STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265872	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Kansas City, LLC	2100 N W Barry Road Kansas City, MO 64154

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to honor a resident request to not have certain staff provide care for one of one resident (Resident (R)26) reviewed for self-determination out of a total sample of 28. This failure had the potential to decrease R26's quality of life. The facility census was 84. Findings include: Review of the facility policy titled, Self-Determination, revised July 2024 and provided by the facility, revealed, Each resident who chooses to reside in this facility has the right to and the facility pledges to promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified as Resident Rights . The resident has a right to choose activities, schedules including but not limited to sleeping and waking times, health care and providers of health care services consistent with his/her interests, assessments, and plan of care and other daily life enhancement enrichment activities on a daily basis. Review of R26's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 08/28/24 and located in the MDS tab of the Electronic Medical Record (EMR), revealed an admitted [DATE]. A Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. The MDS recorded R26 was dependent on staff and had diagnoses of anxiety, acquired absence of right leg below knee, contracture of muscle, left lower leg, and contracture of unspecified hand. Review of R26's Care Plan, dated 08/18/23 and located in the EMR under the Care Plan tab, revealed, [R26] intermittently refuses cares, treatments, and/or medications, including repeated intermittent refusals of use of low air loss mattress for prevention of skin breakdown, repeated refusals of use of longer bed to accommodate his height, repeated refusals to use hand splint. An intervention included, Allow decision making, per resident rights, about treatment regimen, to provide sense of control. Review of R26's bowel continence documentation, dated 09/06/24 and 09/27/24, located in the EMR under the Task tab, revealed Certified Nurse Aide (CNA) 2 provided personal care to R26. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's September 2024 Medication Administration Record (MAR), located in the EMR under the Order tab, revealed Licensed Practical Nurse (LPN) 4 had administered medications to R26 on 09/06/24, 09/12/24, 09/13/24, 09/17/24, and 09/25/24. On 09/30/24 at 11:12 AM, R26 was awake in bed watching television. R26 stated he felt that two staff members, CNA2 and LPN4, did not like him because they were rude and disrespectful to him. R26 stated he reported them to the state Ombudsman and other facility staff. R26 stated he had requested those staff members not to give him care but in the last two months, CNA2 had provided care to him. R26 stated CNA2 was rude, and he felt that she purposefully threw away personal things he had accidentally dropped on the floor, such as his driver's license and denture cup. During an interview on 10/02/24 at 8:05 AM, the General Manager was asked about R26's report of rude staff, a CNA and nurse. The General Manager stated, Yes, she was aware of the complaint, and the staff members had received training. The General Manager went on to say these staff members had not provided care to R26 since his complaint. The General Manager was informed that R26 stated CNA2 had provided care recently. During an interview on 10/02/24 at 9:14 AM, the General Manager provided a coaching worksheet, dated 07/18/2024, for CNA2 and 7/24/2024 for LPN4. The General Manager went on to say R26's complaints were brought up during R26's July 2024 care plan conference. The General Manager stated she completed the coaching for CNA2 on 07/18/24 and the Assistant Director of Nursing (ADON) completed the coaching for LPN4 on 07/24/24. Review of the Coaching Sheet for CNA2, dated 07/18/24 and provided by the facility, revealed Goal: What is the objective of the coaching? . Discuss customer service and appropriateness of language when talking to all patients . Reality: What is happening that needs to be corrected? . Being mindful of tone in words spoken and thinking about what you want to say before speaking . Options: What are the possible courses of action to take? . Ask for your peer CNA to switch assignments or trade patients if a disagreement . Review of the Coaching Sheet for LPN4, dated 07/24/24 and provided by the facility, revealed Goal: What is the objective of the coaching? . To provide appropriate customer service, language and tone when communicating with guests . Reality: What is happening that needs to be corrected? . Deescalating the situation, be mindful of word usage and tone . Options: What are the possible courses of action to take? . Notify nurse management ASAP [as soon as possible] have a peer nurse trade patients with you . During an interview on 10/03/24 at 9:35 AM, the General Manager was asked how she became aware R26 did not want CNA2 to care for him. The General Manager stated R26 had informed her during one of their conversations. The General Manager stated she told R26 that CNA2 would not care for him. The General Manager said she let the staffing coordinator know to keep her off his care. The General Manager was asked if she was aware CNA2 cared for R26 twice in September 2024. The General Manager stated, No, but she would have to get with the staffing coordinator who did the scheduling. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24 at 10:56 AM, the Staffing Coordinator was asked if she was aware of R26's staff complaint. The Staffing Coordinator stated, Yes, she was aware of LPN4 for the past few months, but only found out about CNA2 on 09/27/24. The Staffing Coordinator stated CNAs can switch rooms and nurses can manage it. The Staffing Coordinator stated LPN4 could schedule another nurse to give R26 his medication. The Staffing Coordinator was asked why the MAR reflected LPN4 had signed off on R26's MAR for medication administration. The EMR was reviewed. The Staffing Coordinator stated she was not aware that LPN4 was giving R26 his medications. During an interview on 10/03/24 at 1:34 PM, the Director of Nursing (DON) was asked when she became aware of R26 not wanting CNA2 to provide care. The DON stated on 09/27/24, during his care plan conference. The DON asked if the Ombudsman came in July 2024 and reported to the facility R26's complaint about CNA2 and LPN4. The DON states the Ombudsman only reported LPN4. The DON confirmed the July 2024 coaching worksheets were completed because of R26's complaint of CNA2 and LPN4's rude behavior towards him but again she was not aware of R26's complaint of CNA2. The DON was asked why LPN4 signed off on the MAR indicating she administered medications on 09/06/24, 09/12/24, 09/13/24, 09/17/24, and 09/25/24. The DON stated she thought perhaps LPN4 was having the other nurse give the medications to the resident after LPN4 signed off on it. During a follow up interview on 10/03/24 at 4:43 PM, the General Manager was asked why the staff coordinator was unaware R26 did not want CNA2 to provide him care until 09/27/24 but the coaching occurred 07/18/24. The General Manager stated she was not sure.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview, record review, and facility policy review, the facility failed to provide written notification of a facility-initiated transfer to the resident and responsible party (RP) for two of five residents (Resident (R)19, R38, and R66) reviewed for hospitalization out of a total sample of 28. The failure had the potential to affect the residents and/or their representative concerning the reason for the transfer and the resident's appeal rights. The facility census was 84. Findings include: Review of the facility's Admission, Transfer, & Discharge policy, revised 05/2023, revealed, . Facility staff will document in the clinical record discharge information provided to the resident and the receiving organization, if applicable: the basis for the transfer . instruction provided to the resident and/or surrogate decision-maker prior to discharge . 1. Review of R38's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/24 and located in the MDS tab of the Electronic Medical Record (EMR), revealed an admitted [DATE]. A Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. The MDS recorded R38 had diagnoses that included metabolic encephalopathy, ileostomy status, and cirrhosis of liver. Review of R38's Health Status Note, dated 08/02/24 at 1:50 PM and located in the EMR under the Progress Note tab, revealed, . Patient is not feeling normal she stated that she has pain in her stomach, she have beeing [sic] vimoting [sic] and feeling dizzy . Review of R38's Health Status Note, dated 08/02/24 at 2:54 PM and located in the EMR under the Progress Note tab, revealed, . [name] the NP ordered to send the Patient to the hospital, Family has been Notified . Review of R38's Medication Administration Note, dated 08/02/24 at 3:10 PM and located in the EMR under the Progress Note tab, revealed, . sent to hospital . Review of R38's Transfer Form, dated 08/02/24 and located in the EMR under the Evaluation tab, revealed no appeal information or that the resident/representative was provided a written notice of transfer. Review of R38's Health Status Note, dated 09/07/24 at 4:39 PM and located in the EMR under the Progress Note tab, revealed, . Sent critical labs to NP [nurse practitioner] [name] Bun and creative were critical and NP ordered to send out. Resident went to [hospital name]. [Family member] notified. Resident left via ambulance at 1840 [6:40 PM] . Review of R38's Health Status Note, dated 09/07/24 at 11:04 PM and located in the EMR under the Progress Note tab, revealed, . Resident being admitted to [hospital] for UTI [urinary tract infection] and failed antibiotic treatment . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Transfer Form, dated 09/07/24 and located in the EMR under the Evaluation tab, revealed no appeal information or that the resident/representative was provided with a written notice of transfer. During an interview on 10/02/24 at 4:43 PM, the General Manager was asked if R38 and her representative were provided with a written notice of transfer for R38's facility-initiated transfers to the hospital on 08/02/24 and 09/07/24. The General Manager stated, No, only verbal notices were provided for the transfer for [R38]. The General Manager confirmed written notice had not been given to any residents or their representatives. The General Manager stated, It's something they need to work on, and this will be a PIPs [performance improvement projects]. The General Manager provided a form titled Bed Hold Notice that encompassed the facility-initiated transfer information. The General Manager confirmed neither R38 nor her representative received the form. 42440 2. Review of R19s quarterly MDS, with an ARD of 08/28/24 and located in the MDS tab of the EMR revealed R19 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus and malnutrition. The MDS recorded R19 scored 11 out of 15 on the BIMS, which indicated moderately impaired cognition. Review of R19's Health Status Notes, found in the EMR under the Prog Notes tab, revealed: 11/27/23 - R19 went to the hospital for evaluation and was admitted on [DATE] for acute ischemic encephalopathy with hypoxia and CVA (cerebral vascular accident- stroke) with seizure. 11/30/23 - R19 was sent to the hospital and admitted for seizures and encephalopathy. 06/22/24 - R19 was sent to the hospital and admitted with pneumonia and a blood clot. Review of the Evaluations tab of the EMR revealed no documentation that R19 and his representative were provided with written notice of the transfers to the hospital and the reason for hospitalization . During an interview on 09/30/24 at 2:56 PM, R19 reported he had been hospitalized in the last year but could not recall when. During an interview on 10/02/24 at 4:50 PM, the Administrator stated neither R19 nor his representative received written notice of his transfers to the hospital. The Administrator stated the facility had given verbal notifications and needed to close the loop with the paper documentation.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51626 Based on observation, interview, and record review, the facility failed to ensure a safe and orderly discharge from the facility for five (5) out of the six (6) sampled residents (Resident #1, #2, #3, #4, and #5) when five (5) residents were discharged without proper orders, medications, home health services, dialysis services, and/or follow up appointments. The facility census was ninety 90. Review of the facility's policy for discharge to home, revised 04/2023, showed: - (3.) Social services will meet with the resident and/or family to set up outside services and equipment. - (4.) A discharge form is completed by all involved members of the IDT (interdisciplinary team) that explain the resident care needs at home. - (6.) Teaching will be done with the resident/family on any dressings or special tasks. - (8.) If necessary, therapy will provide any necessary instructions. - (9.) On the day of discharge, the nurse will review the discharge form as well as the medications with the family. - The nursing discharge note should include the time of discharge, destination, mode of transportation, disposition of personal belongings and medications and that all parties are aware of the discharge. Review of the facility's policy for hospital transfer, revised 04/2023, showed: - (1.) Notify the physician regarding a change in resident status and obtain an order for transfer to the hospital. 1. Review of Resident #1's Medical Record showed: - The Resident was admitted to the facility 10/25/2024 after a hospitalization for non-ST elevation myocardial infarction (heart attack). - The Resident was discharged to home on 11/04/24. - Provider order date: 10/25/2024 May be discharged with all medications. - Provider order date: 11/01/24 Patient okay to discharge. Home health to evaluate and treat for physical therapy, occupational therapy, and nursing. Primary care provider to follow. - The resident had thirty (30) medications prescribed at the time of discharge including antibiotics, pain medication, and breathing treatment medications for active pneumonia infection. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Resident's Post-Discharge Resources lists Home Health Care as a resource the resident needed at the time of discharge. - The facility failed to provide the name, address, and/or phone number of any Home Health Agency. - The Resident's Medication Reconciliation indicated that the Resident was sent home with 11-16 medications. - No documentation to show the facility staff provided the Resident with medication names, pill counts, and/or patient education relating to the medications sent home with the Resident. - No documentation to show the facility staff scheduled follow-up visits and/or provided the resident with contact information for his/her cardiac (heart) or surgical providers. During an interview on 12/02/24 at 9:52 A.M., RN Casemanager: - They presented to Resident #1's home on 11/07/2024 for an in-home visit after the resident's Care Navigator initiated a referral to Case Management for an emergency visit. The Care Navigator initiated the referral when he/she became aware that the Resident had just had heart surgery and didn't have follow-up care scheduled or home health care set up. - The Resident had no understanding of his/her discharge plan. - The facility failed to initiate home health care or schedule follow-up visits for the Resident. - The facility failed to provide the Resident with prescriptions for necessary medications. - The facility sent the Resident home with seven (7) medication cards belonging to Resident #2 and one (1) medication card belonging to Resident #4. - The Resident had not taken any of his/her medications from the time of discharge until the in-home visit because he/she was confused by the medications that did not belong to him/her and didn't know what medications to take. - On 12/02/2024 at 12:17 P.M. the complainant provided pictures of Resident #2 and Resident #4's medication cards that had been sent home with Resident #1. - The scheduled an appointment for Resident #1 with his/her primary care physician (PCP) and at this appointment the PCP set up a cardiology follow-up for the Resident on 12/16/2024. 2. Review of Resident #2's medical record showed: - The resident was admitted on [DATE] and discharged to home on 11/04/2024. - Provider order date:10/16/2024 May be discharged with all medications. - Provider order date: 11/04/2024 Patient okay to discharge. Home health to evaluate and treat for physical therapy, occupational therapy, and nursing. Primary care provider to follow. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was taking sixteen (16) prescribed medications at the time of discharge. - The resident's post-discharge resource needs included Home Health Care. - The facility failed to provide the name, phone number, and/or address to any home health care agency at the time of discharge. - The resident did not have any follow-up visits scheduled with any providers. - The resident was not sent home with any medications from the facility. - The resident had prescriptions sent to the pharmacy. - No documentation the facility staff provided the name, phone number, and/or address to the pharmacy where prescriptions were sent at the time of discharge. During an interview on 12/03/2024 at 12:48 P.M., Resident #2 said: - He/she was sent home without anything. - The facility failed to order necessary supplies for the resident prior to discharge, specifically a bed and lift for that the resident was required to use at home. - The facility failed to arrange dialysis care for the resident prior to discharge. - The facility failed to speak to the resident or his/her family about what medications would be required at home or when/how to take them. During an interview on 12/03/2024 at 12:48 P.M., family member #F6 said: - The facility said they had ordered a specialized bed and a lift and that these supplies would be delivered to the resident's home on 11/09/24. When no supplies arrived at the Resident's home, the family member called the facility to ask when they would be delivered. The facility told the family member that the supplies would now take 5 weeks to arrive. The resident's family was forced to find a bed and lift themselves with the help of home health and their local Lion's Club. - Resident #2 was supposed to receive dialysis services, but the facility failed to set this up. - The facility failed to provide discharge instructions to the resident and/or the family. The family member said that the nurse handed him/ser a sheet of paper and said, here, but that no explanation of the paperwork and no education was completed. - The facility failed to set up home health services for the resident. Family member F6 set that up for the resident. 3. Review of Resident #3's medical record showed: (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was admitted on [DATE] and left the facility AMA (against medical advice) on 10/16/2024 at 14:30, - The resident was taking twenty-seven (27) prescribed medications at the time he/she left the facility. During an interview on 10/23/2024 at 5:45 P.M, the resident said the facility told him/her that they sent prescriptions to the pharmacy after he/she left the facility. When the resident presented to the pharmacy to pick up the medications, the pharmacy informed him/her that no prescriptions had been received from the facility. 4. Review of Resident #4's medical record showed: - The resident was admitted to the facility on [DATE] and discharged to the hospital on 10/16/2024. - No documentation the facility staff obtained provider orders prior to discharging the resident to the hospital. - No documentation the facility staff provided discharge/transfer records for Resident #4. 5. Review of Resident #5's medical record showed: - The resident was admitted on [DATE] and discharged to home on 11/25/2024. - The facility failed to provide discharge/transfer records for Resident #5. During an interview on 12/03/2024 at 12:39 P.M., Resident #5 said: - The facility staff did not provide discharge instructions and/or education to him/her at the time of discharge. - Coming home from the facility was kind of a joke. He/she said that the facility was talking to him/her about a diagnosis they were unaware of and failed to provide him/her with information about the physical therapy exercises he/she should be doing at home. During an interview on 12/02/2024 at 12:59 P.M., CMT A said: - Medications are reviewed with the resident by the nurse prior to discharge. - When a resident is being discharged with medications, the staff are supposed to review each medication card as they are prepared for discharge. Resident's name, room number, medication, and the number of pills left in the card are supposed to be verified and documented in the resident's discharge record. During an interview on 12/02/2024 at 1:21 P.M., the facility's Social Services Designee said: - Discharge planning for residents include sending needed referrals for things such as home health care, physical therapy, and/or specialist providers. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a resident required home health care at discharge, both the resident and the chosen home health care agency would be aware prior to the resident's discharge and that setting that up would be that facility's responsibility. - Sometimes insurance authorization can delay home health care, but that in that case the Resident's chart would be updated with the appropriate information when an approved agency is found, and the referral is sent. During an interview on 12/02/2024 at 1:32 P.M., the facility Administrator said: - When a resident is being discharged , a medication list is expected to be completed with the discharge instructions and that the nurse is expected to review each listed medication with the resident during discharge education. - During discharge teaching with the nurse, it is expected that the resident be educated on topics including: services that the resident was receiving while they were in the facility, services and care they will be receiving or should continue after returning home, and medications they are prescribed and how/when to take them. - If a follow-up appointment has been scheduled for a resident, it is expected that staff will list that appointment on the discharge instructions along with the provider's phone number. - If a resident leaves without their medications, or if there are medications with the resident's name on them that will not be sent home with the resident, these medications are expected to be destroyed by a nurse or CMT using Drug Buster. - If a resident is discharged requiring home health care, it is the facility's responsibility to arrange that care. - It is expected that when a resident leaves with medications, that those medications belong to the resident taking them home and that they be labeled with the appropriate resident's name. MO244845

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview and record review the facility failed to provide written notification of the bed hold policy to the resident and responsible party (RP) for two of five residents (Resident (R)38 and R19) reviewed for hospitalization out of a total sample of 28. The failure had the potential to affect the residents planning on returning to the facility. The facility census was 84. Findings include: Review of the facility's policy titled, Bed Hold and Therapeutic Leave, revised 11/2018 and provided by the facility, revealed, . 2. For hospital leaves, the facility will hold a bed (not necessarily that specific bed) for up to 10 days during the hospitalization . On the 11th day, there is no requirement to hold a bed but the resident is still a resident and should receive the next available bed when they are ready to return, even if there is a waiting list . The policy did not include the cost per day or that the notice must be written. Review of the facility's Admission, Transfer, & Discharge policy, dated 07/2020 and revised 05/2023, revealed, . Upon admission, the resident/representative will be informed that if/when the resident is transferred to another health care facility, transferred within this facility, or discharged from this facility, the resident or his/her representative will be informed about the Facility Admission/Transfer/Discharge policies . regardless of the resident's payer source. At the time of move in, transfer to another health care facility or overnight visits outside the facility, the resident and/or representative will be provided with information on how to hold the resident's current room during their absence . 1. Review of R38's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 09/03/24 and located in the MDS tab of the Electronic Medical Record (EMR), revealed an admitted [DATE]. A Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. The MDS recorded R38 had diagnoses that included metabolic encephalopathy, ileostomy status, and cirrhosis of liver. Review of R38's Health Status Note, dated 08/02/24 at 1:50 PM and located in the EMR under the Progress Note tab, revealed, . Patient is not feeling normal she stated that she has pain in her stomach, she have beeing [sic] vimoting [sic] and feeling dizzy . Review of R38's Health Status Note, dated 08/02/24 at 1:54 PM and located in the EMR under the Progress Note tab, revealed, . [name] the NP ordered to send the Patient to the hospital, Family has been Notified . Review of R38's Medication Administration Note, dated 08/02/24 at 3:10 PM and located in the EMR under the Progress Note tab, revealed . sent to hospital . Review of R38's EMR revealed no documentation that a written notice of a bed hold was provided. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Health Status Note, dated 09/07/24 at 4:39 PM and located in the EMR under the Progress Note tab, revealed, . Sent critical labs to NP [nurse practitioner] [name] Bun and creative were critical and NP ordered to send out. Resident went to [hospital name]. [Family member] notified. Resident left via ambulance at 1840 [6:40 PM] . Review of R38's Health Status Note, dated 09/07/24 at 11:04 PM and located in the EMR under the Progress Note tab, revealed, . Resident being admitted to [hospital] for UTI [urinary tract infection] and failed antibiotic treatment . Review of R38's Bed Hold Policy/Ombudsman Notification, dated 09/07/24 and located in the EMR under the Evaluation tab revealed no documentation that a written notice was provided or the cost per day for a bed hold. During an interview on 10/02/24 at 4:43 PM, the General Manager was asked if R38 or her representative were provided with a written notice of bed holds for R38's transfers to the hospital on 08/02/24 and 09/07/24. The General Manager stated, No, only a verbal notice was given for the bed holds for [R38]. The General Manager confirmed written notice had not been given to any residents or their representatives. The General Manager went on to say, It's something they need to work on, and this will be a PIPs [performance improvement projects]. The General Manager provided a blank form titled Bed Hold Notice that encompassed the bed hold transfer information. The General Manager confirmed R38 or her representative did not receive this form. 42440 2. Review of R19's Admission Packet, located in the EMR under the Misc tab, revealed R19 signed a Bed Reserve Policy on 06/30/23. The Bed Reserve Policy recorded, . Under normal circumstances, if you leave the facility for a hospitalization , you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can reserve your existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before. Neither Medicare nor Medicaid will pay to hold your same bed if you are hospitalized . The Nursing Home Care Act requires a nursing facility to hold a bed for a maximum of ten days when you are hospitalized . The facility must hold a bed [not necessarily your specific bed] for up to 10 [ten] days during a hospitalization . On the 11th day there is no requirement to hold a bed, but you are still a Resident and will receive the next available bed when you are ready to return, even if there is a waiting list . In Missouri, . Neither a resident nor the responsible party is required to pay a nursing facility to hold a bed. If the resident/responsible person chooses to, he/she may pay a nursing facility in order to reserve the same bed the participant is leaving. A nursing home has an obligation to inform a resident or the responsible person that paying them to hold a bed is voluntary. When a resident is transferred to a hospital, the nursing home is required, both by federal statute and by federal regulation, to readmit the resident immediately upon the first availability of a bed in a semiprivate room . Review of R19's Health Status Notes, found in the EMR under the Prog Notes tab, revealed: 11/27/23 - R19 went to the hospital for evaluation and was admitted on [DATE] for acute ischemic encephalopathy with hypoxia and CVA (cerebral vascular accident- stroke) with seizure. 11/30/23 - R19 was sent to the hospital and admitted for seizures and encephalopathy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/22/24 - R19 was sent to the hospital and admitted with pneumonia and a blood clot. Review of R19's EMR revealed a quarterly MDS, with an ARD of 08/28/24 and located in the MDS tab revealed R19 had a BIMS score of 11 out of 15, which indicated moderately impaired cognition. During an interview on 09/30/24 at 2:56 PM, R19 reported he had been hospitalized in the last year but could not recall when. Review of the EMR revealed no documentation that the facility provided a written notice of the facility's bed hold policy upon any of the resident's transfers to the hospital. During an interview on 10/02/24 at 4:50 PM, the Administrator stated neither R19 nor his representative received bed hold papers when transferred to the hospital. The facility had given verbal notifications and needed to close the loop with the paper documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interview, and facility policy review, the facility failed to perform ongoing neurological assessments when residents had unwitnessed falls, which could have resulted in head trauma, for three of three residents (Resident (R) 19, R222, and R226) reviewed for falls out of a sample of 28 residents. The lack of proper assessment could result in the facility potentially not noticing symptoms of head trauma and initiating interventions. The facility census was 84. Findings include: Review of the facility's Post-Fall Policy, revised/reviewed 05/2023, revealed, If the resident reports hitting head, if there is any indication of head injury, or if ANY incident is un-witnessed, the neuro check protocol will be implemented, and reported to the physician. Review of the facility's Neurological Assessment procedure, dated 09/2019, revealed, . Neurological assessments are done upon physician order when indicated for a change of resident condition, unwitnessed fall and with all head injuries . Observe behavior and note any significant change from normal . Determine level of consciousness and responsiveness as compared to baseline . Determine orientation to person, place and time as compared to baseline . Determine capability of movement and strength of all extremities as compared to baseline . Check pupil size and reaction to light . Note speech to determine if it is clear, rambling, incoherent and absent as compared to Baseline . Check vital signs . 1. Review of R19's Prof tab of his electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. R19 had diagnoses which included repeated falls and a personal history of traumatic brain injury. Review of R19's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/28/24 and located in the MDS tab of the EMR, revealed R19 scored an 11 out of 15 on his Brief Interview of Mental Status (BIMS), which indicated moderately impaired cognition. Review of R19's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, initiated 07/04/23, . [R19] has experienced actual falls and is at risk for further falls related to impaired mobility, cognitive impairments, incontinence, polypharmacy . It contains an intervention to follow facility fall protocol, dated 07/04/23. Review of facility provided Incident Reports revealed R19 had unwitnessed falls on 01/14/24, 01/22/24, 02/01/24, 02/03/24, 02/11/24, 02/12/24, 03/02/24, 03/03/24, 03/17/24, 04/08/24, 04/18/24, 05/07/24, 05/31/24, and 09/16/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R19's Post Fall Neurological Evaluations, under the Evaluations tab of the EMR, revealed the facility completed one neurological evaluation following falls on 01/14/24, 01/22/24, 02/01/24, 02/03/24, 02/11/24, 03/02/24, 03/03/24, 04/08/24, 04/18/24, and 05/07/24. No Post Fall Neurological Evaluations were completed on 02/12/24, 03/17/24, 05/31/24, or 09/16/24. The Post Fall Neurological Evaluation included documentation of the resident's orientation and alertness, pupil responsiveness to light, vital signs, grip strength, appropriateness of verbalizations, and response to simple commands. Review of R19's Nurse Fall Checklists found under the Misc tab of the EMR, revealed partially completed checklists for falls on 02/01/24, 02/03/24, 02/11/24, 03/03/24, 04/08/24, and 04/18/24. The EMR contained no checklists for falls occurring 01/14/24, 01/22/24, 02/12/24, 03/02/24, 03/17/24, 05/07/24, 05/31/24, and 09/16/24. The checklists included areas to fill in for blood pressure, pulse, respirations, temperature, and oxygen saturation following a fall every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours, every four hours for 24 hours, and every shift for four shifts. The checklists did not contain areas to fill in for orientation and alertness, pupil responsiveness to light, vital signs, grip strength, appropriateness of verbalizations, and response to simple commands. During an interview on 09/30/24 at 2:57 PM, R19 stated he fell multiple times in the past year. During an interview on 10/02/24 at 3:45 PM, Licensed Practical Nurse (LPN) 3 stated when a resident fell , nurses immediately assessed them by doing a skin assessment and vital signs. LPN3 stated the nurses filled out an incident report, and if the resident hit their head or had an unwitnessed fall, nurses completed neurological assessments and filled out the Nurse Fall Checklist, which indicated when they checked the vital signs. The Nurse Fall Checklist asked for only vital signs, but a full assessment could be completed in the EMR. During an interview on 10/02/24 at 3:50 PM, Assistant Chief Nursing Officer (ACNO) 2 stated a complete neurological assessment was under the Evaluations tab. ACNO2 stated for the Nurse Fall Checklist, some nurses filled out the paper, which was then scanned into the EMR under the Misc tab, while others entered vital signs directly into the Wts [weights]/Vitals tab of the EMR. During an interview on 10/03/24 at 1:25 PM, the Director of Nursing (DON) stated she expected that nurses documented neurological assessments for any unwitnessed fall when a resident was confused or could not say if they hit their head. She stated she expected that the first neurological assessment includes all vital signs and pupil dilation, and neurological assessments were expected to be completed for 72 hours unless the resident went out to the hospital and a head scan showed head injury. The DON stated she felt that after nursing completed the first neurological assessment in the Evaluations tab of the EMR under Fall Risk Evaluation, they could then fill out the Nurse Fall Checklist, which contained blood pressure, pulse, respirations, temperature, and oxygen saturations but did not contain orientation and alertness, pupil responsiveness to light, vital signs, grip strength, appropriateness of verbalizations, and response to simple commands. She stated she kept a binder of the Nurse Fall Checklists. On 10/03/24 at 2:30 PM, the DON provided copies of R19's Nurse Fall Checklist sheets that she had in her binder. Completed checklists were provided for every fall; however, these checklists did not contain documentation neurological assessments had been completed per policy and current standards of practice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36917 2. Review of R222's EMR Admission Record revealed that R222 was admitted on [DATE] and had diagnosis that included a compression fracture of T11-12 vertebra, subsequent encounter for fracture with routine healing, wedge compression fracture of fourth thoracic vertebra subsequent encounter for fracture with routine healing, other intervertebral disc degeneration, thoracic region, low back pain, malignant neoplasm of breast, absence of right breast. Review of R222's EMR Progress Notes tab, revealed on 10/01/24, R222 reported she had an unwitnessed fall and hit her head on the toilet on 09/29/24 at 5:23 PM. Review of R222's EMR Assessment tab, revealed a Neurological Evaluation Form, dated 09/29/24, where it was recorded a neurological evaluation was conducted on 09/29/24 at 11:07 PM. Further review of the EMR indicated no follow-up neurological assessments were conducted for R222's fall where she reported she hit her head. During an interview with R222 on 10/03/24 at 4:45 PM, R222 stated she was in the bathroom when she fell and hit her head on the toilet but did not get hurt in the fall. She stated she reported her fall to RN1. During an interview on 10/03/24 at 12:46 PM, Registered Nurse (RN) 1 stated the standard protocol for an unwitnessed fall is to assess the resident, complete an initial neurological evaluation, and then follow-up neurological assessments are to be conducted and documented every 15 minutes for at least 24 hours. When asked if the follow-up neurological assessment is completed if a resident says they did not hit their head, she said the assessment follow up assessments are still conducted. During an interview on 10/03/24 at 1:26 PM, the DON stated if an unwitnessed fall occurs and the resident is alert and oriented and says he/she did not hit their head, then a neuro check is not done. She said an initial evaluation form is to be completed on an unwitnessed fall with all vital sign checked, including pupil reactions and a muscle strength assessment. She said the follow-up neurological assessment form contains evidence of neurological vital checks every 15 minutes that included only the blood pressure, pulse, and temperature but not pupil reaction and muscle strength. She stated she would expect that all vital signs, including pupil reaction and strength, should be assessed and recorded on the neuro sheet. 3. Review of R226's EMR Admission Record tab revealed that R226 was admitted to the facility on [DATE] and had diagnosis that included a fracture of the right arm prior to admission, dementia, and confusion. Review of the EMR Progress Notes tab revealed R226 had an unwitnessed fall in the facility on 09/27/24. The progress notes documented that an initial neurological evaluation was conducted but no follow-up neurological assessments were conducted. During an interview on 10/03/24 at 12:46 PM, RN1 stated the standard protocol for an unwitnessed fall was to assess the resident, complete an initial neurological evaluation, and then follow-up neurological assessments are to be conducted and documented every 15 minutes for at least 24 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/03/24 at 1:26 PM the DON stated if an unwitnessed fall occurs and the resident is alert and oriented and says he/she did not hit their head then a neuro check is not done. She stated an initial evaluation form is to be completed on an unwitnessed fall with all vital signs checked, including pupil reactions and a muscle strength assessment. She said the follow-up neurological assessment form contains evidence of neurological vital checks every 15 minutes that included only the blood pressure, pulse, and temperature but not pupil reaction and muscle strength. She stated she would expect that all vital signs, including pupil reaction and strength, should be assessed and recorded on the neuro sheet.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to ensure orders for ileostomy care were in place for one of one resident (Resident (R)38) reviewed for colostomy care out of a total sample of 28. This had the potential to have a negative effect on R38's skin and quality of life. The facility census was 84. Findings include: Review of the facility policy titled, Physician's Orders, dated 11/2020 and provided by the facility revealed, All medications will be administered as ordered by a health care professional authorized by the state to order medications . Orders for treatments will include: Description of treatment including use of topical medications, Frequency of treatment, Specific precautions or directions if needed, Clinical rationale for order (indication/diagnosis). Review of the facility policy titled, Colostomy- Ileostomy Care, dated 11/2018 and provided by the facility, revealed, . 13. Document changing of colostomy bag on TAR [treatment administration record] . Review of R38's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 09/03/24 and located in the MDS tab of the Electronic Medical Record (EMR), revealed an admitted [DATE]. A Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. The MDS recorded R38 had diagnoses that included metabolic encephalopathy, ileostomy status, and cirrhosis of liver. Review of R38's Care Plan, dated 09/02/24 and located in the EMR under the Care Plan tab, revealed, [R38] requires the use of an ileostomy. An intervention included, Provide ostomy care as per provider's orders. Review of R38's Physician Orders, located in the EMR under the Order tab, revealed no orders for R38's ileostomy. Review of R38's Care Management Note, dated 09/03/24 and located in the EMR under the Progress Note tab, revealed, . refusing OOB [out of bed] due to nausea and dizziness and colostomy is leaking . Review of R38's September and October 2024 TAR, located in the EMR under the Order tab, revealed the last time R38's ileostomy wafer and bag were documented as being changed was 09/08/24. On 09/30/24 at 10:58 AM, R38 was observed in bed awake watching television wearing a hospital gown. R38 stated she did not get out of bed much because her colostomy leaked. R38 stated she wore a hospital gown because it made it easier to clean up the leaks. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 8:35 AM, R38's wound on her abdomen was observed. A Nurse Practitioner (NP) removed the dressing, R38's ileostomy skin barrier was noted about one inch from the wound. Fecal matter was noted under the ileostomy skin barrier. As the Assistant Chief Nursing Officer (ACNO)2 measured the wound, she confirmed the fecal matter. During an interview on 10/02/24 at 8:42 AM, the NP was asked about the fecal matter and R38's complaint about feces leaking into wound during a prior interview. The NP confirmed the feces leaking would negatively impact the wound healing. The NP was asked if there should be ileostomy care orders, and the NP stated, Yes. The NP then reviewed the EMR and confirmed there were no orders for ileostomy care. The NP asked the Director of Nurse (DON) and ACNO2 what happened to the orders. The DON stated, Sometimes they drop off when she [R38] is sent to the hospital. During an interview on 10/03/24 at 2:41 PM, ACNO2 was asked about R38's ileostomy orders. ACNO2 stated R38 had gone to the hospital a few times lately and the orders dropped off. ACNO2 stated, The admission nurse should be checking the orders to ensure it's there.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 36190 Based on interview and record review, the facility failed to employ a qualified director of food and nutrition services. This deficient practice had the potential to affect 87 of 87 residents who received meals prepared in the facility's only kitchen. The facility census was 84. Findings include: Review of the Dietary Manager's (DM) job description, titled Executive Chef, dated 01/08/23, revealed, . Must have Food Service Sanitation certification . Review of the DM's employee file revealed an original date of hire was September 2018. No training course document was included in the file. Review of the Dietary Schedule for 09/29/24 through 10/05/24 revealed the DM was listed as Manager. During an interview on 09/30/24 at 9:35 AM, the DM was asked how long she had worked as the dietary manager and if she was a certified dietary manager (CDM) or had other qualifying credentials as a dietary manager. The DM stated she had been employed at the facility for five years as a cook but had only been the dietary manager for nine months. The DM confirmed she did not have two or more years of experience in the position of director of food and nutrition services in a healthcare setting. The DM went on to say she was not a certified dietary manager and did not have any other qualifying credentials but was currently taking a course in food safety and management. During an interview on 10/01/24 at 9:54 AM, the General Manager was asked about DM's experience and credentials. The General Manager stated the DM was not a CDM but was currently in a course in food safety and management. The General Manager stated DM had been in the manager's position for nine months. During an interview on 10/02/24 at 11:28 AM, the Registered Dietitian (RD) confirmed she was not full-time, and the DM and assistant DM did not have two or more years of experience in the position of director of food and nutrition services in a healthcare setting. The RD confirmed the DM had not completed a course in food safety and management but is currently taking one.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interviews, and facility policy review, the facility failed to 1.) document that residents were offered and provided education about the influenza vaccine during the influenza season for two of five residents (Resident (R) 8 and R35) reviewed for immunizations, and 2.) document that residents were offered and provided education about the pneumonia vaccine for four of five residents (R3, R8, R26, and R35) reviewed for immunizations. This had the potential for residents or their representatives not to make an educated decision regarding obtaining the immunizations at the facility which could lead to illness. The facility census was 84. Findings include: Review of the facility's Immunization Policy, revised/reviewed in 05/2023, revealed, . all admissions throughout the year will be offered the pneumovax injection as recommended by Centers for Disease control [CDC] and desired by the resident and approved by the primary care physician . CDC recommends adults aged [AGE] years old or older who have not previously received PCV or whose previous vaccination history is unknown should receive l [one] dose of PCV [either PCV20 or PCV15] . Each resident's . immunization status will be determined, if possible, prior to vaccination, and will be documented in the resident's clinical record in the [Immunization Record] . If the resident . have no information about immunization history, and none can be obtained from the designated primary care physician, the vaccine[s] will be offered and administered as indicated by the primary care physician . Prior to offering the influenza, pneumovax . vaccine[s], each resident and/or representative will receive current education regarding the benefits and potential side effects of the immunization . Residents . may refuse vaccinations. Vaccination refusal and reasons why will be documented by the facility in addition to education related to risk of refusing immunizations. 1. Review of R3's Prof (Profile) tab of her electronic medical record (EMR) revealed she was [AGE] years old. R3 was admitted to the facility on [DATE]. Review of R3's Immun (Immunizations) tab of her EMR revealed an undated consent refused entry for an unspecified pneumococcal immunization. The facility did not document any history that R3 had received pneumonia vaccines in the past. Review of R3's EMR revealed no signed declination of a pneumonia vaccine, no rationale for why R3 refused the vaccine, and no documentation that the facility provided education regarding the vaccine. 2. Review of R8's Prof tab of her EMR revealed she was [AGE] years old and was admitted to the facility on [DATE]. Review of R8's Immun tab of her EMR revealed an undated not eligible and an undated consent refused entry for influenza vaccines. Review further revealed an undated consent refused entry for an unspecified pneumococcal immunization. The facility did not document any history that R8 had received pneumonia vaccines in the past. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265872	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Kansas City, LLC	2100 N W Barry Road Kansas City, MO 64154

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R8's EMR revealed no signed declinations for the pneumonia and influenza vaccines, no rationale for why R8 refused the vaccines, and no documentation that the facility provided education regarding the vaccines. 3. Review of R26's Prof tab of his EMR revealed he was [AGE] years old and was admitted to the facility on [DATE]. Review of R26's Immun tab of her EMR revealed an undated consent refused entry for an unspecified pneumococcal immunization. The facility did not document any history that R26 had received pneumonia vaccines in the past. Review of R26's EMR revealed no signed declination of a pneumonia vaccine, no rationale for why R26 refused the vaccine, and no documentation that the facility provided education regarding the vaccine. 4. Review of R35's Prof tab of his EMR revealed he was [AGE] years old and was admitted to the facility on [DATE]. Review of R35's Immun tab of her EMR revealed an undated not eligible and an undated consent refused entry for influenza vaccines. Review further revealed an undated consent refused entry for an unspecified pneumococcal immunization. The facility did not document any history that R35 had received pneumonia vaccines in the past. Review of R35's EMR revealed no signed declinations for the pneumonia and influenza vaccines, no rationale for why R35 refused the vaccines, and no documentation that the facility provided education regarding the vaccines. During an interview on 10/03/24 at 11:06 AM, the Infection Preventionist (IP) stated the facility asked all residents and/or their representatives if they wanted the influenza vaccine (during flu season) and pneumonia vaccine. She stated the facility had consent forms for the pneumonia vaccine but did not obtain signatures for refusals. The IP stated the facility used consents for flu shots from the pharmacy who provided the vaccinations as well as from the facility, and the consents asked for a signature for consent but not for refusal. She stated the facility had a new form for the 2024-25 flu season which included a signature for declinations. The IP stated when residents declined immunizations, nursing marked consent refused for the immunization, and if the resident stated they had received a vaccine in the past, nursing marked not eligible and tried to obtain the resident's immunization history. The IP reported she followed up and ensured resident records were updated and immunizations given if requested. During an interview on 10/03/24 at 12:08 PM, the IP verified no education provided to residents who declined influenza and pneumonia vaccines would be documented in the EMR, since this information was only documented on the consent forms. During an interview on 10/03/24 at 1:30 PM, the Director of Nursing (DON) stated she expected a resident's EMR to contain the reason they declined a vaccination and to include any education provided to the resident on the benefits/risks of the vaccination. She stated staff were expected to document any history of vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/24 at 5:00 PM, the DON stated she could not locate any documentation that R3, R8, R26, or R35 had received any recent influenza or pneumonia vaccines prior to admission to the facility.