STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265795	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingswood	10000 Wornall Road Kansas City, MO 64114

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician, Administrator, Director of Nursing (DON) and/or the resident representative of one resident's (Resident #1) changes in skin condition resulting in a delay in treatment out of four sampled residents. The facility census was 67 residents. Review of the facility Change in a Resident's Condition or Status dated 2/2021 showed: -Our facility promptly notifies the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. -The nurse will notify the resident's attending physician or physician on call when there has been a(n) significant change in the resident's physical, emotional, or mental condition and the need to alter the resident's medical treatment significantly. -Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. -Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical or mental condition or status. 1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE] with diagnoses including altered mental status, acute kidney failure, cellulitis of the lower limbs, and abnormalities of gait and mobility. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/8/24 showed the resident was severely cognitively impaired. Review of the resident's Interdisciplinary Notes dated: -10/13/24, 10/16/24, 10/17/24, 10/19/24, 10/24/24 and 10/25/24 Licensed Practical Nurse (LPN) A documented wounds were found. -No documentation was found of notification to the resident's physician and or family from 10/13/24 through 10/25/24 in the interdisciplinary notes. (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: 265795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE**The medical record showed no notification to the physician until 10/28/24 and showed no notification to the family until 11/7/24. During an interview on 12/19/24 at 9:21 A.M. Family Member #3 said: -Upon admission on [DATE], to the facility the resident did not have any open wound on his/her body. -On 11/18/24, the resident's spouse received notification the resident was being sent to the hospital due to coughing up blood. -Upon arrival at the hospital the resident was assessed to have many open wounds to his/her body. -He/she was not told of the resident having any wounds. During an interview on 1/13/25 at 2:31 P.M. LPN A said: -He/She documented new pressure injuries to heels and left ankle, which were not present the day of admission. -He/She reported to someone, but unable to state who he/she reported the pressure injury to or when, and did not document in the nursing notes. -Confirmed documenting the pressure injury to heels and left ankle on 10/13/24, 10/16/24, 10/17/24, and 10/21/24. -He/She did not notify the physician of the pressure injuries observed and documented. -He/She did not notify the family of the pressure injuries observed and documented. -He/She did not notify the nurse accepting the resident on the second floor for LTC on 10/21/24 of the pressure injuries. -When identifying a new wound, it should be documented, notify the wound nurse and put something protective in place. -Wounds should be measured, the physician should be notified, and family notified if they are not aware. -He/She did not know why he/she did not notify the physician or the family of the resident's wounds. -The physician would be notified by nursing when in the facility, including him/herself. During an interview on 1/14/25 at 12:13 P.M. the Nurse Practitioner (NP) said: -There was no notification on 10/13/24 of wounds from the nursing staff. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Confirmed there was no notification of the documented wounds from 10/13/24 through 10/21/24 while on the first floor for skilled services. -Confirmed there was no notification of any skin conditions or concerns from 10/21/24 through 10/28/24 after moving to the second floor for LTC. -He/She expects to be notified when wounds are discovered to put treatments as well as preventative measures in place. During an interview on 1/14/25 at 1:28 P.M. Assistant Director of Nursing (ADON) B said: -If any changes were noted the nurses were to notify the ADONs. -The nurses should have called the doctor or NP and the family. -On 10/28/24 he/she was notified by Certified Nurses Aide (CNA) A of the resident having wounds. -He/She believed the resident had six to eight wounds on 10/28/24. -He/She did not notify the family of the wounds or new orders at any time. During an interview on 1/14/25 at 3:08 P.M. LPN D said when identifying new wounds the nurses were expected to document, give the information to wound nurse, contact the doctor and contact the family after talking to the doctor. During an interview on 1/15/25 at 5:15 P.M. LPN E said: -He/She thought the resident had a coccyx wound while on the skilled unit. -For new wounds he/she would use standing orders, measure the wound and document, contact the doctor and notify the DON. -He/She has never been told to notify the family unless sending the resident out of the facility. During an interview on 1/16/25 at 11:25 A.M. LPN B said: -He/She cared for the resident was on the first floor for skilled services. -He/She documented pressure injury to the ankle on 10/19/24. -He/She notified the Director of Nursing (DON) and wound nurse/ADON, although it was not documented. -He/She felt the family probably already knew, so he/she did not contact the family. During an interview on 1/16/24 at 12:48 P.M. the DON said: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was first notified of the resident's wounds to the inside of his/her knee by ADON B on 10/28/24. -When a new wound is discovered the nurses were to report to DON, ADON A or ADON B and let them decide the next steps. -His/Her expectation was the nurses notify him/her by phone, text, something and then he/she will decide the process. -Nurses may contact the doctor without DON direction, he/she just wanted notified. -As a nurse they should be notifying the physician with any change. -The delayed notification and treatment of the resident's wounds was one that got missed as a result of bad decisions and poor choices by the staff. During an interview on 1/16/25 at 1:39 P.M. ADON A said: -On 10/21/24 when the resident was transferred to the second floor LTC, information related to the wounds and any other relevant information should have been given in a report from LPN A to the LPN D. -He/She expected staff to notify someone when a new wound is discovered, DON, ADON, Administrator, or physician, and put a treatment in place. -He/She still expected the provider to be called. During an interview on 1/16/24 at 4:30 P.M. the Administrator said: -He/She expected CNAs to notify the charge nurse when new wounds are discovered. -He/She expected the nurses to notify the doctor and get orders for treatment or interventions and to notify the family. -After the doctor and family were notified the nurse should notify the ADON, DON and administrator. -Braden assessments are to be done according to policy and quarterly. -He/She was aware the resident's wounds were not reported. -He/She expected family to be notified of any changes before the end of shift. During an interview on 1/21/25 at 10:44 A.M. Family Member #1 said: -The resident was transferred from the hospital to the facility on [DATE] with no skin issues. -He/She was not aware of any wounds until after the resident was sent to the hospital on [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/25 at 10:51 A.M. Family Member #2 said at no time prior to the resident being sent to the hospital on [DATE] was the family made aware of the resident's wounds or any changes in the resident's care. MO00246983

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were reviewed, updated and/or revised for two sampled residents (Residents #1 and #3) out of four sampled residents. The facility census was 67 residents. Review of the facility Care Plans, Comprehensive Person-Centered dated 03/2022 showed: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident physical, psychosocial and functional needs is developed and implemented for each resident. -The comprehensive, person-centered care plan: --Includes measurable objectives and timeframe's. --Describes the services that to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. --Reflects currently recognized standards of practice for problem areas and conditions. -Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. Review of the facility Pressure Injury Risk assessment dated 3/2020 showed: -The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PI). -The purpose of injury risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. -Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be crated to address the modifiable risks for pressure injuries. Review of the facility Prevention of Pressure Injuries dated 4/2020 showed: -The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and intervention for specific risk factors. -Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE] with diagnoses including altered mental status, acute kidney failure, cellulitis of the lower limbs, and abnormalities of gait and mobility. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/8/24 showed the resident: -At risk for pressure ulcers. -Moisture Associated Skin Damage (MASD) identified. -Pressure reducing device for chair and bed. -Turn and repositioning program. -Nutrition and hydration intervention to manage skin problems. -Application of ointment and medications other than to feet. Review of the resident's undated Care Plan showed the resident: -Dietary needs are risk for weight loss, risk for swallowing problems related to oral status of edentulous (no teeth) as well as mechanical soft no added salt diet with thin liquids and two liter fluid restriction, 10/2/24. -At risk for pressure ulcers related to decrease in function mobility and incontinence, 10/2/24. --Skin would remain intact with no new open areas by pressure or friction for the following 90 days. ---Skin assessment Braden Scale weekly for four weeks upon admission/readmission then quarterly, 10/2/24. ---Use pressure reducing mattress, cushion when in bed, wheelchair and float heels when in bed as needed, 10/2/24. ---Low air loss mattress to be in place, 10/14/24. ---MASD to buttock, barrier cream after each incontinent episode and as needed, 10/14/24. ---Treatments as ordered,11/4/24. ---Turn and position as needed, 11/4/24. ---Dietician to evaluate and treat as needed, 11/4/24. ---Pillow between knees while in bed, 11/4/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	---Staff to monitor for changes in mental status and functional abilities and report concerns to physician, 11/4/24. ---Resident is dependent for all cares, staff to anticipate needs, 11/4/24. -Had alteration in circulation resulting in edema, related to congestive heart failure. --Keep limb elevated as necessary to minimize edema, reduction in edema or not increased. ---Monitor skin condition daily to ensure no pressure or vascular wound present. *NOTE: the care plan did not directly address any current acquired pressure injuries. 2. Review of Resident #3's Face Sheet showed the resident was admitted on [DATE] with diagnoses including wedge compression fractures to the second and fifth lumbar, age related osteoporosis, and muscle weakness. Review of the resident's undated Care Plan showed it did not reflect the resident's facility acquired deep tissue injury (DTI) to his/her right heel. During an interview on 1/13/25 at 11:46 A.M. the Assistant Director of Nursing (ADON) B said he/she was responsible for ensuring care plans are in place for all residents on the second floor. 3. During an interview on 1/14/25 at 12:13 P.M. the Nurse Practitioner (NP) said he/she expected care plans to be updated to reflect the current pressure injuries to Resident #1 and Resident #3. During an interview on 1/14/25 at 1:28 P.M. ADON B said: -The ADONs were responsible for updating care plans. -Resident #1's care plan was not updated to reflect the pressure injuries, treatments and other interventions. -Resident #3's care plan was not updated to reflect the DTI to his/her right heel and should have been updated on 11/20/24. During an interview on 1/16/25 at 1:39 P.M. ADON A said: -He/She was responsible for ensuring care plans are in place for all residents on the first floor. -He/She would have updated the Resident #1's care plan if the wounds had been addressed before the resident was moved to the second floor for long-term care (LTC). During an interview on 1/22/25 at 11:25 A.M. the Director of Nursing (DON) said: -The ADONs were responsible for updating care plans for the residents. -He/She expected care plans for all residents to be updated with one week of any noted changes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/25 at 11:45 A.M. the Administrator said he/she expected all care plans to be updated as needed, quarterly and per regulatory standard. MO00246983

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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 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 weekly skin/wound assessments, wound assessments included a detailed description and measurements of the pressure ulcer/injury (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), and to notify the resident's physician of a new pressure ulcer to obtain treatment orders in a timely manner for one sampled resident (Resident #1) out of four sampled residents. The facility census was 67 residents. Review of the facility Pressure Injury Risk assessment dated 3/2020 showed: -The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. -Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure injuries. -Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. -When conducting a risk assessment, if a new skin alteration is noted, initiate a pressure or non-pressure form related to the type of alteration in skin. -The following should be recorded in the resident's medical record utilizing facility forms: --The type of assessment conducted. --Date, time, and type of skin care provided, if appropriate. --Condition of the resident's skin, if identified. --Initiation of a pressure form if new skin alteration noted. --Documentation in medical record addressing physician notification if new skin alteration noted with change of plan of care, if indicated. --Documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care, if indicated. Review of the facility Prevention of Pressure Injuries dated 4/2020 showed: -Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. -Assess the resident on admission (within eight hours) for existing pressure injury risk factors. -Repeat the risk assessment weekly and upon any changes in condition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. -Inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living (ADL's). -Skin Care includes: --Keep the skin clean and hydrated. --Use a barrier product to protect skin from moisture. --Use facility-approved protective dressings for at risk individuals. -Mobility/Repositioning: --Reposition all resident with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. -Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. -Evaluate, report and document potential change in the skin. Review of the facility Pressure Ulcers/Skin Breakdown Clinical Protocol dated 4/2020 showed: -The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, for example immobility, recent wight loss, and history of pressure ulcers. -In addition, the nurse shall describe and document/report the following: --Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudate (drainage) or necrotic (dead) tissue. --Pain assessment. --Resident's mobility status. --Current treatments, including support surfaces. --All active diagnoses. -The staff and practitioner will examine the skin of newly admitted resident for evidence of existing pressure ulcers or other skin conditions. -The physician will assist the staff to identify the type and characteristics of an ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician will help identify factors contributing or predisposing resident to skin breakdown, for example medical comorbidities, and macerated or friable skin. -The physician will clarify the status of relevant medical issues. -The physician will order pertinent wound treatment, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. -The physician will help identify medical interventions related to wound management. -The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors. -As needed the physician will help identify medical and ethical issues influencing would healing. -During resident visits, the physician will evaluate and document the progress of wound healing, especially for those with complicated, extensive, or poorly-healing wounds. -The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. 1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE] with diagnoses including altered mental status, acute kidney failure, cellulitis of the lower limbs, and abnormalities of gait and mobility. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/8/24 showed the resident: -Was severely cognitively impaired. -Impaired functional mobility to one upper extremity. -Impaired functional mobility to both lower extremities. -Used a wheelchair for mobility. -Required substantial to maximum assistance with shower/bath and personal hygiene. -Was dependent for toileting. -Was dependent for all mobility. -Was incontinent with bowel and bladder. -At risk for pressure ulcers. -MASD (moisture associated skin damage) identified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pressure reducing device for chair and bed. -Turn and repositioning program. -Application of ointment and medications other than to feet. Review of the resident's undated Care Plan showed the resident: -Impaired functional status: bed mobility, transfers, toileting, eating, personal hygiene and bathing, 10/2/24. --One to two person assist will all ADL's. -Had incontinence issues, 10/2/24. --Required assistance with staff to manage bowel and bladder incontinence. --Used incontinence briefs. -At risk for pressure ulcers related to decrease in function mobility and incontinence, 10/2/24. --Skin would remain intact with no new open areas by pressure or friction for the following 90 days. ---Skin assessment Braden Scale weekly for four weeks upon admission/readmission then quarterly, 10/2/24. ---Use pressure reducing mattress, cushion when in bed, wheelchair and float heels when in bed as needed, 10/2/24. ---Low air loss mattress to be in place, 10/14/24. ---MASD to buttock, barrier cream after each incontinent episode and as needed, 10/14/24. ---Treatments as ordered,11/4/24. ---Turn and position as needed, 11/4/24. ---Dietician to evaluate and treat as needed, 11/4/24. ---Pillow between knees while in bed, 11/4/24. -Resident is dependent for all cares, staff to anticipate needs, 11/4/24. -Had alteration in circulation resulting in edema, related to congestive heart failure. --Keep limb elevated as necessary to minimize edema, reduction in edema or not increased. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	---Monitor skin condition daily to ensure no pressure or vascular wound present. Review of Interdisciplinary Note dated 10/2/24 at 2:59 P.M. showed Licensed Practical Nurse (LPN) A documented the resident was admitted to the facility and no skin assessment documented at that time. Review of the resident's Braden Scale (a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers) Assessment on 10/2/24 showed a score of 10, indicating the resident was at risk for pressure injury development. Review of the resident's Physician's Orders dated 10/3/24 showed Low Air Loss (LAL) mattress to bed for wound prevention. Review of Interdisciplinary Note dated 10/3/24 at 10:43 A.M. showed the resident was assessed by the physician with no noted skin conditions. Review of the resident's shower sheet dated 10/5/24 showed no concerns. Review of Interdisciplinary Note dated 10/8/24 at 11:01 A.M. showed the resident was assessed by the Nurse Practitioner (NP) with no noted skin conditions. Review of the resident's Certified Nursing Assistant (CNA) shower sheet dated 10/9/24 showed pressure area to left buttock, skin evaluation form showed MASD to right buttock and barrier cream treatment. No documentation of a detailed description of the left buttock, no documentation the resident's family or physician was notified. Review of the resident's Braden Scale Assessment on 10/9/24 showed a score of 11, indicating the resident was at risk for pressure injury development. Review of the resident's Interdisciplinary Note dated 10/10/24 at 10:41 A.M. showed the resident was assessed by the physician with no noted skin conditions. Review of the resident's Interdisciplinary Note dated 10/13/24 at 3:47 P.M. showed LPN A documented: -Pressure areas to bilateral heels and left inner ankle. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right heel, left heel, and left ankle. No documentation the resident's physician or family were notified. Review of the resident's Interdisciplinary Note dated 10/15/24 at 10:20 A.M. showed the resident was assessed by NP with no noted skin conditions. Review of the resident's Interdisciplinary Note dated 10/16/24 at 2:55 P.M. showed LPN A documented: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER: Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE: 10000 Wornall Road Kansas City, MO 64114	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pressure areas to bilateral heels and left inner ankle. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right heel, left heel, and left ankle. No documentation the resident's physician or family were notified. Review of the resident's Interdisciplinary Note dated 10/17/24 at 11:43 A.M. showed the resident was assessed by NP with no noted skin conditions. Review of the resident's Interdisciplinary Note dated 10/17/24 at 1:07 P.M. showed LPN A documented: -Pressure areas to bilateral heels and left inner ankle. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right heel, left heel, and left ankle. No documentation the resident's physician or family were notified. -Low Air Loss (LAL) bed with proper settings and pillows in place to offload pressure areas. Review of the resident's Interdisciplinary Note dated 10/19/24 at 11:19 A.M. showed LPN B documented resident's pressure areas noted. No documentation where these pressure areas were located on the resident's skin. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right heel, left heel, and left ankle. No documentation the resident's physician or family were notified. Review of the resident's Interdisciplinary Note dated 10/21/24 at 2:15 P.M. showed LPN A documented: -Pressure areas to bilateral heels and left inner ankle. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right heel, left heel, and left ankle. No documentation the resident's physician or family were notified. -LAL mattress will be taken upstairs and placed on resident's bed with proper settings. Review of the resident's Physician's Orders dated 10/25/24 showed Silvadene (a topical, antibacterial cream) Twice daily apply to sacrum and coccyx and as needed (PRN) incontinence for wound care. No documentation of treatment orders for the resident's right and left heel wounds and left ankle wound. Review of the resident's Interdisciplinary Note dated 10/25/24 AT 5:33 A.M. showed LPN C documented: -No documentation of the previously identified pressure injuries to the resident's right and left heel and left ankle, identified on 10/13/24. Review of the resident's Physician's Orders dated 10/28/24 showed: -Arginaid 4.5 gram/156 milligram/9.2 gram oral powder packet by mouth twice daily for wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pro-stat Renal Care 15 gram-100 kilocalorie/30 milliliters oral liquid by mouth twice daily for wound healing. Review of the resident's skin evaluation form dated 10/28/24 showed: . -Sacrum pressure injury, 1 cm x 0.5 cm x 0.3 cm, Stage III (full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle is not exposed; slough may be present but does not obscure the depth of tissue loss; it may include undermining or tunneling) type 2 granulation, light serous drainage, treatment of Silvadene. -No documentation of the previously identified pressure injuries to the resident's right and left heel and left ankle, identified on 10/13/24. Review of the resident's Interdisciplinary Note dated 10/28/24 at 6:52 P.M. showed Registered Nurse (RN) A documented: -Wound care nurse (Assistant Director of Nursing (ADON) B) assessed today for new wounds note to inner bilateral knees and buttock. No documentation of measurements, staging, or detailed descriptions for the identified Pressure Injuries on the resident's right knee, left knee, and buttock. No documentation the resident's physician or family were notified. -No documentation of the previously identified pressure injuries to the resident's right and left heel and left ankle, identified on 10/13/24. Review of the resident's Physician's Orders dated 10/29/24 showed: -Aquacel Ag (a dressing that is indicated for moderate to high exuding wounds which are infected or at risk of infection) Extra, 4 inch x 5 inch bandage (Hydrocolloid dressing) 4 inch x 5 inch topical, Once daily cleanse inner knees with wound cleanser, apply Aquacel to wound bed, cover with border foam, change daily and as needed (PRN). -No documentation of treatment orders for the resident's pressure injuries to his/her right and left heel and left ankle discovered on 10/13/24. Review of the resident's skin evaluation form dated 10/29/24: -Right knee pressure injury, 3 cm x 2 cm x 0 cm, healing Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. It may also present as an intact or open/ruptured blister) with light serous (watery, clear, or slightly yellow/tan/pink drainage) drainage, treatment of Aquacel Ag. -Left knee pressure injury, 3 cm x 1.5 cm x 0.1 cm, healing Stage II with light serous drainage, treatment of Aquacel Ag. -No documentation of the previously identified pressure injuries to the resident's right and left heel and left ankle, identified on 10/13/24. Review of the resident's wound assessment document dated 10/29/24 showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Right inner knee, eschar, 4.5 cm x 2.0 cm x 0.1 cm. -Left inner knee, eschar, 3.5 cm x 1.5 cm, x 0.1 cm. -No documentation of staging, or detailed descriptions for the identified Pressure Injuries on the resident's right and left knees. No documentation of the previously identified pressure injuries to the resident's right heel, left heel, and left ankle. Review of the resident's Interdisciplinary Note dated 11/1/24 at 9:36 P.M. showed LPN C documented: -Resident had wounds in the knee area and around the coccyx. No documentation of measurements, staging, or detailed descriptions for the identified wounds. -No documentation of the Pressure Injuries on the resident's right heel, left heel, and left ankle identified on 10/13/24. Review of the resident's Physician's Orders dated 11/3/24 showed: -Paint area to left medial foot with betadine and cover with abdominal pad, wrap with kerlix and secure with tape every other day. -Paint area to right medial heel with betadine and cover with abdominal pad, wrap with kerlix and secure with tape every other day. -Heel protectors on bilateral feet at all times except for personal cares. --NOTE: the resident's right and left heels/ankles were identified to have pressure injuries on 10/13/24. These treatment orders were obtained 21 days after the wounds were initially identified. Review of the resident's skin evaluation form dated 11/3/24: -Right inner heel 6 cm x 8 cm x 0 cm, betadine and cover with abdominal pad, wrap with kerlix and secure with tape every other day. -Pressure reducing mattress and chair documented. -No documentation of staging, or detailed descriptions for the right heel. Review of the resident's Interdisciplinary Note dated 11/3/24 at 11:12 A.M. showed RN A documented: -Noted to have dark purple blisters to left medial foot 3.0 centimeters (cm) X 3.0 cm with no drainage. -Noted new area to right medial heel with purple blister measuring 6.0 cm x 8.0 cm. -Both periwound areas noted to have dark purple discoloration. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE 10000 Wornall Road Kansas City, MO 64114	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Center of both wounds are soft and boggy. -Treatment done: --Pain both areas with betadine, cover with abdominal pads and wrap with kerlix and secure with tape every other day. -All other treatments done as ordered. Review of the resident's wound assessment document dated 11/7/24 showed: -Right heel, Deep Tissue Injury (DTI - Deep tissue injury may be characterized by a purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Presentation may be preceded by tissue that is painful, firm, mushy, boggy, and warmer or cooler as compared to adjacent tissue), bruise. -Right outer foot, 2.0 cm x 1.0, bruise. -Right fifth digit, 1.5 cm x 1.5 cm, maceration. -Left lateral foot, 1.5 cm x 1.3, bruise. -Left ankle, 2 cm x 2 cm, bruised. -Left inner heel, 2.5 cm x 3.5 cm, bruised. Review of the resident's Physician's Orders dated 11/7/24 showed: -Consult wound team. -CBC (complete blood count) and CMP (comprehensive metabolic panel) next lab day. -House supplement 240 cubic centimeter (cc) by mouth three times a day for wound healing. Review of the resident's Interdisciplinary Note dated 11/7/24 at 11:15 A.M. showed NP documented: -Resident seen for general decline. -Developed pressure wound to bilateral heels, bilateral inner knees, bilateral hips and sacrum. -Start Remeron for appetite. -Continue topical wound care. -Offload pressure as much as possible and turn frequently. -LAL mattress. (continued on next page)

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	265795	A. Building B. Wing	01/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Repeat labs and push fluids. --NOTE: No documentation by facility staff of a pressure injury to the resident's right hip. No documentation of treatment orders for the resident's right hip. Review of the resident's Interdisciplinary Note dated 11/7/24 at 1:36 P.M. showed Director of Nursing (DON) documented: -Continues to have skin issues. -Waiting for therapy orders to manage contracture issues. -New abductor wedge ordered for management of wounds on inside of knees. -LAL mattress and will get a roho cushion (an air-filled cushion that's designed to distribute pressure and support the body while sitting) for the resident. -Will be getting wound consult. Review of the resident's Interdisciplinary Note dated 11/7/24 at 2:25 P.M. showed ADON B documented: -Resident continues with multiple wounds to sacrum, coccyx, buttocks, bilateral inner knees, and area to lateral left and right feet. -NP here to see resident and new orders. -Wounds: right and left heels, right and left inner knees, right and left lateral feet, left foot 5th digit, left and right hips, left lower buttocks, left buttocks, left upper buttocks, sacrum, left upper buttocks, left lower buttocks, please see wound reporting log. No documentation a skin/wound assessment was completed on 11/14/24. The resident was discharged to the hospital on [DATE]. During an interview on 12/19/24 at 9:21 A.M. Family Member #3 said: -Upon admission on [DATE], to the facility the resident did not have any open wound on his/her body. -On 11/18/24, the resident's spouse received notification the resident was being sent to the hospital. -Upon arrival at the hospital the resident was assessed to have many open wounds to his/her body. -The infection from the wounds spread to the bone. -On 11/22/24 the resident was admitted to hospice (end of life). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE 10000 Wornall Road Kansas City, MO 64114	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/27/24 the resident succumbed to the infection. During an interview on 1/13/25 at 11:46 A.M. the Assistant Director of Nursing (ADON) B said: -He/She is the ADON for the second floor and wound care nurse for the facility. -He/She was not tracking wounds until the end of October 2024. -There was no wound clinic or third party wound care providers. -He/She does weekly wound care assessments and charts those assessments on the following Monday. -He/She saw the resident for the first time on 10/28/24 when CNA A informed him/her of the resident having wounds. -The resident was on skilled services on the first floor from 10/2/24 through 10/21/24, when he/she was moved to the second floor for long-term care (LTC). -He/She felt the resident should have had skin assessments documented in the skilled nursing documentation while on skilled services. -He/She was concerned the floor nurses were not doing thorough assessments, specifically skin assessments. -When he/she noted the wounds on the resident, the NP was in the facility and assessed the wounds the same day. -He/She discussed his/her concerns about the resident's wounds with the DON. -He/She asked the physician for a diagnosis of unavoidable wounds due to the rate of wound development. -He/She was not aware of the resident having wounds prior to 10/28/24, although the resident's electronic medical record (EMR) Pressure Injury on 10/13/24. During an interview on 1/13/25 at 2:04 P.M. the DON said: -Confirmed the resident was on the first floor for skilled services from 10/2/24 through 10/21/24, then moved to the second floor for LTC. -Confirmed there was Pressure Injury documented by LPN A on 10/13/24, while the first measurement and initiation of treatment was documented on 10/28/24 by ADON B. -Expects the nurse to assess the resident when transferred from one floor to another floor and report to be given. During an interview on 1/13/25 at 2:31 P.M. LPN A said: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was the admitting nurse for the resident on 10/2/24. -Due to the resident's contractures upon admission, he/she recommended a LAL mattress. -Confirmed he/she did the admission assessment on 10/3/24 and there no skin concerns at that time. -He/She documented new PI to heels and left ankle, which were not present the day of admission. -He/She reported to someone, but unable to state who he/she reported the PI's to or when, and did not document in the nursing notes. -Confirmed documenting the PI's to heels and left ankle on 10/13/24, 10/16/24, 10/17/24, and 10/21/24. -He/She did not notify the physician of the PI's observed and documented. -He/She did not notify the family of the PI's observed and documented. -He/She did not notify the nurse accepting the resident on the second floor for LTC on 10/21/24 of the PI's. -There were no treatment orders in place for PI or other skin concerns while the resident was on the first floor for skilled services from 10/13/24 through 10/21/24. -He/She was doing treatments consisting of wound cleanser and border foam, although there was no orders in place. He/She did not document these treatments. -The resident went without appropriate treatment for 15 days to open wounds. -When identifying a new wound, it should be documented, notify the wound nurse and put something protective in place. -Wounds should be measured, the physician should be notified, and family notified if they are not aware. -He/She did not know why he/she did not notify the physician or the family of the resident's wounds. -The physician would be notified by nursing when in the facility, including him/herself. During an interview on 1/14/25 at 12:13 P.M. the NP said: -He/She recalls seeing the resident on the second floor LTC for wounds. -When the resident was on the first floor skilled, he/she does not recall the resident having any wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recalled the resident having diagnoses including failure to thrive and congestive heart failure (CHF). -Recalled seeing the resident wearing booties while on the skilled unit. -There was no notification on 10/13/24 of wounds from the nursing staff. -Did not recall any wounds until after the resident was moved to the second floor LTC. -No documentation from the physician related to skin concerns or wounds while the resident was on skilled services on the first floor. -Expects nurses to document wounds, use standing orders when appropriate or call the provider if the standing orders do not meet the criteria. -Standing orders were available to al the nurses for skin tears, wounds or development of wounds, and other minor concerns, so it is not necessary to call. -If standing orders are used, the nurse should put the order on the Physician's Orders in the EMR and print for signature, which also serves as notification. -From the initial noted PI's on 10/13/24 through 10/28/24 there was no documentation of notification or treatment in the interdisciplinary notes in which timeframe he/she expected the wounds to monitored daily and not have been without treatment or interventions. -Review of the POS showed a treatment order on 10/25/24 for Silvadene, which was from the list of approved standing orders. -Review of the POS showed treatment orders from 11/3/24 were from the approved standing orders. -He/She did not recall the standing orders from 10/25/24 and 11/3/24 being printed to be signed. -When he/she saw the resident on 11/7/24 he/she ordered lab and appetite stimulant due to not eating likely contributing to wounds. -Confirmed there was no notification of the documented wounds from 10/13/24 through 10/21/24 while on the first floor for skilled services. -Confirmed there was no notification of any skin conditions or concerns from 10/21/24 through 10/28/24 after moving to the second floor for LTC. -The resident had documented open wounds from 10/13/24 until sent out of the facility on 11/18/24 and no antibiotics were initiated. -There was an increased risk for infection due to no treatment for open PI's from 10/13/24 through 10/28/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE 10000 Wornall Road Kansas City, MO 64114	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expects to be notified when wounds are discovered to put treatments as well as preventative measures in place. -If he/she would have been notified sooner and interventions could be put in place sooner, however, the resident was prone to wounds due to comorbidities and overall decline. During an interview on 1/14/25 at 1:28 P.M. ADON B said: -He/She was doing wound care once weekly and the floor nurses were expected to do wound care the other six days per week. -If any changes noted, the nurses were to notify the ADONs. -He/She was not aware of standing orders. -The nurses should have called the doctor or NP. -On 10/28/24 he/she was notified by CNA A of the resident having wounds. -He/She believes the resident had six to eight wounds on 10/28/24. -On 10/28/24 he/she did not see any wounds to the heels, but did recall the resident had wounds to his/her knees and sacrum. -No treatment to open PI's for 15 days could have led to the resident's deterioration. During an interview on 1/14/25 at 2:02 P.M. CNA A said: -He/She took care of the resident at times throughout the resident's stay. -He/She notified ADON B about the resident's skin condition concerns on 10/28/24. -If new wounds are noticed during care he/she will report to the charge nurse, then the nurse will address the wound and tell the CNAs what to do. During an interview on 1/14/25 at 2:49 P.M. CNA B said: -He/She works on the second floor LTC. -Recalls the resident moving to the second floor LTC and was in bed most of the time. -He/She noticed wounds to the resident's knees, hip, buttocks and heels. -The resident came from the first floor with the wounds. -When he/she noticed the dressings to the buttocks and hip wounds, he/she thought the nurses were aware due to dressings in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Did recall the resident developing wounds, but unable to recall any other details related to the wounds. -He/She did not know if anything was done for the wounds from 10/13/24 through 10/21/24. -For new wounds he/she would notify the wound nurse/ADON and also notify the doctor and family. -He/She would follow up on new wounds and check for wound care orders. -The nurses on night shift fill out a sheet and chart in the EMR for skin integrity assessments. During an interview on 1/15/25 at 5:40 P.M. Registered Nurse (RN) B said: -When new wounds are discovered the nurse was expected to call the doctor, family and DON and document in the EMR. -Treatment orders are to be put in the EMR to be performed as ordered. During an interview on 1/16/25 at 8:06 A.M. LPN C said: -He/She recalls taking care of the resident on the first floor for skilled care. -He/She did not recall the resident having wounds. -While on skilled services residents are to have a head to toe assessment to include a skin assessment. -He/She moved to the second floor LTC before the resident moved from the first floor. -He/She only saw the resident around three times while passing medications. -He/She thought the resident had been on the second floor for some time bef

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NAME OF PROVIDER OR SUPPLIER: Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE: 10000 Wornall Road, Kansas City, MO 64114	

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Registered Dietitian (RD) was in the facility to perform dietary assessments and to consult with dietary staff in the kitchen. This practice affected two sampled residents (Residents #1 and #2) who needed dietary assessments during the time span when there was no RD coming to the facility out of four sampled residents. The facility census was 67 residents. Review of the facility Dietitian policy dated 11/2022 showed: -A qualified dietitian or other clinically qualified nutrition professional will help oversee food and nutrition services provided to the residents. -The dietitian or nutrition professional may be a full time or part time consultant or an employee depending on the current requirements of the facility. --The requirements are based on: ---Assessments and care plans of resident nutritional needs. ---The over all facility assessment of the number, acuity and diagnoses of the resident population. -Our facility's dietitian is responsible for, but not necessarily limited to: --Assessing nutritional needs of residents. --Developing and evaluating regular and therapeutic diets. 1. Review of Resident #1's Face Sheet showed the resident was admitted on [DATE] with diagnoses including altered mental status, acute kidney failure, cellulitis of the lower limbs, and abnormalities of gait and mobility. Review of the resident's undated Care Plan showed the resident: -Dietary needs are risk for weight loss, risk for swallowing problems related to oral status of edentulous (no teeth) as well as mechanical soft no added salt diet with thin liquids and two liter fluid restriction, 10/2/24. ---Dietician to evaluate and treat as needed, 11/4/24. Review of Interdisciplinary Note dated 11/7/24 at 11:15 A.M. showed Nurse Practitioner (NP) documented: -Resident seen for general decline. -Weight loss of 21 pounds since admission at the beginning of October. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Kingswood		STREET ADDRESS, CITY, STATE, ZIP CODE 10000 Wornall Road Kansas City, MO 64114	

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Developed pressure wound to his/her bilateral heels, bilateral inner knees, bilateral hips and sacrum. -Start Remeron (appetite stimulate) for appetite. Review of Interdisciplinary Note dated 11/7/24 at 1:36 P.M. showed Director of Nursing (DON) documented the resident triggered for weight loss in 30 days. **NOTE**The resident medical record showed no RD note and/or assessments. During an interview on 1/14/25 at 12:13 P.M. the NP said there should have been a Dietitian consult for failure to thrive, abnormal labs and newly acquired wounds, but there were issues with having a RD in facility. 2. Review of Resident #3's Face Sheet showed the resident was admitted on [DATE] with diagnoses including Type II Diabetes, hypomagnesemia, hyperkalemia and anemia. Review of the resident's undated Care Plan showed: -Resident was edentulous (had no teeth). -Resident will be provided diet per physician's order, regular NAS (no added salt), thin liquid diet with a two liter fluid restriction in place. -Educate on diet allowances and restrictions, need for compliance and ill effect of non-compliance, encourage and praise compliance. -Liberalized diet and mealtimes as possible for acceptance and blood glucose stabilization with safe parameters. -Offer bedtime nourishment per recommendations of RD or physician. **NOTE**The resident medical record showed no RD note and/or assessment. 3. During an interview on 1/22/25 at 10:17 A.M. the Director of Nursing (DON) said: -They had not had a RD for a while, although there was one onsite on 1/13/25. -Prior to the recent RD, there had been several weeks where there was not a RD consistently. -He/She was unable to provide any RD notes/consultations for Resident #1 and Resident #3. -He/She expected a RD consult any time something occurs then to follow RD recommendations for the resident. During an interview on 1/22/25 at 11:01 A.M. the Administrator said: -There had been issues with the company in keeping a RD in 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
	265795	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingswood	10000 Wornall Road Kansas City, MO 64114

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Confirmed with invoices there had been no RD in the facility from 11/3/24 through 12/6/24. -Upon his/her hire in 10/24 there were challenges with having a RD in the facility consistently. MO00246983