STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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, interviews, and record review, the facility failed to maintain an appropriate infection control program to include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and others; and failed to ensure appropriate infection control practices were maintained during one sampled resident's (Resident #21) wound care treatment out of 14 sampled residents. The facility census was 53 residents. Review of the facility's policy titled [NAME] Place Infection Prevention Plan dated 9/10/25 showed:-The Director of Nursing (DON) in collaboration with the Infection Prevention nurse had the authority to institute any surveillance, prevention, or control measures or study when there was reason to believe that any resident, personnel, or visitor may be in danger.-This authority and responsibility included, but was not limited to:--Developing and implementing a preventative and corrective program to minimize infection hazards.--Developing a system for identifying, reporting, and analyzing the incidence and causes of healthcare associated infections.--Developing and implementing a system for surveillance and prevention of infections, identifying, reporting, and analyzing clusters of infections, outbreaks, sentinel events, emerging pathogens, and special studies or reports.A policy related to infection control practices during wound care was requested and not provided prior to exit on 1/9/26.1. Review on 1/8/26 at 2:04 P.M. of the facility's Infection Control Log showed:-No records were found for infections that occurred in the facility from January 2025 to September 2025.-No mapping of infections was completed in the month of October 2025.-No mapping of infections was completed in the month of November 2025.-No mapping of infections was completed in the month of December 2025.During an interview on 1/8/26 at 2:04 P.M. the Infection Preventionist (IP) said:-He/She had received his/her IP certification in October 2025 and that was when he/she had taken over the program.-He/She had to build the system himself/herself because the records from previous months could not be accessed.-He/She was not educated by the facility about how the infection control program for tracking infections was done previously.-When a resident had an infection, he/she would put the resident on the infection log.-The log would indicate the resident, type of infection, and what antibiotic the resident was prescribed.-The log was also color coded to indicate the type of infection.-He/She was unaware that mapping of infections also had to be completed.-He/She understood that the current program in place did not meet regulatory requirements.During an interview on 1/9/26 at 10:25 A.M. Licensed Practical Nurse (LPN) B said:-The IP and the Quality and Risk for Post Acute Services Director worked on the infection control program.-He/She was unsure of the facility's method for tracking and trending infections.-He/She thought it was important for the facility to track infections in order to appropriately trend and monitor the infections for patterns and to place residents under the right precautions.During an interview on 1/9/26 at 10:57 A.M. Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator B said:-The IP was responsible for maintaining the facility's infection tracking log.-He/She thought it was important for infection tracking to be completed in order to keep the residents and staff safe.During an interview on 1/9/26 at 11:47 A.M. the DON said:-He/She had only been at the facility (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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	for two weeks and hadn't been able to review the infection tracking log yet.-He/She expected the IP to keep a spreadsheet or binder to track infections, wounds, and antibiotic usage.-It was important for the facility to appropriately track infections to know if there was a breakout of certain infections and to be able to educate the staff when needed.-The current infection tracking log did not meet regulatory standards.-The infection tracking log needed to include mapping of infections and everything else the Centers for Disease Control and Prevention (CDC) recommended.2. Review of Resident #21's admission Record showed the resident readmitted to the facility on [DATE] with a diagnosis of Osteomyelitis (an infection and inflammation of bone tissue).Review of the resident's Order Summary Report dated January 2026 showed:-The resident had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) Pressure Ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin) to his/her coccyx (the small bone at the bottom of the spine).-Staff were to cleanse with normal saline, pat dry, cover with mepilex (used for various exuding wounds like pressure ulcers to promote moist healing by absorbing drainage, minimizing pain and trauma on removal, and preventing maceration) border foam dressing, change every other day and as needed for soiling.Observation on 1/7/26 at 11:35 A.M. of the resident's wound care to his/her coccyx showed:-Licensed Practical Nurse (LPN) B, MDS Coordinator B, and Registered Nurse (RN) A were all in the room assisting with the resident's wound care.-RN A had performed the resident's wound care treatment to his/her coccyx while LPN B and MDS Coordinator B were assisting with the positioning of the resident.-Once the wound care to the resident's coccyx was completed, LPN B and MDS Coordinator B were changing the resident's bed linens.-RN A said to MDS Coordinator B that his/her gloved hands were dirty and that MDS Coordinator B could pull the dirty bed linens from underneath the resident.-When LPN B was assisting the resident to his/her left side, the resident's coccyx dressing had slipped from its original position.-While pulling the dirty bed linens from underneath the resident, MDS Coordinator B readjusted the dressing by sliding it back into place and patting it down to the original location.-MDS Coordinator B then removed the dirty linens from the bed, disposed of the bedding, removed his/her gloves, and went into the bathroom to wash his/her hands.During an interview on 1/8/26 at 11:04 A.M. RN A said:-He/She would not have done anything differently related to the resident's coccyx wound dressing.-He/She did not see MDS Coordinator B move the resident's coccyx dressing back into place.-MDS Coordinator B should not have touched the dressing at all.-MDS Coordinator B should have communicated with LPN B and RN A that the dressing had moved and that the treatment needed to be fixed/redone.-If he/she had noticed that MDS Coordinator B had touched and moved the dressing, then he/she would have redone the treatment.During an interview on 1/9/26 at 10:03 A.M. LPN B said:-He/She would not have done anything differently related to the resident's coccyx wound treatment.-He/She was on the other side of the resident and would not have been able to see the dressing or that MDS Coordinator B had moved the dressing.-MDS Coordinator B should not have touched the dressing and moved it back into place.-MDS Coordinator B should have verbalized that the dressing had been moved and that the treatment needed to be fixed.-If he/she had known that MDS Coordinator B had touched the dressing with his/her dirty gloves, then he/she would have assisted in redoing the treatment.During an interview on 1/9/26 at 10:32 A.M. MDS Coordinator B said:-He/She had been told by that point in time that he/she did not utilize appropriate infection control practices during the resident's coccyx wound treatment.-He/She had dirty gloves on when pulling the dirty bed linens from underneath the resident and had moved the resident's dressing back into place.-He/She should not have touched the resident's dressing with her gloves and moved it back into place.-He/She should have verbalized that the dressing had moved from its original position and that the dressing needed to be fixed.During an interview on 1/9/26 at 11:47 A.M. the DON said:-MDS Coordinator B did not utilize appropriate infection control practices during the resident's coccyx wound treatment.-MDS Coordinator B should not have moved the resident's coccyx dressing back into place after handling dirty linens.-He/She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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	would have expected MDS Coordinator B to verbalize that the dressing had moved from its original position and the dressing needed to be fixed.-The staff should have redone the resident's coccyx treatment after MDS Coordinator B moved the dressing back into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure an antibiotic stewardship (the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients/residents) program was in place which had the potential to affect all residents in the facility. The facility census was 53 residents. Review of the facility's policy titled Antimicrobial Stewardship in Senior Living Communities, GA-457 dated 9/23/25 showed:-The facility would establish and maintain as Antimicrobial Stewardship Program (ASP) to ensure optimal use of antimicrobials in the treatment and prevention of infectious diseases.-The ASP would focus its efforts on reviewing appropriateness of antimicrobial regimens for residents within the facility.-All residents with antimicrobials would be screened/reviewed by the Pharmacist.-Residents whom staff deemed high-level targets would get a formal review and, when appropriate, a recommendation would be made to the clinical staff regarding suggested changes in therapy.-ASP recommendations would be communicated to providers responsible for that resident either by direct contact or other forms of passive communication.-ASP members would serve as a resource to clinical staff to assist in providing evidenced-based practice recommendations regarding antimicrobial therapy for residents.1. Review of the facility's antibiotic stewardship program on 1/8/26 at 2:04 P.M. showed the facility did not have an antibiotic stewardship program currently in place.During an interview on 1/8/26 at 2:04 P.M. the facility's Infection Preventionist (IP) said:-He/She had been certified as the facility's IP since October 2025.-He/She was not sure if the facility had an antibiotic stewardship program.-He/She did not have any records from the previous IP to indicate that a program was in place before he/she became the facility's IP.During an interview on 1/9/26 at 10:36 A.M. Licensed Practical Nurse (LPN) B said:-The facility's Medical Director was responsible for overseeing antibiotic usage.-He/She was unsure if the facility had an antibiotic stewardship program or what it entailed.During an interview on 1/9/26 at 10:59 A.M. Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator B said:-He/She was unsure if the facility had an antibiotic stewardship program in place.-The antibiotic stewardship program was important because it helped the facility stay within the recommended guidelines for antibiotic usage.During an interview on 1/9/26 at 11:47 A.M. the Director of Nursing (DON) said:-He/She had only been at the facility for two weeks.-He/She was unaware that the facility did not have an active antibiotic stewardship program.-He/She expected the IP to maintain the antibiotic stewardship program.-The antibiotic stewardship program was important because it ensured the facility was using antibiotics appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure their facility Criminal Background Investigations policy showed a check of the Nurse Aide (NA) Registry would be completed for all potential facility employees and volunteers; subsequently, three facility employee records (Employees C, D, and E) out of five facility employee records sampled did not have NA Registry background screenings completed prior to hire, potentially affecting any resident at the facility. The facility census was 53 residents.Review of the facility's Criminal Background Investigations, HR-008 policy, revised 2/28/22, showed:-Applicants will complete the Post-Offer Credit Report Act (FCRA) Disclosure and confirm their understanding of the criminal background check requirement. Applicants who do not agree to a post-offer background check will not be allowed to move further in the on-line application process.-A post-offer background check will review any history of felony convictions in the past seven years or pending criminal charges when the third-party vendor e-consent form is completed.-The Human Resources (HR) Department will use a third-party investigative agency to complete criminal background checks on new hires, volunteers, and students according to applicable state laws.-A representative from the HR Department at each Missouri entity will check with the Employee Disqualification List (EDL) from the Missouri Department of Health and Senior Services for each new hire and quarterly for all current employees.-Employees whose name appears on the EDL will not be considered for employment in any patient/resident contact position.--NOTE: The policy failed to show a check of the NA Registry would be completed for all new applicants.Review of 42 Code of Federal Regulations (CFR) 483.012 showed:-The NA Registry documents findings against a Certified Nurse Aide (CNA) of abuse, neglect, or misappropriation of property.-Certified long-term care facilities and the long-term care unit of a hospital are required to check the Registry before allowing a person to work or volunteer.Review on 1/14/26 of the Office of Inspector General (OIG) website showed:-The OIG's List of Excluded Individuals/Entities (LEIE) only contained actions taken by the OIG. -The LEIE does not contain actions taken by other agencies. -The OIG's exclusion authorities do not include the NA Registry.1. Review of Employee E's background checks showed:-He/She was hired as an Activity Coordinator on 1/20/25.-The employee did not have a NA Registry background check.2. Review of Employee C's background checks showed:-He/She was hired as a Licensed Practical Nurse (LPN) on 9/29/25.-The employee did not have a NA Registry background check.3. Review of Employee D's background checks showed:-He/She was hired as a Housekeeper on 10/6/25.-The employee did not have a NA Registry background check.4. During an interview on 1/7/26 at 11:45 A.M. the Candidate Experience Coordinator (CEC) manager said:-The CEC team was responsible for background checks for both the hospital and the Skilled Nursing Facility (SNF).-They did the Family Care Safety Registry (FCSR) background checks which included the Employee Disqualification List (EDL) background check and did criminal background checks prior to hire.-They were not doing the NA Registry checks on all employees.During an interview on 1/9/26 at 10:25 A.M. the Human Resources Business Partner for the facility said:-He/She was responsible for supporting department heads, managers, supervisors, and directors by providing them with information and guidance.-He/She was not involved with doing the background checks. The CEC team did all the employee background checks for the facility.-If someone applied for the position of a CNA the CEC team completed their NA Registry background check prior to hire. The CEC was not doing NA Registry background checks on any other potential applicant.-He/She wasn't sure if anyone audited the CEC team's background checks for employees of the facility, but he/she had not been doing that.During an interview on 1/9/26 at 10:58 A.M. with the Facility President and the Administrator, the Facility President said:-The OIG background screenings were completed prior to hire and monthly thereafter on all facility employees. -It was the facility's opinion that the OIG screenings covered more than the NA Registry background checks.-NA Registry checks were completed for candidates applying for the CNA position and were not being completed on all facility employees.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive care plans were up to date and reflected three sampled residents (Resident #50, #57, and #73) current status out of 14 sampled residents. The facility census was 53 residents.Review of the facility's policy titled Bishop [NAME] Place (BSP) Service/Care Plans dated 10/6/25 showed:-The purpose of the policy was to identify the components of a resident's service/care plan and provide guidance on how the service/care plan should be created and implemented for the resident's daily care routine.-Service/Care plans should incorporate measurable goals, objectives and timetables that lead to the resident's highest obtainable level of independence.-Service/Care plans should be used in developing the resident's daily care routines and would be available to staff personnel who have responsibility for providing care or services to the resident.-The Interdisciplinary Team (IDT) was responsible for the development of an individualized, comprehensive service/care plan.-Each resident's comprehensive service/care plan was designed to:--Incorporate identified problem areas.--Incorporate risk factors associated with identified problems.--Reflect treatment goals and objectives in measurable outcomes.--Identify the professional services that were responsible for each element of care.--Reflect currently recognized standards of practice for problem areas and conditions.--Aid in preventing or reducing declines in the resident's functional status and/or functional levels.--Enhance the optimal functioning of the resident by focusing on a rehabilitative program. 1. Review of Resident #57's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 12/24/25 showed:-The resident felt down, depressed, or hopeless two to six days during the look back period.-The resident had an Anxiety Disorder.-The resident had Depression.-The resident had Bipolar Disorder. Review of the resident's admission Record dated 1/6/26 showed:-He/She admitted to the facility with a diagnosis of Major Depressive Disorder (MDD a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Recurrent, Mild.-During the resident's stay at the facility he/she had been diagnosed with the following:--Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Unspecified.--Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats), Unspecified. Review of the resident's care plan on 1/7/26 showed:-The resident's care plan indicated that the resident used psychotropic medication (chemical substances, typically prescription drugs, that alter brain chemistry to affect mood, perception, consciousness, and behavior) for his/her Anxiety Disorder and Depression.-The resident did not have a care plan related to his/her diagnosis of Bipolar Disorder.-The resident did not have a care plan specifically related to his/her diagnosis of Anxiety Disorder.-The resident did not have a care plan specifically related to his/her diagnosis of MDD. 2. Review of Resident #73's admission Record showed he/she admitted to the facility on [DATE] with a diagnosis of Aftercare Following Joint Replacement Surgery. Review of the resident's list of MDS's showed he/she did not have an admission MDS completed prior to his/her discharge from the facility on 1/8/26. Review of the resident's care plan on 1/7/26 showed:-The resident was newly admitted to the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for aftercare related to his/her right knee replacement.-There were no goals in place related to effective pain control management.-There was one intervention in place related to his/her pain control, which was marked yes. 3. During an interview on 1/9/26 at 9:31 A.M. Certified Nursing Assistant (CNA) A said:-The MDS Coordinator was responsible for the completion of care plans.-Care plans should be up to date and reflect the resident's current status.-Care plans should include pain management.-The care plan should indicate the best pain control methods for the resident including pharmacological and non-pharmacological interventions.-Care plans should include mental health diagnoses.-The care plan should indicate the symptoms, medications, and interventions specifically related to each mental health diagnosis. During an interview on 1/9/26 at 10:22 A.M. Licensed Practical Nurse (LPN) B said:-The MDS Coordinator was responsible for completing all care plans.-He/She was unsure if there was anyone specifically responsible for ensuring all care plans were up to date.-All care plans should be up to date and reflect the resident's current status.-Pain management should be included in care plans.-Mental health diagnoses should be included in care plans.-Care plans needed to be up to date because they help to understand the best way to manage each individual resident. During an interview on 1/9/26 at 10:47 A.M. MDS Coordinator B said:-He/She was responsible for baseline and comprehensive care plans.-There was not a designated person to check completion of care plans.-He/She would normally verbalize to management when care plans were updated.-Care plans should be up to date and reflect the resident's current status.-Pain management should have been included in Resident #73's care plan.-Resident #73's care plan should have included all pain management techniques.-All of Resident #57's mental health diagnoses should have been included in his/her care plan.-All medications, interventions, and behaviors for each mental health diagnosis should have been included on Resident #57's care plan. During an interview on 1/9/26 at 11:47 A.M. the Director of Nursing (DON) said:-He/She had only been at the facility for two weeks and had not been able to look at resident care plans by that point in time.-To his/her knowledge the care plans were completed by department.-The MDS Coordinators were responsible for ensuring completion of the care plans.-Care plans needed to be specific to each resident and not generalized.-Pain management should have been included in Resident #73's care plan.-Resident #73's care plan should have included all pain management techniques.-All of Resident #57's mental health diagnoses should have been included in his/her care plan.-All medications, interventions, and behaviors for each mental health diagnosis should have been included on Resident #57's care plan and on the Medication Administration Record (MAR). -Care plans needed to stay up to date so each staff person understood how to care for each resident. 4. Review of Resident #50's admission Record showed he/she was admitted to the facility on [DATE] with diagnoses that included:-Dementia (significant cognitive decline in memory, thinking, judgment, and language severe enough to interfere with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.-Unspecified depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). Review of the resident's quarterly MDS dated [DATE] showed:-The resident was moderately cognitively impaired.-The resident had no inattention, disorganized thinking, or altered level of consciousness (e.g. lethargy or vigilance).-The resident felt down, depressed or hopeless two to six (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	days out of the past 14 days and was rarely socially isolative.-Had no hallucinations (perceptions in the absence of external stimuli) or delusions (firmly held misconception contrary to reality).-Did not have physical or verbal behaviors directed toward others or other behaviors not directed at others (e.g. scratching self, rummaging, or disruptive vocalizations like screaming).-Did not reject cares or wander. Review of the resident's progress notes dated October 2025 showed:-On 10/18/25 at 7:26 P.M. the resident continued on Seroquel for depression. The resident was outside the facility entrance certain his/her family member lived in the apartments across the street. Social services went out to redirect the resident and after a short period of time was able to redirect him/her back into the facility to eat lunch. The Director of Nursing (DON) was made aware.-On 10/23/25 at 7:44 A.M. the resident was agitated and difficult to redirect. He/She was sitting in the hall with a gown on yelling his/her spouse's name, using vulgar language and name calling directed at staff. When staff attempted to assist the resident in getting dressed he/she became more agitated. The resident was assisted to his/her room for calm environment and a room tray was provided for breakfast.-On 10/28/25 at 6:31 P.M. indicated that at approximately 5:00 P.M. the resident was going up and down the hallway yelling out profanities and calling staff names. The resident went up to a Certified Nurse Assistant (CNA) and kicked the back of his/her shoe while his/her back was turned. Review of the resident's progress notes dated November 2025 showed:-On 11/19/25 at 3:55 P.M. the resident refused a shower. Attempts were made several times to get the resident into the shower and the resident continued to refuse.-On 11/19/25 at 5:15 P.M. the resident refused all scheduled medications and all treatments. He/She was observed being agitated, yelling, and cursing repeatedly stating staff was trying to hurt him/her. When staff attempted to perform wound care the resident would not allow anyone to touch him/her and became physically aggressive, kicking and hitting staff. The supervisor was notified and the resident's safety was maintained. Review of the resident's progress notes dated December 2025 showed:-On 12/24/25 at 8:55 A.M. the resident held his/her Senna (medication for constipation) in his/her closed hand and pretended it was taken. When questioned why he/she was still holding the pill the resident said he/she didn't want to take it.-On 12/24/25 a CNA tried to assist the resident to the dining room for dinner. The resident responded shut up bitch.-On 12/29/25 at 8:01 A.M. the resident refused to allow the nurse to take his/her vital signs (measurements of the body's essential functions including temperature, heart rate, breathing rate, and blood pressure). The nurse tried to take vital signs on the resident three times and all attempts were unsuccessful. Review of the resident's Physician Orders dated December 2025 showed:-Monitor for signs and symptoms of adverse reactions related to use of psychotropic medication use and document in nurses' notes starting 2/14/25.-Seroquel (an antipsychotic medication (a psychoactive drug (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis) oral tablet 50 milligrams (ml) daily for depression starting 11/30/25.-Sertraline HCl (a serotonin reuptake inhibitor (SSRI) oral tablet 25 mg at bedtime for dementia starting 12/29/25. Note: The order was changed on 1/8/26 to reflect indication for use as depression.-Symptoms related to depression were not identified on the orders. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated December 2025 and January 2026 showed there was no monitoring for symptoms of depression on the MAR or TAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Comprehensive Care Plan on 1/8/25 showed:-A care plan for the use of antipsychotic medication for the diagnosis of depression, revised 12/19/25, showed Monitor patterns of target behaviors. The care plan did not show symptoms related to depression that were typical for the resident and any non-pharmacological interventions to address the symptoms.-There was no behavioral care plan. There were no interventions on any individual care plan that identified the resident's behaviors of sometimes refusing medications and cares and verbal and physical behaviors. There was no documentation showing when the resident's various behaviors were most likely to occur and what staff should do when behaviors were exhibited. Observation on 1/5/26 at 10:03 A.M. showed:-When the resident was told good morning the resident asked in a hostile tone of voice what's good about it? -Then the resident yelled out repeatedly I need help and help although staff had been observed in the resident's room just prior to the outbursts and had approached the resident in a calm, quiet, non-confrontive manner. During an interview on 1/8/26 at 2:14 P.M. CNA C said:-It was the first day he/she had worked on the resident's hall, so he/she didn't know the resident's behaviors or usual symptoms of depression.-The care plan should show what the resident did when depressed such as if they tend to isolate themselves or stop going to activities. It should show what staff could do to address any signs of depression. -The behavior care plan should describe the resident's behaviors and when they were most likely to exhibit those behaviors.-The CNAs had electronic access to resident care plans so he/she should be able to look at the resident's care plan to see his/her behaviors, symptoms of depression, and any interventions to address them. -There should be interventions to show what staff should do when the resident displayed certain behaviors or symptoms of depression. -Interventions to calm the resident down or to help with symptoms of depression might be to play a certain type of music he/she liked, assist the resident in calling his/her family, accompany the resident outside, or taking a wheelchair ride or walk down the hall. Staff should be able to look at the resident's care plan to see what they could do that was most likely to help the resident when they had behaviors or symptoms of depression. During an interview on 1/8/26 at 2:20 P.M. CNA D said:-He/She had observed the resident yelling out hello and yelling out in general and calling out for his/her spouse a lot. Sometimes the resident said he/she wanted to get out of this place. -Staff asked the resident what he/she needed if he/she was yelling out. -The CNAs and other nursing staff had access to resident interventions on their electronic care plan. The resident's care plan should show the resident's behaviors and how staff should intervene. -He/She had never seen any symptoms of depression for the resident and didn't know what they were. The care plan should show what the resident tended to do when his/her depression was worse. During an interview on 1/8/26 at 2:27 P.M. CNA E said: -The CNAs had access to the resident care plans. The Behavioral care plan should show interventions when a resident had behaviors.-The Depression care plan should show how staff could tell if the resident was becoming more depressed. It should show what staff were to do to help the resident with their symptoms.-Resident #50's behaviors were verbal outbursts like calling out help and calling for his/her spouse. If staff tried to quiet the resident he/she would still continue to call out for his/her spouse. He/She wasn't sure if there were any interventions to address that. It might be on the resident's care plan. -When the resident started yelling out staff asked him/her how they could help. Sometimes it helped the resident calm down when staff took him/her to his/her room.-He/She had never noticed any symptoms of depression in the resident and didn't know how staff would know if depression symptoms were increasing or what they should do about it. -The resident liked to play the piano and played it pretty (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	well. Maybe that could be an intervention for the resident's behaviors or for symptoms of depression. During an interview on 1/8/26 at 2:44 P.M. MDS Coordinator A said: -If the resident had behaviors the Social Worker would let the MDS Coordinators know or behaviors would be discussed in morning meetings. -The MDS Coordinators were responsible for care planning behaviors. He/She was pretty sure he/she cared planned Resident #50's behaviors.-Resident #50 got agitated from time to time. He/She got verbally loud and accused staff of flirting with his/her spouse.-Every now and then the resident would wander, mainly down the hallway and back. The resident took a daily walk down the hall and staff watch out for him/her. He/She would circle back to the unit. The facility did have a wander guard on the back of the resident's wheelchair for a time, but the resident would take it off. It would likely upset the resident to have it on his/her person. When the resident had gone out of the building in December it was the door close to the nursing desk. He/She was there when the resident left and he/she couldn't redirect the resident. The Social Worker took him/her for a walk and the resident willingly came back with the Social Worker, but he/she wasn't sure what the Social Worker did or said to get the resident to come back.-He/She wasn't aware the resident had ever hit or kicked staff or refused medications. The resident refused some cares and was convinced sometimes that a particular aide was having an affair with his/her spouse.-The CNAs have electronic access to the resident's care plan. When the resident yelled out staff should redirect him/her. That was usually effective for the resident. -He/She thought the direction to monitor for signs and symptoms of depression was on the resident's Depression care plan, but there were no specific symptoms of depression mentioned for the resident. He/She didn't know what symptoms of depression typically looked like for the resident. During an interview on 1/9/26 at 10:50 A.M. Registered Nurse (RN) A said: -Nursing staff received a full day of training and education for working with residents with dementia and behaviors. For the CNAs it was part of their yearly training. Staff were educated to try de-escalation techniques and to walk away for a while.-Resident #50 would call out for his/her spouse, sometimes starting at 7:00 A.M. The spouse would bring their dog which the resident loved. The resident would call staff names and accused one CNA of having an affair with his/her spouse. He/She refused cares and showers and would wander up and down the hall. He/She would hit or kick. Once during a shower he/she called everybody trying to help him/her bitch.-The resident had an increase in physical aggression in December. When the facility did a urinalysis (UA) the resident was diagnosed with a urinary tract infection (UTI). -The CNAs have access to the electronic Cardex which has the resident's interventions. The care plan should have interventions for the resident's behaviors and should mention what his/her target behaviors were.-The resident was started on Sertraline (an antidepressant) in hopes they could gradually reduce the resident's Seroquel.-Symptoms related to depression that were typical for the resident should be on the resident's Depression care plan. -The MDS Coordinator developed the care plan, but he/she wasn't sure who was responsible for auditing their work. During an interview on 1/9/26 at 11:40 A.M. with RN A and the Interim DON, the DON said:-The MDS Coordinators were responsible for resident care plans, with each department providing information for individual care plans. The MDS Coordinator was responsible for ensuring completion of the Comprehensive care plan. -The care plans should be up to date and reflect each resident's status.-Residents with behaviors should have pharmacological interventions as applicable and non-pharmacological interventions.-The care plan should be specific on what staff were to do for the resident and which staff would do it. The care plan should be comprehensive so that everyone knew how to take care of the resident. -There should be symptoms listed for residents who took psychotropic drugs on the resident's MAR where specific symptoms could be identified. Symptoms (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	typical for the resident and target behaviors should be on the Comprehensive care plan.-He/She had only been at the facility a couple of weeks and wasn't sure if anyone had been auditing resident care plans for thoroughness. He/She would be responsible for auditing care plans or assigning that to a designee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the residents [NAME] Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) for a resident on hospice services by not marking section J item number J1400 for prognosis less than six months to live for one sampled resident (Resident #54) out of 14 sampled residents the facility census was 53 residents.Review of the facility policy titled [NAME] Place (BSP) Minimum Data Set revised 12/2/25 showed:-A Registered Nurse (RN), also known as the MDS Coordinator, would be responsible for conducting and coordinating the development, completion, and submission of the MDS Assessment for each resident.-The individual who completed a portion of the MDS must have certified the accuracy of that portion of the assessment. -The MDS Coordinator or designee would be responsible for ensuring that a resident assessment was submitted to Federal and state MDS database in accordance with current federal and state guidelines. 1. Review of Resident #54's admission Record showed the resident admitted to the facility on [DATE].Review of the resident's Order Summary Report dated 3/19/25 showed the resident had an order to admit to a hospice provider (end of life care) dated 3/19/25.Review of the resident's care plan dated 5/27/25 showed the resident was on hospice services. Review of the resident's quarterly MDS dated [DATE] showed:-Section J1400 was marked no.-Section O was marked yes for hospice care.Review of the resident's quarterly MDS dated [DATE] showed:-Section J1400 was marked no.-Section O was marked yes for hospice care.Review of the resident's significant change MDS dated [DATE] showed:-Section J1400 was marked no.-Section O was marked yes for hospice care.Review of the resident's comprehensive MDS dated [DATE] showed:-Section J1400 was marked no.-Section O was marked yes for hospice care.During an interview on 1/8/26 at 12:29 P.M., MDS Coordinator A said:-The resident was on hospice and received hospice care. -When a resident was on hospice services this was documented in section O.-To qualify for hospice services the resident's life expectancy was six months or less.-He/She did not document in section J1400 because the doctor did not write an order saying the resident had six months or less of life expectancy.-He/She did not realize the Hospice Certification the doctors had to sign every six months would count as enough to mark yes in section J1400.-A significant change MDS would be done when the resident went on hospice. -A significant change MDS was done as soon as it was discovered that one was not done for the resident.During an interview on 1/8/26 at 12:35 P.M., MDS Coordinator B said:-He/She was responsible for the skilled MDS assessments.-The other MDS Coordinator was responsible for the non-skilled long-term residents.-When a resident was on hospice services this was documented in section O.-That to qualify for hospice services the resident's life expectancy was six months or less.-He/She did not document in section J because the doctor did not write an order saying the resident had six months or less of life expectancy.-He/She did not realize the Hospice Certification the doctors had to sign every six months would count as enough to mark section J yes.During an interview at 1/9/26 at 11:47 A.M., the Director of Nursing (DON) said: -He/She had just been at the facility for two weeks. -He/She did not do the anything with the MDS, the MDS Coordinators did that.-The MDS Coordinator RN verified the MDS was correct accurate. -He/She expected that the MDS would be correct and accurate for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR a requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) for one sampled resident (Resident #57) was reviewed for accuracy and updated after admission to the facility out of 14 sampled residents. The facility census was 53 residents.A policy related to PASRRs was requested and not received prior to exit on 1/9/26.1. Review of Resident #57's PASRR Level One Screening dated 9/1/21 showed:-The screening had been completed by a local hospital prior to the resident's admission to the facility.-The resident did not show any signs or symptoms of a major mental disorder.-The resident had never been diagnosed with a major mental disorder. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 12/24/25 showed:-The resident felt down, depressed, or hopeless two to six days during the look back period.-The resident had an anxiety disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).-The resident had Depression.-The resident had bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's admission Record dated 1/6/26 showed:-He/She admitted to the facility with a diagnosis of Major Depressive Disorder (MDD a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Recurrent, Mild.-During the resident's stay at the facility he/she had been diagnosed with the following:--Bipolar Disorder, Unspecified.--Anxiety Disorder, Unspecified.Review of the resident's care plan dated 1/7/26 showed:-The resident used psychotropic medication (chemical substances that alter brain chemistry, impacting mental processes, moods, emotions, and behaviors) for his/her anxiety disorder and Depression.-The resident did not have a care plan related to his/her diagnosis of bipolar disorder.-The resident did not have a care plan specifically related to his/her diagnosis of anxiety disorder.-The resident did not have a care plan specifically related to his/her diagnosis of MDD.An updated PASRR for the resident was requested and not received prior to exit on 1/9/26.During an interview on 1/9/26 at 10:18 A.M. Licensed Practical Nurse (LPN) B said:-The admissions Coordinator was responsible for ensuring the completion of PASRRs.-He/She assumed that the admissions Coordinator would also be responsible for updating PASRRs when needed.-He/She was not sure about the timeline of PASRRs and when they needed to be updated.During an interview on 1/9/26 at 10:42 A.M. MDS Coordinator B said:-He/She was unsure of the facility's responsibility related to PASRRs.-He/She knew PASRRs needed to be completed prior to the resident's admission to the facility.-The Health Information Specialist would ensure completion of PASRRs upon admission.-The Health Information Specialist would also be responsible for auditing the PASRRs to ensure accuracy.-The Health Information Specialist would let the facility social workers or the admission Coordinator know if a PASRR needed to be updated.-PASRRs needed to be updated for any new diagnoses and any significant changes. -Resident #57's PASRR should have been updated to reflect the resident's current condition.During an interview on 1/9/26 at 11:16 A.M. the Health Information Specialist said:-He/She mainly ensured that there was a physician signature when he/she looked at PASRRs upon admission.-It would not be his/her responsibility to ensure the accuracy of the PASRRs.-It would not be his/her responsibility to see if any PASRRs needed to be redone.-He/She thought that the responsibility would fall under the admission Coordinator or Social Workers.During an interview on 1/9/26 at 11:23 A.M. the admission Coordinator, Social Worker A, and Social Worker B said:-The Health Information Specialist was responsible for ensuring completion of PASRRs upon admission to the facility.-All PASRRs were audited in 2025.-The audit that was completed only verified that PASRRs were in each resident's records and not for accuracy.-There was no one at the facility responsible for ensuring new PASRRs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were completed when indicated.-Resident #57 should have had a new PASRR completed to indicate his/her mental health diagnoses.During an interview on 1/9/26 at 11:47 A.M. the Director of Nursing (DON) said:-He/She had only been at the facility for two weeks and was unsure what the facility's protocol was for PASRR completion.-In his/her experience, the facility Social Workers or the MDS Coordinators were responsible for ensuing PASRRs were completed and up to date.-A diagnosis of bipolar disorder would indicate the need for Resident #57's PASRR to have been redone.-He/She would have expected staff to have started the PASRR process within 30 days of the diagnosis.-To his/her knowledge, there was no one at the facility specifically responsible for ensuring the accuracy of PASRRs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident's (Resident #21) wound care orders were followed during observation of his/her wound care out of 14 sampled residents. The facility census was 53 residents.A policy related to following physician orders was requested and not received prior to exit on 1/9/26.1. Review of Resident #21's admission Record showed the resident readmitted to the facility on [DATE] with a diagnosis of Osteomyelitis (an infection and inflammation of bone tissue).Review of the resident's Order Summary Report dated January 2026 showed:-The resident had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) Pressure Ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin) to his/her coccyx (the small bone at the bottom of the spine).-Staff were to cleanse with normal saline, pat dry, cover with mepilex (used for various exuding wounds like pressure ulcers to promote moist healing by absorbing drainage, minimizing pain and trauma on removal, and preventing maceration) border foam dressing, change every other day and as needed for soiling.-NOTE: There was no order for zinc barrier paste (a thick, medicated topical skin protectant containing zinc oxide as a primary active ingredient) to be applied to the resident's coccyx area.Observation on 1/7/26 at 11:35 A.M. of the resident's wound care to his/her coccyx showed:-Licensed Practical Nurse (LPN) B, Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator B, and Registered Nurse (RN) A were all in the room assisting with the resident's wound care.-MDS Coordinator B and LPN B were assisting in the positioning of the resident while RN A was preparing the treatment for the resident.-After RN A cleansed the resident's wound site, RN A instructed LPN B and MDS Coordinator B to apply zinc barrier paste to the resident's coccyx area.-RN A then applied the mepilex border foam on top of the resident's wound bed.During an interview on 1/8/26 at 11:04 A.M. RN A said:-He/She would not have done anything differently related to the resident's coccyx wound dressing.-He/She was unsure why he/she had instructed MDS Coordinator B and LPN B to put the zinc oxide paste to the resident.-He/She initially thought it was a different cream that should have been applied before placing the mepilex dressing but looked up the resident's order and realized that no cream should have been applied to the wound bed at all.-He/She should have followed the wound care instructions as ordered.-It was important for staff to follow wound care orders for wounds to be able to heal properly.During an interview on 1/9/26 at 10:03 A.M. LPN B said:-He/She would not have done anything differently related to the resident's coccyx wound treatment.-He/She thought all of the wound treatments were completed as ordered.-He/She did not realize that the coccyx wound treatment had been done incorrectly.-He/She should not have placed the zinc oxide paste on the resident's coccyx.-It was important for staff to follow wound care orders to ensure wounds were healing appropriately.During an interview on 1/9/26 at 10:32 A.M. MDS Coordinator B said:-He/She had been told by that point in time that he/she and LPN B had applied the zinc oxide paste to the resident's coccyx wound and that was not a part of the treatment order.-He/She should have followed the wound care instructions as ordered.-It was important for staff to follow wound care orders to ensure that the treatments were effective.During an interview on 1/9/26 at 11:47 A.M. the Director of Nursing said:-All wound care treatments needed to be followed as ordered by the physician.-The staff should not have applied the zinc oxide paste to the resident's coccyx wound as that was not a part of the order.-He/She would have expected the staff to have followed the wound care treatment order, as ordered.-It was important for staff to follow wound care orders to promote wound healing and to ensure treatments were effective.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #58) out of 14 sampled residents had bed assist devices installed in a timely manner, clarified if the resident needed a right side bed assist bar or bilateral bed devices, and failed to ensure the resident's care plan identified specifically the equipment needed to improve the resident's independence with bed mobility and transfers. The facility census was 53 residents.Review of the facility's Bed Rails Policy, revised 12/24/25 showed:-Bed rails will also refer to grab bars, halo bars, assist bars, and safety rails (adjustable metal or rigid plastic bars that attach to a bed). Transfer bars, mobility enhancers, and bed canes are rails used on beds and are intended to 1) reduce the risk of falling from bed, 2) assist the resident in repositioning in bed, and/or 3) assist the resident in transitioning into or out of the bed.-The Interdisciplinary Team will use data collected from individual bed rail assessments and evaluations to assist in care planning.-The facility will complete the following if a bed rail/bed assist device is used:--Assessment of resident for risk of entrapment from bed rails prior to installation.--Therapy will assess the resident.--A physician order will be obtained.--Consents will be obtained from the resident/representative for side rail use.--Individual bed rail assessments and evaluations will be performed upon admission, upon initiation of a bed rail, and at least annually utilizing the bed rail assessment.--Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to use.--When deemed necessary and appropriate the facility will provide education to residents and/or their representative pertaining to the risk and benefits of the use of bed rails/assist bars. 1. Review of Resident #58's admission Record showed the resident readmitted to the facility on [DATE] with diagnoses that included:-Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Repeated falls. Review of the resident's Assistance with Activities of Daily Living (ADL - dressing, grooming, bathing, eating, and toileting) Care Plan, initiated 12/27/24, showed:-The resident had impaired mobility and general weakness.-The resident would have a positioning device on his/her bed to assist with bed mobility and transfers starting 12/27/24. -NOTE: The care plan did not show that the bed assist bar was no longer needed at any point after 12/27/24 or specify either a right side grab bar or the need for bilateral mobility/transfer devices at any time after 12/27/24.Review of the resident's Fall Risk Evaluation, dated 9/14/25 showed the resident:-Had no falls within the past three months.-Was ambulatory and continent.-Had no gait or balance issues.Review of the resident's Bed Rail Assessment, dated 9/14/25 showed:-The resident was ambulatory.-The resident did not express a desire for a bed rail/bed assist bar.-The resident's interventions included: lower bed to the floor, provide toileting assistance at night, and reminders to use the call light.-Recommendations were for no side rails/bed assist bars as they were not indicated.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 10/2/25 showed the resident:-Was cognitively intact.-Used a walker and a manual wheelchair for mobility.-Required supervision for toileting hygiene; moving from a seated to a standing position; and chair to chair and toilet transfers. Needed partial to moderate assistance (the helper does less than half the effort) for shower transfers.-Could independently go from a lying position to sitting on the side of his/her bed.-Was occasionally incontinent of urine.-Had no falls since the previous MDS quarterly assessment dated [DATE].-Was taking a diuretic (a medication that makes a person urinate more, helping the kidneys remove excess salt and water to lower blood pressure and reduce fluid buildup).Review of the resident's Physical Therapy Treatment Note, dated 11/17/25 showed the resident would benefit from bed assist rails bilaterally to improve independence with bed mobility and transfers.Review of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's Order Summary Report showed a new order dated 12/2/25 for a grab bar to the right side of the bed for mobility and to promote independence per therapy recommendations.Review of the resident's progress notes dated 11/17/25 through 12/2/25 showed no explanation why the Physical Therapy recommendation showed bed assist rails bilaterally and the physician orders showed a grab bar to right side of the bed.Review of the resident's Bed Rail Assessment, dated 12/9/25 showed the resident:-Was non-ambulatory.-Expressed a desire to have side rails/bed assist bar(s).-Had interventions for a lowered bed, assistance with toileting at night, and reminders to use the call light.-A side rail/bed assist bar to the right was indicated to serve as an enabler to promote independence.-Positive and negative aspects of a side rail/bed assist bar were discussed with the resident, family, and/or responsible party.-The assessment did not indicate the exact type of bed assist device the resident needed.Review of the resident's Maintenance Work Order ending in #648 showed:-An order submitted by Social Worker (SW) A for a transfer bar installation to the right side of the resident's bed was created on 12/9/25.-The order was assigned to Maintenance Engineer A on 12/10/25.-The work due date was 12/12/25.Review of the resident's Event Information report, dated 12/15/25 showed:-At 5:55 A.M. staff entered the resident's room and observed the resident in a sitting position on his/her buttocks in the middle of the room. The physician was notified. The Director of Nursing (DON) was notified. The oncoming shift was informed.-The resident was considered at high risk of falls before the fall. -Resident was forgetful before and after the fall. -He/She was alone and resting in bed before the fall.-Resident was toileted at 2:00 A.M.-New interventions for lowered bed and call light visible and within reach.Review of the resident's progress notes, dated 12/15/25, showed installation of a grab bar to the right side of the resident's bed completed on this date. To be assessed for continued need quarterly by the nurse.Review of the resident's Maintenance Work Order ending in #648 showed the transfer bar installation was completed on 12/15/25 at 3:55 P.M.Review of the resident's Order Summary Report showed a new order for the resident's bed to be in the lowest position and a fall mat for safety every night starting 12/20/25.Observation on 1/6/26 at 11:07 A.M. showed:-The resident was lying in bed with his/her eyes open and used the bed assist bar to his/her right while coming to a seated position on the side of his/her bed.-A fall mat was at the right side of the resident's bed and the bed was in a lowered position.-The resident had one bed assist bar on the right side of his/her bed.During an interview on 1/6/26 at 11:08 A.M. the resident said:-He/She had been at the facility for years and always had a bed assist rail on his/her bed, but it was removed some time back. -He/She didn't know why it was removed or when it was removed.-He/She couldn't remember how long it was missing before they installed a bed assist bar, but thought it had been missing for several weeks. -When he/she noticed the bed assist rail missing she didn't think much about it and never voiced any concerns about it being gone. He/She knew before the night he/she fell out of bed the rail had been removed.-He/She wasn't sure the date he/she fell, but thought it was before Christmas. He/She had never fallen out of bed before then.-The night he/she fell a bed rail or bar was not on the bed and there was nothing to grab hold of to try to prevent the fall. He/She thought if a rail or bar had been attached to the bed he/she might have been able to grab it to prevent the fall.-He/She had to go to the bathroom a lot due to being on a diuretic and might have needed staff to take him/her to the toilet the night of the fall, but couldn't remember for sure. -He/She hit his/her head on the bedside table.-He/She was holding his/her call light when he/she fell but couldn't get it to work.-He/She had already gone to sleep before he/she fell and didn't know the approximate time of the fall.-A nurse checked him/her out for injuries and he/she and at least two Certified Nurse Assistants (CNAs) helped him/her up into his/her wheelchair.During an interview on 1/8/15 at 9:50 A.M. Maintenance Engineer A said:-All the residents' beds had been replaced within the past few months. The previous beds all had an upside down U-shaped assist rail. He/She was responsible for maintaining bed assist devices and making sure they were tight and secure. All previous resident beds had the upside down U shape.-When the beds were replaced the company who brought the current beds started installing bed assist bars as soon (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as the beds were delivered. Someone from the facility told the company they couldn't install assist bars on the beds and the company removed the grab bars they had just installed, so at the time none of the resident beds had a grab assist bar.-After the new beds were delivered the therapists had to check residents out for the need for a bed assist bar. The therapist was supposed to fill out a form and send it to SW A to initiate the work order. They had 24 hours to put a work order in after the therapy evaluation. -He/She typically installed the bed assist bars within 2 or 3 days. Installing the bed assist bars shouldn't take more than four or five days after the therapist evaluates a resident for the need for assist bars.-He/She received a work order after a doctor's order was obtained for a grab bar and installed the grab bar either the day of or day after the resident fell. During an interview on 1/8/26 at 10:30 A.M. SW A said:-The process for a resident to have a bed assist bar started with the Occupational Therapy (OT) or Physical Therapy (PT) evaluation to see if a resident could benefit from it. -The next step was for Therapy to tell the resident's nurse of the bed assist device need. -A Bed Rail Assessment form was then completed by the nurse and the therapist. -Then the nurse puts an order in for the bed assistance device. Once the orders were approved, the nurse would inform him/her the order was approved. -He/She was responsible for getting the consent signed by the resident or their representative. Once the consent was signed he/she would put a work order in for maintenance to install the bed assist bar.-Maintenance usually installed the assist bar within a day or two.-He/She tracked when a work order was completed and made rounds weekly to ensure the device was installed. -Maintenance would send him/her an e-mail when the installation had been completed. -He/She put a work request in for the resident on 12/9/25. It was installed on the 15th. -Maintenance received a lot of bed assist bar requests around that time because of everyone getting a new bed. During an interview on 1/8/25 at 11:10 P.M. OT A said:-None of the residents had bed assist bars when they got new beds starting around November 10, November 11, or November 12. -The bed assist bar evaluation was done by PT on 11/17/25. -The Physical Therapy Assistant (PTA) who evaluated the resident wrote a note recommending bilateral bed assist rails.-When the therapist or therapy assistant determined someone needed a bed assist device he/she would tell the nurse and the nurse notified the doctor. -The next quarter a bed rail assessment would be due, but therapy was not involved in the bed rail assessment because they already had done their evaluation. -The nurse should let the doctor know the same day therapy made their recommendation and should have the order within 24 hours. -Therapy would let Social Services know of the recommendations for a bed assist device.-The nurse would let Social Services know when the order had been approved and Social Services created the maintenance work order for the bed assist device that same day. -Once maintenance knew there was an order for the bed assist device they usually installed it within a few days' time, and sometimes that same day or the next.During an interview on 1/8/2026 at 2:44 P.M. MDS Coordinator A said:-Social Services would e-mail him/her when there was a physician order for a bed assist bar that should be added to the resident's care plan. -The care plan interventions were generic and usually written the same for all residents who had a bed assist bar.-Therapy determined if the bed assist bar should be one or two and the care plan should reflect Therapy staff's recommendation. -Originally, every resident had a positioning device on their bed. When the facility got new beds in November 2025 nobody had a positioning device on their bed. If they wanted one therapy had to determine if they got one. -If a nurse or CNA or other staff person thought a resident could benefit from a bed assistance device they would go to SW A who would let Therapy know of the concern.-The bed assistance device should be installed within two or three days of the therapy recommendation. During an interview on 1/9/2026 at 9:29 A.M. Registered Nurse (RN) A said:-He/She or the charge nurse was notified by either therapy when they did their evaluation or by Social Services of the bed assistance device recommendation. -The nurse would put in the order for the therapy recommendation that same day. Usually the doctor approved the therapy recommendation that day or the next and the nurse notified Social Services as soon as the order was approved.-Social Services created a maintenance work order through an electronic notification that same day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Maintenance should install the bed assistance device that day or the next. Ideally the whole process should be less than 24 hours. If the resident was assessed for a bed assist bar on a Friday afternoon it might be Monday before the bed assist bar was installed.-If therapy said bilateral bed rails were recommended the order shouldn't say right side only bed assist bars.-The facility got all new beds in November. -All the residents had the upside-down U-shaped bed assist bars on their beds and got a new bed on either 11/10/25 or 11/17/25. The resident got his/her new bed on 11/10/25. Nobody had a grab bar on their new bed until they were assessed by Therapy for the need for one. The previous interim DON said the facility had to assess everyone for a bed assist bar.-Therapy did assessments on everyone with a new bed the week they got their bed.-The resident's Bed Rail Assessment and physician order showed a right side bed assist bar, but it should be consistent with the therapy recommendation which showed bilateral bed assist devices. During an interview on 1/9/25 at 11:40 A.M. with RN A and the DON:-The Social Worker was responsible for doing weekly audits to ensure the bed assist bar installation process was completed.-The MDS Coordinators were responsible for resident care plans which should be specific and comprehensive and reflect the resident's current status and needs. -Bed assist devices should be approved by the physician within 24 hours of the therapy evaluation. -The Social Worker should put in the work order for a bed assist bar the same day the order was approved provided the facility could get the consent of the resident or their responsible party that same day. If they couldn't get ahold of them for a day or two attempts to contact the responsible party should be documented in the resident's progress notes. Once they had the consent a work order should be created.-Maintenance should install the device within 24 hours of receiving the work order. -If a therapy recommendation was made on a Friday the bed assist device should be installed by Monday as long as the facility could get ahold of the resident's responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide catheter care, document catheter care, or refusal of catheter care for one sampled resident (Resident #33) out of 14 sampled residents. The facility census was 53 residents. Review of facility policy titled Management of Foley Catheters revised 12/2/2025 showed:-Document the care in the electronic medical record. 1. Review of Resident #33's Admissions Record showed the resident's readmission date of 11/11/25 with the following diagnoses:-Urinary tract infection.-End stage renal disease (ESRD is when you have permanent kidney failure that requires a regular course of dialysis or a kidney transplant). Review of the resident's Treatment Administration Record (TAR) dated November 2025 showed 13 out of 38 opportunities where catheter care was not documented.Review of the resident's progress notes dated November 2025 showed no documentation where catheter care was refused by the resident. Review of the resident's Order Summary Report dated November 2025 showed an order for catheter care every shift dated 11/12/25.Review of the resident's TAR dated December 2025 showed 20 out of 62 opportunities where catheter care was not documented.Review of the resident's progress notes dated December 2025 showed no documentation where catheter care was refused by the resident. Review of the resident's care plan dated 12/2/25 showed:-Catheter care was to be provided every shift.-The resident refused catheter care at times. Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/23/25 showed:-He/She had an indwelling catheter. -He/She had end stage renal disease.-He/She had a urinary tract infection.During an interview on 1/8/26 at 12:48 P.M., Certified Nursing Assistant (CNA) C said the catheter care when on the TAR was performed by the nurse, and he/she would not have done it. During an interview on 1/8/26 at 12:49 P.M., Licensed Practical Nurse (LPN) A said:-Catheter care was charted on the TAR.-When catheter care was charted on the TAR, the initials of the person that charted it and the time was charted would be shown. -When the space was blank on the TAR then catheter care was not done. -When a resident refused cares, it would have been attempted later. -When a resident refused care after several attempts, it was documented as a refusal with a progress note that would have shown that education was given to the resident and what the resident was educated on. -When there were no progress notes of refusals and blank spaces on the TAR then it was an issue. During an interview on 1/8/26 at 12:54 P.M., LPN C said:-The TAR was where catheter care was charted.-When catheter care was charted on the TAR, the initials of the person that charted it and the time would be shown. -When the space was blank on the TAR then it would be assumed that catheter care was not done. -The [NAME] in nursing was if it was not charted the care was not done. -When care was refused by a resident it would have been attempted later. -When care was refused after several attempts it would have been documented as a refusal with a progress note that would have shown that education was given, and what the resident was educated on. -When there were no progress notes of refusals and blank spaces on the TAR then it was a problem. During an interview on 1/9/26 at 11:47 A.M., the Director of Nursing (DON) said:-It was his/her expectation when catheter care that was ordered that it would be performed. -It was his/her expectation that the nurses would have documented the care performed. -If a care was not documented then the care was not done.-It was his/her expectation when a resident refused cares the nurse would chart a progress note with the refusal and the education provided. -It was his/her responsibility or the appointed designee to audit charts to ensure cares were being documented and there were no missed cares, and for any refusal there was a progress note charted. -He/She just started two weeks ago as the DON and had not had time to get things figured out.