

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Blue Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 20511 E Trinity Place Blue Springs, MO 64015	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure a medication error did not occur when one sampled resident (Resident #2) received Resident #14's medications instead of his/her own ordered medications out of 14 sampled residents. The facility census was 89 residents.</p> <p>On 4/24/25, the Administrator was notified of the past non-compliance which occurred on 4/16/25. Facility staff were educated on medication administration and the five rights during medication administration. Interventions were put into place to mitigate future occurrences. The deficiency was corrected on 4/17/25.</p> <p>Review of the facility's policy titled Administration of Medications dated October 2024 showed:</p> <ul style="list-style-type: none"> -A physician or Nurse Practitioner order was required for administration of all medication. -The licensed staff were expected to check the medication administration record prior to administering medication for the right medication, dose, route, resident, and time. -Staff were expected to identify the resident by reading the resident's wristband or checking the picture in the Medication Administration Record (MAR). <p>1. Review of Resident #2's admission Record showed he/she admitted to the facility with the following diagnoses:</p> <ul style="list-style-type: none"> -End-Stage Renal Disease (ESRD-a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of dialysis). -Respiratory Syncytial Virus Pneumonia (RSV- inflammation of the small airway passages entering the lungs). -Generalized Anxiety Disorder (GAD- any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats). -Pulmonary Hypertension (high blood pressure in the blood vessels that supply the pulmonary arteries). -Dependence of Renal Dialysis (the removal of excess water, solutes, and toxins from the blood in people whose kidneys no longer perform the functions naturally). <p>Review of the resident's discharge Minimum Data Set (MDS- a federally mandated assessment</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>instrument completed by facility staff for care planning) dated 4/21/25 showed the resident was cognitively intact.</p> <p>Review of the facility's Medication Error Investigation dated 4/16/25 showed:</p> <ul style="list-style-type: none"> -On the morning of 4/16/25 Resident #2's nurse reported that he/she believed that he/she accidentally administered the incorrect medications to the resident. -Resident #2 received a different resident's medications. -The resident was sent out to the local hospital for further evaluation and treatment if needed. -The nurse reported that Resident #2 seemed lethargic after he/she received the wrong medications. -Resident #2's nurse was unable to explain what happened. -It was determined that the medication error was accidental. -Resident #2 required no treatment while at the local hospital's emergency room (ER). <p>Review of Resident #2's and Resident #14's medical record showed Resident #2 received the following un-ordered medication:</p> <ul style="list-style-type: none"> -Cetirizine Hydrochloride (HCl) (medication used to treat allergy symptoms) Oral Tablet 10 milligrams (mg), give one tablet by mouth one time a day for allergies. -Famotidine (medication typically used to treat Gastro-Esophageal Reflux Disease (a digestive disease in which stomach acid or bile irritates the food pipe lining)) 20 mg, give one tablet by mouth one time a day for GERD. -Furosemide (Lasix- used to treat fluid retention) 20 mg, give two tablets by mouth one time a day for edema (swelling caused by too much fluid trapped in the body's tissues). -Multiple Vitamins-Minerals Tablet, give one tablet one time a day as a supplement. -Prednisone (a steroid medication that can treat many diseases that cause inflammation) Oral tablet 20 mg, give a half tablet one time a day for Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation). -Apixaban (Eliquis- used to treat or prevent blood clots) Oral Tablet five mg, give one tablet by mouth two times a day for Deep Vein Thrombosis (DVT- a blood clot in a deep vein, usually in the legs) prophylaxis. -Colace (Docusate Sodium- used to treat constipation) 100 mg, give one capsule by mouth two times a day for constipation. -Hydrocodone-Acetaminophen (Norco- used to treat severe pain) 5-325 mg, give one tablet by mouth every morning and at bedtime for pain. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe environment for one sampled resident (Resident #3) when on 3/8/25 he/she was found on the floor outside of his/her bathroom with his/her bathroom track door. The facility census was 89 residents.</p> <p>1. Review of Resident #3's admission Record showed he/she admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses). -Generalized Muscle Weakness. -Other Abnormalities of Gait and Mobility. -Cognitive Communication Deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem solving, and safety awareness). -Need for Assistance with Personal Care. <p>Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 2/19/25 showed:</p> <ul style="list-style-type: none"> -The resident had moderately impaired cognition. -The resident needed partial/moderate assistance (helper does less than half the effort) with toileting hygiene. <p>Review of an Un-Witnessed Fall Incident Report dated 3/8/25 at 8:50 A.M. completed by Registered Nurse (RN) A showed:</p> <ul style="list-style-type: none"> -Staff heard a loud bang come from the resident's room. -RN A had been called out into the hallway. -RN A went into the resident's room and noted the resident to be in a left lateral position asking for help to get up. -The resident's bathroom door was noted to be on the floor. -The resident could not give a description of what had happened. - The resident had a hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space) on his/her face. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-OT A had not seen the resident prior to the resident's fall.</p> <p>-OT A had been in the hallway, then he/she heard a loud noise and joined RN A in the resident's room to assist.</p> <p>-The resident was wearing non-skid socks at the time of the fall.</p> <p>-The resident stated, he/she was trying to come out of the bathroom.</p> <p>-OT A assisted the resident in setting up his/her breakfast and began to eat his/her food.</p> <p>During an interview on 4/18/25 at 9:21 A.M. the Maintenance Director said:</p> <p>-There is an online system that staff could use to put in work orders.</p> <p>-Any staff person had access to the online system to put in work orders.</p> <p>-He/She was unaware of any issues with the resident's track bathroom door prior to the resident's fall on 3/8/25.</p> <p>-He/She had not received any requests from staff or family to fix the resident's bathroom track door prior to the resident's fall on 3/8/25.</p> <p>-He/She was notified immediately after the resident's fall that the resident's bathroom track door had fallen off the track.</p> <p>-He/She then came up to the facility to ensure there was nothing wrong with the resident's bathroom track door and to see if there were any issues with the door's track system.</p> <p>-He/She had not found anything wrong with the door or track system.</p> <p>-He/She then completed an audit of all the resident bathroom doors on 3/8/25, and no other issues were found.</p> <p>-All resident bathroom doors throughout the facility have the same door and track system.</p> <p>During an interview on 4/18/25 at 12:11 P.M. the Maintenance Director said:</p> <p>-The housekeepers complete a room flip checklist whenever a resident discharges.</p> <p>-The facility has a high volume of discharges, so the housekeepers perform the room flip checklist frequently.</p> <p>-The housekeepers were expected to let the Maintenance Director know of any issues once the room flip checklist had been completed.</p> <p>-The nurses and CNAs also were in the resident rooms frequently and were expected to place any work orders in the online system or let the Maintenance Director know of any issues.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The bathroom track door could not be permanently removed from the track because the resident lived in a semi-private room with a roommate.</p> <p>-He/She had tightened the bump stops on the resident's track bathroom door after the incident occurred out of caution and not because they were loose.</p> <p>-None of the staff were able to report how the bathroom door came off the track when the resident fell on 3/8/25.</p> <p>-If the door were to be bumped with enough leverage there would be a chance that the door could come off the track.</p> <p>During an interview on 4/18/25 at 12:30 P.M. RN A said:</p> <p>-He/She had not received any reports from the resident or resident's family about there being any issues with the resident's door.</p> <p>-The resident was found outside of his/her bathroom doorway with his/her feet towards the doorway and the resident's head towards the fork of the room that split the room in two sections.</p> <p>-The door was not found on top or really near the resident when the resident fell.</p> <p>-The resident was able to report to him/her that the door had not fallen on him/her.</p> <p>-The resident did not seem to be injured at the time of the fall and seemed to be embarrassed by the whole situation.</p> <p>-The resident had some scratches on his/her head and arms after the fall.</p> <p>-The resident reported that he/she was in pain a few hours after the fall occurred.</p> <p>-The resident's roommate at the time reported that the door had not hit or fallen on the resident when the resident fell.</p> <p>During an interview on 4/18/25 at 12:47 P.M. Licensed Practical Nurse (LPN) A said:</p> <p>-He/She had heard a crash and ran to the resident's room.</p> <p>-When he/she got to the room OT A was helping the resident up from the floor.</p> <p>-The resident's bathroom door was lying on the ground next to the resident.</p> <p>-He/She was unsure if the door had hit the resident.</p> <p>During an interview on 4/18/25 at 12:52 P.M. OT A said:</p> <p>-He/She had been in a different resident's room when he/she heard a loud bang.</p> <p>-He/She saw the resident lying on the ground on his/her left side with his/her feet towards the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-There had not been any issues with the resident's bathroom track door prior to the incident.</p> <p>-He/She had not reported any issues to the Maintenance Director prior to the incident.</p> <p>-He/She did not think the roommate visualized the incident but had been in the room at the time of the incident.</p> <p>-He/She had only ever spoken with Family Member A about the resident's care and not about any maintenance issues during his/her stay.</p> <p>During an interview on 4/22/25 at 2:51 P.M. LPN C said:</p> <p>-He/She had worked with the resident the day before the incident on 3/7/25.</p> <p>-He/She had not remembered anything wrong or abnormal about the resident's bathroom track door that day or at anytime prior to the incident.</p> <p>-The resident's bathroom track door was usually open.</p> <p>During an interview on 4/22/25 at 3:49 P.M. LPN D said:</p> <p>-He/She had not remembered there being any issue with the resident's bathroom track door prior to the incident.</p> <p>-He/She felt like he/she would have noticed if there was anything wrong with the bathroom track door.</p> <p>-There had not been any reports of any issues with the resident's bathroom track door.</p> <p>-The resident's bathroom track door seemed to always be open.</p> <p>-He/She felt like if the bathroom track door was pushed/pulled hard enough, it could come off the track.</p> <p>Observation on 4/23/25 at 10:05 A.M. showed all residents had the same bathroom track doors.</p> <p>During an interview on 4/24/25 at 9:00 A.M. the Maintenance Director said:</p> <p>-He/She had only performed an audit of all resident bathroom track doors after the incident.</p> <p>-Nothing else needed to be done after that point in time.</p> <p>-He/She had never had an issue with any resident bathroom track door like what happened during the incident prior to the incident.</p> <p>-The safety mechanisms that were in place to keep the bathroom track door on the track were all intact at the time of the incident.</p> <p>-No additional safety mechanisms were placed on the resident's bathroom track door prior to the</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265880	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Blue Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 20511 E Trinity Place Blue Springs, MO 64015	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>incident.</p> <p>-The facility was looking into an extra safety precaution or mechanism that could be put in place to prevent an incident like what occurred from happening again.</p> <p>During an interview on 4/24/25 at 10:16 A.M. the DON said:</p> <p>-He/She was unaware of any issues with the resident's bathroom track door prior to the incident.</p> <p>-There had not been an issue with any other residents bathroom track doors like what happened during the this incident.</p> <p>-He/She was not a part of the investigation, so he/she was unsure if anything besides the bathroom track door audit had been completed after the incident.</p> <p>During an interview on 4/24/25 at 10:35 A.M. the Administrator said:</p> <p>-The incident had been an isolated incident.</p> <p>-He/She had not thought that what happened in the incident was even a possibility.</p> <p>-The Maintenance Director did not have to fix anything with the bathroom track door or track system after the incident occurred.</p> <p>-He/She was unaware of any issues with the resident's bathroom track door prior to the incident.</p> <p>-The facility was looking into any hardware that could be placed on the bathroom track doors to prevent an incident like what occurred from happening again.</p> <p>During an interview on 5/12/25 at 9:35 A.M. the Maintenance Director said all resident bathroom track doors were installed when the facility was first built.</p> <p>MO00252789</p>