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	02/11/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the environment of two sampled residents remained free of accident hazards when the facility failed to ensure oxygen stored in Resident #131's room was stored in accordance with NFPA 99, 1999 Edition, when one type E oxygen cylinder was stored unsecured on the floor in the resident's room and when the resident's room contained more than one emergency use type E oxygen cylinder, and when the facility failed to provide a safe gait belt transfer for Resident #12 when CNA B failed to securely place the gait belt around the resident's waist and also when CMT A grabbed Resident #12 under the arm during a transfer. This affected two of 18 sampled residents (Resident #131 and Resident #12. The facility census was 86. Review of the facility's Oxygen Storage policy dated May 2024, showed:-Fasten cylinders securely in an upright position. Review of NFPA 99, 1999 edition 8-3.1.11 Storage Requirements showed:8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3).(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors).(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either:1. A minimum distance of 20 ft (6.1 m), or2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.(j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:CAUTIONOXIDIZING GAS(ES) STORED WITHINNO SMOKING19 CSR 30-86.022:2) General Requirements.(A) All National Fire Protection Association (NFPA) codes and standards cited in this rule: NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition; NFPA 13R, Installation of Sprinkler Systems, 1996 edition; NFPA 13, Installation of Sprinkler Systems, 1976 edition; NFPA 13 or NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up to and Including Four Stories in Height, 1999 edition; NFPA 13, Standard for the Installation of Sprinkler Systems, 1999 edition; NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cooking Operations, 1998 edition; NFPA 101, The Life Safety Code, 2000 edition; NFPA 72, NationalFire Alarm Code, 1999 edition; NFPA 72A, Local Protective Signaling Systems, 1975 edition; NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition; and NFPA 101A, Guide to Alternative Approaches to Life Safety, 2001 edition, with regard to the minimum fire safety standards for residential care facilities and assisted living facilities are incorporated by reference in this rule and available for purchase from the National Fire Protection Agency, 1 Batterymarch Park, [NAME], MA 02269- 9101; www.nfpa.org; by telephone at (617) [PHONE NUMBER] or [PHONE NUMBER]. This rule does not incorporate any subsequent amendments or additions to the materials listed above.This rule does not prohibit facilities from complying with the standards set forth in newer editions of the incorporated by reference material listed in this subsection of this rule, if approved by the department. 1. Review of Resident #131's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/20/25 showed:-No cognitive impairment;-Substantial assistance from staff for Activities of Daily Living (ADL)s;-Incontinent of bowel and bladder;-Diagnoses included heart failure, pneumonia and respiratory failure. Review of the resident's care plan dated 2/8/26 showed:-The resident had an ADL self care deficit related to imitated physical mobility;-Respiratory impairment related to respiratory failure;-The resident used supplemental oxygen. Observation on 02/8/2026 at 7:58 A.M., showed:-The resident in bed with oxygen applied via nasal cannula;-Two oxygen concentrators in the residents room;-One type E cylinder of oxygen with the plastic seal over the valve sat on the floor in the resident's room unsecured;-One type E cylinder of oxygen with the plastic seal over the valve sat in an oxygen tank holder in the resident's room;-One empty type E cylinder of oxygen sat in an oxygen tank holder in the resident's room. Observation and interview on 02/8/2026 at 1:22 P.M., showed:-The resident in bed with oxygen applied via nasal cannula;-Two oxygen concentrators in the residents room;-One type E cylinder of oxygen with the plastic seal over the valve sat on the floor in the resident's room unsecured;-One type E cylinder of oxygen with the plastic seal over the valve sat in an oxygen tank holder in the resident's room;-One empty type E cylinder of oxygen sat in an oxygen tank holder in the resident's room.-The resident said he/she used oxygen to help his/her breathing;-The resident said he/she did not know why there were three portable oxygen tanks in his/her room;-The resident said the staff took care of the oxygen. During an interview on 02/11/2026 at 11:43 A.M., Certified Nurse's Aide (CNA) F said:-The CNAs and nurses got the oxygen tanks from the oxygen closet if the residents needed them;-Unsecured oxygen tanks should be put in an oxygen holder;-Extra oxygen tanks whether they empty or full should be taken back to the oxygen closet;-There should not be more than one portable oxygen tank in the resident's room;-Portable oxygen tanks should be secured and not sat on the floor. During an interview on 02/11/2026 at 12:17 P.M., Licensed Practical Nurse (LPN) H said:-The CNAs and nurses removed the oxygen tanks from the oxygen closet and returned oxygen tanks to the closet;-Portable oxygen tanks should not be sat on the floor;-Oxygen tanks should either be in an oxygen holder or in a holder on the back of the resident's wheel chair;-There should not be excessive oxygen that is not in use the resident's room. During an interview on 02/11/2026 at 02:37 P.M., the Director of Nursing (DON) said:-No unsecured (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen tanks should be on the floor in Resident #131's room;-All oxygen tanks should be secured in an oxygen tank holder or the oxygen closet;-She said the was no limit to the number of oxygen tanks a resident could have in there room;-She expected staff to secure oxygen tanks if they were unsecured. During an interview on 02/11/2026 at 02:45 P.M., the Administrator said:-There was no limit to the number of oxygen tanks that could be stored in a resident's room;-Oxygen should be secured and not sat on the floor in a resident's room;-She expected staff to secure oxygen if they saw it was setting on the floor;-Resident #131 should not have unsecured oxygen in his/her room. Review of the facility's policy for Gait Belts (a specialized sturdy belt placed securely around a person's waist to assist with transfers), revised 4/2023, showed: - Gait belts should be used by all staff when ambulating or transferring a resident with an unsteady gait. - Apply the belt around the resident's waist, with the belt not touching the resident's skin. - Ensure the belt is not too tight; allow three fingers between belt and resident. - To transfer the resident, assist to standing position by holding belt at waist and pivot resident to the chair. - Care plan use of gait belt. 2. Review of Resident #12's care plan, initiated 12/21/25 showed: - The resident had an activity of daily living (ADL) self-care performance deficits and limitations in physical mobility relate to weakness, cardiomyopathy, protein calorie malnutrition, and a pressure ulcer on the sacrum. Required partial/moderate assistance with toileting and chair to bed transfers. - The care plan did not address the use of a gait belt. Review of the resident's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/27/25 showed: - Cognitive skills moderately impaired. - Dependent on the assistance of staff for toilet use. - Substantial to maximum assistance with transfers. - Frequently incontinent of bowel and bladder. - Diagnoses included cancer, dementia, and diabetes mellitus. - Had one Stage III (full thickness skin loss) pressure ulcer. - Had two falls with no injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/10/26 at 11:33 A.M., showed: - Certified Nurse Aide (CNA) B sanitized, donned a gown and gloved, entered the resident's room and placed the resident's wheelchair by the bed and the resident locked the brakes. CNA B placed the gait belt around the resident's waist and grabbed each side of the gait belt under the resident's arms and the gait belt slid up in the front and back and was under the resident's arm pits and transferred the resident from his/her wheelchair to the bed and sat him/her down. - CNA B provided incontinent care to the resident and re-dressed the resident. - CNA B assisted the resident to sit on the side of the bed and placed the gait belt over the resident's breasts. CNA B grabbed each side of the gait belt and it slid up in the front and back and up under the resident's arm pits. CNA B tried three times to transfer the resident from the side of the bed to his/her wheelchair and was unable to do so. CNA B assisted the resident to lie down on the bed, removed his/her gown and gloves, washed his/her hands and left the room. - At 11:50 A.M., CNA B and Certified Medication Technician (CMT) B sanitized, gloved and donned gowns and entered the resident's room. - CNA B and CMT B assisted the resident to sit on the side of the bed. CNA B and CMT B placed one arm under the resident's arm pit and grabbed the back of the gait belt with their other hand and transferred the resident into his/her wheelchair. CNA B removed the gait belt During an interview on 2/11/26 at 2:32 P.M., the Administrator and the Director of Nursing (DON) said: - For a one person transfer with a gait belt, staff should place the gait belt under the resident's breasts, on the resident's waist and staff should grab the sides of the gait belt. - For a two person transfer with a gait belt, staff should place their hands on the front and the back of the gait belt. - Staff should not place their arm under the resident's arm pits to transfer them. - The gait belt should be tight enough for the resident's comfort level and would expect it to slide up. During an interview on 2/11/26 at 11:15 A.M., CNA B said: - He/She placed the gait belt on the resident per their preference, either over or under their breasts, but should not be over their chest. The gait belt should not slide up under the resident's arm pits. - The gait belt should not slide up in the front or back. - For a one person transfer with a gait belt, he/she placed one hand on the back of the gait belt and the other hand on the side of the gait belt towards the back. - For a two person transfer with a gait belt, he/she placed one arm under the resident's arm pit and grabbed the back of the gait belt with his/her other hand. - He/She had training on gait belt transfers but was unable to recall when it occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/26 at 1:58 P.M., CMT B said: - The gait belt should be placed around the resident's waist; it should be under the resident's breasts. - The gait belt should not slide up in the front or back and should not slide up under the resident's arm pits. - For a one person transfer with a gait belt, he/she grabbed the gait belt on each side. - For a two person transfer with a gait belt, he/she placed one hand on the side of the gait belt and one hand on the back of the gait belt. - He/She should not have placed his/her arm under the resident's arm pit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident's who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections when the facility failed to ensure staff properly clean catheter tubing for Resident #142 and when facility staff failed to wear Enhanced Barrier Precautions (EBP, an infection control strategy where staff wear a gown and gloves when providing direct care to residents with indwelling medical devices) for two Resident's #142 and #4. This affected two of 18 sampled resident's. The facility census was 86.Review of the facilities Catheter Care policy, dated January 2026, showed:- The purpose of catheter care is to prevent possible urinary tract infections from bacteria from spreading from the perineal area and external catheter into the bladder;- Begin cleaning starting at the ureteral meatus wiping away from the body;- The policy did not address using a single cleansing wipe more than once to clean the catheter tubing. Review of the facilities Enhanced Barrier Precautions (EBP) policy, dated March 2024, showed:- EBP expands personal protective equipment use beyond standard precautions when there is anticipated exposure to blood or body fluid;- Gowns and gloves are used during high-contact activities with increased risk for infections;- EBP is to be used when a resident was infected with a multidrug-resistant organism, wounds including any skin opening requiring a dressing regardless of MDRO colonization status, indwelling medical devices regardless of MDRO colonization status including but not limited to central lines, urinary catheters, feeding tubes, and tracheostomy/ventilators;- EBP will be followed when providing hygiene, changing linen, changing briefs or assisting with toileting, device care or use including but not limited to: urinary catheters (a thin tube inserted into the bladder , feeding tubes, and wound care. 1. Review of Resident #142's Care Plan, dated 2/9/26, showed:- The resident had a urinary catheter; - The resident required used of EBP due to an indwelling urinary catheter;- The resident had an activities of daily living self-care deficit due to limited physical mobility and required staff to care for indwelling urinary catheter. Observation on 02/10/2026 at 7:20 P.M. showed:- Signage indicating the need for EBP to be worn posted on the resident's door frame;- Certified Nursing Assistant (CNA) A provided catheter care for the resident;- CNA A sanitized hands and put gloves on, then picked up a trashcan in the resident's room with the same gloves on;- Another staff member brought a gown in for CNA A to wear and CNA A put the gown on;- CNA A did not change gloves and perform hand hygiene after picking up the trashcan before emptying the resident's urinary catheter drainage bag;- CNA A took off the gown and gloves and performed hand hygiene;- CNA A put new gloves on without putting a gown on;- CNA A cleaned the catheter tubing with a disposable cleansing wipe from the insertion site down approximately 3 inches, folded the soiled cleansing wipe and cleaned the catheter tubing from the insertion site approximately 3 inches;- CNA A walked around the resident's bed to get to the trashcan to throw the disposable cleansing wipe away then picked up the trashcan and carried it to the other side of the resident's bed;- CNA A did not change gloves after picking up the trashcan before putting a new incontinent brief on the resident. During an Interview on 02/10/2026 at 7:27 P.M. CNA A said:- He/she should have changed gloves after picking up the trashcan before providing care to the resident;- He/she did not know when EBP should have been worn;- He/she did not know that hand hygiene should be performed with every glove change;- It was okay for him/her to use a disposable cleansing wipe more than once while cleaning catheter tubing. During an Interview on 02/11/2026 at 1:36 P.M. CNA D said:- Hand hygiene should be perform with every glove change;- Hands should be washed and gloves should be changed after touching any objects in the resident's room before providing care to the resident;- Disposable cleansing wipes should not be folded and used more than once when cleaning catheter tubing. During an Interview on 02/10/2026 at 7:40 P.M. CNA E said:- Hands are supposed to be washed between each glove change;- He/she knows to wear EBP when caring for resident's when (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there is a sign posted on the resident's door;- Each disposable cleansing wipe should only be used once when cleaning catheter tubing. 2. Review of Resident #4's Significant change MDS, dated [DATE], showed:- The resident was cognitively intact; - The resident was dependent on staff regarding toileting hygiene;- The resident had diagnoses of urinary tract infection within the last 30 days, generalized muscle weakness, and neuromuscular dysfunction of bladder. Review of Resident #4's care plan, dated 11/26/25, showed:- The resident was at risk for urinary tract infection (UTI) due to having an indwelling urinary catheter;- The resident required the use of EBP due to wounds and indwelling urinary catheter;- The resident was dependent on staff for performing activities of daily living. Observation on 02/11/2026 at 1:22 P.M. showed: - CNA D entered the resident's room to empty his/her catheter drainage bag;- CNA D put on gloves but did not put on a gown;- The catheter bag and catheter tubing touched the floor while CNA D was moving the catheter tubing to collect the urine from the catheter tubing into the catheter drainage bag. During an Interview on 02/11/2026 at 1:36 P.M. CNA D said:- He/she should have worn a gown while emptying the resident's catheter bag;- Catheter tubing and catheter drainage bags should never touch the floor. During an Interview on 02/11/2026 at 2:19 P.M. the Infection Preventionist said:- EBP should be worn when providing direct care for residents with catheters;- Catheter tubing and catheter drainage bags should not touch the floor;- Hands should be either washed or sanitized between glove changes;- Hand hygiene and glove change should be performed after picking up a trashcan to move it before proving care for a resident;- Staff are trained and required to use EBP when there was a magnet on each door frame around eye level and there is an isolation cart outside of the resident's room. During an Interview on 02/11/2026 at 2:32 P.M. the Director of Nursing (DON) said:- EBP should be utilized when providing direct care for resident's with indwelling urinary catheters;- Catheter tubing and catheter bags should not touch the floor and if they do they should be changed;- He/she would have to check the facilities policy to determine if disposable cleansing wipes could be used multiple times while cleaning catheter tubing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure the kitchen was in good repair and maintained the kitchen in a clean and sanitary manner when cooking and food prep areas where dirty with dust and food debris, and when repairs in the kitchen had not been completed. This had the potential to affect all residents who received a meal from the kitchen. The facility census was 86. The facility did not provide a policy on cleaning and repairs in the kitchen. Observation of the kitchen on 02/08/26 at 09:12 A.M. showed:-The grill with a thick layer of encrusted grease and food debris;-The shelf above the stove with a thick layer of grease and food debris;-The ceiling in the dish room with a round brown stain the size of a basketball with pieces of ceiling tile hanging down.Observation of the kitchen on 02/11/26 at 10:42 A.M. showed:-The grill with a thick layer of encrusted grease and food debris;-The shelf above the stove with thick layer of grease and food debris;-The ceiling in the dish room with a round brown stain the size of a basketball with pieces of ceiling tile hanging down;-The trays the residents were served meals on with missing pieces of tray that come off when touched;-The wheels and brakes on the two hot boxes with grease build up, dirt and debris;-The knobs on the steam table covered with food debris, grease and grime;-The vents on the sides of the refrigerator caked with dust.During an interview on 02/11/26 at 1:36 P.M., [NAME] A said:-The cooks are in charge of cleaning the grill;-The grill should be cleaned daily;-The grill should not have a buildup of encrusted grease and food debris.During an interview on 02/11/26 at 1:44 P.M., the Dietary Manager said:- The kitchen should be clean and in good repair;- The maintenance department is responsible for repairs to the kitchen;- The maintenance log should be utilized for maintenance requests;- The maintenance man quit two days ago and he/she new about the water stain in the dish room but it did not get fixed yet.During an interview on 02/11/26 at 2:08 P.M., the Registered Dietitian said:-The kitchen should be clean and in good repair;-The trays the residents eat from should be in good condition and not have pieces breaking off of them;-The dietary manager is in charge of ensuring the kitchen in clean.During an interview on 02/11/2026 at 02:45 P.M., the Administrator said:-The kitchen should be clean and in good repair;-The cleaning schedules should be followed in the kitchen;-The kitchen is responsible for ensuring that cleaning is done;-Maintenance should complete the repairs in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections when the facility failed to ensure staff wore enhanced barrier precautions (EBP, an infection control strategy where staff wear a gown and gloves when providing direct care to residents with wounds or indwelling medical devices) for Resident #142, and Resident #4 and failed to ensure dirty gloves were changed before providing catheter care for resident #142. Facility staff failed to provide a barrier between a resident's wound and the floor when performing a dressing change for resident #16. This affected three of 18 sampled residents. The facility census was 86. Review of the facilities Infection Control Policy dated May 2024, showed: - Perform hand hygiene when moving from contaminated body sites to clean body sites during resident care; - Perform hand hygiene after touching objects and medical equipment in immediate resident care area; - All staff had a responsibility to be aware of local and national policies, procedures and campaigns related to standard infection control precautions. Review of the facilities Enhanced Barrier Precautions (EBP) policy, dated March 2024, showed: - EBP expands personal protective equipment use beyond standard precautions when there is anticipated exposure to blood or body fluid; - Gowns and gloves are used during high-contact activities with increased risk for - EBP was used when a resident was infected with a multidrug-resistant organism, wounds including any skin opening requiring a dressing regardless of MDRO colonization status, indwelling medical devices regardless of MDRO colonization status including but not limited to central lines, urinary catheters, feeding tubes, and tracheostomy/ventilators; - EBP will be followed when providing hygiene, changing linen, changing briefs or assisting with toileting, device care or use including but not limited to: urinary catheters (a thin tube inserted into the bladder, feeding tubes, and wound care. 1. Review of Resident #142's Care Plan, dated 2/9/26, showed: - The resident had a urinary catheter; - The resident required used of EBP due to an indwelling urinary catheter; - The resident had an activities of daily living self-care deficit due to limited physical mobility. Observation on 2/10/26 at 7:20 P.M., showed a sign on the resident's door frame for EBP. The CNA A sanitize his/her hands and put on gloves, entered the resident's room. The CNA picked up a trashcan in the resident's room with gloved hands, set down the trashcan. Observation showed another CNA (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handed CNA A a gown. The CNA put on the gown and emptied the resident's catheter with the same gloves he/she used to move the trashcan. The CNA removed his/her gown and gloves, washed hand and applied a new pair gloves. The CNA did not don a gown. The CNA cleaned the catheter tubing from the insertion site, walked around the resident's bed picked up the trashcan and carried it to the other side of the bed. The CNA did not change his/her gloves or sanitize his/her hands. With the same gloves, the CNA placed a new brief on the resident. During an Interview on 02/10/2026 at 7:27 P.M. CNA A said: - He/she should have changed gloves after picking up the trashcan before providing care to the resident and hand hygiene completed with every glove change; - He/she did not know when EBP should have been worn; - It was okay for him/her to use a disposable cleansing wipe more than once while cleaning catheter tubing. During an Interview on 02/11/2026 at 1:36 P.M. CNA D said: - Hand hygiene should be performed with every glove change; - Hands should be washed and gloves should be changed after touching any objects in the resident's room before providing care to the resident; - Disposable cleansing wipes should not be folded and used more than once when cleaning catheter tubing. During an Interview on 02/10/2026 at 7:40 P.M. CNA E said: - Hands are supposed to be washed between each glove change; - EBP is to be worn when caring for resident's when there is a sign posted on the resident's door; - Each disposable cleansing wipe should only be used once when cleaning catheter tubing. 2. Review of Resident #4's Significant change MDS, dated [DATE], showed staff assessed the resident as the following: - Cognitively intact; - Dependent on staff for toileting hygiene; - Diagnoses of urinary tract infection within the last 30 days, generalized muscle weakness, and neuromuscular dysfunction of bladder. Review of Resident #4's care plan, dated 11/26/25, showed the resident: - At risk for urinary tract infection (UTI) due to having an indwelling urinary catheter; -Requires the use of EBP due to wounds and indwelling urinary catheter; (continued on next page)

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	265872	A. Building B. Wing	02/11/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for performing activities of daily living. Observation on 02/11/26 at 1:22 P.M., showed CNA D entered the resident's room, put on gloves, and emptied the resident's catheter. Observation showed the CNA did not don a gown and the catheter tubing touching the floor when the catheter bag was emptied. During an Interview on 02/11/2026 at 1:36 P.M. CNA D said: - He/she should have worn a gown while emptying the resident's catheter bag; - Catheter tubing and catheter drainage bags should never touch the floor. During an Interview on 02/11/2026 at 2:19 P.M. the Infection Preventionist said: - EBP should be worn when providing direct care for residents with catheters; - Catheter tubing and catheter drainage bags should not touch the floor; - Hands should be either washed or sanitized between glove changes; - Hand hygiene and glove change should be performed after picking up a trashcan to move it before proving care for a resident; - Staff know that a resident requires EBP when there is a magnet on each door frame around eye level and the isolation cart is outside of the resident's room. During an Interview on 02/11/2026 at 2:32 P.M. the Director of Nursing (DON) said: - EBP should be utilized when providing direct care for residents with indwelling urinary catheters; - Catheter tubing and catheter bags should not touch the floor and if they do, they should be changed; - He/she would have to check the facilities policy to determine if disposable cleansing wipes could be used multiple times while cleaning catheter tubing. What was the policy 3.Review of Resident #16's admission MDS, dated [DATE]., showed staff assessed the resident as followed: -Cognition Intact -Diagnoses of Diabetes -Requires substantial to maximal assistance to lower body mobility, dressing, and hygiene. Review of the resident care plan, dated 1/23/26 showed: -Goal was resident will be free from skin impairment and staff to educate the resident regarding diabetes and skin risks; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted on [DATE]; -At risk for skin concerns related to mobility and self-care debility; -Staff are to observe for signs/symptoms of open areas including, redness, pain, warmth to touch, drainage, and to notify nurse or provider of signs and symptoms present; Review of resident's wound assessment completed on 2/5/26 showed: - At high risk for skin breakdown; - Discovery of foot ulcer over a boney area to the left heel; - Circular area measuring 2.50 centimeters (cm) x 3.00 cm x 0.10 cm (L x W x D) in size where the center blistered area had opened exposing bright red tissue to the center of the wound and tissue surrounding the wound with redness. Review of the wound order treatment, ordered by the physician on 2/6/26., showed cleanse the left heel with normal saline of wound cleanser, pat dry and apply hydrofera blue, then cover with a border foam dressing three time a week on Monday, Wednesday, and Friday and as needed. Observation of the resident's treatment to left heel wound on 2/9/26 at 10:00 A.M., showed NP A entered the resident's room, applied gloves removed the resident's shoe and sock. Observation showed no dressing to the resident's heel. The NP sat the resident's left heel onto the floor without a barrier. The NP lifted the left heel, measured the wound, and rested the resident's heel back onto the floor without a barrier. During an interview on 2/9/26 at 10:30 A.M., NP A said he/she should have placed a barrier between the floor and the wound to prevent exposing the wound to bacteria and germs on the floor. During an interview on 2/9/26 at 11:30 A.M., the wound nurse said any open wound should not ever touch the floor. Ideally the resident should lay down so the foot wound on the bottom of the wound can be easily viewed and cared for properly. During an interview on 2/9/26 at 12:15 P.M., the Administrator said failure to place a barrier between an open wound and the floor is not acceptable and she would have expected during a treatment for NP A to have placed a barrier between the floor and wound for protection against dirt and bacteria. During an interview on 2/11/26 at 1:35 P.M., the Infection Preventionist said a barrier should be in place to protect an open wound from the floor.

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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. Based on observation, interview, and record review, the facility failed to treat Resident #131 with dignity and respect when staff failed to assist the resident with trimming facial hair. This affected one of 18 sampled residents. The facility census was 86. Review of the facilities Resident Rights policy, dated May 2023, showed: - Resident's had rights to a dignified existence, self-determination, and communication; - The facility must protect and promote the rights of the resident's; - The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Review of the facility's Bathing policy dated April 2023, showed:-All residents are given a bath or shower in accordance with their preferences;-If no preference is voiced a bath or shower will be offered twice a week. Review of Resident #131's admission MDS a dated 10/20/25 showed:-No cognitive impairment;-Substantial assistance with showers and bathing;-Substantial assistance with personal hygiene;-Diagnoses included heart failure, pneumonia and respiratory failure. Review of the resident's care plan dated 2/8/26 showed:-The resident had an Actives of Daily Living (ADL) self-care deficit related to imitated physical mobility;-Respiratory impairment related to respiratory failure;-The resident required substantial assistance with showers and personal hygiene. Review of shower sheets for the resident's hall dated 2/2/26 through 2/9/26 showed no shower sheet or documentation that the resident had received a shower or shave was found. Review of shower refusal sheets for the resident's hall dated 2/2/26 through 2/9/26 showed no refusal or documentation to show the resident had been offered and refused a shower or shave. Observation and interview on 02/8/2026 at 9:18 A.M. showed:-The resident in his/her room in bed;-The resident's skin looked dry and flakey;-The resident's hair was disheveled and greasy;-The resident had facial hair;-The resident had body odor;-The resident said he/she had been at the facility since Tuesday and had not received a shower, bed bath or a shave;-The resident said the staff kept saying they would give him/her at least a bed bath and trim his/her facial hair but they never do it;-The resident said he/she is here because he/she needs help and he/she said he/she has not got the help he/she needed;-He/She said it made him/her feel self-conscious and uncomfortable because he/she had not been clean and groomed. During an interview on 02/8/2026 at 11:43 A.M., CNA F said:-Residents should get at least two showers per week or more if needed:-He/She worked with the resident 2 days last week and he/she did not get a shower when he/she worked;-The resident was here for respite care and only here for five days;-He/She would expect the resident to have at least one shower within that time;-The staff helped residents with grooming and shaving;-Residents should be well groomed and dignified;During (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 02/11/2026 at 12:18 P.M., LPN H said:-Residents should get at least two showers a week;-The residents can refuse showers:-If a resident refused a shower the staff filled out a form starting when and why the resident refused the shower;-Resident #131 was here only five days but still should have received a shower;-If resident #131 refused there should be a refusal in his/her record;-Residents that request to be shaved should get that help from the staff;-All residents should be well groomed and clean. During an interview on 02/11/2026 at 02:37 P.M., the DON said:-She expected resident's to be offered a shower at least twice per week;-Residents can refuse and there is a refusal form that should be completed;-She would expect Resident #131 to receive a shower during his/her five day stay;-She expected staff to assist residents with shaving if they asked;-Residents should be clean, dry and well groomed. During an interview on 02/11/2026 at 02:45 P.M., the Administrator said:-She expected residents to be offered a shower at least twice per week;-Residents can refuse and there is a refusal form that should be completed;-She expected staff to assist residents with shaving;-Resident should be clean, dry and well groomed. Intake 2708511

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review the facility failed to ensure Resident #143 received insulin as with meals ordered when staff served the resident the noon meal tray at 12:05P.M. and administered insulin at 12:37 P.M. This affected on of 18 sampled residents. The facility census was 86. Review of the facility's Administration of Medication Policy dated 04/2023, showed:-Staff to read each order entirely;-Read label of medication three times;-If there is a discrepancy between Medication Administration Record (MAR) and label, check orders before administering medications;-Follow instructions written on label.Review of the facility's Pharmacy Services Policy dated 05/2024, showed:-Staff to follow specific monitoring related to medications, such as blood sugar;-Staff to follow specific timing and parameters of medications (e.g. before or after meals)Review of the facility's Insulin Administration Procedure Policy dated 05/2023, showed:-Insulin is only given with a practitioner order;-Objective is to safely and accurately inject insulin.Review of resident #143's POS dated 02/11/2026, showed NovoLOG FlexPen 100unit/ML. Instructions read to Inject 4 unit subcutaneously before meals for diabetics.Observation on 02/11/2026 between 11:40 A.M and 12:37 P.M showed LPN A:-Obtained blood glucose reading at 11:40 A.M.;-Meal tray delivered by dietary staff at 12:05 P.M. to the resident;-Administered 4 units of insulin to resident at 12:37P.M., after the resident had eaten the entire meal. During an interview on 02/11/2026 at 11:30A.M.,LPN A said that he/she was only responsible for blood glucose monitoring and insulin administration of two residents that shift for each meal. During an interview on 02/11/2026 at 9:45 A.M., the DON said:-Orders should be followed as written by staff administering medications;-Staff should read all orders entirely;-Staff should read medication packaging and labels to ensure accuracy;-Insulin should be administered when meal is delivered, before resident eats.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (AQDLs) received the necessary services to maintain good personal hygiene when staff used a soiled incontinence wipe to perform per-care and did not fully clean the peri-area, which affected one of the 18 sampled residents, (Resident #12). The facility census was 86. Review of the facility's policy for Perineal Care, reviewed 5/23 showed:- Perineal care is done daily and as needed for all residents requiring assistance and/or those residents with a Foley catheter (sterile tube inserted into the bladder to drain urine).Wash perineal area with peri wash and water using a washcloth. If appropriate, rinse with warm water. For males, retract foreskin if present, wash, dry and replace foreskin. When complete, remove gloves and cleanse hands. 1. Review of Resident #12's care plan dated 12/21/25, showed: - The resident had bowel incontinence. Check resident every two hours and assist with toileting as needed. Provide peri care after each incontinent episode. Provide skin care with each incontinent episode. - The resident experienced urinary/bowel incontinence related to diuretic medication use and impaired mobility. Check regularly and as needed to incontinence, change brief, change brief, provide appropriate skin/peri-care, apply moisture barrier cream, change clothing as needed after incontinent episodes. Review of the resident's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/27/25 showed:- Cognitive skills moderately impaired.- Dependent on the assistance of staff for toilet use.- Substantial to maximum assistance with transfers.- Frequently incontinent of bowel and bladder.- Diagnoses included cancer, dementia, and diabetes mellitus.- Had one Stage III (full thickness skin loss) pressure ulcer. Observation of Resident # 12 receiving incontinence care on 2/10/26 at 11:33 A.M., showed:- CNA B removed gloves, washed, and applied new gloves. CNA B removed the resident's pants and unfastened the wet and soiled brief. - CNA B wiped down one side of the groin, used a new wipe and wiped down the other side of the groin.- CNA B did not separate and clean all the skin folds.- CNA B turned the resident on his/her side and removed the soiled and wet dressing from the resident's sacrum (a large, triangular-shaped bone located at the base of the spine), dated 2/10/26. - CNA B wiped from front to back with fecal material, folded the wipe and wiped again with fecal material on the wipe. CNA B used a new wipe and wiped front to back with fecal material on the wipe, folded the wipe and wiped again with fecal material on the wipe. CNA B wiped twice more with a different wipe each time with a smear of fecal material on the wipe and folded each wipe and wiped again with a smear of fecal material on each wipe. CNA B used a new wipe and with the same area of the wipe, wiped back and forth to remove fecal material from the resident's buttocks. - CNA B removed the wet and soiled incontinent brief, removed his/her gloves, sanitized and applied new gloves and placed a clean incontinent brief under the resident and fastened it. CNA B assisted the resident to put his/her pants back on. During an interview on 2/12/26 at 11:15 A.M., CNA B said:- He/She should have cleaned all areas of the skin where urine or feces had touched.- When he/she provided peri care that was just urine, he/she folded the wipe. He/She should not have folded the wipe when cleaning fecal material. Observation on 2/10/26 at 7:31 P.M., showed:- CNA C sanitized, gloved and did not don a gown and entered the resident's room. CNA C used the gait belt and transferred the resident to the side of the bed and removed the resident's pants and wet incontinent brief. CNA C removed gloves, washed hands, and applied new gloves. - CNA C did not separate and clean all areas of the skin folds and turned the resident on his/her side. CNA C wiped from front to back with a smear of fecal material on the wipe. Used a new wipe and wiped the rectal area with a smear of fecal material on the wipe. CNA C used a new wipe and wiped again front to back.- CNA C removed the wet incontinent brief, removed gloves, washed hands and applied new gloves then placed a clean incontinent brief under the resident and fastened it. CNA C did not return the surveyor's phone call for an interview. During an interview on 2/11/26 at 2:32 P.M., the Director of Nursing (DON) said:- She expected staff to separate and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean all areas of the skin where urine or feces had touched.- Staff should not fold the wipe when cleaning fecal material.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure staff prepared foods in a form designed to meet the needs of individual residents when they did not ensure the puree (a texture-modified diet in which all foods have a soft, pudding-like consistency) food had a smooth and appropriate consistency. This affected one resident identified by the facility as having an order for a pureed diet (Resident #115). The facility census was 86. The facility did not provide the requested policy on pureed diets.1. Review of Resident #115's Discharge Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/6/26 showed:-Moderate cognitive impairment;-Supervision with eating;-Mechanically altered diet;-Diagnoses included diabetes, dysphagia (difficulty swallowing, causing pain or choking) and asthma. Review of the resident's care plan dated 2/9/26 showed:-Moderate assistance with Activities of Daily Living;-The resident is on a pureed diet related to dysphagia.Review of the resident's Dietitian Evaluation dated 11/08/25 showed:-The resident was on a pureed diet;-The resident had problems swallowing.Review of the residents Physician's Order Sheet (POS) dated February 2026 showed Start date 2/6/26: Order for pureed diet. Observation of meal preparation for lunch on 02/11/26 at 11:01 A.M., showed:- [NAME] A began preparing the pureed lunch meal; - He/she placed two cups of the broccoli rice mixture into the food processor;- He/she then turned on the food processor and began adding ham broth and blended until it was the desired consistency;- The mixture was thick with visible pea sized chunks in it.Observation of meal preparation for lunch on 02/11/26 at 12:30 P.M., showed:- [NAME] A placed two cups of baked ham into the food processor;- He/she added ham broth and blended until it was the desired consistency;- The mixture was thick, sticky and hard to stir;- The Regional Dietary Manager told [NAME] A to remake the pureed ham;- [NAME] A placed two more cups of baked ham into the food processor;- He/she added ham broth and blended until it was the desired consistency;- The mixture was still thick;- [NAME] A placed the pureed ham on Resident #115's meal tray.Observation of lunch service on 02/11/26 at 12:53 P.M., showed Resident #115 being served his/her pureed meal that was thick and had chunks in it.Observation of the pureed lunch meal on 02/11/26 at 01:12 P.M., showed:- Pureed ham: thick and allowed a spoon to remain standing. The mixture had particles of ham, similar to the consistency of rice, that required chewing; - Broccoli rice mixture: thick and allowed a spoon to remain standing with pieces of rice that required chewing.During an interview on 02/11/26 at 1:36 P.M., [NAME] A said:- Pureed food should be a smooth, mashed potato like consistency with no chunks or particles; - He/she did not realize the pureed food was chunky. During an interview on 02/11/26 at 1:44 P.M., the Dietary Manager said:- Pureed food should be a smooth, pudding like consistency with no chunks or particles; - Pureed food should not require chewing;- He/she did not realize the pureed food was chunky. During an interview on 02/11/26 at 2:08 P.M., the Registered Dietitian said:- Pureed food should be a pudding like consistency;- There should be no particles in the pureed food;- The pureed food should not be thick and require chewing.During an interview on 02/11/2026 at 02:45 P.M., the Administrator said:-Residents are on a pureed diet if they have a problems with chewing or swallowing;-Adverse outcomes to not serving a correctly prepared pureed diet can be choking or death;-There should be no chunks of food that require chewing in a pureed diet.