AN ADMINISTRATOR SIGNATURE COULD NOT BE OBTAINED.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265872	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IGNITE MEDICAL RESORT KANSAS CITY, LLC	2100 N W BARRY ROAD KANSAS CITY, MO 64154

(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
F 600 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, interview, and record review, the facility failed to protect Resident#1's right to be free from abuse when he/she was hit in the face by another resident (Resident #2). Resident #1 sustained a laceration to the lower lip. Facility census was 79. On 1/9/25, the Administrator was notified of the past noncompliance which began on 1/1/2025. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented. The noncompliance was corrected on 1/2/2025. Review of the facility's Abuse Policy, dated November 2018, showed: -Abuse is defined as an infliction of physical, sexual, or emotional injury or harm, including financial exploitation by any person, firm, or corporation;	F 600	Past noncompliance: no plan of correction required.	

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

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F 600	Continued From page 1 -This facility prohibits abuse, neglect, or mistreatment of residents. The facility will educate all employees upon hire and at least annually on the Abuse Policy and all components. The facility Administrator will be designated as the facility's Abuse Coordinator and is responsible for overseeing all components of the abuse policy; -The resident care plans will be reassessed on a regular basis and any necessary changes will be implemented as needed. Resident behaviors will be monitored regularly for any changes and any aggressive behaviors that might lead to abuse will be assessed and any necessary interventions will be implemented; -This facility will make every effort to identify residents who are at high risk for potential abuse of other residents. Facility staff will report immediately to facility administration any identified behaviors, injuries, bruises, and/or any concerns of potential abuse of residents; -If another resident is identified in the allegation, a licensed staff member will complete an evaluation of the resident's status and condition and notify the physician to determine if any treatment is necessary. Facility Administrator or designee will assess all of the relevant information to determine whether or not a discharge from the facility is needed. The resident will be prohibited from having any contact with the resident alleging abuse while the investigation is completed. The facility Administrator or designee will determine if further action and/or intervention is needed upon completion of the investigation. 1. Review of Resident #1's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 11/2/2024, showed:	F 600		

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F 600	Continued From page 2 -He/She has the diagnoses of chronic embolism and thrombosis of left lower extremity (a condition where blood clots form in the deep veins of the leg, and can lead to long-term complications), mild cognitive impairment (the in-between stage between typical thinking skills and dementia), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), cognitive communication deficit (a difficulty with communication that's caused by an underlying issue with cognition), supraventricular tachycardia (a faster than normal heart rate beginning above the heart's two lower chambers); -He/She scored 11 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). This score indicates moderately impaired cognition skills; -He/She had adequate hearing, clear speech, makes self understood and able to understand others. He/She has displayed no behaviors. Review of Resident #1's comprehensive care plan, dated 1/1/2025, showed: -The resident occasionally refused care, medications, and treatments; -He/She had a history of displaying behaviors, including throwing his/her meal tray, yelling at staff and other residents, flipping off (rude hand gesture) staff, throwing medications in the trash). The resident was involved in physically aggressive behavior on 1/1/2025; -The resident was at risk for wandering and elopement. 2. Review of Resident #2's quarterly MDS, dated 11/26/2024, showed:	F 600		

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F 600	Continued From page 3 -He/She has the diagnoses of chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), orthopnea (discomfort when breathing while lying down flat), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hemiplegia/hemiparesis to left side (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), carviovascular accident (CVA, a medical condition in which poor blood flow to the brain causes cell death), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), mass in lung (abnormal growth in lung), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), aortic aneurysm without rupture (a bulge in the aorta, the body's main artery, that can occur anywhere from the chest to the abdomen); -He/She scored 11 on the BIMS, indicating moderately impaired cognitive skills; -He/She had adequate hearing, clear speech, makes self understood and able to understand others. He/She has displayed no behaviors. Review of Resident #2's comprehensive care plan, dated 1/1/2025, showed: -The resident occasionally refused care, treatment and medications; -He/She had potential for behaviors (stealing things from the facility cafe, being sexually inappropriate with staff, yelling at other residents);	F 600		

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F 600	Continued From page 4 -He/She was a risk for wandering and elopement. Review of the facility investigation, dated 1/1/2025, showed: -On 1/1/2025 , at approximately 2:45 P.M., Resident #1 was brought to the Administrator's office by staff. The staff member stated he/she did not witness anything, but that Resident #1 needed some help. The Administrator escorted the resident to the nurses' station. Some blood and a laceration (cut) were noted to the resident's lower lip. When asked what happened, Resident #1 stated that Resident #2 hit him/her in the face. Resident #1 stated he/she could not recall exactly what was said between the two. The physician was notified of the incident and treatment orders were obtained for the area to the lip. The resident was also offered counseling services but he/she declined; -During an interview, Resident #2 said that Resident #1 was sitting at Resident #2's table, and and asked Resident #2 to move away from the table. Resident #2 said he/she was tired of Resident #1 and hit him/her; -During an interview, Resident #3 said that he/she was in the dining room after bingo. Resident #1 liked to hang out at the back table by the window with his/her items. Resident #3 saw Resident #2 come in the dining room and head to the back table. He/She could hear Resident #1 ask Resident #2 something, but could not understand what was said. He/She then heard Resident #2 say "I'm going to slap you" and the next thing Resident #3 heard was Resident #1 whimper and put his/her hand to his/her face, saying "he/she hit me." During an interview on 1/9/2025 at 1:07 P.M., Resident #1 said:	F 600		

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F 600	Continued From page 5 -He/She declined to discuss the incident with Resident #2; -He/She confirmed that he/she was struck by another resident; -He/She also confirmed the facility offered counseling services, but he/she declined; -He/She felt safe in the facility. Review of the facility Staff Education sign in sheets showed that staff education on Resident to Resident Abuse and Prevention was completed on 1/1/25 and 1/2/25. During an interview on 1/9/25 at 1:40 P.M., the Administrator said: -The incident was very unexpected as neither resident has displayed physical behaviors while residing at the facility; -Staff have been educated on resident to resident abuse and prevention; -It is his/her expectation that residents refrain from acting out towards one another. It is also his/her expectation that staff be aware of the possibility of resident to resident abuse. MO247374	F 600		