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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265880	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Blue Springs	20511 E Trinity Place Blue Springs, MO 64015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46519 Based on observation, interview and record review, the facility failed to ensure indwelling urinary catheter (a catheter which is inserted into the bladder in the urethra and remains in place to drain urine) orders were in place including catheter care for one sampled resident (Resident #2) out of six sampled residents. The facility census was 90 residents. Review of the facility's policy titled Foley Catheter (a brand name for one of many brands of urinary catheters) Care dated April 2023 showed: -The purpose of catheter care was to prevent possible urinary tract infections (UTI- an illness in any part of the urinary tract) from bacteria spreading from the perineal area and external catheter into the bladder. -A physician's order for catheterization should include the reason/indications for catheterization, frequency, and type of irrigation if necessary. 1. Review of Resident #2's Face Sheet showed he/she admitted to the facility on [DATE] with the following diagnoses: -Periprosthetic (a structure in close relation to an implant) Fracture Around Internal Prosthetic Left Hip Joint (a broken bone that occurs around the implants of a total hip replacement). -Encounter for other Orthopedic (a branch of medicine dealing with the correction of deformities of bones and muscles) Aftercare. -Unspecified Macular Degeneration (a degenerative condition affecting the central part of the retina and resulting in distortion or loss of central vision). -Need for Assistance with Personal Care. Review of the resident's January 2024 Physician Order Sheet showed: -There was no order for an indwelling catheter. -There was no order for the resident to receive indwelling catheter care. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's January 2024 Treatment Admission Record (TAR) showed no documentation related to his/her indwelling catheter care. Review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/25/24 showed: -The resident was significantly cognitively impaired. -The resident was completely dependent (helper does all the effort) on staff for toileting hygiene. -The resident had an indwelling catheter. Review of the resident's care plan dated February 2024 showed: -The resident had an Activities of Daily Living (ADL) self-care performance deficit and physical limitations in physical mobility with an intervention that the resident needed partial/moderate assistance for toileting hygiene. -The resident had a urinary catheter with the following interventions: --Check placement of tubing each shift. --Monitor/document for pain/discomfort due to catheter. --Monitor/record/report to MD for signs or symptoms of a UTI. Review of the resident's February 2024 Physician Order Sheet showed: -The resident had an order for staff to change foley catheter every 30 days and pro re nata (PRN- as needed) dated 2/7/24. -The resident had an order for the resident to receive foley catheter care every shift and PRN dated 2/7/24. -The resident had an order for staff to monitor foley catheter output every shift and PRN dated 2/7/24. NOTE: The resident discharged from the facility on 2/7/24. Review of the resident's February 2024 TAR showed documentation of the resident receiving foley catheter during the day shift on 2/7/24, which was the only documented record of the resident receiving foley catheter care during his/her stay at the facility. Review of the resident's discharge MDS dated [DATE] showed he/she discharged from the facility on 2/7/24 with return anticipated. Review of a Health Status Note dated 2/7/24 at 2:15 P.M., completed by Licensed Practical Nurse (LPN) E documented: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility's physician had seen the resident. -The resident needed to be sent to the local hospital for evaluation due to a wound infection. During an interview on 2/21/24 at approximately 3:00 P.M., LPN B said: -There should be an order for catheter care to be completed. -Common sense would indicate that the care still needed to be provided regardless of an actual order. -An order should have been in place for the resident to receive catheter care. -Nurses and Certified Nursing Assistants (CNA) were responsible for completing catheter care. -A progress note could be made to indicate catheter care was completed, but there would not be a place on the TAR to document without an order in place. -If there was not an order or progress notes then there would not be a way to verify catheter care was completed. During an interview on 2/23/24 at 11:18 A.M., CNA A said: -CNAs and nurses were responsible for catheter care. -He/She was not responsible for documenting catheter care completion. -He/She would document the output of catheters only. During an interview on 2/23/24 at 11:50 A.M., LPN C said: -If a resident had a catheter, then any nurse would be able to put in catheter care orders. -There should be an order in place for catheter care to be done. During an interview on 2/23/24 at 12:13 P.M., LPN C said: -Nurses and CNAs were responsible for the completion of catheter care. -There would be no way to verify catheter care completion without documentation in place. Observation on 2/23/24 at 12:56 P.M., the Director of Nursing (DON) and the [NAME] President of Clinical Operations for the local area showed they were unable to find an order for the resident to receive catheter care prior to the resident's discharge on 2/7/24. During an interview on 2/23/24 at 1:17 P.M., LPN D said: -The resident did receive catheter care while at the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There would not be able to verify the catheter care was received without an order in place. During an interview on 2/23/24 at 1:51 P.M., CNA C said: -He/She would know catheter care needed to be done for residents with catheters. -He/She was not responsible for documenting catheter care. During an interview on 2/23/24 at 2:07 P.M., the DON said: -He/She expected catheter care to be done every shift and when any perineal care in being done. -There should be an order in place for catheter care to be completed. -Without an order, there would not be a place for the nurses to document the completion of the care. -The facility has standing orders for foley catheter. -He/She would have expected the nurses to have put in the catheter care orders before the resident's discharge on 2/7/24. MO00231755

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to ensure the call light system was adequately equipped and functioning including that the system was not turned off at the nurse's station only which affected the care of two sampled residents (Resident #1 and Resident #4) out of six sampled residents. The facility census was 90 residents. Review of the facility's policy titled Call Light-Ability to Use dated January 2024 showed: -The call light system was provided as a tool for residents to communicate with staff. -Staff members will acknowledge and respond to the call light by entering the resident's room and determining and assisting with the resident's needs. 1. Review of Resident #1's Face Sheet showed he/she was admitted to the facility with the following diagnoses: -Heart Failure. -Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses). -Muscle Wasting and Atrophy (decrease in size and wasting of muscle tissue). -Need for Assistance with Personal Care. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/8/23 showed: -The resident was moderately cognitively impaired. -The resident needed partial/moderate assistance (helper does less than half the effort) with toilet hygiene. During a phone interview on 2/21/24 at 10:10 A.M. Family Member #1 said: -On the evening of 10/11/23 Family Member #2 was with the resident. -Family Member #2 had pressed the call light two times with no response from staff. -Family Member #2 had to go to the nurse's station to get assistance for the resident to go to the bathroom. -The staff at the nurse's station said that he/she would have to wait for an aide to assist the resident to the bathroom. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A Certified Nursing Assistant (CNA) had come to help the resident about five minutes after going to the nurse's station. -The resident needed to speak with a nurse related to his/her condition and the aide had told the resident he/she would let the nurse know. -Family Member #2 waited for the nurse to come and pressed the call light two more times. -The nurse never came to the resident's room before Family Member #2 had to leave for the evening. During a phone interview on 2/21/24 at 10:35 A.M. Family Member #2 said: -He/She could not remember how long he/she and the resident waited for assistance from staff on the evening of 10/11/23. -He/She had pressed the call light two times for the resident to get assistance to the bathroom. -He/She had to go to the nurse's station to request help due to the lack of response from the staff. -A CNA did eventually come to the resident's room to assist the resident to the bathroom. -The resident was assisted back into bed and had requested to speak with the nurse. -The CNA told him/her and the resident that he/she would let the nurse know. -He/She waited for the nurse and had to press the call light two times to get staff back into the room. -The CNA had told him/her that he/she did notify the nurse. -The nurse never came to check in on the resident before he/she left the facility. 2. Review of Resident #4's Face Sheet showed he/she was admitted to the facility with the following diagnoses: -Spina Bifida (a congenital of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone, often causing paralysis of the lower limbs), Unspecified. -Need for Assistance with Personal Care. Review of the resident's annual MDS dated [DATE] showed: -The resident was cognitively intact. -The resident needed assistance with toileting hygiene and lower body dressing. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan dated February 2024 showed the resident had an Activities of Daily Living (ADL) self-care deficit and limited physical mobility related to Spina Bifida with paralysis and needed physical assistance with dining, bathing, dressing, transfers, and toileting. During an interview on 2/21/24 at 12:45 P.M. the resident said: -When he/she was first at the facility, he/she was more independent. -Due to his/her condition he/she was now requiring more help with care. -There had been an issue in the past with the call lights, but it was much better now. During an interview on 2/21/24 at 9:25 A.M. the Administrator said: -The call light system had recently been fixed. -The staff used to be able to answer the call light with the telephone at the nurse's station. -The call light would turn off once the telephone was answered. -Now the system is set up to where the staff could still answer the phone at the nurse's station, but they had to go into the residents' rooms to turn off the call lights. During an interview on 2/21/24 at 10:04 A.M. the Maintenance Director said: -The call light system was changed about two months ago. -The staff now had to go into the residents' rooms to turn off the call light instead of the call light turning off when the staff picked up the phone at the nurse's station. During an interview on 2/21/24 at approximately 3:00 P.M. Licensed Practical Nurse (LPN) B said: -All staff were responsible for answering call lights. -There was a recent change to the system in which the staff now had to go into the residents' rooms to turn off the call light instead of the call light turning off by just answering the phones. -He/She had not received a call light complaint recently. During an interview on 2/23/24 at 11:18 A.M. CNA A said there had been a change to the call light system recently in which staff had to now go into the residents' rooms to turn off any call lights that were on. During an interview on 2/23/24 at 12:13 P.M. LPN C said: -He/She had not received any complaints recently related to call light response times. -Anyone can answer call lights. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/23/24 at 1:44 P.M. CNA B said: -He/She had not received any complaints recently related to call light response times. -Originally the staff could answer call lights by answering the phone at the nurse's station. -The system was updated recently, and the staff could still answer the call light by using the phone at the nurse's station, but the staff would have to go into the residents ' rooms to turn the call light off. -The new system had helped the facility and the residents seemed to be happier with call light response times. During an interview on 2/23/24 at 1:51 P.M. CNA C said: -He/She had not received any complaints recently related to call light response times. -In the past, he/she would receive multiple complaints related to call light response times. -The facility had a new system in place which had helped with the complaints. -The staff now had to go into the residents/ rooms to get the call lights to turn off as opposed to only answering the phone at the nurse's station. During an interview on 2/23/24 at 2:07 P.M. the Director of Nursing (DON) said the recent change in the call light had helped decrease the amount of complaints related to call light response times. MO00231418