STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265850	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Rehab and Healthcare Center	15600 Woods Chapel Road Kansas City, MO 64139

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the administration of the facility failed to safeguard the medication administration of each resident. The administration failed to provide Certified Medication Technician (CMT) A his/her own sign in to pass medications once notified the sign on was not working. CMT A used Licensed Practical Nurse (LPN) A's sign in to pass medications to the facility residents. This has the potential to affect all residents. The facility census was 74 residents.Review of the facility undated Onboarding Standard Operating Procedure showed:-Interview applicant. -If an offer is made and accepted proceed to the next step.-Collect all necessary documents to run necessary background and license checks.-Start new hire onboard electronically through Hosted Time.-Preferably while they are in the office.-All new hires must complete new hire documentation electronically.-Run all necessary background checks while new hire is completing onboarding via Host Time.-All the above steps should be performed as timely as possible before a new hire leaves the facility. Review of the facility Employee Handbook dated 1/1/24 and 1/1/25 showed:-The facility expects that all personnel know and comply with the federal False Claims Act (FCA) and any state false claims laws, rules or regulations.--Examples of false claims includes falsifying records or signatures.-General Expectations for use of facility technology and equipment are.--Employees with access to computer files and records may not release or disseminate any information without authorization.--Staff may not share passwords with any unauthorized persons.--Users prohibited from attempting to access restricted files or portions of operating systems, security systems, or administrative systems to which they have not been given authorization and/or access, including electronic mail, data, programs, or information protected under state or federal laws. 1.Review of the facility undated Acknowledgment of Receipt and Review of Facility Handbook showed:-CMT A and LPN A had received a copy of the Employee Handbook and acknowledge they were responsible for reading and complying with the Handbook.-They agreed to comply with the policies in the Handbook.-By their signature below, they confirm that he/she had read and understood the above statements and that they received a copy of the facility's Employee Handbook.-Was signed by CMT A on 12/17/24.-Was signed by LPN A on 4/14/25. During an interview on 2/11/26 at 3:25 P.M., Director of Nurses (DON) said:-Human Resources (HR) does the staff credentials and sets up the employees sign in to the computer for medical records.-He/She can reset an employee's password if locked out of the computer.-He/She was not aware CMT A was having trouble with his/her sign in and was using LPN A's sign in to pass medications to the residents.-LPN A went as needed (PRN) in November 2025.-LPN A's last shift was 11/28/25 and had not worked since then.-He/she would not ask a new hire to use another employee's sign in to chart in resident's medical records.-Staff can contact him/her or HR 24 hours; seven days a week by texting or calling, if there in problems signing in to the computer. During a phone interview on 2/11/26 at 4:06 P.M., HR said:-He/She sets up the new hire's sign in for the computer once the background checks comes back and the new hire accepts the offer the facility had made.-He/She always tells the staff to never give out his/her sign in (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information to anyone.-He/She would expect staff to follow the employee handbook that they read and sign at the time of hire.-CMT A was a Certified Nursing Aide (CNA) before getting his/her CMT license in 10/2025 and already had a sign in.-CMT A was transferred over from the CNA credentials, so he/she could pass medications. -He/She had reset CMT A's password a couple of times.-CMT A said he/she could use another staff members sign in to pass medications until his/her sign in worked.-He/She told CMT A he/she could not use another employee's sign in to pass medications.-He/She was not aware that CMT A was still having problems and was using LPN A's sign in to pass medications.-If an employee terminates employment from the facility, he/she was responsible for deleting the employee from the system.-He/She does not delete the employee the same day sometimes it is a couple of days before he/she gets the deleting done.-If an employee was PRN, then the employee's sign in stays active all the time and is not shut off in-between shifts.-The DON can reset passwords, but he/she cannot change the credentials.-LPN A would have had to give CMT A his/her sign in to use, that was the only way CMT A could have gotten the sign in from LPN A. During an interview on 2/11/26 at 4:43 P.M., CMT A said:-He/She had told the Administrator, HR, DON and Assistant Director of Nursing (ADON) he/she was still having problems signing in to the computer to pass medications on several occasions but noting was every done to correct the problem.-The DON said he/she could not fix his/her sign in only HR could fix the problem.-He/She could sign in as a CAN but not as a CMT.-HR kept assigning him/her shifts to pass medications even though HR knew he/she was having problems getting into the resident's Medication Administration Records (MAR) and Treatment Administration Records (TAR).-He/She and LPN A had worked a shift together and he/she could not chart that he/she had passed medications, so LPN A let him/her sign in with his/her sign in to chart in the resident's medical records.-He/She kept using LPN A' sign in to pass medications after LPN A went PRN.-He/She quite working at the facility because the administration could not get his/her sign in fixed, and he/she knew it was wrong to keep using LPN A's sign in to pass medications.-He/She would sign out the controlled substance medications in the book with his/her name and then use LPN A's sign in to chart the medication was given to the resident with LPN A initials. During an interview on 2/11/26 at 5:01 P.M., Administrator said:-LPN A went PRN in November and had not worked at the facility since.-He/She was not aware that CMT A was having problems with their sign in and did not know CMT A was using LPN A's sign in to pass medications. During an interview on 2/11/26 at 5:01 P. M., Regional Nurse said:-HR was responsible for entering the staff members information into the facility computer to get a sign in for the staff member.-Housekeeping would be given a sign in for housekeeping duties, and nurse would be given a sign in for nursing duties and a CMT would be given a sign in to pass medications and CNA duties as they can work both positions.-He/she would expect every staff member to have his/her own sign in to work.-Staff members shouldn't work if there is a problem with his/her sign in because they would not be able to chart in the resident's medical records.-If there is a problem with signing in, staff need to notify HR, DON or ADON of the problem.-Staff should not give another staff member his/her sign in for the computer.-He/she was not aware that CMT A was using LPN A's sign in to pass resident medication.-A PRN staff member who had not worked in over three months should be put in-active in the computer and sign in shut off until scheduled to work again.-He/she would never tell another staff member to sign in under another staff member to document in resident's medical records. During an interview on 2/18/26 at 11:09 A.M., LPN A said:-He/She was not aware of CMT A was using his/her sign in to pass medications to the residents.-He/She did not give CMT A permission to use his/her sign in and did not give CMT A his/her sign in information.-He/she had not worked since 11/28/25 and went PRN.-When he/she would come on shift, the computer was already on.-All he/she had to do was click on the drop-down (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	box and click on his/her name and he/she was signed in to work under his/her name.-Sometime the computer would ask for his/her password to sign in and other times the computer would show the password.-One time the computer showed a password, and it was not his/her password, and he/she clicked go and the computer signed him/her in even though it was the wrong password.-The whole time he/she worked at the facility he/she was never asked to change his/her password. 2724968

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff-maintained documentation of medications as provided on the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for eight sampled residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #7, Resident #8 and Resident #9), when Certified Medication Technician (CMT) A used Licensed Practical Nurse (LPN) A's electronic sign in when he/she administered resident's medications for three months for eight of the nine sampled residents. The facility census was 74 residents.Review of the facility revised Medication Administration Policy dated 10/24/22 showed:-Purpose.--To provide practice standards for safe administration of medications for the residents in the facility.-Procedure.--The Licensed Nurse or CMT will chart the drug, time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR.-Documentation.--The time dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment.--Recording will include the date, time, and dosage of the medication or type of the treatment.--Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record. 1. Review of Resident #1's undated admission Record showed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnosis:-Dementia (a decline in mental ability resulting in memory loss, and other mental abilities severe enough to interfere with daily functioning). -Chronic Kidney Disease Stage 3 (a progressive loss of kidney function, sometimes over years, leading to permanent kidney failure).-Hyperlipidemia (HDL - high levels of lipids (fats) in the blood).-Major Depressive Disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest).-High Blood Pressure. 2. Review of Resident #2's undated admission Record showed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnosis:-Dementia.-Major Depressive Disorder.-High Blood Pressure.-Thrombotic Pulmonary Emboli (a blockage in the lung's arteries, usually caused by a blood clot that travels from the legs or pelvis). 3. Review of Resident #3's undated admission Record showed the resident was admitted to the facility on [DATE] with the following diagnosis:-Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks).-Chronic Obstructive Pulmonary Disease (COPD - a lung disease that restricts airflow and makes breathing difficult).-Dementia.-Delusion Disorder (a serious mental illness characterized by holding one or more false, persistent, and unshakable beliefs).-Major Depressive Disorder.-Anxiety.-Chronic Kidney Disease Stage 3B. 4. Review of Resident #5's undated admission Record showed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnosis:-Chronic Kidney Disease Stage 3A.-Dementia.-Anxiety.-Hypothyroidism (is when the thyroid gland doesn't make enough thyroid hormones to meet the body's needs causing the metabolism to slow down).-Chronic Pain.-Neuropathy (is nerve damage causing symptoms like numbness, tingling, burning pain and muscle weakness often in the hands and feet).-Peripheral Vascular Disease (PVD - a circulatory condition causing narrowed blood vessels outside the heart/brain, often affecting the legs). 5. Review of Resident #6's undated admission Record showed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnosis:-COPD.-Alzheimer's Disease.-High Blood Pressure.-Chronic Kidney Disease.-Dementia.-Hyperlipidemia.-Diabetes Type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar). -Cerebrovascular Disease (CVD - a group of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorders affecting the heart and blood vessels).-Stroke. 6. Review of Resident #7 undated admission Record showed the resident was admitted to the facility on [DATE] with the following diagnosis:-Hypothyroidism.-Dementia.-Major Depressive Disorder.-Anxiety.-Malignant neoplasm (cancer) of the head, face, and neck. 7. Review of Resident #8's undated admission Record showed the resident was admitted to the facility on [DATE] with the following diagnosis:-Alzheimer's Disease.-High Blood Pressure.-Major Depressive Disorder.-Anxiety.-Diverticulosis (a common condition where small, non-inflamed pouches form in the colon wall). 8. Review of Resident #9's undated admission Record showed the resident was admitted to the facility on [DATE] with the following diagnosis:-High Blood Pressure.-Chronic Kidney Disease Stage 3.-Dementia.-Depression.-Delusional Disorder. 9. Review of the facility Timecard record showed LPN A's last shift worked was on 11/28/25. Review of the facility Timecard Detail Report dated 10/1/25 to 2/14/26 showed CMT A worked 11/29/25, 11/30/25, 12/1/25 to 12/9/25, 12/11/25 to 12/13/25, 12/16/25,12/19/25 to 12/22/25, 12/26/25 to 12/28/25, 12/31/25, 1/1/26 to 1/4/26, 1/6/26 to 1/11/26, 1/13/26, 1/14/26, 1/17/26, and 1/18/26. Review of the facility's November 2025 MAR and TAR showed LPN A administered medications and treatments:-On 11/29/25 to Resident #1, Resident #3.-On 11/30/25 to Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5, Resident #6 and Resident #7. Review of the facility‘s December 2025 MAR and TAR showed LPN A administered medications:-On 12/1/25 to Resident #9.-On 12/4/25 to Resident #2 and Resident #7.-On 12/5/25 to Resident #4, Resident #5, Resident #6 and Resident #9.-On 12/6/25 to Resident #1 and Resident #3.-On 12/7/25 to Resident #1 and Resident #3.-On 12/8/25 to Resident #3.-On 12/12/25 to Resident #2, Resident #7, Resident #8 and Resident #9.-On 12/16/25 to Resident #2, Resident #7 and Resident #8.-On 12/19/25 to Resident #4, Resident #5, Resident #6 and Resident #9.-On 12/20/25 to Resident #3.-On12/21/25 to Resident #1 and Resident #3.-On 12/27/25 to Resident #4, Resident #5, Resident #6 and Resident #9.-On 12/28/25 to Resident #4, Resident #5, Resident #6 and Resident #9.-On 12/31/25 to Resident #1 and Resident #3. Review of the facility's January 2026 MAR and TAR showed LPN A administered medications to:-On 1/2/26 to Resident #4, Resident #5, Resident #6 Resident #8 and Resident #9.-On 1/3/26 to Resident #1, Resident #2 and Resident #3.-On 1/4/26 to Resident #2 and Resident #7.-On 1/6/26 to Resident #2 and Resident #7.-On 1/7/26 to Resident #3.-On 1/9/26 to Resident #3, Resident #4, Resident #5, Resident #6 and Resident #7, Resident #8 and Resident #9.-On 1/10/26 to Resident #2 and Resident #7.-On 1/11/26 to Resident #2 and Resident #7.-On 1/13/26 to Resident #2 and Resident #7.-On 1/17/26 to Resident #1 and Resident #3.-On 1/18/26 Resident #4, Resident #5, Resident #6, Resident #8 and Resident #9. During a phone interview on 2/11/26 at 4:06 P.M., Human Resources (HR) said:-CMT A was a Certified Nursing Aide (CNA) before getting his/her CMT license in 10/2025 and already had a sign in.-CMT A was transferred over from the CNA credentials, so he/she could pass medications. -He/She had reset CMT A's password a couple of times.-CMT A said he/she could use another staff members sign in to pass medications until his/her sign in worked.-He/She told CMT A he/she could not use another employee's sign in to pass medications.-He/She was not aware that CMT A was still having problems and was using LPN A's sign in to pass medications.-If an employee terminates employment from the facility, he/she was responsible for deleting the employee from the system.-He/She does not delete the employee the same day sometimes it is a couple of days before he/she gets the deleting done.-If an employee was PRN, then the employee's sign in stays active all the time and is not shut off in-between shifts.-The DON can reset passwords, but he/she cannot change the credentials.-LPN A would have had to give CMT A his/her sign in to use, that was the only way CMT A could have gotten the sign in from LPN A. During an interview on 2/11/26 at 4:43 P.M., CMT A said:-He/She had told the Administrator, HR, Director of Nursing (DON) and Assistant Director of Nursing (ADON) that he/she was still having (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problems signing in to the computer to pass medications on several occasions, but nothing was ever done to correct the problem.-The DON said he/she could not fix his/her sign in only HR could fix the problem.-He/She could sign in as a CNA not a CMT.-HR kept assigning him/her shifts to pass medications even though HR knew he/she was having problems getting into the resident's Medication Administration Records (MAR) and Treatment Administration Records (TAR).-He/she and LPN A had worked a shift together and he/she could not chart in the resident's medical record that he/she had passed medications, so LPN A let him/her sign in with LPN A's sign in to chart in the resident's medical records.-He/She kept using LPN A' sign in to pass medications after LPN A went PRN.-He/She quite working at the facility because the administration could not get his/her sign in fixed, and he/she knew it was wrong to keep using LPN A's sign in to pass medications.-He/She would sign out the controlled substance medications in the book with his/her name and then use LPN A's sign in to chart the medication was given to the resident with LPN A initials. During an interview on 2/11/26 at 5:01 P.M., the Administrator said:-LPN A went PRN in November and had not worked at the facility since.-He/She was not aware that CMT A was having problems with their sign in and did not know CMT A was using LPN A's sign in to pass medications.-Staff were not share passwords. During an interview on 2/18/26 at 11:09 A.M., LPN A said:-He/She was not aware of CMT A was using his/her sign in to pass medications to the residents.-He/She did not give CMT A permission to use his/her sign in and did not give him/her his/her sign in information.-He/she had not worked since 11/28/25 and went PRN.-When he/she would come on shift the computer was already on.-All he/she had to do was click on the drop-down box and click on his/her name and he/she was signed in to work under his/her name.-Sometime the computer would ask for his/her password to sign in and other times the computer would show the password.-One time the computer showed a password, and it was not his/her password, and he/she clicked go and the computer signed him/her in even though it was the wrong password.-The whole time he/she worked at the facility he/she was never asked to change his/her password. 2724968