STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175548	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY , KANSAS CITY, Kansas, 66112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A partial extended recertification survey with complaint investigation was conducted on 05/12/2026-05/14/2026 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers 2991620 and 2790734 were investigated. The facility census on the first day of the survey was 66. The sample included 17 residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility's noncompliance with F609 and F610 constituted Substandard Quality of Care as defined at 42 CFR 488.301.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents remained free from staff-to-resident verbal and/or mental abuse when Resident (R)9 reported during the resident council meeting attended by staff in 11/2025 that Licensed Nurse (LN) K and Certified Nurse Aide (CNA) QQ made fun of him. The abuse resulted in	F0600		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175548	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

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F0600 SS = G	Continued from page 1 feelings of shame, sadness, and anger for R9, who further felt fear of retaliation from staff for bringing up the abuse. Findings included: - The Electronic Medical Record (EMR) for R9 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), blindness in the right eye, posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (major mood disorder that causes persistent feelings of sadness), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The “Quarterly Minimum Data Set” (MDS) dated 03/16/26 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition for R9. The MDS documented R9 had an impairment to both sides of his upper extremities and used a wheelchair for mobility. The MDS documented R9 was independent with all activities of daily living (ADL). The MDS documented R9 had active diagnosis of DM, schizophrenia, anxiety, and depression. R9’s "Care Plan" documented: 02/18/21- R9 was at risk for re-traumatization related to the diagnosis of PTSD; R9 was abandoned by his father as a child and suffered physical and emotional abuse from his mother. 02/18/26- Staff to monitor R9 for side effects and adverse reactions of psychoactive medication. 05/15/25 (after the event was identified)- R9 was seen by psychologists for supportive one-to-one service as needed.	F0600		

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F0600 SS = G	Continued from page 2 Review of the "Resident Council Minutes" dated 11/19/25 documented in the "Miscellaneous" section that some residents did not like to speak about things going on in the facility, as they feared the nurses and nurse aides would treat them worse because they told on them. The minutes documented education was provided to the resident council in attendance, which explained that the residents had the right to express or file a grievance or complain about anything that they felt was not right, without the fear of being mistreated, and to let someone know if they were being mistreated. The minutes recorded by one resident, R9, stated that the night nurse, LN K, makes fun of him, but he did not like to say anything because he thought the facility staff would retaliate. Review of R9's clinical record lacked evidence the above allegation was followed up on, and lacked evidence of resolution, psychosocial monitoring, and further actions related to the abuse allegation. Upon request, the facility was unable to provide an investigation dated prior to the survey that addressed the abuse allegation. A "Facility Internal Investigation" report dated 05/13/26, documented during the annual state survey, surveyors identified from the November 2025 resident council notes that LN K made fun of R9. R9 did not like to say anything because he thought there would be retaliation. The investigation also noted that on 01/21/26, Certified Nurse Aide (CNA) QQ yelled at a couple of the residents. The facility documented they changed Administrators in 03/2026 and the Director of Nursing in 04/2026, due to ongoing issues in the facility. The investigation also documented the current administration was not aware of the issues in the resident council minutes. Once the facility became aware of the situation, the facility immediately interviewed R9, who made the allegation about LN K. Administrative Staff A and Administrative Nurse D met with R9 for approximately 20 minutes. At that time, R9 reiterated several times that he felt safe, and although a few months ago he felt like LN K was "laughing at him", he did not feel any tension between them now. R9 stated LN K gave him his medication on time and rubbed cream on his shoulder. The facility notified R9's representative of the situation and investigation. The facility also called LN K and placed her on a 72-hour leave pending investigation. The facility continued the process of interviewing	F0600		

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F0600 SS = G	Continued from page 3 residents on the west side to ensure they felt safe and free of abuse. CNA QQ was terminated from employment on 02/2026 for yelling at two residents, though the facility was uncertain which two residents. On 05/13/26 at 02:30 PM, Activities Director Z stated she did not remember the incident with R9 reporting abuse by LN K. She stated if there were any concerns at the resident council meetings, she would take each concern to the department the residents had concerns about. Activities Director Z stated each department was given a sheet of paper to address the concerns on, and that paper was returned to her. She stated she went over the responses with the residents at the following meeting. Activities Director Z stated if there was a concern of abuse or neglect, she would take that concern not only to the director of nursing, but also to the administrator. On 05/14/26 at 07:40 AM, R9 stated the facility administrative staff came to talk to him about the incident with LN K. He stated that it was the first time anyone had visited him about the incident. R9 stated LN K and another staff member named [CNA QQ] would make fun of him. He stated they would tell him he could be a “baby momma” because he had a very big abdomen. R9 stated LN K and CNA QQ would make fun of his speech, and he explained he came from a family that did not speak English. R9 stated he had to learn English on his own, and he knew he had an accent, but he tried to speak good English. R9 stated when LN K and CNA QQ made fun of him, it made him feel sad and mad. He stated that since CNA QQ no longer worked at the facility, LN K had been on good behavior. On 05/14/26 at 07:35 AM, Administrative Staff C stated the facility began an investigation of the allegation, and LN K had been suspended. Administrative Staff C stated Administrative Staff A and Administrative Nurse D spoke to R9 and other residents to ensure the residents were safe and felt safe. Administrative Nurse D stated all staff were educated. She stated the facility did not look at the past resident council minutes and should have ensured resident concerns were followed up on. She stated the facility had a plan in place and would follow up with the resident council each month. On 05/14/26 at 01:59 PM, Certified Nurse Aide (CNA)	F0600		

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F0600 SS = G	Continued from page 4 N stated she had Abuse and Neglect training on 05/13/26, during the survey. She stated she had never heard any staff member yell or make fun of a resident. CNA N stated if she heard or witnessed abuse, she would call her administrator at that moment. On 05/14/26 at 02:51 PM, LN J stated she received Abuse and Neglect training on 05/13/26, during the survey. She stated she had not heard a staff member yell or make fun of a resident. She stated she would call the director of nursing and the administrator and report the incident. On 05/14/26 at 02:51 PM, Administrative Nurse D stated she did not follow up on the resident council minutes prior to when she became the director of nursing. She stated that when the nursing department heads were put in place, the department heads picked five of what they felt were the most important care areas to work on. She stated the department heads should have read the resident council minutes and followed up. The facility's "Abuse: Prevention of and Prohibition Against" dated 04/26 documented that it was the policy of the facility that each resident had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. It was also the policy of the facility to recognize the residents' right to personal privacy and confidentiality of their physical body, personal care, and personal space or accommodations. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the residents' medical symptoms. This also includes taking, keeping, using, or distributing photographs or video recordings of residents in any manner that would demean or humiliate a resident, regardless of consent provided or the resident's cognitive status.	F0600		
F0609 SS = SQC-F	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F0609		

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F0609 SS = SQC-F	Continued from page 5 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure staff reported Resident (R)9's allegation of verbal/mental abuse to the administrator and State Agency (SA) as required, leaving R9 and all the other residents at risk for ongoing abuse. (Refer to F600 and F610) Findings included: - Review of the "Resident Council Minutes" dated 11/19/25 documented in the "Miscellaneous" section that some residents did not like to speak about things going on in the facility, as they feared the nurses and nurse aides would treat them worse because they told on them. The minutes documented education was provided to the resident council in attendance, which explained that the residents had the right to express or file a grievance or complain about anything that they felt was not right, without the fear of being mistreated, and to let someone know if they were being mistreated. The minutes recorded by one resident, R9, stated that the night nurse, Licensed Nurse (LN) K, makes fun of him, but he did not like to say anything because he thought the facility staff would retaliate. Review of R9's clinical record lacked evidence the above allegation was followed up on, and lacked	F0609		

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F0609 SS = SQC-F	Continued from page 6 evidence of resolution, psychosocial monitoring, and further actions related to the abuse allegation. Upon request, the facility was unable to provide an investigation dated prior to the survey that addressed the abuse allegation and could not provide evidence the allegations were reported to the SA. A “Facility Internal Investigation” report dated 05/13/26, documented during the annual state survey, surveyors identified from the November 2025 resident council notes that LN K made fun of R9. R9 did not like to say anything because he thought there would be retaliation. The investigation also noted that on 01/21/26, Certified Nurse Aide (CNA) QQ yelled at a couple of the residents. The facility documented they changed Administrators in 03/2026 and the Director of Nursing in 04/2026 due to ongoing issues in the facility. The investigation also documented that the current administration was not aware of the issues in the resident council minutes. Once the facility became aware of the situation, the facility immediately interviewed R9, who made the allegation about LN K. Administrative Staff A and Administrative Nurse D met with R9 for approximately 20 minutes. At that time, R9 reiterated several times that he felt safe, and although a few months ago he felt like LN K was “laughing at him”, he did not feel any tension between them now. R9 stated LN K gave him his medication on time and rubbed cream on his shoulder. The facility notified R9’s representative of the situation and investigation. The facility also called LN K and placed her on a 72-hour leave pending investigation. The facility continued the process of interviewing residents on the west side to ensure they felt safe and free of abuse. CNA QQ was terminated from employment on 02/2026 for yelling at two residents, though the facility was uncertain which two residents. On 05/13/26 at 02:30 PM, Activities Director Z stated she did not remember the incident with R9 reporting abuse by LN K. Activities Director Z stated if there was a concern of abuse or neglect, she would take that concern not only to the director of nursing, but also to the administrator. On 05/14/26 at 07:40 AM, R9 stated the facility administrative staff came to talk to him about the incident with LN K. He stated that it was the first	F0609		

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F0609 SS = SQC-F	Continued from page 7 time anyone had visited him about the incident. On 05/14/26 at 07:35 AM, Administrative Staff C stated the facility had just begun an investigation of the allegation, and LN K had been suspended. She stated the facility did not look at the past resident council minutes and should have ensured resident concerns were followed up on. On 05/14/26 at 02:51 PM, Administrative Nurse D stated she did not follow up on the resident council minutes prior to when she became the director of nursing. She stated that when the nursing department heads were put in place, the department heads picked five of what they felt were the most important care areas to work on. She stated the department heads should have read the resident council minutes and followed up. The facility's policy "Abuse: Prevention Of and Prohibition Against" dated 04/2026 documented all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. The Facility will ensure that all individuals who are involved in the reporting or investigation process are free from retaliation or reprisal.	F0609		
F0610 SS = SQC-F	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance	F0610		

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F0610 SS = SQC-F	Continued from page 8 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to investigate an allegation of verbal/mental abuse and further failed to implement protective measures after Resident (R) 9's alleged Licensed Nurse (LN) K verbally and mentally abused him, which permitted LN K to continue to have access to R9 and all residents in the facility. (Refer to F600 and F609). Findings included: - Review of the "Resident Council Minutes" dated 11/19/25 documented in the "Miscellaneous" section that some residents did not like to speak about things going on in the facility, as they feared the nurses and nurse aides would treat them worse because they told on them. The minutes documented education was provided to the resident council in attendance, which explained that the residents had the right to express or file a grievance or complain about anything that they felt was not right, without the fear of being mistreated, and to let someone know if they were being mistreated. The minutes recorded by one resident, R9, stated that the night nurse, Licensed Nurse (LN) K, makes fun of him, but he did not like to say anything because he thought the facility staff would retaliate. Review of R9's clinical record lacked evidence the above allegation was followed up on, and lacked evidence of resolution, psychosocial monitoring, and further actions related to the abuse allegation. Upon request, the facility was unable to provide an investigation dated prior to the survey that addressed the abuse allegation. A "Facility Internal Investigation" report dated 05/13/26, documented during the annual state survey, surveyors identified from the November 2025 resident council notes that LN K made fun of R9. R9 did not like to say anything because he thought there would be retaliation. The investigation also noted that on 01/21/26, Certified Nurse Aide (CNA) QQ yelled at a couple of the residents. The facility	F0610		

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F0610 SS = SQC-F	Continued from page 9 documented they changed Administrators in 03/2026 and the Director of Nursing in 04/2026, due to ongoing issues in the facility. The investigation also documented that the current administration was not aware of the issues in the resident council minutes. Once the facility became aware of the situation, the facility immediately interviewed R9, who made the allegation about LN K. Administrative Staff A and Administrative Nurse D met with R9 for approximately 20 minutes. At that time, R9 reiterated several times that he felt safe, and although a few months ago he felt like LN K was “laughing at him”, he did not feel any tension between them now. R9 stated LN K gave him his medication on time and rubbed cream on his shoulder. The facility notified R9’s representative of the situation and investigation. The facility also called LN K and placed her on a 72-hour leave pending investigation. The facility continued the process of interviewing residents on the west side to ensure they felt safe and free of abuse. CNA QQ was terminated from employment on 02/2026 for yelling at two residents, though the facility was uncertain which two residents. On 05/13/26 at 02:30 PM, Activities Director Z stated she did not remember the incident with R9 reporting abuse by LN K. Activities Director Z stated if there was a concern of abuse or neglect, she would take that concern not only to the director of nursing, but also to the administrator. On 05/14/26 at 07:40 AM, R9 stated the facility administrative staff came to talk to him about the incident with LN K. He stated that it was the first time anyone had visited him about the incident. On 05/14/26 at 07:35 AM, Administrative Staff C stated the facility had just begun an investigation of the allegation, and LN K had been suspended. She stated the facility did not look at the past resident council minutes and should have ensured resident concerns were followed up on. On 05/14/26 at 02:51 PM, Administrative Nurse D stated she did not follow up on the resident council minutes prior to when she became the director of nursing. She stated that when the nursing department heads were put in place, the department heads picked five of what they felt were the most important care areas to work on. She stated the department heads should have read the resident council minutes and followed up.	F0610		

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F0610 SS = SQC-F	Continued from page 10 The facility's policy "Abuse: Prevention of and Prohibition Against" dated 04/2026 documented after receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record. If an allegation of abuse, neglect, misappropriation of resident property, or exploitation is reported, discovered or suspected, the Facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation: Make room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator and protect the involved persons from retaliation.	F0610		
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure four of the four Certified Nurse Aide (CNA) and one Certified Medication Aide (CMA) staff reviewed had yearly performance evaluations completed. Findings included: - A review of the facility's staffing list revealed the following CNAs and CMAs were employed with the facility for more than 12 months: CNA MM, hired 06/05/24, had no yearly performance evaluation upon request. CNA NN, hired 02/05/25, had no yearly performance evaluation upon request. CNA 00, hired 06/03/21, provided a yearly performance evaluation which lacked a date and	F0730		

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THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY , KANSAS CITY, Kansas, 66112

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F0730 SS = F	Continued from page 11 signature. CMA S, hired 03/27/25, had no yearly performance evaluation upon request. On 05/14/26 at 01:23 PM, Administrative Staff B stated each of the department heads were responsible for ensuring the yearly evaluations were completed. Administrative Staff B stated she would assist with tracking the due dates for the employees' yearly evaluations. The facility was unable to provide a policy related to yearly performance evaluation as requested on 05/14/26.	F0730		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F0880		

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F0880 SS = F	Continued from page 12 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to implement adequate infection control practices when staff failed to store Resident (R)13's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) in a sanitary manner when not in use. The facility failed to ensure wet briefs were not left in R28's trash can and failed to ensure clean linen was not placed on a Personal Protective Equipment (PPE) cart. The facility failed to ensure dirty laundry bags were not placed on the residents' floor and failed to ensure a sanitary barrier was placed under a blood	F0880		

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F0880 SS = F	Continued from page 13 glucose monitor. The facility failed to ensure R86's nasal canula was stored in a sanitary manner when not in use. The facility further failed to ensure clean laundry was stored in a sanitary manner. Findings included: - On 05/12/26 at 07:45 AM, during the initial walk-through of the facility, R13's nebulizer mask laid on his windowsill, R13's nebulizer mask was not stored in a sanitary container. A wet brief laid open, wet with urine in the trash can next to R28's bed. Clean linen laid on a PPE cart directly on top of a box of opened gloves in the west hallway. Certified Nurse Aide (CNA) O placed soiled linen from the floor into a plastic bag and then placed soiled incontinent products off the floor into another plastic bag. On 05/13/26 at 07:53 AM, CNA O placed a bag of soiled linen and a bag of trash into the soiled utility room. CNA O exited the soiled utility without performing hand hygiene. CNA O entered the clean linen room, removed clean sheets from the room, and walked down the hallway without performing hand hygiene. On 05/12/26 at 08:17, Licensed Nurse (LN) I placed a blood glucose monitor on the bottom bed rail in R9's room. LN I did not have a clean barrier on the bed rail. LN I obtained R9's blood glucose reading, and laid the monitor back on the bottom bed rail. On 05/12/26 at 9:26 AM, R86's wheelchair had a portable O2 tank, and her nasal canula tubing was laying in the seat of the wheelchair. R86's nasal cannula was not stored in a sanitary container. 05/14/26 at 01:59 Certified Nurse Aide (CNA) N stated nasal cannulas were to in a dated bag when not in use. She stated wet briefs should be taken out of resident's rooms when staff leave the room. CNA N stated hand hygiene should be performed when going from clean to dirty, or dirty to clean. She stated laundry, even if its dirty should not be placed on the floor. On 05/14/26 at 02:25 PM, LNJ stated all respiratory equipment should be placed in a dated bag when not in use. She stated staff should not lay clean	F0880		

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F0880 SS = F	Continued from page 14 linens on a PPE cart. LN J stated hands should be washed anytime you leave a resident's room, when taking trash, from clean to dirty, and dirty to clean. She stated nursing should have laid a paper towel down before laying down the glucose monitor in a resident's room. She stated staff should always take wet briefs out of a resident's room. On 05/14/26 at 02:51 PM, Administrative Nurse D stated respiratory equipment should be placed in a bag with the date. She stated hands should be washed or use sanitizer between clean and dirty, and clean linens should not be left on a PPE cart. Administrative Nurse D stated dirty linens should not be placed on the floor. She stated nursing should sanitize the glucose monitor and use a sanitary barrier in residents' rooms. "The facility's "Infection Prevention and Control Program" dated 04/26 documented the infection prevention and control program was a facility -wide effort involving all disciplines and individuals, and was an internal part of the quality assurance performance improvement program the elements of infection prevention and control program consist of coordination, oversight, surveillance and data analysis. The facility's "Hand Hygiene" dated 02/26 documented it was the policy of the facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which was one of the most effective measures to prevent the spread of infection, based on accepted standards. The facility's "Oxygen Equipment" policy dated 01/26 documented it was the policy of the facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use humidifiers, tubing, masks, and cannulas for residents receiving oxygen. The equipment was to be discarded after use by a resident. The facility would maintain clean tanks, connectors and concentrators.	F0880		
F0941 SS = F	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is NOT MET as evidenced by:	F0941		

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F0941 SS = F	Continued from page 15 Based on record review and interviews, the facility failed to ensure agency staff received the required communication training. Findings included: - On 05/14/26 at 10:40 AM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) P, CNA Q, and Licensed Nurse (LN) K revealed the following: The facility was unable to provide documentation that CNA P had completed the communication training. The facility was unable to provide documentation that CNA Q had completed the communication training. The facility was unable to provide documentation that LN K had completed the communication training. On 05/14/26 at 01:23 PM, Administrative Staff B stated she was responsible for scheduling the agency staff. Administrative Staff B stated the facility expected the agency had provided the required training and in-services to their agency staff prior to scheduling the staff at the facility. The facility was unable to provide a policy related to staff required in-services as requested on 05/14/26.	F0941		
F0942 SS = F	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. Findings included: - On 05/14/26 at 10:40 AM, a review of the training	F0942		

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F0942 SS = F	Continued from page 16 provided by the facility for agency Certified Nurse Aide (CNA) P, CNA Q, and Licensed Nurse (LN) K revealed the following: The facility was unable to provide documentation that CNA P had completed the resident rights training. The facility was unable to provide documentation that CNA Q had completed the resident rights training. The facility was unable to provide documentation that LN K had completed the resident rights training. On 05/14/26 at 01:23 PM, Administrative Staff B stated she was responsible for scheduling the agency staff. Administrative Staff B stated the facility expected the agency had provided the required training and in-services to their agency staff prior to scheduling the staff at the facility. The facility was unable to provide a policy related to staff required in-services as requested on 05/14/26.	F0942		
F0949 SS = F	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required behavioral health training. Findings included: - On 05/14/26 at 10:40 AM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) P revealed the following: The facility was unable to provide documentation that CNA P had completed the behavioral health training. On 05/14/26 at 01:23 PM, Administrative Staff B stated she was responsible for scheduling the agency staff. Administrative Staff B stated the facility expected the agency had provided the required	F0949		

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F0949 SS = F	Continued from page 17 training and in-services to their agency staff prior to scheduling the staff at the facility. The facility was unable to provide a policy related to staff required in-services as requested on 05/14/26.	F0949		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F0584		

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F0584 SS = E	Continued from page 18 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the facility provided a safe and clean homelike environment for the residents when staff failed to ensure the walkway/sidewalk into the building did not have missing tiles/blocks on the walkway. The facility failed to ensure the east resident dining area was free from ants. The facility failed to ensure the ceiling light in Resident (R) 19's room was working properly. Findings included: - On 05/12/26 at 07:29 AM, observation revealed several red tiles/bricks with raised dots were missing from the walkway into the building entrance. On 05/12/26 at 09:47 AM, observation revealed ants crawling across the table in the east dining room. Dietary Staff BB stated she had reported there had been ants noted on the table. On 05/12/26 at 10:44 AM, R19 stated the light above his bed had not worked since he was admitted to the facility on 03/20/26. On 05/13/26 at 01:30 PM, Maintenance U stated the facility had a TELS system (a building management platform designed for senior living with integrated asset management, life safety, and maintenance solutions) to report items that needed replaced or fixed. Maintenance U stated there was also a dry-erase board in the maintenance office to write things on as well. Maintenance U stated that pest control came out the previous day after the ants were reported and there was a work order placed for the repair of the bricks to the walkway. Maintenance U stated that they had not been informed of the light not working above R19's bed but said staff would get it repaired. The facilities "Safe and Homelike Environment" undated policy documented it was the policy of this facility to ensure that resident's that reside here were provided the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. The facility would provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; adequate	F0584		

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F0584 SS = E	Continued from page 19 and comfortable lighting levels in all areas (adequate lighting means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform).	F0584		
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents received the necessary activities of daily care (ADL) care needed when staff failed to provide consistent bathing to dependent Residents (R) 47, R6, and R77. Finding included: - 1. R47's Electronic Medical Record (EMR) documented diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), central cord syndrome (the spinal cord's ability to transmit some messages to or from the brain is damaged or reduced below the site of injury to the spinal cord). R47's "Admission Minimum Data Set" (MDS) dated 03/23/26 documented at Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R47 had functional limitation in range of motion on both sides of his upper and lower extremities. R47 used a wheelchair to assist in mobility. R47 was dependent on staff for shower/bathing. R47's "Functional Abilities Care Area Assessment" (CAA) dated 03/25/26 documented he was at risk for more contractures (abnormal permanent fixation of a joint or muscle), pain, impaired seated balance, impaired skin integrity, malnutrition, and fluid deficit. R47 had difficulty grasping objects with his hands. R47 is currently receiving physical and occupational therapy to address his risks. R47's Care Plan, dated revised on 04/06/26, directed staff he required assistance with bathing to allow R47 time to answer questions and to verbalize his feelings, perceptions, and fears; staff was to	F0677		

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F0677 SS = E	Continued from page 20 encourage him to make choices in his daily care routine. The Care Plan lacked staff direction on R47's preferred bathing day/time. R47's March 2026 "Documentation Survey Report" in the EMR documented his scheduled bathing time was on Wednesday and Saturday evenings. The report documented one shower given on 03/23/26. R47 refused a shower/bath on 03/19/26, 03/22/26, and 03/25/26. The report documented not applicable "NA" on 03/18/26, 03/19/26, 03/20/26, 03/21/26 and 03/28/26. R47's April 2026 "Documentation Survey Report" in the EMR documented his scheduled bathing time was on Wednesday and Saturday evenings. The report documented "NA" on five of nine bathing opportunities. R47 refused bathing on three of nine bathing opportunities. The report documented no shower or bath given to R47 in the month of April. R47's May 2026 "Documentation Survey Report" in the EMR documented his scheduled bathing time was on Wednesday and Saturday evenings. The report documented a shower given on 05/06/26. The report documented "NA" on three of four bathing opportunities reviewed. On 05/12/26 at 08:45 AM, R47 laid in his bed, resting his hair and beard had a dirty appearance. On 05/13/26 at 09:38 AM, Certified Nurse Aide (CNA) PP gathered bathing towels and clean linen for R47. CNAPP stated she was going to give him a bath since he agreed to it this morning. CNA PP stated R47 refused to bathe at times. - 2. R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (a spontaneous, emergency bleeding within the brain) affecting the left non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of left forearm, and left hand, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).	F0677		

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F0677 SS = E	Continued from page 21 The "Quarterly Minimum Data Set" (MDS) dated 04/02/26 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R6 had an impairment on one side of his upper and lower body. The MDS documented R6 needed set up or clean up assistance with eating and was dependent on staff for toileting and oral hygiene. R6's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 10/01/26 documented for R6 was dependent on staff for all self-care and mobility tasks except eating. R6's “Care Plan” documented: 12/17/18-Sometimes R6 refuses baths or showers. Encourage R6 to allow bathing. 01/04/24-Provide R6 with clear, concise instructions. Repeat as needed. Ask R6 to voice understanding. Limit R6's choices but provide chances for R6 to choose in my daily care routine. R6 EMR under “Task” documented R6's preferred days for bathing were Wednesday and Saturday evenings. R6's “Bathing” documented R6 was given a shower on 04/22/25 and a shower on 05/09/25. R6's EMR under “Documents” revealed the last scanned bath sheet was 12/10/25, documenting a shower was given. On 05/12/25 at 10:25 AM, R6 sat in his room in his Broda chair (specialized wheelchair with the ability to tilt and recline). R6 had grey whiskers on his face, and his hair was matted down. R6 had brown substances under his fingernails. - 3. R77's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure (the lungs cannot adequately supply oxygen to the blood (hypoxemia) or remove carbon dioxide, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), sleep apnea (a disorder of sleep characterized by periods without respirations), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and pneumonia (an infection in the lungs). The “Quarterly Minimum Data Set" (MDS) dated	F0677		

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F0677 SS = E	Continued from page 22 03/20/26 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R77 had an impairment of the extremities on one side of her upper body and both sides of her lower extremities. The MDS documented R77 was dependent on staff for oral hygiene and needed substantial/maximal assistance with bathing and toileting. R77's "Urinary Incontinence/Indwelling Catheter" dated 12/18/25 documented R77's frequent incontinence was noted in the lookback period. The CAA documented R77's risk factors, which included CHF, increased pain, and need for assistance with personal care. The CAA documented staff were to monitor and report concerns to physicians. R77's "Care Plan" documented: 12/15/25-R77 was incontinent, staff were to wash, rinse, and dry perineum, and change clothing after incontinent episodes. Staff were to encourage R77 to make choices in her daily routine. 01/29/26-R77 was dependent on staff for bathing and shower transfers. R77's EMR under "Task" under "Bathing" documented R77 preferred days for showers were Monday and Wednesday in the morning. R77's "Bathing" for the months of April and May of 2026 revealed R77 received three full sponge baths on 04/02, 04/06, 04/13, and three sponge baths on 04/20, 04/23, and 04/30, and R77 received one shower on 05/09, and one sponge bath on 05/11. R77's "Documents" revealed one bath sheet on 02/21/26. On 05/12/26 at 08:22 AM, R77 laid on her bed on her back. R77 had her nasal cannula oxygen in place. R77's fingernails had been polished. R77 had a brown substance under her fingernails. On 05/12/25 at 08:22 AM, R77 stated she did not have a scheduled shower day. She stated she had not had a shower since she had come to the facility. R77 stated she would like a shower. She stated staff stated they were always short of help, and that staff had a lot of residents that needed more care. R77 stated the staff would just come in when they had a minute to wash her. She stated the staff would use a washcloth and an emesis basin or just wipes for her bed bath.	F0677		

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F0677 SS = E	Continued from page 23 On 05/14/26 at 09:22 AM, Certified Nurse's Aide (CNA) M stated he was not sure of the R77's bathing schedule. He stated when he answered her call light, she asked if she could have a shower today. CNA M stated he was an agency and did not work at the facility. He stated if a resident wanted a shower, he would give the resident a shower. On 05/14/26 at 01:59 PM, Certified Nurses Aide (CNA)N stated she was unsure if bathing had been done on the evening shift. She stated she had talked to management and voiced her concerns about a bath aide to help with bathing for the residents. CNA N stated a bath sheet was done on each resident on the days the resident was to have a shower, and signed by the nurse if the resident refused. On 05/14/26 at 08:15 AM, Licensed Nurse (LN) I stated that residents had scheduled bath days/times per their preference. LN I stated that R47 did have scheduled bathing days and preferred them in the evening, but would frequently refuse. On 05/14/26 at 02:51 PM, Administrative Nurse D stated what was supposed to happen was the CNA was to give the shower, fill out a shower sheet, then sign the shower sheet after the shower was given. She stated if the resident refused the shower, the nurse was to talk to the resident later to see if another time worked better for the resident. Administrative Nurse D stated she would expect the nurse to chart in the residents chart if a shower was refused or offered. Administrative Nurse D stated the facility was aware there were problems with bathing. She stated staff have been educated about the importance of bathing. Administrative Nurse D stated that "NA" should not be used when documenting a shower or bath. The Facility's "Activities of Daily Living (ADL), Services to carry out" policy dated March 2026 documented it was the policy of this facility that residents were given the appropriate treatment and services to maintain or improve his/her abilities. Residents who were unable to carry out ADLs would receive necessary services to maintain: good nutrition; grooming; personal hygiene; and oral hygiene.	F0677		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F0759		

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F0759 SS = E	Continued from page 24 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure the medication error rate did not exceed five percent (%) when staff administered seven of Resident (R) 1's 14 medications outside of the 60 minutes before or 60 minutes after window. This resulted in a medication error rate of 21.88%. Findings included: - On 05/13/26 at 09:35 AM, Certified Medication Aide (CMA) R had R1's "Medication Administration Record" (MAR) pulled up on his laptop on the medication cart. A couple of R1's medications had a pink background to indicate that the medication was late. CMA R began popping R1's medications out of their bubble pack card into a medication cup. CMA R entered R1's room to administer the medications to R1. CMA R hand R1 the medication cup and R1 took her medications without difficulty. On 05/14/26 at 08:31 AM, an "Administration History Report" was requested for R1's medication administrations from 05/13/26. The report revealed that seven morning medications were administered outside of the time window of one hour before and one hour after the scheduled time. 1. Ascorbic Acid (vitamin c) 500 milligram (mg) chewable tablet, give one tablet by mouth once a day for Vitamin C. The scheduled administration time was 08:00 AM, the medication was administered late at 09:48 AM. 2. Buspirone HCl (a medication used to treat anxiety) 10 mg tablet by mouth every 12 hours. This medication was scheduled to be given at 08:00 AM, and the medication was administered late at 10:11 AM. 3. Hydralazine HCl (a medication used to treat high blood pressure) oral tablet 25 mg to be given between 07:00 AM and 09:00 AM. The medication was given late at 10:11 AM. 4. Pantoprazole sodium (a medication used to reduce acid in the stomach), delayed release of 40 mg tablet	F0759		

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F0759 SS = E	Continued from page 25 by mouth in the morning before breakfast. The medications scheduled time was 07:00 AM to 09:00 am, the medication was given late at 10:11 AM. 5. Baclofen (a medication used to relax muscles of the body) 15 mg tablet by mouth three times a day. The medication was scheduled to be given between 07:00 AM and 09:00 AM and was given late at 10:11 AM. 6. Systane ophthalmic solution 0.6% (eye drops used to prevent tear evaporation), one drop in both eyes three times a day. The eye drops were scheduled for 07:00 AM to 09:00 AM, the eye drops were given late at 10:11 AM. 7. Ipratropium bromide nasal solution 0.03% (a nasal spray used for relief of a runny nose due to allergies), two sprays in each nostril two times a day. This medication was scheduled to be administered from 07:00 AM to 09:00 AM but was not administered until 10:11 AM. On 05/13/26 at 09:35 AM, Certified Medications Aide (CMA) R stated he was running behind that day and trying to get the residents' medications given correctly and efficiently. CMA R stated that a couple of R1's medications.	F0759		
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to keep the facility free from pests and maintain an effective pest control program when ants were seen in the east dining room. Findings included: - On 05/12/26 at 09:47 AM, an observation noted ants crawling across the table in the east dining room. On 05/12/26 at 09:47 AM, Dietary Staff BB stated she had reported to maintenance that there had been ants noted on the table in the east dining room.	F0925		

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F0925 SS = E	Continued from page 26 On 05/13/26 at 09:15 AM, Administrative Staff C stated pest control came to the facility monthly and as needed when pests were noted in between the visits. Administrative Staff C stated an order was put in the TELS (a building management platform designed for senior living with integrated asset management, life safety, and maintenance solutions). On 05/13/26 at 01:30 PM, Maintenance U stated that he had been notified by a resident in the dining room and by staff of the ants yesterday. Maintenance U stated pest control came to the facility monthly and as needed. The pest control was called and would be coming tomorrow to spray for the ants in the dining room and to look for any other pests in the areas. Maintenance U stated it was spring, and the ants were looking for food, and it was possible for them to get inside the building. The facility's "Pest Control" policy dated March 2026 documented it was the policy of this facility to provide an environment free of pests. The facility would have a pest contract that provided frequent treatment of the environment for pests. It would allow for additional visits when a problem was detected. Monitoring of the environment would be done by the facility's staff.	F0925		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R)6 and R43's call light was within his reach to enable him to call for staff assistance. Findings included: - R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a nontraumatic	F0558		

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F0558 SS = D	Continued from page 27 intracerebral hemorrhage (a spontaneous, emergency bleeding within the brain) affecting the left non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of left forearm, and left hand, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Quarterly Minimum Data Set" (MDS) dated 04/02/26 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R6 had an impairment on one side of his upper and lower body. The MDS documented R6 needed set up or clean up assistance with eating and was dependent on staff for toileting and oral hygiene. R6's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 10/01/26 documented R6 was dependent on staff for all self-care and mobility tasks except eating. R6's "Care Plan" documented the following: 09/28/22-R6 was provided with a soft touch call light for ease of use. 01/18/23-R6 was to have brightly colored tape to his soft touch call light to remind R6 to use his call light to get out of bed. On 05/12/26 at 01:26 PM, R6 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) chair, positioned on the side of his bed. R6 was yelling out "Help". R6's soft touch call light was laid in the middle of his bed. R6 was grabbing for the blankets on the bed, though he was unable to pull the blankets close enough to him to reach his call light. On 05/13/26 at 02:10 PM, R6 sat in his Broda chair, next to his bed. R6's soft touch call light was placed behind R6 on his bedside table. R6 was unable to reach his call light. 2. R43's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of aphasia (condition with disordered or absent language function), gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the	F0558		

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F0558 SS = D	Continued from page 28 stomach), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The “Admission Minimum Data Set (MDS)” dated 01/27/26 documented severely impaired cognition. The MDS documented R43 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on upper and lower extremities on one side of her body. The MDS documented R43 was dependent on staff assistance for all of activities of daily living. R43's "Cognitive Loss/Dementia Care Area Assessment (CAA)”, dated 02/03/26, documented she had impaired memory. R43's “Care Plan” documented the following interventions: 01/22/26-Be sure the call light is within reach and encourage R43 to use it to call for assistance as needed. On 05/13/26 at 2:37 PM, R43 laid on the bed with the head of her bed only elevated slightly. R43’s gastrostomy feeding (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) was patent. R43’s call light was attached to her bed and the call light cord and button hung behind her bed. R43’s bilateral heels rested directly on the mattress. On 05/14/26 at 01:59 PM, Certified Nurse Aide (CNA) N stated the call light should always be within the residents reach. On 05/12/26 at 01:30 PM, Licensed Nurse (LN) G stated R6 and R43’s call light should be within their reach. LN G stated R6 was unable to reach his call light. On 05/14/26 at 02:51 PM, Administrative Nurse D stated call lights should always be within the reach of the resident. The facility’s “Accommodation of Needs” policy dated 08/25 documented it was the policy of the facility to assure that a resident had the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other resident would be endangered.	F0558		

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F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628		

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F0628 SS = D	Continued from page 30 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the	F0628		

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F0628 SS = D	Continued from page 31 mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F0628		

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F0628 SS = D	Continued from page 32 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure a discharge summary was completed and a recapitulation of Resident (R) 83's stay at the facility. The facility also failed to notify the state ombudsman of his discharge from the facility. Findings included: - R83's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of chronic pain and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R83's EMR revealed a "Nursing Note: dated	F0628		

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F0628 SS = D	Continued from page 33 04/10/26 at 03:06 PM, that documented R83 was to be discharged home with his medications and all his personal belongings. Discharge instructions were reviewed with R83 and voiced no concerns. The Facility provided the Ombudsman notification for the past three months. Review of the items provided by the facility revealed the facility had sent copies of the bed-hold and hospital transfers to the state ombudsman's office. On 05/13/26 at 09:25 AM, Administrative Staff C stated she was unable to locate a discharge summary to have R83's recapitulation of his stay. On 05/14/26 at 11:10 AM, Social Services X stated she had only sent the list of residents who had transferred to the hospital. On 05/14/26 at 02:51 PM, Administrative Nurse D stated social services would start the discharge process and open the discharge summary form in the resident's EMR. Administrative Nurse D stated the charge nurse on duty would complete the discharge summary at the time of the discharge. The facility's "Admission, Transfer, and Discharge" policy dated 03/03/26 documented it was the policy of the Facility that each resident would remain in the Facility and not be transferred or discharged unless the discharge or transfer was appropriate as per the existing criteria. When the Facility transferred or discharged a resident, the Facility would ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider.	F0628		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by:	F0679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175548	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY , KANSAS CITY, Kansas, 66112

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F0679 SS = D	Continued from page 34 Based on observation, record review, and interview, the facility failed to implement and activities program to support Resident (R)6's social needs with involvement in both individual and group activities in order to support his highest psychosocial wellbeing when staff failed to offer and provide one on one activity or diversions from his red bag of activities in his room. Findings included: - R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (a spontaneous, emergency bleeding within the brain) affecting the left non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of left forearm, and left hand, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Quarterly Minimum Data Set" (MDS) dated 04/02/26 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R6 had an impairment on one side of his upper and lower body. The MDS documented R6 needed set up or clean up assistance with eating and was dependent on staff for toileting and oral hygiene. R6's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 10/01/26 documented for R6 was dependent on staff for all self-care and mobility tasks except eating. R6's "Care Plan" documented: 12/17/18-R6 was dependent on staff assistance with activity participation due to cognitive impairment and left side hemiplegia. Staff to invite R6 to schedule activities. 09/03/19-R6's preferred activities were happy hour, ice cream socials, baking buddies, bingo, and going outside.	F0679		

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F0679 SS = D	Continued from page 35 10/01/25-R6 needed one to one bedside visits and activities in his room if he was unable to attend out of the room events. 02/25/26-R6 was to be given as many choices as possible about care and activities. R6 had a red activity bag in his room hanging on his wall. The sign above the red activities bag stated give R6 something from his activities bag if he needs redirection. R6's EMR under "Progress Notes" under "Activities Notes" dated 09/25/25 documented R6 attended a group activity. On 05/12/26 at 08:55 AM, R6 sat in the dining room at a table by himself and ate his breakfast. R6 was pushed to his room, and his Broda chair was backed next to his bed. R6 was not provided one to one time and was not offered anything from his red activities bag. On 05/12/26 at 11:10 AM, R6 was pushed back to the dining room and sat in the corner eating his lunch. R6 was pushed back to his room at 01:15 PM. R6 was backed into his room next to his bed. R6 was not provided one to one and was not offered anything from his red activities bag. On 05/13/26 at 09:55 AM, R6 sat in the dining room at a table by himself and ate his breakfast. R6 was pushed to his room, and his Broda chair was backed next to his bed. R6 was not provided one to one and was not offered anything from his red activities bag. On 05/13/26 at 11:44 AM, R6 was pushed back to the dining room and sat in the corner eating his lunch. R6 was pushed back to his room when he finished his lunch. R6 was backed into his room next to his bed. R6 was not provided one to one and was not offered anything from his red activities bag. On 05/14/26 at 08:15 AM, R6 sat in the dining room at a table by himself and ate his breakfast. R6 was pushed to his room, and his Broda chair was backed next to his bed. R6 was not provided one to one time and was not offered anything from his red activities bag. On 05/14/26 at 01:15 PM, Activities Director Z stated she ensures all residents have an activities calendar in their rooms. She stated R6 was very disruptive in activities, and if he does come to activities, a staff member would have to come with him. She stated	F0679		

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F0679 SS = D	Continued from page 36 he had not been to many activities. Activities Director Z stated she had placed a red bag in R6's room. She stated staff could give him anything in the bag to occupy him. She stated she had not had a lot of time to do one-to-one activities with residents, because it was just her. Activities Director Z stated the facility was looking to get her an assistant. On 05/14/26 at 01:59 PM, Certified Nurses Aide (CNA) N stated R6 did not come out of his room for many activities. She stated he had behaviors when he was at activities. She was unsure who would do one to one activities with the residents, she thought that would be activities. CNA N stated she knew R6 had a red bag of things he could be given to keep him busy. She stated she knew her co-worker had given him something from the bag once. On 05/14/26 at 02:25 PM, Licensed Nurse (LN) J stated any staff can take a resident to activities. She stated the residents' preference for activities should be on the care plan. LNJ stated if a resident had an activity bag in their room, staff should make sure the resident had something from the bag. On 05/14/26 at 02:51 PM, Administrative Nurse D stated staff should be interacting with all residents. She stated she knew R6 had behaviors while he was at activities. She stated R6 should still be offered activities and interactions. Administrative Nurse D stated staff should be giving R6 something from his red bag for distractions if he was not going out to activities. The facility's "Care of Dementia" dated 03/25 documented It was the policy of the facility that all residents would have an individualized plan of care and have the least restrictive approaches to care. Staff were offered specialized training in the care of the dementia population, appropriate approaches to care, and managing behaviors.	F0679		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F0686		

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F0686 SS = D	Continued from page 37 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to provide adequate care and services to promote the healing of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 4, and R43 when staff failed to provide their heel boots. Findings included: - R4's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), pressure ulcer and Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) to right and left heels. The "Modification of Quarterly Minimum Data Set" (MDS) for R2, dated 04/06/26, recorded a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R4 had an impairment on both sides of her upper and lower extremities of her body. The MDS documented R4 was dependent on staff for all activities of daily living (ADLs). The MDS documented R4 received intravenous (into a vein) (IV) medications during the observation period. The MDS documented R4 was at risk for developing a pressure ulcer/injury. The MDS documented R4 had one unhealed pressure ulcer/injury. R4's MDS documented R4 had two Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters), and two	F0686		

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F0686 SS = D	Continued from page 38 unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus). R4's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 10/05/25 documented a pressure ulcer Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) was noted to the sacrum, and left foot had unstageable wounds. The CAA documented R4 had multiple areas of moisture-associated skin damage (MASD-inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous), related to contracture (abnormal permanent fixation of a joint or muscle), the need for assistance with personal care, and urinary incontinence. R4's "Care Plan" documented the following: 09/30/25- R4 was at risk for impaired skin integrity related to limited mobility, contractures, and incontinence 10/03/25- R4 should always have pressure relieving ankle foot orthosis (Prafo) boots on both feet at times. 05/12/26- Staff to provide treatment to R4's site of resolved pressure injury on left heel as ordered for prevention. R4's EMR under the "Orders" tab revealed the following physician orders: Low air loss mattress for skin maintenance every shift for skin integrity, ensure low air loss mattress was functioning and set per manufacturer settings dated 04/29/26. Wound treatment: cleanse right heel with wound cleaner, pat dry, apply a small amount of Santlyl (ointment used to actively break down and remove dead tissue from severe burns and chronic skin ulcers) directly to the wound bed, cut and apply HBlue (antimicrobial foam dressing), then wrap with Kerlix (stretchy gauze bandage) every day and as needed dated 04/28/26. Wound treatment: apply Skin-prep (liquid skin protectant) to left heel, then cover with Foam Secure (an absorbent, breathable medical bandage), change every day and as needed if wound dressing was not intact for protection every shift. Report redness, increased drainage, odor, warmth, signs of infection,	F0686		

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F0686 SS = D	Continued from page 39 decline or lack of improvement in wound to physician dated 04/28/26. On 05/12/26 at 08:44 AM, R4 laid on her bed, on her back. R4 had her eyes closed. R4's tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube) was running. R4 had a boot on her right heel, R4's left heel laid directly on the mattress. R4 did not have her boot on her left heel as care plan was documented. On 05/14/26 at 01:59 PM, Certified Nurses Aide (CNA) N stated the CNA's put the residents' boots on and ensure the if a resident needed their heels floated, they would also do that. She stated she would know if a resident needed. CNA N stated she had a place on shift documentation to mark if she floated a resident's heels or applied a boot to the residents' heels. CNA N stated when she worked in the R4's hall she made sure her boots were on her heels. On 05/14/26 at 02:25 PM, Licensed Nurse (LN) J stated R4 should always have both of her boots on her heels. She stated the CNAs apply the residents' boots; it was also the nurse working that halls responsibility to ensure residents have what was ordered. LN J stated she was not sure if R4 should have boots, she would check R4's care plan and physicians orders. On 05/14/26 at 02:51 PM, Administrative Nurse D stated if a resident's care plan stated the resident should have boots, the CNA and the LN should ensure the resident should have her boots on. The facility's "Skin and Wound Monitoring and Management" policy dated 03/26 documented a resident who entered the facility without pressure injury does not develop a pressure injury unless individuals' clinal condition or other factors demonstrate that a developed pressure injury was unavoidable; and a resident having pressure injury receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. - 2. R43's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of aphasia (condition with disordered or absent language function), gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to	F0686		

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F0686 SS = D	Continued from page 40 lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The “Admission Minimum Data Set (MDS)” dated 01/27/26 documented severely impaired cognition. The MDS documented R43 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on upper and lower extremities on one side of her body. The MDS documented R43 was dependent on staff assistance for all of activities of daily living (adls). The MDS documented R43 was at risk for development of pressure ulcer injury. The MDS documented R43 had an unhealed pressure injury. The MDS documented a pressure reducing device was placed on her bed and in her chair. R43's "Pressure Ulcer Care Area Assessment (CAA)”, dated 02/03/26, documented she was at risk of current wound becoming chronic and the development of new pressure related injuries. R43 was dependent on staff assistance for her ADLs. R43's “Care Plan” documented the following interventions: 01/22/26- requires pressure relieving/reducing device on the bed and wheelchair. Has a low air loss mattress. 01/23/26- Pressure reducing devices. 04/22/26- Prafo boots (special pressure-reducing heel protectors) as ordered. R43‘s EMR under the “Orders” tab revealed the following physician orders: Prafo boots on at all times, bilateral lower extremities dated 04/10/26. On 05/13/26 at 2:37 PM, R43 laid on the bed with the head of her bed only elevated slightly. R43’s gastrostomy feeding (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) was patent. R43’s call light was attached to her bed and the call light cord and button hung behind her bed. R43’s bilateral heels rested directly on the mattress. On 05/14/26 at 09:23 AM, R43 laid on the bed with	F0686		

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F0686 SS = D	Continued from page 41 her bilateral heels resting directly on the mattress. - 3. R53's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of repeated falls, disorientation, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), need for assistance with personal care, and multifocal motor neuropathy (a rare condition that causes muscle weakness due to nerve damage). R53's "Quarterly MDS" dated 03/30/26 documented he had a Brief Interview for Mental Status (BIMS)score of eight that indicated moderately impaired cognition. The MDS documented R53 was at risk for pressure ulcer development. R53 had a pressure-reducing device for his chair and bed. R53 was on a turning/repositioning program. R53's "Pressure Ulcer Care Area Assessment (CAA)", dated 02/23/26 documented he had no active pressure ulcers/injuries. His risk factors include a history of diabetes, incontinence, increased pain, and the need for assistance with cares. The staff was to monitor and report any concerns to the physician. R53's "Care Plan" documented the following: 07/20/25 – R53 was to have pressure reducing devices. R53 required a pressure relieving/reducing device on bed and wheelchair Turn and reposition as tolerated. R53's EMR under the "Assessment" tab revealed a "Braden Scale" dated 01/19/26, documenting R53 was at moderate risk for development of pressure related injuries. On 05/12/26 at 02:15 PM, R53 laid awake on his bed in the lowest position. R 53's wheelchair sat next to the bed with a Dycem (non-slip mat used for stabilization and gripping to prevent slipping) on the seat of his wheelchair, the wheelchair lacked a cushion and anti-tip device on the back of his wheelchair. R53 stated his buttocks would hurt after sitting in the wheelchair. On 05/13/2026 at 07:49 AM, R53 propelled his wheelchair down the hallway from the dining room to his room. The wheelchair lacked a cushion on the wheelchair seat and lacked anti-tip devices on the back of his wheelchair. R53 stated his bottom still	F0686		

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F0686 SS = D	Continued from page 42 hurt after sitting in the wheelchair.	F0686		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide care and services to prevent further decline in range of motion when staff failed to place Resident (R)6's hand splint on his left hand for contracture (abnormal permanent fixation of a joint or muscle) prevention. Findings Included: - R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (a spontaneous, emergency bleeding within the brain) affecting the left non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of left forearm, and left hand, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait,	F0688		

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F0688 SS = D	Continued from page 43 muscle rigidity, and weakness). The "Quarterly Minimum Data Set" (MDS) dated 04/02/26 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R6 had an impairment on one side of his upper and lower body. The MDS documented R6 needed set up or clean up assistance with eating and was dependent on staff for toileting and oral hygiene. R6's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 10/01/26 documented for R6 was dependent on staff for all self-care and mobility tasks except eating. R6's “Care Plan” documented the following: 01/04/24- Staff to limit R6’s choices and provide chances for R6 to choose in his daily care routine. 01/08/25-Staff may offer a resting hand splint as tolerated for contracture prevention to left hand. R6’s EMR under “Orders” revealed the following physicians’ orders: May offer resting hand splint as tolerated for contracture prevention to left hand every shift, dated 07/09/24. R6’s EMR under “Treatment Administration Record” (TAR) from 05/01/26-05/14/26 documented “N” for No form 05/01/26-05/14/26 for staff may offer a resting hand splint as tolerated for contracture prevention. R6’s EMR lacks documentation R6’s refusals for R6’s resting hand splint. On 05/12/26 at 01:26 PM, R6 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline), positioned on the side of his bed. R6 was reaching for his call light. R6 did not have a splint on his left hand. R6’s fingers on his left hand were curled down onto the palm of his hand. On 05/13/26 at 02:10 PM, R6 sat in his Broda chair, next to his bed. R6 fingers on his left hand were curled down onto the palm of his hand. R6’s room had a sign hanging which stated, “Please help me put on my left hand brace every morning.” “Please remove before bed”. On 05/14/25 at 01:59 PM, Certified Nurses Aide	F0688		

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THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY , KANSAS CITY, Kansas, 66112

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F0688 SS = D	Continued from page 44 (CNA) N stated R6 had a sign hanging in his room to apply his brace. She stated she did not know who would put the brace on. She started nursing or therapy. CNA N stated she had never applied R6's brace to his left hand. On 05/14/25 at 02:25 PM, Licensed Nurse (LN) J stated it was the CNA's duty to apply R6's splint. She stated the LN working that hall should check to ensure R6 had his brace on. 05/14/25 at 02:51 PM Administrative Nurse D stated if a resident should have a brace placed daily, that should be on the residents care plan. She stated it would be the CNA's responsibility to apply the splint. She stated the nurse should double check to ensure the brace was on the resident. The facility's "Quality of Care" policy dated 03/26 documented it was the policy of the facility that residents were given the appropriate treatment and services to maintain or improve his or her abilities.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review the facility failed to secure pressurized supplemental oxygen tanks in a safe, locked area, and out of reach of the cognitively impaired, independently mobile residents. The facility additionally failed to ensure fall interventions were in place for Resident (R) 53 and R16, which placed the residents at risk for preventable accidents and injuries. Findings included: - On 05/12/26 at 08:01 AM, during the initial walkthrough of the facility, an unsecured oxygen storage room revealed on the west hallway. The	F0689		

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F0689 SS = D	Continued from page 45 room contained 34 pressurized supplemental oxygen cylinder tanks stored in floor racks. The room had a key lock on the entry door. On 05/12/26 at 08;17 AM, an oxygen cylinder sat in the corner directly on the floor of R77's room. The oxygen cylinder cart was in R77's room. The oxygen cylinder was not placed in a cart. 1. R53's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of repeated falls, disorientation, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), need for assistance with personal care, and multifocal motor neuropathy (rare condition that causes muscle weakness due to nerve damage). R53's "Quarterly MDS" dated 03/30/26 documented he had a Brief Interview for Mental Status (BIMS)score of eight that indicated moderately impaired cognition. The MDS documented R53 required supervision to touch assistance when moving from a sitting position to standing, and when he transferred from chair-to-chair transfers. The MDS documented that he was independent during a transfer on and off the toilet. R53's "Falls Care Area Assessment (CAA)", dated 02/23/26, documented he had two non-injury falls noted in the lookback period. His risk factors included a history of diabetes, a decline in cognition, incontinence, and the need for assistance with cares. The staff was to monitor and report concerns to the physician. R53's "Care Plan" documented the following: 04/29/26- Staff would orient R53 to the location of the call light after each round. R53 was sent to the ER for further evaluation after his fall. 05/7/26- Staff would apply anti-tippers to R53's wheelchair. On 05/12/26 at 02:15 PM, R53 laid awake on his bed in the lowest position. R 53's wheelchair sat next to the bed with a Dycem (non-slip mat used for stabilization and gripping to prevent slipping) was on the seat of his wheelchair, the wheelchair lacked a cushion and anti-tip device on the back of his wheelchair. R53 stated his buttocks would hurt after sitting in the wheelchair.	F0689		

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F0689 SS = D	Continued from page 46 On 05/13/2026 at 07:49 AM, R53 propelled his wheelchair down the hallway from the dining room to his room, The wheelchair lacked a cushion on the wheelchair seat and lacked anti-tip devices on the back of his wheelchair. R53 stated his bottom still hurt after sitting in the wheelchair. - 2. R16's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), contracture (abnormal permanent fixation of a joint or muscle) of muscle, muscle weakness, and lupus (an autoimmune disease that damages the immune system, damages organs, and tissue throughout the body. The “Annual Minimum Data Set" (MDS) dated 03/31/26 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated cognition. The MDS document R16 needed set up or cleaned up for eating and substantial/maximal assistance with bathing and oral care, and was dependent on staff for toileting. The MDS documented R16 had no fall during the observation period. The "Fall Care Area Assessment " dated 03/31/25 documented R16 was non-ambulatory and had bilateral hand contractures. The CAA documented R16 had not had a fall since 06/2025. R16’s "Care Plan” documented the following: 03/27/25-R16 was at risk for falls due to contractures, muscle weakness, and reduced mobility. 06/26/25-Staff to use slide board with transfers to and from wheelchair for R16. 06/27/25-Ensure call light was within R16’s reach and encourage R16 to use call light for assistance. 05/01/26 -Place bolsters on R16’s bed to help define bed parameters R16’s EMR under “Progress Notes” under “Nursing Note” documented on 05/01/26 at 03:03 PM R16 was found on the floor by a Certified Nurse Aide (CNA). R16 was on the floor with the bed sheet beneath him. R16 was assessed and assisted to bed. R16 denied pain. R16’s EMR under “Fall Risk Evaluation” dated 12/06/25 documented a medium risk of seven. On 05/12/26 at 08:47 AM, R16 laid curled up on his	F0689		

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F0689 SS = D	Continued from page 47 bed. R16's bed was in a high position. R16's call light was wrapped around the right-hand side rail of his bed and dangling down. R16 stated he could not reach or find his call light, and he did not like his bed in a high position. R16 stated staff put his bed in a high position when doing his care. On 05/14/26 at 01:59 PM, Certified Nurse Aide (CNA) N stated call lights should always be within the resident's reach. She stated a resident's bed could be in a high position if the resident wanted the bed in a high position. CNA N stated R16 was a fall risk and his bed should be in a lower position. On 05/14/26 at 02:25 PM, Licensed Nurse (LN) J stated call lights should be within the resident's reach. She stated all residents' beds should be in a lower position. LN J stated R16 was a fall risk and staff should place his bed in a low position, if he was agreeable. LN J stated the oxygen storage room should always be kept locked and any oxygen cylinders should be stored on an oxygen cart. LN J stated everyone was responsible for ensuring fall interventions are in place to prevent future falls. On 05/14/26 at 02:51 PM, Administrative Nurse D stated call lights should be within the resident's reach. She stated beds should be in a low position. Administrative Nurse D stated oxygen should be stored behind a locked door when not in use and secured on an oxygen cart. Administrative Nurse D stated that it was everyone's responsibility to ensure fall interventions were in place. Administrative Nurse D stated, but ultimately, it was her responsibility. The facility's "Fall Management System," dated 03/26, documented it was the policy of the facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F0693		

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F0693 SS = D	Continued from page 48 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review the facility failed to ensure Resident (R)43 received treatment and services for enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) to prevent complications or adverse consequences when staff did not position R43 to prevent potential aspiration. Findings included: - R43's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of aphasia (condition with disordered or absent language function), gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The “Admission Minimum Data Set (MDS)” dated 01/27/26 documented severely impaired cognition. The MDS documented R43 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on the upper and lower extremities on one side of her body. The MDS documented R43 was dependent on staff assistance for all activities of daily living (ADLs). The MDS documented R43 had coughing or choking during meals or when swallowing medications. The MDS documented R43 had received 51 percent or more of her total calories through tube feeding. R43's "Feeding Tube Care Area Assessment (CAA)”,	F0693		

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F0693 SS = D	Continued from page 49 dated 02/03/26, documented she had suffered a CVA and was dependent on staff assistance for ADL and gastrostomy nutrition. R43's “Care Plan” documented the following interventions: 01/27/26- elevate R43’s head of bed at least 30-45 degrees at all times during feeding. R43‘s EMR under the “Orders” tab revealed the following physician orders: Enteral feed orders every shift and elevate head of bed at least 30-45 degrees at all times during feeding and 1 hour after, dated 01/21/26. On 05/13/26 at 2:37 PM, R43 laid on the bed with the head of her bed only elevated slightly, but less than 30-45 degrees. R43’s gastrostomy was infusing. R43’s call light was attached to her bed, and the call light cord and button hung behind her bed. R43’s bilateral heels rested directly on the mattress. On 05/14/26 at 09:25 AM, Administrative Nurse E stated R43’s head of bed should be elevated at least 30 to 45 degrees at all times. The facility’s “Gastrostomy Tube Care and Management” policy dated 04/2026 documented it was the policy of this facility to provide proper care and maintenance of gastrostomy tubes.	F0693		
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide services consistent with the standards of care related to the care of Resident (R) 4’s peripherally inserted central line (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) when staff failed to follow the physicians order for the in-facility removal of the PICC line when the	F0694		

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F0694 SS = D	Continued from page 50 intravenous antibiotic was finished for three days, failed to document the full removal of the line including the tip and failed to adequately monitor the site for complications after removal. Findings included: - R4's EMR from the "Diagnosis" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), and Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) to right and left heels. The "Modification of Quarterly Minimum Data Set" (MDS) for R4, dated 04/06/26, recorded a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R4 had an impairment on both sides of her upper and lower extremities of her body. The MDS documented R4 was dependent on staff for all activities of daily living (ADLs). The MDS documented R4 received intravenous (IV-administered directly into a vein) medications during the observation period. R4's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 10/05/25 documented pressure ulcer Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) noted to the sacrum, and the left foot was unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus). The CAA documented R4 had multiple areas of moisture-associated skin damage (MASD-inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous), related to contracture (abnormal permanent fixation of a joint or muscle), the need for assistance with personal care, and urinary incontinence. R4's "Care Plan" documented:	F0694		

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F0694 SS = D	Continued from page 51 09/30/25-Administer analgesia (medication for pain) as per orders. Staff to monitor for pain. R4's "Care Plan" did not address the PICC line or associated care. R2's EMR under the "Orders" tab revealed the following physician orders: Change PICC line dressing to the upper left extremity every day shift, every seven days, dated 03/31/26, discontinued on 05/12/26. Change PICC line caps weekly and as needed with each blood draw, every seven days or as needed dated 03/31/26, discontinued on 05/12/26. Daptomycin Sodium Chloride (antibiotic)Intravenous solution 500-0.9 milligrams (mg) per 50 milliliters (mls), use 600 mg intravenously in the evening for osteomyelitis (local or generalized infection of the bone and bone marrow) dated 04/29/26 until 05/08/26. Flush each port with 10ml of normal saline once daily before and after medication administration every day shift dated 03/31/26, discontinued on 05/12/26. R4's EMR under "Nursing Notes" dated 05/12/26 at 05:02 PM documented the PICC line removed this shift by RN on duty. Compression dressing applied. No complications noted. Resident tolerated well. R4's EMR under "Nursing Notes" dated 05/13/26 at 11:13 AM documented PICC line removed from left upper arm per physician's orders noted on 04/29/26 at 11:00 AM. R4 tolerated the removal with no issues. Nurse on duty instructed to monitor for abnormal bleeding or any other complications. R4's EMR under "Orders" lacked a physician's order to remove PICC line. R4's EMR under "Documentation" dated 04/29/26 continue Daptomycin/Cerftiax through 05/08/26 then remove PICC line and discontinue weekly labs, facility to follow up wound care and offload. R4's EMR lacked documentation related to inspection of the PICC line after removal to ensure the entire line, including the tip was removed without complications.	F0694		

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F0694 SS = D	Continued from page 52 On 05/13/26 at 09:34 AM, Administrative Nurse E stated she was in the facility when LN I stated R4's antibiotic had ended. Administrative Nurse E stated LN I had an order for the removal of R4's PICC line. She stated she should have charted the removal and what the site looked like. Administrative Nurse E stated she should do a late entry of charting for the removal of R4's PICC line removal. On 05/13/26 at 09:35 AM, Administrative Nurse D stated the office personnel had taken the order off the scanner. She stated the office personnel had sent the order out to all department heads. Administrative Nurse D stated nursing had not done anything with the order. She stated the office personnel scanned the order into R4's chart. Administrative Nurse D stated it should be the practice of the facility to document the removal of the PICC line, and any monitoring or complications. The facility's "Quality of Care" dated 03/26 it was the policy of the facility that residents were given the appropriate treatment and services to maintain or improve their abilities.	F0694		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide adequate respiratory care and services for Resident(R) 77's. bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps breathing), and her nasal cannula, when staff failed to ensure the equipment was stored in a sanitary manner when not in use. Findings included: - R77's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure (the lungs cannot adequately	F0695		

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F0695 SS = D	Continued from page 53 supply oxygen to the blood (hypoxemia) or remove carbon dioxide, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), sleep apnea (a disorder of sleep characterized by periods without respirations), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and pneumonia (an infection in the lungs). The “Quarterly Minimum Data Set" (MDS) dated 03/20/26 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R77 had an impairment of the extremities on one side of her upper body and both sides of her lower extremities. The MDS documented R77 was dependent on staff for oral hygiene and needed substantial/maximal assistance with bathing and toileting. The MDS documented R77 had shortness of breath when resting. The MDS documented R77 required oxygen therapy during the observation period. R77's “Care Plan” documented the following: 12/15/25-Nursing to administer medication/puffers as ordered by physician. Nursing to monitor effectiveness and side effects. BIPAP at night and as needed (PRN) settings, intelligent volume airway pressure (IVAP) at Inspiratory Positive Airway Pressure (IPAP) 25 centimeters/ water (H20), Expiratory Positive Airway Pressure. (EPAP) at 15 H20, 7.2 liters of airflow/oxygen per minute. Flow oxygen bleed 4 (Lt) liters per minute. Elevate head of bed. Nursing to monitor and document changes in orientation, increased restlessness, anxiety, and air hunger. Provide oxygen as needed. R77’s EMR under “Orders” documented the following physician orders: Rinse oxygen concentrator filters weekly every night shift on Wednesdays for maintenance dated 12/17/25. Oxygen at 4 liters/minute continuous per nasal cannula for shortness of breath and COPD dated 12/12/25.	F0695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 54 Change oxygen tubing and humidifier bottle every week, every night shift on Wednesday, dated 02/25/25. Durable Medical Equipment (DME) provides BIPAP settings as follows: I VAPS, 16 breaths rate, title volume 350-550, pressure support 4-20 EPAP 5-15, 6L bleed in pressure circuit to wear at night dated 02/05/26. Rinse out BIPAP mask daily every shift dated 03/16/26. R77's EMR under "Progress Notes" under "Nursing Notes" documented the following: On 04/09/26, R77 was sent to the Emergency Department (ED) for shortness of breath, heaviness, and pain to her chest. Nurse was called to R77's room at 10:42 PM for complaint of shortness of breath. R77 had her nasal canula on at four liters. R77's oxygen saturations were 79-82 percent, assisted resident with putting on her BIPAP oxygen saturations increased about 91 percent and fluctuated. R77 was stable for about 30minutes and became short of breath again with oxygen saturations dropping. R77 removed her BIPAP and placed nasal cannula at five liters of oxygen, and sats increased. R77 was given breathing treatment as needed, with encouragement to take deep breaths, her oxygen levels began to fluctuate, and R77 complained of pain in her chest, and her oxygen level dropped to 59percent. Emergency Management System was called due to not being able to maintain oxygen saturations above 91percent. R77 was transferred to the ED, and her guardian, physician and assisted director of nursing was notified. Rinse out BIPAP mask daily every shift. R77 was on 4liters of oxygen via nasal cannula, no BIPAP mask was seen in her room. Dated 04/29/25. Rinse out BIPAP mask daily every shift. R77 was on 4liters of oxygen via nasal cannula, no BIPAP mask was seen in her room. Dated 04/30/25. On 05/12/26 at 09:30 AM, R77 laid in her bed on her back. R77 had her nasal cannula in place. R77's BIPAP mask laid on the floor next to her bed side table. R77's oxygen nasal cannula laid on the floor next to her portable oxygen tank. R77's BIPAP, and nasal oxygen were not contained in a sanitary manner. On 05/13/26 at 08:22 AM, R77 sat up in her	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175548	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

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F0695 SS = D	Continued from page 55 wheelchair, eating her breakfast. R77's BIPAP mask laid draped over her BIPAP machine, and R77's nasal cannula was wrapped around the portable oxygen tank. On 05/13/26 at 08:25 AM, R77 stated she did not wear her BIPAP mask every night. She stated the nurses do not know what the settings should be on, or the nurse cannot find the mask for the BIPAP. R77 stated she would just wear her nasal cannula at night. On 05/14/26 at 01:59 PM, Certified Nurse Aide (CNA) N stated nasal cannulas and BIPAP mask should be placed in a dated bag when not in use. She stated anyone can place the mask or nasal cannula in a bag. 05/14/26 at 02:25 PM, Licensed Nurse (LN) J stated oxygen mask should be in a dated bag. She stated the bags were changed every Wednesday by the night shift. LNJ stated that all nursing staff can put the respiratory equipment in a bag when not in use. She stated it was the nurse on duty's responsibility to ensure the mask and oxygen tubing were not placed on the floor. On 05/14/26 at 02:51 PM, Administrative Nurse D stated all respiratory equipment not in use should be in a plastic bag. She stated all staff had been trained in the importance of keeping respiratory equipment off the floor and in a bag during the infection control training. The facility's "Oxygen Equipment" policy dated 01/26 documented it was the policy of the facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use humidifiers, tubing, masks, and cannulas for residents receiving oxygen. The equipment was to be discarded after use by a resident. The facility would maintain clean tanks, connectors, and concentrators.	F0695		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0697		

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F0697 SS = D	Continued from page 56 Based on observation, record review, and interviews, the facility failed to provide effective pain management, including ongoing assessment and monitoring for effectiveness of pain relief, for Resident (R)16, who had pain. Findings Included: - R16's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), contracture (abnormal permanent fixation of a joint or muscle) of muscle, muscle weakness, and lupus (an autoimmune disease that damages the immune system damage organs and tissue throughout the body. The “Annual Minimum Data Set" (MDS) dated 03/31/26 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R16 received pain medication and received as needed (PRN) medications or was offered and declined during the observation period. The "Psychotropic Drug Use Care Area Assessment " dated 03/31/25 documented R16 was prescribed an antidepressant (a class of medications used to treat mood disorders), due to chronic pain. The CAA documented no side effects had been reported. R16’s "Care Plan” documented the following: 12/08/25-R16 had rheumatoid arthritis (a chronic autoimmune disorder where the immune system mistakenly attacks the joint lining, causing painful inflammation, stiffness, and potential bone erosion) of bilateral hands. 04/10/25-R16’s pain was aggravated by prolonged activity Staff to reposition for comfort. Administer pain medication as ordered by physician. Administer antidepressant as ordered for chronic pain. Staff to monitor R16’s complaints of pain or request for pain treatment. Nursing was to notify physicians if interventions were unsuccessful.	F0697		

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F0697 SS = D	Continued from page 57 Nursing to do pain assessment every shift. R16's EMR under "Orders" documented the following physician orders. Duloxetine HCL (pain medication) oral capsule delayed release particle 30mg, give one capsule by mouth one time a day for chronic pain dated 03/01//26. Oxycodone HCL (pain medication) gives one capsule by mouth every six hours as needed for breakthrough pain dated 05/02/26. Review of R6's EMR on 05/12/26 at 08:55 AM under "Treatment Administrative Record" T(AR) documented R16 had a pain level of 10 with indicated excruciating pain. R16 was given oxycodone HCL, one capsule, five milligrams (mgs) ordered every six hours as needed for breakthrough pain. On 05/12/26 at 08:47 AM, R16 was yelling "Help" and stated he was in pain and had been yelling for pain medication. R16 stated he could not find his call light. R16's call light was wrapped around the right-hand side rail of his bed and dangling down. R16 stated he could not reach or find his call light. On 05/12/26 at 01:2576, a resident in a room next to R16. stated he hears R16 yelling for help often. R76 stated nursing takes a long time to come to R16's room. R16 started not very often, only twice a week he had to find nursing to help R16. R 76 stated R16 was unable to get out of bed by himself and find a nurse. On 05/14/26 at 01:59 PM, Certified Nurses Aide (CNA) N stated she conducts rounds on her halls to ensure the residents were not yelling out for help for pain. CNA N stated she would get a nurse as soon as she heard a resident yell out. On 05/14/26 at 02:25 PM, Licensed Nurse (LN)J stated it was all staff's responsibility to ensure R16 was monitored for pain. She stated residents should not be the people looking for nursing staff to assist other residents, a nurse should monitor residents' pain. On 05/14/26 at 02:51 PM, Administrative Nurse D stated that all staff should monitor R16's pain. She stated residents should not have to find and notify a nurse of R16's needs. Administrative Nurse D stated it was nursing's responsibility to ensure the	F0697		

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F0697 SS = D	Continued from page 58 residents were assessed and provided what each resident needed. The facility's "Quality of Care" dated 03/26, it was the policy of the facility that residents were given the appropriate treatment and services to maintain or improve their abilities.	F0697		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to provide dementia (a progressive mental disorder characterized by failing memory, and confusion) related care and services for Resident (R) 10 to promote his highest practicable level of well-being when staff failed to provide diversions and one to one attention per his plan of care. Findings included: - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The "Admission Minimum Data Set (MDS)" dated 02/16/26 documented a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R10 was dependent on staff assistance for mobility. R10's "Cognitive Loss/Dementia Care Area Assessment (CAA)", dated 02/19/26, documented he had memory problems and impaired decision-making ability. R110's "Care Plan," documented the following interventions: 02/10/26, Communication, staff would identify	F0744		

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F0744 SS = D	Continued from page 59 themselves with every interaction. Staff would face R10 when speaking and make eye contact. Staff would reduce any distractions- turn off the TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Staff would orient R10 to the facility surroundings, time, and location as needed. Staff would explain the need for care and procedures as needed. Social Services would provide psychosocial support as needed. 02/12/26, staff to provide 1:1 program to support in-room activities with supplies, conversation, and comfort. Being legally blind, he does not do any arts, crafts, drawing or play any games. He does like to listen to rock and roll music and listen to cowboy movies. He would benefit from in-room visits two times a week. Potential alteration in diversional activities related to benefits from 1:1 activity visit. Review of R10's EMR under the "Reports" tab of the "Documentation Survey Report" from 03/01/26 to 05/12/26 (73 days) revealed one activity documented on 04/04/26. On 05/12/26 at 09:47 AM, R10 sat reclined in a Broda chair (specialized wheelchair with the ability to tilt and recline) next to the nurse station with his eyes closed. On 05/13/2026 at 07:49 AM, R10 sat in a reclined Broda chair in the dining room alone. On 05/13/26 at 08:10 AM, R10 sat by nurse station in a Broda chair. On 05/13/26 at 08:45 AM, nursing staff pushed R10 to his room. Staff placed him reclined in the Broda next to his bed. Window blinds were pulled shut and room lights were off in the room. On 05/14/26 at 01:15 PM, Activities Director Z stated she documented all the activities resident attended in their EMR under the point of care charting. She stated she ensures all residents have an activities calendar in their rooms. She stated R10 would benefit from 1:1 activity. She stated she had not had a lot of time to do one-to-one activities with residents, because it was just her. Activities Director Z stated the facility was looking to get her an	F0744		

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F0744 SS = D	Continued from page 60 assistant. On 05/14/26 at 01:59 PM, Certified Nurse Aide (CNA) N stated she had worked with R10 some, and he did not attend any activities. She was unsure who would do one-to-one activities with the residents, she thought that would be activities. On 05/14/26 at 02:25 PM, Licensed Nurse (LN) J stated any staff could take a resident to or provide activities. She stated the residents' preference for activities should be on the care plan. LN J stated if a resident had an activity bag in their room, staff should make sure the resident had something from the bag. On 05/14/26 at 02:51 PM, Administrative Nurse D stated all staff should be interacting with all residents. She stated residents with a diagnosis of dementia should be offered activities or provided 1:1 interaction. The facility's "Care of Dementia" dated 03/25 documented It was the policy of the facility that all residents would have an individualized plan of care and have the least restrictive approaches to care. Staff were offered specialized training in the care of the dementia population, appropriate approaches to care, and managing behaviors.	F0744		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F0761		

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F0761 SS = D	Continued from page 61 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to store medication and biologicals adequately when staff failed to lock and secure an unattended medication cart. Findings included: - On 05/13/26 at 08:15 AM, the medication aide cart on the northeast hall was left unlocked and unattended when Certified Medication Aide (CMA) R stepped away from his cart to go into a resident's room. On 05/13/26 at 02:07 PM, the medication cart for the northeast hall was left unlocked. The cart was CMA R's, who was cleaning up the medication cart for the southeast hall. Administrative Nurse E walked up to the cart and locked the cart. On 05/13/26 at 08:17 AM, CMA R stated he only stepped away from his cart briefly, but he should have locked it when he stepped away from it. On 05/13/26 at 08:18 AM, Licensed Nurse (LN) H stated the medication cart should be locked anytime you walk away from the cart or when not being used. On 05/13/26 at 02:07 PM, Administrative Nurse E stated that the medication carts should always be locked when staff walk away from the cart. Administrative Nurse E stated this medication cart did not have any narcotic medications in it. The facility's "Medication Access and Storage" policy dated October 2025 documented it was the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. Medication carts are locked when the person administering medications steps away from the cart. All medications are kept secured in the cart or medication storage room until they are used.	F0761		

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F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F0883		

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F0883 SS = D	Continued from page 63 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to offer and administer or obtain an informed declination for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial pneumonia infections) and influenza (highly contagious viral infection) vaccination for Resident (R)3. Findings included: - Review of R3's clinical record revealed refusals for PCV20 and influenza vaccines. R3's clinical record lacked documentation the PCV20, and influenza was offered or declined, and lacked documentation of a historical administration or a physician documented contraindication. 05/13/26 at 08:40 AM, Administrative Nurse C stated she was unable to find R3's declination. On 05/14/26 at 02:51 PM, Administrative Nurse D stated the nurse that was admitting the resident was responsible to ensure the resident or family signed a consent or declination for immunizations. She stated the facility had changes in the administration, and the infection preventionist should be the one following up on any consent or declination of immunizations. The facility did not provide an immunization policy as requested on 05/14/26.	F0883		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F0732		

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F0732 SS = C	Continued from page 64 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by:	F0732		

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F0732 SS = C	Continued from page 65 Based on observation, record review, and interviews, the facility failed to ensure the daily nurse staffing data was posted and failed to ensure the daily posted nursing staffing included the required information. Findings included: - On 05/12/26 at 08:01 AM, review of the daily posted nursing staffing sheet revealed a date of 05/08/26. Review of the posted staffing sheets from 05/11/24 to 05/11/26 revealed the form used 05/01/26 to 05/07/26 lacked a daily census on the posted sheets. On 05/13/26 at 08:06 AM, Administrative Nurse D stated Administrative Staff B was responsible for ensuring the daily posted nursing staff sheets were posted. Administrative Nurse D stated the on the weekend receptionist would post the daily nursing sheets that had been provided by Administrative Staff B, and the daily census information should be included. The facility's "Posted Direct Care Daily Staffing Numbers" policy last revised 08/2022, documented the facility would post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.	F0732		