide and serve diet as ordered.--RD to evaluate and make diet change recommendations Pro re nata (PRN- as needed).Review of the resident's RD Note dated 9/11/25 showed:-The resident was being seen due to a weight warning with a decrease in weight.-The resident had lost 6.3 percent (%) of his/her weight since admission.-The RD recommended the resident be put on the supplement Boost (nutritional supplement) or an equivalent supplement three times a day.Review of the resident's Order Summary Report dated September 2025 showed:-An order for a regular diet, with a regular texture and regular consistency.-An order for Boost or Boost Breeze three times a day that was ordered on 9/13/25.During an interview on 9/15/25 at 2:18 P.M. the resident said:-He/She had lost some weight since being admitted to the facility.-He/She was unsure of the exact amount of weight that he/she had lost.Observation on 9/17/25 at 10:58 A.M. showed the resident was drinking an eight ounce Ensure (nutritional supplement) supplement drink.Review of a nurse note dated 9/18/25 showed:-All parties had been notified of the resident's weight loss including the Medical Director, RD, and Director of Nursing (DON).-Refer to the RD note dated 9/11/25.-Staff were to continue current Plan of Care (POC).-No further recommendations at that time.During an interview on 9/22/25 at 1:14 P.M. the resident said:-His/Her family brought his/her supplements up to the facility and they were stored in his/her mini fridge.-He/She had already had two Ensure drinks that day because he/she did not like the breakfast that was served.-He/She had liked the meals the day prior and had one Ensure drink the entire day.-He/She had been drinking the Ensure drinks since admission to the facility and was unaware that the facility had ordered different supplements for him/her.-Staff had not been (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asking him/her the amount of supplement he/she was drinking. During an interview on 9/22/25 at 2:12 P.M. the DON said:-The resident had lost weight since being admitted to the facility.-The Assistant Director of Nursing (ADON) and the DON were responsible for reviewing the RD recommendations.-He/She was unsure if supplements had been recommended by the RD for the resident.-If a supplement was ordered for the resident, then he/she would expect the staff to document when the resident received his/her supplement and the amount the resident drank.-He/She was unaware that the resident had been drinking his/her own supplements brought from home since admission.-He/She would need to talk with the RD to see if his/her recommendation would still be the same since the resident had already been drinking a nutritional supplement.Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated September 2025 showed:-Staff had not been documenting that the resident had been given his/her Boost Supplement or documenting the amount he/she drank as of 9/23/25.During an interview on 9/23/25 at 11:42 A.M. Licensed Practical Nurse (LPN) E said:-He/She was unsure if the resident had an order for a supplement.-He/She was unsure if the resident had lost weight.-Usually nursing staff would document when a supplement was given and the amount the resident drank.-He/She was unsure why staff were not documenting on the supplement order.During an interview on 9/23/25 at 12:18 P.M. Certified Medication Technician (CMT) B said:-The resident was on a supplement.-The kitchen staff or nursing staff could give residents supplements.-Regardless of who were to give the resident his/her supplement, staff would need to document when the supplement was given and how much the resident drank if indicated.-He/She was unaware that the resident was bringing in his/her own nutritional supplements.-The staff would need to store the resident's supplements in order to ensure the resident was getting the correct amount.-If the resident preferred a different supplemental drink to the one that the RD recommended, then the RD would need to be contacted to ensure that the preferred supplement was appropriate.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 #17 and #149) who were fed by enteral (a form of nutrition that is delivered into the digestive system as a liquid) means received the appropriate treatment and services to prevent complications of enteral feeding by failing to assess the percutaneous endoscopic gastrostomy tube (PEG tube) a tube that is placed into a patient's stomach as a means of feeding them when they are unable to eat) for placement out of 31 sampled and five supplemental residents. The facility census was 122. Review of facility policy entitled Feeding Tube-Administration of Medication revised 10/24/22 showed:-Check for tube placement by checking residual.--If residual is greater than 100 milliliters (ml), withhold medications.--Reattempt administration of medications in one hour.--If residual of 100 ml or greater is obtained, hold medications and notify Attending Physician for further instructions. -Re-instill any gastric content obtained back into the tube. -If no gastric content appears, the tube may be against the lining of the stomach or the tube may be obstructed. Reposition the resident and repeat above steps. -If you continue to meet resistance as you aspirate for stomach content, stop the procedure. Notify the Attending Physician promptly. 1. Review of Resident #17's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Dysphagia (inability or difficulty swallowing) following Cerebral Infarction (stroke).-Hemiplegia and Hemiparesis (paralysis/weakness affecting one side of the body) following Cerebral Infarction affecting left non-dominate side.-Cerebral Infarction. -Encounter for surgical aftercare following surgery on the digestive system. Review of the resident's Care Plan dated 5/27/25 showed: -The resident required tube feeding related to NPO (nothing by mouth) status. -Check for tube placement and gastric contents/residual volume per facility protocol and record. -Monitor/document/report any signs/symptoms of aspiration-fever, shortness of breath, tube dislodgement, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, abdominal distension, abdominal tenderness, constipation, diarrhea, nausea, and vomiting.-Obtain and monitor lab/diagnostic work as ordered. Report results to Medial Doctor (MD) and follow up as indicated. -Provide local care to PEG-Tube site as ordered and monitor for signs and symptoms of infection.-Registered Dietician (RD) was to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. -Speech Therapy (ST) evaluation and treatment as ordered. Review of the resident's Order Summary Report dated 5/31/25 showed:-Enteral Feed Order every shift Fibersource HN (brand of enteral feed) 1.2 at 75 milliliters (ml) per hour continuous. -Enteral Feed Order every day and night shift ensure that head of bed was always up to 30-45 degrees. -NPO (nothing by mouth) diet NPO texture, NPO consistency.-Enteral Feed Order every day shift wash tube site with warm soap and water, dry thoroughly and place T sponge daily. -Flush peg tube with 150 ml of water every four hours for hydration. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/14/25 showed:-The resident had a feeding tube. -The resident's mental status was severely cognitively impaired. Observation on 9/16/25 at 1:34 P.M. showed: -Tube feeding was running at 75 ml/hour and was dated (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/15/25.-PEG tube site showed no redness or open areas. Observation on 9/18/25 at 2:32 P.M. showed: -Tube feeding was running at 75 ml/hour and was dated 9/18/25.-PEG tube site showed no redness or open areas. Observation on 9/19/25 at 1:02 P.M. of Licensed Practical Nurse (LPN) B showed:-LPN B picked up a syringe and injected 10 ml of air into the PEG tube and listened with his/her stethoscope.-LPN B then pulled back and checked residual which was zero ml of residual. During an interview on 9/19/25 at 1:10 P.M., LPN B said: -The PEG tube would be assessed for signs of infection or complications each shift. -The PEG tube would be assessed for placement by auscultation (the act of listening for sounds within the body) and residual. -This was the way he/she was taught to assess PEG tubes in nursing school.-The facility had not taught any other ways to assess PEG tube placement.-He/She followed the facility policy. During an interview on 9/23/25 at 8:30 A.M., Certified Medication Technician (CMT) A said that giving medications through a PEG tube was not in his/her scope of practice and he/she did not do anything with PEG tubes. During an interview on 9/23/25 at 8:35 A.M., LPN C said:-He/She would check PEG tube placement by auscultation, residual, and if there were numbers on the PEG tube, he would verify those. -This was how he/she has assessed PEG tubes as he was taught in nursing school. 2. Review of Resident #149's admission Record showed the resident was admitted to the facility with a diagnosis of gastrostomy (G-tube: surgical procedure that creates an opening in the stomach through the abdominal wall) Review of the resident's undated care plan showed no focus, goal, or interventions in place for the resident's G-Tube. Review of the resident's Order Summary Report dated September 2025 showed:-An order for staff to check residual and measure every shift if over 50 ml during feeding, medication administration, or flushes, then staff were to call the physician.-An order for staff to flush the G-tube with 30 ml of water before and after medication administration, flush with five to ten ml water in between medications.-An order for Gabapentin (a medication used to treat seizures and nerve pain) capsule 400 milligrams (mg), give one tablet via G-tube two times a day for Neuropathy (damage or dysfunction of the peripheral nerves, which can cause pain, burning, or prickling sensations).-An order for Ibuprofen (used to treat pain and inflammation) tablet 200 mg, give one tablet four times a day for inflammation. Observation on 9/17/25 at 2:45 P.M. of the resident's G-tube medication administration completed by LPN E showed:-LPN E prepared the Ibuprofen 200 mg tablet and Gabapentin 400 mg capsule for G-tube administration.-LPN E then went into the resident's room and placed the supplies down on a barrier.-LPN E then used a syringe to check the resident's residual.-LPN E did not get any residual into the syringe.-LPN E did not use any other way to check the placement of the G-tube.-LPN E then preceded to give the resident his/her medication. During an interview on 9/17/25 at 3:22 P.M. LPN E said he/she would not have done anything differently related to how he/she checked the placement of the resident's G-tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 9/22/25 at 2:12 P.M. the DON said:-He/She had recently found out that the facility was not assessing PEG tubes correctly and the facility was coming up with a new policy.-Prior to the survey the expectation for assessing PEG tubes placement was to auscultate and check residual.-LPN E had not checked Resident #149's G-tube placement correctly.-If LPN E had not gotten any residual back from the G-tube, then LPN E should have contacted the facility's physician to get an order for a Kidney, Ureter, and Bladder (KUB- an x-ray that visualizes these organs) to check the G-tube placement. During an interview on 9/23/25 at 11:42 A.M. LPN E said:-Staff were to check the placement of G-tubes using two different methods.-Staff could check placement using the residual with a pH (a figure to express the acidity of a liquid) strip (a small strip of paper or other material containing a pH indicator that changes color when dipped into a liquid).-Staff could also check for placement of the G-tube by measuring the resident's G-tube.-Staff could check for placement by auscultating (listening) via a stethoscope.-He/She had not remembered how he/she had checked the resident's placement of his/her G-tube prior to the resident's medication administration. During an interview on 9/23/25 at 12:35 P.M. the Assistant Director of Nursing (ADON) said:-Staff were expected to check the placement of G-tubes by using pH strips after getting residual from the resident's G-tube.-The facility's policy was getting updated to reflect the current standard of practice when checking G-tube placement.-The policy previously stated that staff could check placement by checking for residual and auscultating.-There could be difficulty in checking G-tube placement by measurement of the tube if the facility did not have the correct measurement upon admission.-If staff were to check the placement of a G-tube by checking the pH of the residual and there was no residual, then staff were to call the provider.-The staff person had not administered the medications appropriately if/she had not checked for appropriate placement.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate under five percent (%) for one supplemental resident (Resident #149) out of five supplemental residents. Two medication errors were detected out of 28 observed opportunities resulting in an error rate of 7.14 %. The facility census was 122 residents.Review of the facility's policy titled Feeding Tube-Administration of Medication dated 10/24/22 showed staff needed to verify that medication cups were clear of any remnants of crushed pills or liquid medication. 1. Review of Resident #149's admission Record showed the resident was admitted to the facility with a diagnosis of gastrostomy (G-tube: surgical procedure that creates an opening in the stomach through the abdominal wall).Review of the resident's Order Summary Report dated September 2025 showed:-An order for staff to check residual and measure every shift if over 50 milliliters(ml) during feeding, medication administration, or flushes, then staff were to call the physician.-An order for staff to flush the G-tube with 30 ml of water before and after medication administration, flush with five to ten ml water in between medications.-An order for Gabapentin (a medication used to treat seizures and nerve pain) capsule 400 milligrams (mg), give one tablet via G-tube two times a day for Neuropathy (damage or dysfunction of the peripheral nerves, which can cause pain, burning, or prickling sensations).-An order for Ibuprofen (used to treat pain and inflammation) tablet 200 mg, give one tablet four times a day for inflammation. Observation on 9/17/25 at 2:45 P.M. of the resident's G-tube medication administration completed by Licensed Practical Nurse (LPN) E showed:-LPN E placed the Ibuprofen 200 mg tablet into a medication cup and opened the Gabapentin 400 mg capsule and poured the contents into the same cup.-LPN E then placed the contents of the medication cup into a small bag in order for medications to be crushed together.-LPN E then put the crushed medications back into the medication cup and poured 30 ml of water into the cup in order for the medications to be mixed together.-LPN E then went into the resident's room and placed the supplies down on a barrier.-LPN E then used a syringe to flush the G-tube with 30 ml of water, poured the resident's medications into the syringe, and flushed the G-tube with 30 ml of water.-LPN E did not ensure all of the medication was given to the resident. Observation on 9/17/25 at 2:52 P.M. of the resident's medication cup showed there was medication remnants left over in the cup. During an interview on 9/17/25 at 3:22 P.M. LPN E said he/she would not have done anything differently during the resident's medication administration. During an interview on 9/22/25 at 2:12 P.M. the Director of Nursing (DON) said:-LPN E had not administered the resident's medications appropriately.-He/She would have expected LPN E to put additional water into the medication cup and looked for any medication remnants to ensure the resident received the full dosage of medication. During an interview on 9/23/25 at 11:42 A.M. LPN E said:-He/She would normally fill the medication back up with water and mix it to ensure that the resident was given the full dose of medication.-He/She could not remember if he/she had done that during the resident's medication administration. During an interview on 9/23/25 at 12:35 P.M. the Assistant Director of Nursing (ADON) said:-LPN E had not administered the resident's medication appropriately.-LPN E should have ensured that the resident was given the full dosage of medication by putting more water into the medication cup and looking for any additional medication remnants.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to properly contain waste and refuse in outdoor dumpsters, to prevent the harboring and/or feeding of pests. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility and/or ate food from the kitchen. This facility had a census of 122 residents with a licensed capacity of 170 residents at the time of the survey.1. Observation on 9/15/25 between 11:43 A.M. and 2:41 P.M. during the initial Life Safety Code (LSC) facility outer perimeter inspection showed the following:-The south lid of the south dumpster outside the Service Hall was flipped back completely open.-The facility itself had large, wooded areas on the north and west sides. Observation on 9/17/25 at 11:44 A.M. during the LSC facility walk-through inspection with the Director Plant Operations (DPO) showed outside the Service Hall the south dumpster had both its lids flipped back open and the north dumpster had its north lid flipped back. Observation on 9/17/25 at 1:09 P.M. during the follow-up LSC facility outer perimeter inspection showed the south dumpster was overflowing with boxes and had both lids flipped back open and the north dumpster had its north lid flipped back. Observation on 9/19/25 at 8:23 A.M. during a concluding LSC facility outer perimeter inspection showed the north lid of the north dumpster was flipped back open. During an interview on 9/19/25 at 9:32 AM the Administrator said the following:-Dumpster lids should be kept closed at all times. -All departments use the dumpsters. During an interview on 9/19/25 between 10:37 A.M. and 12:59 P.M. the DPO said the following:-The housekeeping, dietary, and maintenance departments frequently use the dumpsters, but activities or nursing use was seldom.-He/She knew the lids should not be left open.-They even closed them yesterday morning in the rain.-He/She thought they had done that at least eight times during this survey.