

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER University Health Lakewood Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 Lee's Summit Road Kansas City, MO 64139	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #1 and #2) out of 10 sampled residents were free physical and mental abuse from Certified Nurse Aide (CNA) A. On 4/17/25, Certified Nurse Aide (CNA) A grabbed Resident #1's arm, resulting in bruising and calling the resident a name. Additionally, CNA A refused to take the resident to the toilet and told the resident to be quiet. Later the same day, Resident #2 was heard asking CNA A to let the water warm up before being showered. CNA A said he/she didn't have time and placed the resident into the shower and sprayed him/her with cold water and then left him/her alone in the shower room partially naked for approximately five minutes while the resident was heard repeatedly yelling loudly for help and that he/she was cold while in the shower room and heard crying following the shower. The facility census was 134 residents.</p> <p>On 4/30/25 at 4:26 P.M., the Administrator was notified of the immediate jeopardy (IJ) past noncompliance that occurred on 04/17/25. Corrective measures began immediately. The CNA was suspended. All staff were re-educated on abuse and neglect. The IJ was corrected 4/18/25.</p> <p>Review of the facility's Abuse and Neglect policy, revised 7/26/24 showed:</p> <ul style="list-style-type: none"> -The facility will prohibit abuse. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury or mental anguish. -The individual must have acted deliberately. -Physical abuse included hitting, slapping, pinching, kicking and controlling behaviors through corporal punishment. -Involuntary seclusion is separation of a resident from others, from his/her room, or confinement against the resident's will. -Mental abuse included but was not limited to humiliation, harassment, threats of punishment, or deprivation. It may occur through verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately, remain with the resident, and do not leave the resident unattended.</p> <p>-Immediately summon for assistance by repeatedly calling for help until help arrives.</p> <p>-The facility will protect residents from further harm during an investigation, provide a safe environment, and assign a representative to monitor the resident's feelings concerning the incident.</p> <p>Review of the facility's Resident Abuse and Neglect training, dated 3/22/25, showed:</p> <p>-CNA A signed the in-service roster indicating he/she had attended the training.</p> <p>Review of the Staffing Schedule sheet for 4/17/25 showed CNA A worked on one hall during the day shift (7:00 A.M. to 7:00 P.M.) and was scheduled on a different hall on 4/17/25 during the night shift from 7:00 P.M. until 11:00 P.M.</p> <p>1. Review of Resident #1's admission Record showed he/she admitted to the facility on [DATE] with diagnoses including:</p> <p>-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).</p> <p>-Cerebral infarction (a type of stroke where brain tissue dies due to lack of oxygen caused by lack of blood flow) affecting left non-dominant side.</p> <p>Review of the resident's comprehensive care plan report, undated, showed the resident:</p> <p>-Had an Impaired Cognitive Functioning and Thought Processes care plan, initiated 9/29/24, related to dementia and stroke history. Staff were to cue, reorient and supervise as needed; keep routine and caregivers as consistent as possible to decrease confusion, and assist resident with decision-making.</p> <p>-Had a Communication Problem care plan, initiated 9/29/24, related to dementia and stroke history. Staff were to monitor for physical and non-verbal indicators of discomfort and/or distress and follow-up as needed.</p> <p>-Had a Behavioral care plan, revised 10/14/24, showing a history of agitation, anxiety, and frustrations that can present as hitting, yelling, grabbing, and making derogatory statements at staff. He/She has increased frustration when minority staff were assisting with his/her cares. Staff were to anticipate the resident's needs, offer tasks which divert his/her attention, and attempt to determine underlying cause considering location, time of day, persons involved, and situation.</p> <p>-Had an Activity of Daily Living (ADL) Self-Care Deficit care plan, initiated 1/10/25, related to dementia. Staff were to provide physical assistance with showers, dressing, personal hygiene, toileting, and extensive physical assistance for transfers between surfaces.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Had a Stroke care plan, initiated 1/15/25, showing it affected the resident's left side. Staff were to provide assistance as needed.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/27/25, showed the resident:</p> <p>-Was severely cognitively impaired with fluctuating disorganization.</p> <p>-Had no physical or verbal behaviors towards others, did not refuse cares, and did not have other behaviors.</p> <p>-Required substantial/maximal assistance (the helper does more than half the effort) for most ADLs (dressing, grooming, bathing, eating, and toileting) and for all transfers, including transfers to the toilet.</p> <p>-Was frequently incontinent of urine and occasionally incontinent of bowel.</p> <p>Review of the resident's two most recent Skin Assessments showed:</p> <p>-A skin assessment dated [DATE] showed skin was within normal limits and there were no areas of concern.</p> <p>-A skin assessment dated [DATE] showed the resident had an area of concern involving bruising to his/her right forearm.</p> <p>Review of the resident's Abuse/Neglect Investigation Summary, dated 4/23/25, written by the facility Administrator showed:</p> <p>-On 4/18/25 the Assistant Director of Nursing (ADON) verbally reported abuse towards Resident #1.</p> <p>-The allegation was given to him/her verbally by a staff member (Certified Medication Technician-CMT A) who wanted to remain anonymous due to fear of retaliation by the perpetrator (CNA A).</p> <p>-CNA A used foul language toward Resident #1 during cares.</p> <p>-Conclusion: Resident #1 sustained a bruise to his/her right arm that he/she alleged was done by CNA A.</p> <p>-Action Plan: CNA A was suspended until the investigation by Human Resources (HR) is complete.</p> <p>Review of the Document of Just Culture Assessment, dated 4/18/25, showed:</p> <p>-The worksheet was used to help gather information.</p> <p>-On 4/18/25 a resident showed the Director of Nursing (DON) bruises on his/her arm and stated a CNA pulled his/her arm.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Policy and Procedure: Residents are treated with respect and care that doesn't harm the resident. Gait belts are used for safe transfers. Residents are not transferred by their arms. Policy and procedure show residents have the right to be cared for with dignity and respect and to not be harmed.</p> <p>-CNA A refused to give a statement.</p> <p>-Abuse/Neglect education was part of the employee's initial orientation. Most recently Abuse/Neglect education was presented formally in the March meeting in which CNA A was a participant.</p> <p>-Algorithm analysis of duties and expectations showed the resident was physically harmed by CNA A. The employee had a duty to avoid causing unjustifiable risk or harm and to follow procedural rule. The employee chose reckless behavior.</p> <p>-Punitive consequences would be determined in collaboration with HR (the facility's Employee Relations partner). On 4/18/25 the facility recommended separation of employment.</p> <p>Review of a written Statement, dated 4/18/25, signed by the Quality and Safety Nurse (RN A) and the ADON showed:</p> <p>-On 4/18/25 at 4:20 P.M., RN A and the ADON conducted an investigation interview with CNA A regarding an incident that was anonymously reported that same day. CNA A was informed an investigation had been initiated.</p> <p>-CNA A confirmed he/she was assigned to Resident #1's hall.</p> <p>-CNA A was informed he/she would need to provide a written statement which CNA A declined to provide, stating he/she would consult his/her union representative before proceeding. The ADON informed CNA A the written statement could be submitted by e-mail.</p> <p>-CNA A was informed he/she would need to clock out due to the open investigation and CNA A left the facility immediately following the interview.</p> <p>During an interview on 4/29/25 at 10:05 A.M., the ADON said:</p> <p>-The incident was reported by CMT A the day after it happened on the afternoon of 4/18/25.</p> <p>-He/She pulled CNA A into his/her office and CNA A initially refused to write a statement. He/She was sent home immediately.</p> <p>-CNA A sent the statement on 4/22/25. The incident happened on 4/17/25.</p> <p>Observation on 4/29/25 at 11:47 A.M., showed:</p> <p>-Two fading dark purple dots on the resident's right forearm in the shape of fingertips.</p> <p>-One dot was approximately one-half inch in diameter. The other was approximately one-fourth inch in diameter.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 at 11:48 A.M., Resident #1 said:</p> <ul style="list-style-type: none"> -The bruising was almost gone. -Staff from upstairs grabbed his/her arm hard. The resident asked the staff what he/she was doing to his/her arm and the staff said he/she didn't like the resident, because he/she talked to all the white people. -The staff held on to the resident after grabbing him/her. -The resident told the staff he/she was going to tell and the staff said he/she didn't care what he/she did. -When CNA A grabbed his/her arm it hurt. That was about a week or so ago. -CNA A had never hurt him/her before and he/she had never seen the staff do anything like that before to anyone else. His/Her arm was sore for days. -When CNA A grabbed him/her, he/she was so surprised. He/She didn't expect anything like that. He/She was angry when CNA A said, CNA A didn't like him/her because he/she talked to white people. -Staff know it was CNA A who hurt him/her. He/She told staff it was CNA A. <p>(It should be noted the resident never explicitly said CNA A, but did point at CNA A.)</p> <p>Review of Restorative Aide (RA) A's written statement, dated 4/30/25, showed:</p> <ul style="list-style-type: none"> -He/She was at the desk. -Resident #1 was upset. CNA A was talking to Resident #1 disrespectfully, calling him/her a lesbian. -The resident said, look at my arm and he/she had three small marks on his/her arm. <p>During an interview on 4/29/25 at 2:25 P.M., RA A said:</p> <ul style="list-style-type: none"> -He/She left the facility at 3:30 P.M. on 4/17/25. -He/She noticed CNA A was rough and quick-tempered that day and snapped at Resident #1 towards the end of his/her shift, somewhere between 1:00 P.M. and 3:00 P.M. It might have been between 2:30 P.M. and 3:00 P.M. CNA A's tone of voice was irritated and angry. He/She could tell by the tone of CNA A's voice he/she had snapped at the resident, but he/she couldn't hear what had been said. How CNA A spoke to the resident was very unprofessional. -He/She happened to be at the nurses' station charting. -CNA A was not a regular on the floor and usually worked a different hall. It was unusual for him/her to work on the floor Resident #1 resided on. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-From afternoon onwards for the rest of the shift until 7:00 P.M. CNA A was argumentative and loud in general and had an angry look all afternoon. He/She was rough in speech with all the residents like they were inconveniencing him/her.</p> <p>-CNA A normally worked on a different floor.</p> <p>-He/She was in shock of what happened and didn't report it that evening and told the ADON the next day.</p> <p>Review of CNA A's e-mailed written statement, dated 4/22/25, showed:</p> <p>-He/She was responding to an allegation that he/she pulled a resident's arm on 4/17/25. The resident was in bed when he/she arrived on the unit. CNA B got the resident up out of bed.</p> <p>-Before breakfast he/she was transferring the resident into the chair where he/she eats. During the transfer the resident said his/her arm was hurt by an aide from upstairs who worked with him/her overnight and had pulled his/her arm.</p> <p>-As CNA A was getting clarification as to what the resident said, another aide (a name was mentioned for the CNA in the write up, but nobody by that name was on the schedule for 4/17/25 and the DON confirmed that person did not work on that day) asked what the resident said.</p> <p>-CNA A reported to that aide (the aide who was in the area at the time), Licensed Practical Nurse (LPN) A, and he/she thought CMT A, were all witness to what the resident had said.</p> <p>-The resident repeated the staff from upstairs pulled his/her arm.</p> <p>-CNA A asked the resident about the race of the person who bruised his/her arm and the resident confirmed the race.</p> <p>-CNA A said to the resident so, he/she looks like you pertaining to race and the resident said yes.</p> <p>-Again, what the resident said was reported to LPN A at the nursing station who overheard the conversation</p> <p>-We all (staff who were in the area at the time) went about our day and it wasn't brought up anymore.</p> <p>-CNA A hadn't done any cares on the resident at that time. CNA A's only interaction with the resident was assisting him/her in the chair to eat which is when the resident reported the pulling of his/her arm.</p> <p>-CNA A wasn't sure at which point the allegation switched to him/her.</p> <p>-The only interaction he/she had with the resident was caught on camera. It can be clearly seen by camera where CNA A was by the resident's chair talking with him/her and they were speaking to others (meaning staff) behind the nurses' station.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 4/29/25 at 3:45 P.M., CNA A said:</p> <ul style="list-style-type: none"> -The resident told him/her it someone who worked the night shift prior to the 4/17/25 day shift that pulled his/her arm. At the time LPN A, a CNA, and a CMT were at the nurses' station. -He/She was transferring the resident and he/she said it was the girl last night who pulled his/her arm. The resident didn't mention a name. -He/She never pulled or grabbed the resident's arm. -He/She didn't call the resident a lesbian and wasn't yelling at him/her. -He/She was asked to write a statement on 4/18/25 and had been off work since then. -Resident #1 wasn't upset. He/She was transferring the resident when he/she said the girl from night shift bruised him/her. The resident mentioned the person's presumed race. <p>Review of CNA B's statement, undated, showed:</p> <ul style="list-style-type: none"> -Throughout the day Resident #1 was continuously ignored by CNA A to the point other staff had to take the resident to the bathroom and found his/her brief wet and he/she still needed to go. -Instead of taking the resident, CNA A yelled at him/her Be quiet. I already took you. This kept happening all day until CNA A clocked out. <p>During an interview on 4/30/25 at 3:10 P.M., CNA B said:</p> <ul style="list-style-type: none"> -He/She didn't know anything about a bruise on anyone's arm. -On 4/17/25 CNA A refused to toilet Resident #1 all day. -The resident kept calling out to use the restroom and CNA A kept telling him/her he/she had already toileted him/her and to shut up. CNA A did this all throughout the morning, afternoon, and early evening hours and kept telling the resident to stop asking. -Other CNAs took the resident throughout the day. -He/She reported the resident requesting to be taken to the bathroom and CNA A refusing to do so to both LPN A and LPN B. -He/She knew the resident was upset and he/she tried to comfort him/her. When Resident #1 gets upset he/she gets verbally agitated. That shift the resident was talking about leaving the facility. He/She does this when he/she was upset. -The resident didn't say what he/she was upset about, except for not being taken to the toilet. <p>During an interview on 4/30/25 at 5:00 P.M., the DON said:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Had no verbal or physical behaviors toward others, did not refuse cares, and had no other behaviors.</p> <p>-Said it was very important to have choices about daily preferences including choosing what to wear and his/her bedtime and shower protocol.</p> <p>-Required partial to moderate assistance (the helper does less than half the effort) with showers and lower body dressing and supervision and/or assistance with steadying for transfers.</p> <p>-Was diagnosed with arthritis (swelling in one or more joints causing pain and/or stiffness).</p> <p>Review of the resident's Abuse/Neglect Investigation Summary, dated 4/23/25, written by the facility Administrator showed:</p> <p>-On 4/18/25 the ADON verbally reported an allegation of abuse towards Resident #2.</p> <p>-The allegation was given to him/her verbally by a staff member (CMT A) who wanted to remain anonymous due to fear of retaliation by the perpetrator (CNA A).</p> <p>-The allegations involved verbal abuse towards Resident #2 in the shower.</p> <p>-CMT A accounted overhearing the perpetrator using foul language toward the resident and overhearing the resident asking the perpetrator to allow the water to run longer to avoid getting a cold shower.</p> <p>-The perpetrator would not allow the water to run longer thus giving the resident a cold shower.</p> <p>-Conclusion: Resident #2 was adamant about what happened to him/her in the shower involving CNA A and his/her account of the verbal abuse and cold shower.</p> <p>Review of the Document of Just Culture Assessment, dated 4/18/25, showed the worksheet was used to help gather information, showing:</p> <p>-On 4/18/25 Resident #2 called the Administrator and reported to the ADON his/her CNA forced him/her into a cold shower and was verbally abusive.</p> <p>-Policy and Procedure: Residents should be treated with respect and care that doesn't harm the resident. Showers should be warm before residents enter. Policy and procedure show residents have the right to be cared for with dignity and respect and will not be harmed.</p> <p>-CNA A refused to give a statement.</p> <p>-Abuse/Neglect education was part of the employee's initial orientation. Most recently the Abuse/Neglect education was presented formally in the March meeting in which CNA A was a participant.</p> <p>-Algorithm analysis of duties and expectations showed the resident was given a cold shower against his/her wishes. The employee had a duty to avoid causing unjustifiable risk or harm and to follow procedural rule. The employee chose reckless behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Punitive consequences would be determined in collaboration with HR. On 4/18/25 the facility recommended separation of employment.</p> <p>Review of Resident #2's statement, dated 4/18/25, written by the ADON showed Resident #2 stated the following:</p> <p>-Staff didn't give him/her a shower the previous day.</p> <p>-CNA A put him/her in the shower chair and said, go ahead; shower yourself since you want this shower so damn bad.</p> <p>-He/She told CNA A he/she wanted the water to run for a little bit to warm up.</p> <p>-CNA A said, I don't have time and sprayed him/her with cold water and only washed under his/her breast and bottom.</p> <p>-The shower was cold, the water was too cold, and he/she was shivering.</p> <p>-The staff put him/her back in the bed and stated he/she would get him/her some socks and never came back.</p> <p>During an interview on 4/29/25 at 10:30 A.M., Resident #2 said:</p> <p>-CNA A told him/her the morning of 4/17/25 he/she would give him/her a shower and asked how much of it he/she could do by himself/herself.</p> <p>-He/She told CNA A he/she couldn't do much and CNA A said he/she didn't believe that.</p> <p>-CNA A came in at 7:00 P.M. or a little before to give him/her a shower and told him/her CNA A had an appointment outside the building earlier in the day and that was why he/she was so late in getting his/her shower.</p> <p>-He/She told CNA A it had to run a long time to get warm enough or it would be cold.</p> <p>-CNA A put him/her in the shower and turned the water on immediately. It hit his/her feet first and he/she said, oh, it's too cold and he resident was crying and hollering and said it was too cold and to get him/her out of here.</p> <p>-CNA A said he/she was getting on his/her nerves crying like that and he/she was in there now and he/she was going to take his/her shower and stop all that crying.</p> <p>-CNA A just turned the water off without actually having washed him/her. CNA A was going to dry his/her back, but he/she told the CNA it wasn't wet. CNA A never washed him/her at all.</p> <p>-The resident wiped under his/her breast with a washcloth to show he/she could do something.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-CNA A said he/she was making his/her bed and left him/her naked in the shower room a long time. He/She might have had a towel around his/her shoulders, but not his/her legs and he/she was cold. He/She told the CNA he/she needed his/her socks. He/She was left alone in the shower room about 10 minutes.</p> <p>-He/She kept hollering and crying. Nobody came into the shower room. There was a call light in the shower room, but he/she never put it on because he/she thought CNA A would come back and be mad.</p> <p>-CNA A dressed him/her in the shower room and brought him/her back into his/her room and said he/she was going to look for socks. CNA A left the room and he/she never saw CNA A again. He/She didn't think the CNA would come back because it was about 10 minutes past 7:00 and his/her shift was over.</p> <p>-He/She was angry when CNA A did that. He/She just couldn't believe he/she was doing that. He/She felt shocked and scared, but more angry than anything.</p> <p>-He/She was still hollering and crying after CNA A left.</p> <p>-Another nursing staff member put his/her socks on after he/she was back in his/her room and he/she reported to him/her what had happened.</p> <p>-He/She was really upset when the ADON came to talk with him/her about it the next day.</p> <p>During an interview on 4/29/25 at 2:10 P.M., the ADON said:</p> <p>-Resident #2 left a voice message on his/her voice mail saying he/she didn't get a shower the previous day.</p> <p>-He/She asked CMT A if he/she would shower the resident and that was when CMT A opened up and told him/her what he/she had observed.</p> <p>Review of CMT A's undated and unsigned written statement showed:</p> <p>-On 4/17/25 CNA A didn't give Resident #2 a shower all day long and waited until the resident was upset about it. CNA A said, come on (resident's name), you want your shower so bad let's get started and rushed the resident in the shower.</p> <p>-The resident said, can you let the water run? It's going to be cold.</p> <p>-CNA A said, I aint got time to be letting the shower run. Hurry up so I can get off this floor.</p> <p>-CNA A then said, here; wash yourself. There aint no reason you can't wash yourself and left the resident in the bathroom crying, help me, Jesus! because he/she was cold and left alone to shower himself/herself.</p> <p>-While the resident was crying CNA A was yelling outside the door, okay (resident's name); damn! I aint got no patience.</p> <p>-This was taking place at 6:15 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 at 5:30 P.M., CMT A said:</p> <ul style="list-style-type: none"> -He/She was in Resident #2's room maybe around 5:30 P.M. or 6:00 P.M. -The resident mentioned CNA A still hadn't given him/her a shower. -He/She asked if the resident wanted him/her to get CNA A to give him/her a shower. The resident said he/she would wait. -A short while later CMT A told CNA A the resident wanted his/her shower and CNA A said, come on (resident's name), you wanted your shower so bad so let's go. It was close to 7:00 P.M. before he/she started the shower. -The resident asked CNA A if he/she could let it run a so it warmed up and CNA A said, we aint got no 30 minutes to wait for that water to warm up. -At the time CMT A was in the resident's hallway passing medications. -The shower room door was open when he/she came down the hallway and he/she saw the resident sitting in the shower chair with his/her pants off. His/Her top was on at the time. He/She saw CNA A hand the resident a rag and tell him/her to wash himself/herself. The resident told CNA A he/she needed help. -CMT A heard the water come on and the resident was crying and yelling, help me, Jesus! Help me, Jesus real loud. -CMT A gives the resident showers and knew the water was cold and had to let it run during the time he/she made the resident's bed and gets the resident's clothes ready. That warms the water up. It probably takes five minutes. It still isn't super warm then. -CNA A said, okay, hurry up. Let's get this done so I can leave the unit. He/She was saying this in a loud tone of voice. -When CNA A noticed CMT A in the hallway CNA A said, I'm sorry; I aint got no patience for this. CNA A wasn't really talking to CMT A or to the resident, he/she was just talking out loud. -CNA A got the resident out of the shower room. He/She had left him/her in there probably five minutes by himself/herself. -Resident #2's body stiffens. He/She needed staff to wash him/her. The resident can reach his/her upper body. The resident's legs will lock up on him/her, so he/she does the shower for the resident when he/she gives it. -The resident was dressed when he/she was brought out of the shower room. He/She didn't know if the resident dressed himself/herself that evening. -The resident told him/her after CNA A left that CNA A didn't even shower him/her. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-CNA A leaves at 7:00 P.M. It was close to that before he/she started the shower. CNA A had all day to shower the resident.</p> <p>-CNA B was also working the floor during the time Resident #2 was being showered.</p> <p>-He/She was just so much in shock and couldn't believe it was happening.</p> <p>-The next day the ADON told him/her the resident didn't get his/her shower the previous day and asked him/her to give it. That was when he/she told the ADON what happened the evening before and the DON asked him/her to write a statement.</p> <p>Review of CNA A's e-mailed statement, dated 4/21/25, showed:</p> <p>-He/She was replying to accusations made against him/her. One being he/she gave a resident a cold shower.</p> <p>-He/She was assigned to two showers.</p> <p>-Upon arriving there were several residents still down. He/She began to get residents up and was not done until after all dining rooms had already been served. That pushed back his/her morning routine.</p> <p>-After breakfast he/she took residents that were supposed to be toileted to the bathroom and began his/her first shower. As he/she predicted, that shower took quite a while because the resident continued getting up several times throughout the shower and trying to walk off so much so that he/she had to call for assistance to finish him/her. He/She says all that to say by the time he/she finished the first shower and took his/her first 15-minute break it was already lunch time.</p> <p>-He/She then went to the resident who made the accusation of the cold shower and notified him/her he/she would get to the resident's shower after lunch when he/she was done with his/her lay-downs and afternoon rounds. The resident said, okay.</p> <p>-Once lunch was over and he/she completed his/her other duties he/she went to try and do the shower. The resident was already in an upset state and said he/she did not want to do it at that time because he/she fell recently and was hurting and the nurs</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely reporting of abuse allegations per the facility policy for two sampled residents (Resident #1 and #2) out of 10 sampled residents. Certified Nurse Aide (CNA) A was allowed to continue his/her shift on 4/17/25 and to work part of his/her shift on 4/18/25 potentially affecting all residents in his/her assignment. The facility census was 134 residents.</p> <p>On 4/30/25 the Administrator was notified of the past noncompliance which took place from mid-afternoon on 4/17/25 and 4/18/25. Corrective measures began immediately. The CNA was suspended. All staff were re-educated on abuse and neglect reporting. The deficiency was corrected on 4/18/25.</p> <p>Review of the facility's Abuse and Neglect policy, revised 7/26/24, showed:</p> <ul style="list-style-type: none"> -The facility will implement an abuse prohibition program to include training of employees, identification of possible incidents or allegations which need investigation, protection of residents during investigations, and reporting incidents. -Training will be provided to all employees through orientation and at a minimum annually and will include how staff should report their knowledge related to allegations without fear of reprisal and what constitutes abuse, neglect, and misappropriation of resident property. -Preventing abuse includes providing staff with information on how and to whom they may report concerns without retribution. -Staff will identify events such as suspicious bruising that may constitute abuse. Anyone witnessing an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of resident property shall report the suspected abuse immediately to the Administrator. -The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. -Information concerning a report of suspected or alleged abuse, mistreatment, neglect, involuntary seclusion, or injuries of unknown origin will be investigated upon receipt to determine if abuse or neglect is suspected. -Immediately, not to exceed 24 hours, notify the SA, utilizing the Mandated Reporter Form if reporting between 12:00 A.M. and 7:00 A.M. If the resident sustains serious bodily injury report no later than two hours after forming the suspicion. <p>Review of Resident Abuse and Neglect Training objectives, supporting the Abuse and Neglect policy, showed:</p> <ul style="list-style-type: none"> -Staff should immediately communicate suspected abuse and neglect. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The phone numbers of the Administrator, Director of Nursing (DON), ADON, Evening Supervisor, and Weekend Supervisor for reporting purposes were included as part of the training.</p> <p>-The training showed staff could report in person, by telephone, or through e-mail and could do so anonymously.</p> <p>1. Review of Resident #1's admission Record showed he/she was admitted 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).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/27/25, showed the resident was severely cognitively impaired with fluctuating disorganization.</p> <p>Review of the resident's Abuse/Neglect Investigation Summary, dated 4/23/25, written by the facility Administrator showed:</p> <p>-On 4/18/25 the Assistant Director of Nursing (ADON) verbally reported abuse towards Resident #1.</p> <p>-Allegations were given to the ADON verbally by Certified Medication Technician (CMT) A who wanted to remain anonymous due to fear of retaliation by CNA A.</p> <p>During an interview on 4/29/25 at 10:05 A.M. the ADON said:</p> <p>-Two allegations of abuse were reported by CMT A the afternoon of 4/18/25.</p> <p>-CMT A alleged CNA A spoke abusively to Resident #1 and grabbed the resident's arm the afternoon of 4/17/25.</p> <p>-CMT A also reported he/she heard Resident #2 ask CNA A to let the water warm up and CNA A said he/she didn't have time to do that and sprayed the resident with cold water on 4/17/25 a little before 7:00 P.M. resulting in the resident yelling out for help and crying. CMT A alleged CNA A also spoke to Resident #2 in an abusive manner during the time of the resident's shower.</p> <p>-An abuse/neglect investigation was started immediately on 4/18/24 upon receiving the allegations.</p> <p>During an interview on 4/29/25 at 11:48 A.M., Resident #1 said:</p> <p>-A staff person from upstairs grabbed his/her arm hard. He/She asked the staff what he/she was doing to his/her arm, and the staff member said he/she didn't like the resident because the resident talked to all the white people.</p> <p>-When the staff member grabbed his/her arm it hurt. That was about a week or so ago. and it was sore for days.</p> <p>-He/She told staff right after it happened.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 at 2:25 P.M., RA A said:</p> <p>-On 4/17/25 he/she noticed CNA A was rough and quick-tempered that day and snapped at Resident #1 towards the end of his/her shift, somewhere between 1:00 P.M. and 3:00 P.M. It might have been between 2:30 P.M. and 3:00 P.M.</p> <p>-CNA A's tone of voice was irritated and angry. He/She could tell by the tone of CNA A's voice he/she had snapped at the resident, but he/she couldn't hear what had been said. How CNA A spoke was very unprofessional.</p> <p>-Before he/she left for the day the resident showed his/her arm. He/She was still in the recliner and the resident held his/her arm up and said, look! He/She grabbed my arm indicating it was CNA A who had done it.</p> <p>-He/She didn't make a big deal about it because he/she wasn't sure at the time what had happened, so he/she didn't report it to anyone. He/She didn't know if a nurse was in the area at the time, but he/she did not report it to a nurse or to administrative staff.</p> <p>-CMT A was there near the resident, but he/she couldn't remember who else was in the area, but he/she thought at least two staff were there. Since there were others there, he/she didn't report it and went back and finished charting.</p> <p>-He/She went to all the facility in-services. If something comes up we should have reported it to the charge nurse. From there he/she was supposed to go to the ADON or the DON if the charge nurse was busy. He/She didn't report it because he/she knew someone else who was in the area would report it.</p> <p>During an interview on 4/29/25 at 2:45 P.M., CMT A said:</p> <p>-When he/she got to the unit he/she saw Resident #1 was upset. He/She could tell by his/her body language. The resident was shooing CNA A away and saying, leave me alone and the resident looked visibly upset like he/she was very frustrated.</p> <p>-CNA A said you're a lesbian to the resident. The resident said he/she wasn't a lesbian and CNA A said yes, you are, and you raped me because you touched my butt. CNA A was being very rude, and his/her tone of voice was very rude.</p> <p>-CMT A said, (resident's name), what's wrong and the resident said, he/she hurt me, meaning CNA A. The resident raised his/her right arm and there were three red marks on the resident's upper forearm. They looked like fingertip circles.</p> <p>-After he/she came to the resident, CNA A walked away and went to the nurses' station. The resident said he/she needed to go to the bathroom and CNA A yelled across the room, I already took you and grabbed his/her purse and left the unit to go to lunch.</p> <p>-CMT A had been educated to report suspicions of abuse immediately, but was so stunned and caught off guard about what he/she had witnessed that he/she didn't report it at the time. He/She told the ADON the next day.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25 at 5:00 P.M., the DON said:</p> <p>-He/She first heard about the incident with Resident #1 when the ADON reported it either mid-morning or in the afternoon on 4/18/25.</p> <p>-CMT A had reported it to the ADON on 4/18/25.</p> <p>-He/She asked the resident if he/she could show his/her arm. The resident lifted his/her arm and said, that boy/girl pulled my arm. I don't like the way he/she treats me.</p> <p>-All nursing staff were trained on reporting possible abuse and neglect. He/She would have expected the events of 4/17/25 to have been reported immediately for Resident #1.</p> <p>During an interview on 4/30/25 at 5:30 P.M., the Administrator said:</p> <p>-Staff reported abuse of Resident #1 on 4/18/25.</p> <p>-The allegations about the CNA A should have been reported immediately by CMT A and RA A to the charge nurse or they could have contacted the ADON, DON, or himself/herself (the Administrator).</p> <p>2. Review of Resident #2's admission Record showed he/she was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a chronic nervous disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait).</p> <p>Review of the resident's annual MDS, dated [DATE], showed the resident was cognitively intact with no disorganization or inattention.</p> <p>Review of the resident's Abuse/Neglect Investigation Summary, dated 4/23/25, written by the facility Administrator showed:</p> <p>-On 4/18/25 the ADON verbally reported an allegation of abuse towards Resident #2.</p> <p>-The allegation was given to him/her verbally by a staff member (CMT A) who wanted to remain anonymous due to fear of retaliation by the perpetrator (CNA A).</p> <p>-The allegations involved verbal abuse towards Resident #2 in the shower.</p> <p>-The reporter (witness) accounts overhearing the perpetrator using foul language toward the resident and overhearing the resident asking the perpetrator to allow the water to run longer to avoid getting a cold shower.</p> <p>During an interview on 4/29/25 at 10:30 A.M., Resident #2 said:</p> <p>-CNA A came in at 7:00 P.M. or a little before to give him/her a shower.</p> <p>-He/She told CNA A it had to run a long time to get warm enough or it would be cold.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA A put him/her in the shower and turned the water on immediately. It hit his/her feet first and he/she said, oh, it's too cold and the resident was crying and hollering and said it was too cold and to get him/her out of here.</p> <p>CNA A said he/she was getting on his/her nerves crying like that and he/she was in there now and he/she was going to take his/her shower and stop all that crying.</p> <p>-CNA A just turned the water off without actually having washed him/her.</p> <p>-CNA A said he/she was making his/her bed and left him/her naked in the shower room a long time. He/She might have had a towel around his/her shoulders, but not his/her legs and he/she was cold. He/She was left alone in the shower room about 10 minutes.</p> <p>-He/She kept hollering and hollering and crying. Nobody came into the shower room. There was a call light in the shower room, but he/she never put it on because he/she thought CNA A would come back and be mad.</p> <p>-He/She was angry when CNA A did that. He/She just couldn't believe he/she was doing that. He/She felt shocked and scared, but more angry than anything.</p> <p>-He/She was still hollering and crying after CNA A left.</p> <p>-A nursing staff put his/her socks on after he/she was back in his/her room, and he/she reported to him/her what had happened.</p> <p>-The resident was really upset when the ADON came to talk with him/her about it the next day.</p> <p>During an interview on 4/29/25 at 2:10 P.M., the ADON said:</p> <p>-Resident #2 left a voice message on his/her voice mail saying he/she didn't get a shower the previous day.</p> <p>-He/She asked CMT A on 4/18/25 if he/she would shower the resident and that was when CMT A opened up and told him/her what he/she had observed.</p> <p>During an interview on 4/29/25 at 2:45 P.M., CMT A said:</p> <p>-On 4/17/25 between 6:00 P.M. and 7:00 P.M. he/she told CNA A that Resident #2 wanted his/her shower and CNA A said, come on (resident's name), you wanted your shower so bad so let's go. It was close to 7:00 P.M. before he/she started the shower.</p> <p>-The resident asked CNA A if he/she could let it run a so it warmed up and CNA A said, we ain't got no 30 minutes to wait for that water to warm up.</p> <p>-At the time he/she was in the resident's hallway passing medications.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER University Health Lakewood Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 Lee's Summit Road Kansas City, MO 64139	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The shower room door was open when he/she came down the hallway and he/she saw the resident sitting in the shower chair with his/her pants off. His/Her top was on at the time. He/She saw CNA A hand the resident a rag and tell him/her to wash himself/herself. The resident told CNA A he/she needed help.</p> <p>-CMT A heard the water come on and the resident was crying and yelling, help me, Jesus! Help me, Jesus real loud.</p> <p>-CMT A gives the resident showers and knew the water was cold and had to let it run to water up. It probably takes five minutes. It still isn't super warm then.</p> <p>-CNA A said in a loud tone of voice, okay, hurry up. Let's get this done so I can leave the unit and I'm sorry; I ain't got no patience for this.</p> <p>-CNA A left the resident alone in the shower room probably five minutes.</p> <p>-The resident told him/her after CNA A left that CNA A didn't even shower him/her.</p> <p>-On 4/18/25 the ADON told him/her the resident didn't get his/her shower the previous day and asked him/her to give it. That was when he/she told the ADON what happened the evening before.</p> <p>-He/She was just in so much shock and couldn't believe it was happening the evening of the shower. He/She was still processing what was happening is why he/she didn't report the incident at the time.</p> <p>During an interview on 4/30/25 at 1:47 P.M., the ADON said:</p> <p>-On 4/18/25 around lunchtime he/she noticed a voicemail message had been left from Resident #2. The resident said he/she didn't get his/her shower the previous night.</p> <p>-He/She told the resident he/she would ask CMT A to give his/her shower that day (4/18/25).</p> <p>-He/She asked CMT A if he/she could give the resident his/her shower and CMT A said the resident got a shower yesterday (meaning 4/17/25) and then told him/her what he/she had overheard while passing medications on 4/17/25.</p> <p>-He/She went back to the resident's room and asked the resident what happened yesterday evening after dinner and the resident said:</p> <p>--The resident asked CNA A for a shower the evening of 4/17/25 and the CNA said, you want your shower so damn bad, come on; let's get it over with.</p> <p>--The aide turned the water on and the resident told him/her to let it run to warm up, but CNA A sprayed him/her with cold water.</p> <p>--The resident didn't want CNA A to give him/her a shower again.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff should have reported the incident the evening it happened. Staff are all trained to report abuse/neglect and mistreatment.</p> <p>During an interview on 4/30/25 at 5:00 P.M., the DON said:</p> <p>-On 4/18/25 Resident #2 told the ADON about the shower incident and the ADON told him/her and the Administrator.</p> <p>-He/She spoke with the resident who restated the event. The resident said he/she was crying because he/she didn't get a shower and CNA A said, okay, you want your shower. Fine. The resident said he/she told CNA A he/she had to wait and let it warm up for a long time. CNA A said he/she didn't have time to wait and pushed the resident's shower chair into the cold shower.</p> <p>-The resident said he/she was cold and crying and that CNA A only washed under his/her breasts and sprayed cold water on him/her.</p> <p>-When the resident told the DON he/she was sprayed with the cold water he/she was crying and became emotional. He/She (the DON) hugged the resident to help calm him/her.</p> <p>-He/She told the resident CNA A wouldn't be caring for him/her anymore.</p> <p>-Staff were educated on abuse and neglect in the March, 2025 staff meeting. They were all educated upon hire and two additional times during the skills fair in June and December. The education included the protocol for all staff to report abuse and neglect.</p> <p>-He/She felt like the situation was abuse. The cold shower against the resident's will could be physical abuse, because it caused him/her discomfort. It was psychological abuse as well, causing emotional distress.</p> <p>-He/She would have expected staff to have reported any suspected abuse/neglect or mistreatment immediately to the Administrator, who is the Abuse/Neglect coordinator. If the Administrator is not here staff should report to him/her (the DON) or the ADON. At the very minimum they should report to the charge nurse who in turn should report to the Administrator so that they can address the issue right away.</p> <p>-Reporting should have happened on 4/17/25 as soon as the witnesses saw that something wasn't right.</p> <p>-When he/she asked CMT A why he/she didn't report immediately he/she said he/she feared CNA A would do something to him/her. All three employees should have followed protocol and CMT A, CNA B, and RA A should have reported their observations. If they told a charge nurse the charge nurse should have reported to the Administrator.</p> <p>During an interview on 4/30/25 at 5:30 P.M., the Administrator said:</p> <p>-CMT A first reported the incidents of the previous day to the ADON on the afternoon of 4/18/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff all know and are educated on abuse and neglect upon hire, twice yearly during the skills fair, and most recently in March of 2025. The education included how staff were to report suspicions of abuse and neglect.</p> <p>-He/She thought what happened to Resident #2 was verbal abuse.</p> <p>-His/Her expectation was the aides should have followed the chain of command and should have gone immediately to the charge nurse and reported what they witnessed. CMT A expressed fear of retaliation. That was probably why he/she didn't report it immediately. They also could have contacted the ADON, the DON, or himself/herself (the Administrator). They have all been told in Abuse/Neglect training they can contact any one of them and they can also contact the security person who is on duty.</p> <p>MO00252988</p> <p>MO00252990</p> <p>MO00253102</p>		