STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265845	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Health Lakewood Medical Center	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure six sampled residents (Residents #2, #5, #10, #11, #13, #14) out of 14 sampled residents were treated with dignity and respect and cared for in a manner that promoted maintenance or enhancement of their quality of life. The facility census was 130 residents. The Administrator and Director of Nurses (DON) was notified on 3/20/26 of Past Non-Compliance which occurred on 3/12/26. On 3/12/26 the facility administration suspended Certified Nurses Aide (CNA) A, begun an investigation, and notified appropriate parties. Facility staff and residents were interviewed. Facility staff in-services were started on abuse and neglect policy which included dignity for all employees. The deficiency was corrected on 3/13/26. Review of the facility's policy titled, Abuse and Neglect dated 8/11/23 showed:-Residents had the right to maintain good mental and psychosocial well-being.-Facility staff were required to ensure the prevention of use of verbal or nonverbal conduct that caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.The facility did not have a separate policy on dignity. 1. Review of Resident #2's care plan dated 1/13/26 showed:-The resident admitted to the facility on [DATE].-The resident required assistance by one staff to move between surfaces with partial assistance.-The resident required assistance with his/her cares due to Parkinson's disease (brain disorder causing unintended or uncontrolled movements), osteoarthritis (chronic degeneration of the joint cartilage), diabetes (Metabolic disease), and impaired balance. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 1/20/26 showed the following staff assessment of the resident:-Was admitted to the facility on [DATE].-Was moderately cognitively impaired.-Had clear speech.-Understood others and others understood him/her.-Was frequently incontinent of bowel and bladder.-Used a wheelchair.-Required partial/moderate assistance for going from sitting to standing and transferring to the toilet.-Some of his/her diagnoses included diabetes, Parkinson's disease, and arthritis (an inflammatory condition of the joints). Review of the resident's interview dated 3/12/26 conducted by facility staff showed the resident said:-CNA A was rough with him/her and his/her roommate.-A week ago, this resident told CNA A that he/she had to use the bathroom after dinner.-He/She could stand as long as he/she used the grab bar.-CNA A said his/her back didn't feel well.-He/She asked CNA A why he/she would not get him/her some help.-CNA A said to just get up in bed and that he/she had a diaper.-He/She told CNA A that he/she needed to have a bowel movement.-CNA A said to have it in his/her diaper.-CNA A said he/she was not going to tear his/her back up to help him/her use the bathroom.-CNA A knew he/she ended up having a bowel movement in his/her brief and his/her brief was not changed until the next morning.-The day before this incident, CNA A was changing his/her brief while he/she was still going to the bathroom.-CNA A said, You are still shitting on yourself.-He/She already felt bad that he/she was not independent and didn't need CNA A making him/her feel worse about himself/herself.-CNA A seemed burned out.-CNA A was impatient with him/her and rude. During an interview on 3/20/26 at 8:23 A.M. the Administrator said:-The resident told a family member who then reported it to facility staff that CNA A refused to (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: 265845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
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	

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist the resident to the toilet and told the resident to have the bowel movement in his/her brief.-The resident was able to describe the events consistently several times during interviews. During an interview on 3/20/26 at 9:26 A.M., the resident said:-It seemed like CNA A was angry all of the time when he/she was taking care of him/her.-CNA A said things like, I don't have time to be walking all the way down here.-He/She was already in bed for the evening when he/she asked CNA A to take him/her to bathroom because he/she needed to have a bowel movement.-CNA A she said he/she could not hold the resident up to go to the bathroom.-The resident asked CNA A to go get some help.-CNA A said there was no one to help.-CNA A said he/she couldn't do it because his/her back and feet were hurting.-CNA A did not take him/her to the restroom and told him/her to just have the bowel movement in his/her brief.-His/Her brief was changed by someone else when he/she woke up the next morning.-CNA put him/her in bed kind of rough.-CNA A said things like shit and piss.-CNA A said he/she had to clean up the resident's shit or his/her roommate pissed all over the place.-He/She felt bad enough needing help, he/she didn't need CNA A making him/her feel worse.-He/She confirmed his/her written statement to the facility was accurate. During an interview on 3/20/26 at 4:15 P.M., the Administrator and Director of Nursing (DON) said:-This resident reported his/her concern about CNA A not taking him/her to the toilet and left to have a bowel movement in his/her brief to a family member who then reported to Administration.-This resident could be continent when put on the toilet.-This resident did have accidents and was incontinent at times.-This resident did not like CNA A saying he/she was shitting on or pissing on himself/herself.-CNA A should have assisted the resident to the toilet and not spoken to the resident that way. 2. Review of Resident #13's care plan showed:-The resident re-admitted to the facility on [DATE].-Revisions on 11/6/25 showed:--The resident had a colostomy (surgical procedure that brings one end of the large intestine out through the abdominal wall) related to neurogenic bowel (the loss of normal bowel function due to nerve damage from spinal cord injuries, certain neurological diseases, or stroke) and the colostomy bag was to be changed as needed.--The resident had Ogilvie syndrome, or acute colonic pseudo-obstruction (ACPO- a rare, sudden, and severe paralysis of the colon causing massive abdominal distension and gas buildup without a mechanical blockage. Commonly triggered by major surgery, trauma, or severe illness, it causes severe bloating, abdominal pain, nausea, and vomiting).--The resident was totally dependent upon staff for most cares.--The resident had diabetes, high blood pressure, balance problems, decreased mobility, traumatic brain injury, chronic pain and osteoarthritis (chronic degeneration of the joint cartilage).-Revisions on 1/23/26 showed:-- The resident had depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), anxiety (psychiatric disorder that involve extreme fear, worry and nervousness), and schizoaffective (mental health condition that includes features of both schizophrenia and a mood disorder) disorder. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-admitted to the facility on [DATE].-Had clear speech.-Understood others and others understood him/her.-Cognitively intact.-Had range of motion impairment on one side of his/her upper extremity (shoulder, elbow, wrist, hand).-Had range of motion impairment on both sides of his/her lower extremities (hip, knee, ankle, foot).-Used a wheelchair.-Was dependent upon staff for all cares.-Had a catheter (a tube passed through the urethra into the bladder to drain urine) and a colostomy.-Some of his/her diagnoses included high blood pressure, diabetes, seizure disorder (a medical condition that is characterized by episodes of abnormal surges of electrical activity in one's brain leading to a sudden, violent involuntary series of contractions of muscles), anxiety disorder, and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's interview dated 3/11/26 conducted by facility staff showed the resident said:-CNA A was very abrasive, not very cooperative, and dishonest.-CNA A was not a good care giver.-CNA A seemed burned out and very argumentative.-CNA A would tell him/her no whenever he/she asked CNA A to do anything for him/her. During an interview on 3/20/26 at 3:11 P.M., the resident said:-CNA A was abrasive and not cooperative.-CNA did not want to do (continued on next page)

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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	

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her job.-CNA argued with him/her and said he/she didn't feel like doing whatever he/she asked him/her to do such as taking him/her to the bathroom.-Once CNA A changed his/her colostomy bag in front of everybody at the nurses' station and it humiliated him.-Once CNA A didn't take him/her to the bathroom (before he/she started using a catheter) and he/she lied and told other staff that he/she did take him/her.-He/She confirmed his/her written statement to the facility was accurate. 3. Review of Resident #11's care plan dated with multiple dates from 2024 to 2026 showed:-The resident had expressive/receptive aphasia (loss of ability to produce or comprehend language due to brain injury) and kept paper and pen with him/her in case he/she was unable to get out the words he/she wanted.-He/She used a wheelchair.-He/She required physical assistance for dressing, personal hygiene, using the toilet, transferring from one surface to another.-Some of her diagnoses included a stroke, kidney disease, high blood pressure, diabetes, depression, anxiety, osteoarthritis, and neuropathic pain (a chronic, often severe type of pain caused by damage to or dysfunction of the nervous system).-Received diuretic (any medication that elevates the rate of urination) medication.-Had a stroke affecting his/her dominant side. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-The resident was admitted to the facility on [DATE].-Had clear speech.-Usually understood others and others usually understood him/her.-Was severely cognitively impaired.-Was always continent of bladder and bowel.-Some of his/her diagnoses included high blood pressure, diabetes, a stroke, hemiparesis (paralysis/weakness affecting one side of the body) or hemiplegia (complete paralysis on one side of the body), seizure disorder, and depression. Review of the resident's interview dated 3/13/26 conducted by facility staff showed the resident said:-His/her legs were so swollen that he/she was on strict bedrest.-He/She kept calling out to get his/her brief changed.-CNA A would answer his/her call but would not come down to change him/her.-When the nurse came in and saw that he/she was wet, he/she brought CNA A down to the room.-CNA A claimed he/she did not know this resident needed to be changed even though he/she had responded to the call light.-He/She was wet through his/her brief and his/her sheets were wet.-CNA A took him/her to the restroom and cleaned him/her up.-CNA A threw all of his/her blankets on the floor.-It was a disrespectful way to treat all of his/her belongings on the bed.-CNA A put him/her into bed naked and hanging halfway off the bed with the bed in a high position.-CNA A put a brief on him/her but did not fasten it fully, left the rest of him/her naked, and did not put any sheets on the bed.-CNA A was mean, rude, and dismissive.-CNA A acted like he/she did not want to be there.-CNA A wouldn't ask him/her what he/she wanted to eat and would just bring food and then got mad when he/she did not eat it because it wasn't what he/she wanted.-CNA A did not want to be bothered.-Whenever he/she asked CNA A for something, CNA A did not want to do it.-CNA A would come down to the room, say he/she would be right back but he/she never came back.-CNA A did that all the time and would turn off the call light.-CNA A got mad at him/her when it took him/her a long time to get his/her words out. During an interview on 3/20/26 at 3:21 P.M., the resident said:-He/She used the call light multiple times and yelled out for help multiple times after breakfast.-Resident #12 (Resident #11's roommate) said Resident #11 called out for help at least five times.-He/She was wet from urine and his/her legs were too swollen for him/her to get up and go to the bathroom on his/her own.-He/She was normally more independent but not during this time when his/her legs were so swollen.-His/her clothes and bedding were wet too.-CNA A said, You're too fat and I ain't gonna do you no more.-The nurse came down to administer medication around 12:30 P.M. and saw how wet he/she was and that the urine was all over the floor so the nurse told CNA A to change him/her.-CNA A raised this resident's bed and threw everything off the bed and onto the floor.-CNA A left him/her lying naked and half hanging off the bed.-CNA A refused to put the bed down and walked out of the room.-This resident called back for CNA A to finish helping her.-CNA A said, You're too heavy. -CNA said he/she's been down to his/her room three times already and was not going to come back again.-CNA A would not ask him/her what he/she wanted to eat. -CNA A would bring whatever he/she wanted to bring for their meals and would get mad at her for not eating the (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food he/she did not want.-He/She confirmed his/her written statement to the facility was accurate. During an interview on 3/20/26 at 3:21 P.M., with Resident #11's approval, Resident #12 (quarterly MDS dated [DATE] showed the resident was cognitively intact) said he/she witnessed everything Resident #12 said and it was all true. 4. Review of Resident #10's care plan dated with multiple dates from 2024 to 2026 showed:-The resident admitted to the facility on [DATE].-He/She used an electric wheelchair.-Some of his/her diagnoses include diabetes, Parkinson's disease, chronic kidney disease, glaucoma (a condition of increased pressure inside the eye which could lead to blindness), and polyneuropathy (a neurological disorder caused by damage to multiple peripheral nerves throughout the body, commonly resulting in pain, numbness, tingling, and weakness).-Required physical assistance with getting dressed and for using the toilet.-Required extensive physical assistance by staff to move from one surface to another.-Required setup and supervision for meals.-Had bladder incontinence related to impaired mobility. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-admitted to the facility on [DATE].-Had clear speech.-Understood others and others understood him/her.-Was moderately cognitively impaired.-Had no range of motion impairment in his/her upper extremities (shoulder, elbow, wrist, hand).-Had range of motion impairment on one side of his/her lower extremities (hip, knee, ankle, foot).-Used a wheelchair.-Was independent with eating.-Was dependent on staff for toileting hygiene, lower body dressing, going from sitting to standing, and transferring on and off the toilet.-Was occasionally incontinent of bladder.-Was always continent of bowel.-Some of his/her diagnoses included kidney disease, and diabetes. Review of the resident's interview dated 3/13/26 conducted by facility staff showed the resident said:-CNA A put his/her food tray on a table in the corner of his/her room.-He/She said he/she needed it on his/her bedside table.-He/She asked his/her name, but he/she wouldn't tell him/her because he/she said he/she didn't want him to get him/her in trouble.-He/She could not get to the table where CNA A put the food tray.-CNA A would not do the things asked or needed of him/her.-CNA A left him/her on the toilet but someone else eventually came.-CNA A cussed and said derogatory things.-In the mornings, CNA A would already be complaining about being tired.-CNA A had a nasty attitude.-CNA A's attitude was that he/she was lucky that he/she was waiting on him/her. During an interview on 3/20/26 at 3:36 P.M., the resident said:-CNA A was always a troubled person and was always negative.-CNA A put his/her food tray on a table in the corner of his/her room.-He/She told CNA A he/she needed it on his/her bedside table.-He/She asked his/her name, but he/she wouldn't tell him/her because he/she said he/she didn't want the resident to get him/her in trouble.-CNA A moved the tray after that.-CNA A always complained about being tired.-CNA A said, You expect too much.-He/She needed to go to the bathroom so he/she pushed the call button.-CNA A came into his/her room, put him/her on the toilet, and left.-He/She turned the light on when he/she was done and still on the toilet.-CNA A came in and said to turn the light off.-He/She said, No to CNA A.-CNA A said, turn the damn light off but he/she did not.-Someone else came and helped him/her.-After that, CNA A would not take care of him/her.-He/She confirmed his/her written statement to the facility was accurate. 5. Review of Resident #5's care plan dated with multiple dates from 2024 to 2026 showed:-He/She required assistance getting into bed.-Required dialysis (the process of removing blood from an artery (as of a kidney patient), purifying it by dialysis, adding vital substances, and returning it to a vein).-Required a mechanical sit to stand lift for transferring from one surface to another.-Required physical assistance with bathing/showering as necessary.-Required extensive physical assistance for dressing.-Was totally dependent on staff for repositioning and turning in bed.-Some of his/her diagnoses included heart failure, high blood pressure, diabetes, and kidney disease.-Received diuretic medication for edema and high blood pressure.-Was incontinent of bladder. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-admitted to the facility on [DATE].-Had clear speech.-Understood others and others understood him/her.-Was cognitively intact.-Used a wheelchair.-Had no range of motion impairment.-Was dependent upon staff for toileting (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene, lower body dressing, and transferring from one surface to another.-Required partial/moderate assistance for bathing/showering.-Was occasionally incontinent of bladder and frequently incontinent of bowel.-Some of his/her diagnoses include heart disease, high blood pressure, kidney failure, and diabetes. Review of the resident's interview dated 3/13/26 conducted by facility staff showed the resident said:-When he/she took a shower, he/she told CNA A that he/she could not wash his/her legs, back, or feet but CNA A would not do it for him/her.-CNA A did not answer call lights in a timely manner.-CNA A could be very hateful in his/her attitude and expressions.-CNA A made excuses that he/she was too tired.-CNA A complained that he/she was too busy.-CNA A did not do his/her work.-CNA A did not want to care for him/her. During an interview on 3/20/26 at 3:46 P.M., the resident said:-He/She could not reach the back of his/her legs when showering.-CNA A would not help clean the back of his/her legs during showers, or if he/she did help, he/she would not do it well.-CNA A would not put fitted sheets on his/her bed and did not make the bed right.-CNA A did not answer the call light when he/she called.-CNA A didn't want to help him/her so he/she stopped asking him/her for help.-CNA A would always say he/she was too busy or too tired to do anything.-He/She confirmed his/her written statement to the facility was accurate. 6. Review of Resident #14's care plan dated with multiple dates from 2024 to 2026 showed:-He/She was able to complete most self-cares and call for assistance as needed.-Some of his/her diagnoses included diabetes, kidney disease, anxiety disorder, chronic pain, and high blood pressure. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident:-admitted to the facility on [DATE].-Had clear speech.-Understood others and others understood him/her.-Cognitively intact.-Used a wheelchair.-Had no range of motion impairment.-Was independent with most cares.-Was occasionally incontinent of bowel and bladder.-Some of his/her diagnoses included high blood pressure, kidney disease, diabetes, and anxiety disorder. Review of the resident's interview dated 3/13/26 conducted by facility staff showed the resident said:-CNA A was horrible and very mouthy.-He/She saw CNA A being rude at the nurses' station by answering the call light phone, hanging up, and then saying he/she was not that resident's aide and complained, That's not my job.-CNA A did not help the residents.-CNA A would not change his/her sheets on his/her shower days.-CNA A throws your plate down in front of you.-CNA A was not patient or kind and he/she hated to see CNA A coming. During an interview on 3/20/26 at 3:52 P.M., the resident said:-CNA A would not answer his/her call light.-Refer to his/her written statement he/she provided to the facility staff as it covered his/her concerns. 7. During an interview on 3/20/26 at 10:38 A.M., CNA A said:-He/She was wrongfully accused of talking badly to the residents, not cleaning residents, and refusing to do showers.-Administration said they had several complaints about leaving residents soiled.-He/She did not do any of those things.-He/She did not say that doing his/her work was breaking his/her back. During an interview on 3/20/26 at 12:06 P.M., CNA A said:-If he/she did what he/she was accused of, there surely would have been more previous complaints about him/her and there have not been.-He/She has not been rough or talked mean with any of the residents.-He/She has never told a resident to just have a bowel movement in their brief.-He/She knows better than that.-If a resident was unable to move, he/she usually put them in bed and cleaned them up while in bed.-He/She checked and changed residents every other hour if they were incontinent.-If a resident was continent, he/she took them to the bathroom.-He/She never said he/she couldn't take care of any of the residents.-He/She never said he/she didn't have time to take care of any of the residents. 8. During an interview on 3/20/26 at 4:15 P.M., the Administrator and DON said:-They interviewed multiple residents about CNA A during their investigation and several of them had the same type of concerns about how CNA A was not caring and not helpful.-CNA A had two other write-ups due to his/her demeanor and him/her being rude.-CNA A should have provided cares when asked.-They expected professional, approachable, caring, and respectful care from their employees and CNA A was not. 2802972