

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/17/2026	
NAME OF PROVIDER OR SUPPLIER WILLOW POINT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE , KANSAS CITY, Kansas, 66104			
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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations 3173246, 3136033, and 3136636 The census was 46. The sample included 13 residents.			F0000			
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be			F0801			

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
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F0801 SS = F	Continued from page 1 deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. \$483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to employ a full-time Certified	F0801					

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F0801 SS = F	Continued from page 2 Dietary Manager who had the required credentials and/or had completed the required education.. Findings included: - On 09/15/2026 at 08:14 AM, during the initial tour of the kitchen, Dietary Staff (DS) reported DS BB was the manager of the dietary department. On 09/16/2026 at 01:08 PM, DS BB verified she was the dietary manager and reported that she had enrolled in a Certificated Dietary Manager course through a university but verified she was not currently certified. DS BB confirmed an enrollment period of 08/06/2026 to 08/06/2027. The facility's undated "Dietary Staffing: Food service director and Dietician" policy documented a qualified dietician or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F0801					
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812					

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F0812 SS = F	Continued from page 3 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner for the residents who reside in the facility and receive meals from the facility kitchen. Findings included: - On 09/15/2026 at 08:14 AM, during the initial tour of the kitchen, the dry storage room freezer lacked documentation of temperature readings for five previous days in September 2026. The small upright freezers labeled #10 and #11 lacked documentation of temperature readings for seven previous days in September 2026. The kitchen also had a large refrigerator in the main kitchen area with a sign posted "Out of Order" that did not have food stored within. On 09/16/2026 at 01:08 PM, following the meal preparation and serving, the following was observed: The ceiling sheetrock paper facing was loose and peeling in several places throughout the kitchen. The ceiling round vents had brownish debris around the edges. The air intake vent was covered with brown, fuzzy material. The flooring had split/open areas throughout the kitchen and dishwasher area. Two of the ceiling lights had insect debris. On 09/16/26 at 01:08 PM, Dietary Staff (DS) BB stated that the temperatures of the refrigerators should be recorded twice a day. DS BB stated that the facility's ownership had plans to update the kitchen area with new refrigerators and freezers, along with repairing the kitchen as needed. On 09/17/2026 at 01:58 PM, Administrative Staff A reported that the refrigerator and freezer temperatures should be recorded daily, and the			F0812			

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F0812 SS = F	Continued from page 4 facility was to get new refrigerators and freezers, along with repair of the kitchen roof and other items needed in the kitchen, such as ceiling and floor repairs. Upon request, the facility did not provide a policy addressing temperature logs of the refrigerator and freezers, maintenance of the kitchen, and cleanliness of the kitchen.	F0812					
F0880 SS = E	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 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880					

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F0880 SS = E	Continued from page 5 (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 wear Personal Protective Equipment (PPE) as required for Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) while doing a wound dressing, the facility failed to ensure trash bagged and residents bagged laundry was not placed on the floor. The facility failed to ensure clean linens were transported in a sanitary manner. Findings included: - On 09/15/2026 at 07:52 AM, the linen cart was	F0880					

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F0880 SS = E	Continued from page 6 parked in the 300 hall with sheets, and pillow covers; the linen cart was not covered. On 09/15/2026 at 08:55 AM, two white trash bags laid on the floor in Resident (R)48's room; one had trash, and one had laundry. On 09/16/2026 at 02:46 PM, two white trash bags laid on the floor in R45's room, at the bathroom door. One had trash and one had laundry. On 09/15/2026 at 12:37 PM, Administrative Nurse E and Administrative Nurse F assisted R5 with positioning in bed to provide wound treatment to the right thigh wounds. Both Administrative Nurse E and F donned gloves but failed to put on gowns. The wound treatment was administered by Administrative Nurse E as prescribed by the physician. Gowns were available on R5's door. On 09/16/2026 at 04:30 PM, Administrative Nurse E verified that she should have worn a gown during R5's wound treatment. On 09/17/2026 at 12:55 PM, Administrative Nurse D verified that R5 had ongoing wounds and was being treated with antibiotics, and staff should have donned gloves and a gown for the dressing change. Administrative Nurse D stated laundry and trash even in trash bags should not be placed on the floor. Linens and residents' personal clothing should be covered while in the hall. The facility's "Infection Control Program" policy dated 04/2025 documented the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The facility's "Infection Prevention and Control-Linens" policy dated 01/2026 documented soiled laundry/bedding would be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. The facility's "Skin and Wound Monitoring and Management" policy dated 12/2025 states that a resident having pressure injury (s) receive necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The facility provides care and services to promote the healing of pressure injuries that are present (including prevention of infection to the extent possible).			F0880			

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to revise Resident (R) 48's "Care Plan" to include a fall intervention after a fall with injury. Findings Included: - R48's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), intellectual and developmental disability (IDD- a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), and aphasia (condition with disordered or absent language function).	F0657					

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F0657 SS = D	Continued from page 8 R48's "Quarterly Minimum Data Set" (MDS) dated 08/02/2026 documented a Brief Interview of Mental Status (BIMS) score of 99, which indicated R48 was rarely or never understood. The MDS documented R48 needed set up or clean up assistance with eating and oral hygiene. The MDS documented R48 had no falls since admission or reentry or prior assessment. R48's "Functional Abilities (Self-Care) Mobility" documented R48 was nonverbal, R48 was able to read lips and gestures when staff showed her what she needed to do. R48's MDS documented staff were to face R48 when talking. R48's "Care Plan" documented: 12/04/2025 R48 was at risk for falls due to her diagnosis. Staff were to keep needed items within her reach. Maintain a clear pathway, free of obstacles. Perimeter Mattress to assist in identifying edge of bed. Provide R48 with a lower bed, and lower chairs in the dining room for easier independent use. R48 would remove shoes/nonskid footwear at times and walk barefoot; staff to assist R48 in putting her shoes back on. R48's "Care Plan" lacked intervention for a fall with injury on 08/15/2026. R48's EMR dated 08/14/2026 at 02:27 PM documented Licensed Nurse (LN) was notified by kitchen staff R48 had fall. R48 was lying flat on her back with the walker standing next to her. R48 had non-skid sneakers. R48 toilets herself. R48's vitals were obtained and pressure was applied to the back of her head, and 911 was called. LN attempted to call family with no response and was unable to leave a message. The Director of Nursing stated she would call the physician. R48 left the building for the emergency department. On 08/15/2026 at 09:32 AM, R48 was in the dining room, sitting at the table. R48 took her right shoe off and was putting her shoe back on. On 08/17/2026 at 12:36 PM, Certified Nurse's Aide (CNA) N stated she was unsure if she had access to	F0657					

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F0657 SS = D	Continued from page 9 the care plan, but she did have access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident) for each resident. CNA N stated if there was something important or a change in a resident, she would be told in nursing report. She stated nurses kept her updated on residents falls. On 08/17/2026 at 12:55 PM, Licensed Nurse (LN) G stated the nurse on duty was to put an immediate intervention in the resident's care plan after a fall. She stated R48 being transferred to the hospital was the immediate intervention. LN G stated the Interdisciplinary Team (IDT) would put the long-term goal in the resident's care plan during the IDTs weekly meeting. On 08/17/2026 at 01:29PM Administrative Nurse D stated the nurse on duty would put an immediate intervention into the resident's care plan. She stated when the IDT would meet, the team goes over all the residents' interventions and puts a long-term goal into the residents' care plan. Administrative Nurse D stated the IDT should have put a new intervention in R48's care plan when she returned from the hospital for her fall. The facility did not provide a policy for care plan revision as requested on 09/17/2026.			F0657			
F0677 SS = D	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, interview, and record review, the facility failed to provide necessary assistance with activities of daily living when staff failed to assist Resident (R) 4, who had weakness and/or paralysis on one side of her body and required staff assistance, with mealtime assistance, including cutting food up and receiving and drinking liquids. Findings included: - R4's Electronic Medical Record (EMR) included diagnoses of delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorders, adult failure to thrive			F0677			

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F0677 SS = D	Continued from page 10 (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), dementia (a progressive mental disorder characterized by failing memory and confusion), moderate protein-calorie malnutrition, and contracture (abnormal permanent fixation of a joint or muscle) of the left hand, left knee, and right knee. R4's "Annual Minimum Data Set" (MDS) dated 08/15/2026 documented moderately impaired cognition, fluctuating inattention, and functional range-of-motion impairment of the upper and lower extremities on one side. R4 required supervision or touch assistance with eating. R4 was dependent on staff with all other activities of daily living and mobility. R4 received a scheduled pain medication regimen, an antidepressant (a class of medications used to treat mood disorders), a diuretic (a medication to promote the formation and excretion of urine), and anticonvulsant. R4's "Care Plan," dated 08/20/2026, documented an alteration in self-care and directed staff to supervise; R4 had contractures in both hips and knees. R4's physician ordered a regular diet, texture, and thin liquids. The "Speech Therapy" background assessment, dated 09/03/25, documented medical precautions: fall risk, delusional, and drink six to eight glasses of water/day. The "Annual Nutritional Evaluation," dated 04/28/2026, documented R4 had a regular diet, regular texture/consistency. R4 liked milk and ate independently. The nutritional needs required were 2000 calories a day and 2400 milliliters (ml) of fluid a day. On 09/15/2026 at 12:28 PM, R4 sat in the dining room in her wheelchair at a table with another resident. R4's meal consisted of a chicken leg, rice, lettuce salad, dessert, and one eight-ounce glass of orange liquid. R4 was eating with her fingers and had chunks of chicken and rice on her clothing protector. On 09/15/26 at 01:15 PM, staff removed R5 from the dining room without offering additional fluids.			F0677			

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F0677 SS = D	Continued from page 11 On 09/16/2026 at 08:13 AM, R4 sat in the dining room. Staff brought her breakfast, which consisted of hot cereal in a bowl, and placed it to the left of her plate, along with a bowl of grapes and breakfast pizza. The breakfast pizza was approximately six by six inches. R4 had to reach with her right arm across to the left side of the plate to eat the cereal. R4 used her hands to pick up the breakfast pizza. No staff assisted R4 in cutting the pizza into bite-size pieces. R4 also had an eight-ounce glass of milk and red liquid, which she consumed completely and readily, but was not offered additional fluids. On 09/16/2026 at 10:36 AM, R4 sat in her room in her wheelchair, watching TV. R4's room lacked a drinking glass and water pitcher for self-hydration. On 09/16/2026 at 02:51 PM, Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) M assisted R4 into her bed, using a mechanical lift. R4 was not offered fluids and lacked a water mug for self-hydrating. On 09/16/2026 at 01:08 PM, Dietary Staff (DS) BB reported the menu recipes did not specify the number of fluids at mealtimes, but ensured all residents received at least one eight-ounce glass of fluids with each meal. DS BB was not sure who was responsible for offering more fluids at mealtimes among the dietary and nursing departments who assisted residents in the dining room. On 09/16/2026 at 04:38 PM, CNA P reported fresh water was to be passed after breakfast and lunch. CNA P stated that all residents should have a water mug in their room and within reach. CNA P verified that R4 had no water mug in her room. On 09/17/2026 at 01:30 PM, Administrative Nurse D stated that water mugs should be available in residents' rooms for self-hydration and verified R4 required assistance cutting up food. The facility's "Activities of Daily Living (ADL), Services to Carry Out" policy, dated 12/2025, states that residents are given the appropriate treatment and services to maintain or improve his/her abilities. Residents who are unable to carry out activities of			F0677			

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F0677 SS = D	Continued from page 12 daily living (ADL) will receive necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene.	F0677					
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 observation, record review, and interview, the facility failed to ensure Resident (R) 34's fall investigations included a root cause analysis. Findings included: - R34's Electronic Medical Record (EMR) documented diagnoses of epilepsy (brain disorder characterized by repeated seizures), wedge compression fracture of lumbar vertebra (the front part of a lower-spine vertebra collapses into a wedge shape while the back remains intact), and dementia (a progressive mental disorder characterized by failing memory and confusion). R34's "Quarterly Minimum Data Set (MDS)" dated 08/24/2026 documented she had both long- and short-term memory problems. R34 needed partial/moderate assistance with toileting, dressing, and bathing. R34 was independent with transfers and walking. R34 has had two or more falls since the last assessment, one with injury. R34's "Falls Care Area Assessment (CAA)" dated 10/30/2025 was triggered due to the resident receiving an antidepressant (a class of medications used to treat mood disorders) and a history of falls. R34's "Care Plan" last revised on 07/31/2026, directed staff she was at risk for falls. The plan directed staff to implement fall mats at her bedside; will apply bilateral enabler bars to bed to help with stability when resident sits up on the bed;	F0689					

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F0689 SS = D	Continued from page 13 encourage the resident to wear nonskid socks or footwear; keep needed items, water, etc., in reach; maintain a clear pathway, free of obstacles; offer her a place to sit if she is standing at the nurses station for an extended period of time or if she appears fatigued. R34's EMR documented "Fall Committee Interdisciplinary (IDT)" progress note on 12/17/2025 at 06:17 AM documenting the IDT reviewed a fall this shift. R34 had a fall on 12/13 around 1150 by staff. R34 was observed on the floor in her room playing in her feces. The resident was unsteady on her feet and wasn't answering yes or no questions and was grinding her teeth. The resident was ambulatory at baseline without assistance or assistive device. The nurse notified the provider on call and new orders were received to send the resident to the emergency room (ER) for evaluation and treatment. The resident was transferred to the hospital, and family was called and voicemail was left. R34's 05/18/2026 at 11:36 AM "Fall Committee IDT" progress note documented the IDT met on this date to discuss her fall. R34 had a witnessed fall on 5/17/26 at 04:45 PM. She was observed walking up the hallway by a staff member and staff noted that the resident was walking extremely fast compared to her baseline and staff attempted to help slow the resident down when resident lost her balance and fell into the adjacent wall. R34 was noted to have hemorrhaging from her face. The nurse called 911 immediately and the resident was sent to the ER via emergency medical services (EMS), and report was called to the hospital. The on-call physician was notified and agreeable to the plan of care the family was notified. R34's 06/03/2026 at 10:48 AM "Fall Committee IDT" progress note documented the IDT met this date to discuss her fall. R34 had a fall on 05/29/2026 at 12:00 PM. The nursing staff was notified that R34 was having increased pain in her left wrist and was very guarded with the wrist. Staff was unsure R34 had a fall and got herself up. The provider was notified and new orders were received for a Xray of the left wrist. The X-ray was completed of the left wrist and per the report the resident had acute fracture. The resident was sent out to the hospital and their X-ray was negative. R34's 07/07/2026 at 08:33 AM, a "Fall Committee IDT" progress note documented the IDT met this date to discuss a fall. R34 had an unwitnessed fall			F0689			

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F0689 SS = D	Continued from page 14 on 07/0720/26 at 06: 40 AM. Upon assessment, the resident was observed sitting on the floor next to her bed. R34 was unable to describe what happened due to her cognition. R34's brief was noted to be wet. The resident denied any pain and vital sign were within normal limits. The resident was assisted off the floor and changed and dressed for the day and staff assisted the resident to the dining room. The new intervention was that bilateral enabler bars would be applied to bed to help with stability when resident sat up on the bed. The provider and family were notified of the fall. R34's 07/13/2026 at 09:44 AM "Fall Committee IDT Note" documented the IDT met this date to discuss R34's fall. R34 had a fall on 07/12/26 at 07:15 AM. The resident was observed on the floor in her room. The resident was observed resting with both knees on the floor and waist up she was bent over resting face down on the bed with her head turned on it. R34 had non-skid socks on. R34 expressed pain to her left knee, and her knees were dark red and blanchable. R34 had full range of motion of all extremities and vital signs within normal limits. R34 was assisted up with staff and ambulated independently to the nurse's station with no complaints. Neurological checks were initiated per protocol. A new intervention was put in place for fall mats to both sides of bed. The provider and family were notified. R34's 07/21/2026 at 08:41 AM "Fall Committee IDT Note" documented the IDT met this date to discuss falls. R34 had a witnessed fall on 07/20/26 at 09:20 AM. The certified nurse aide (CNA) was assisting the resident in her room before breakfast and was walking with resident when the resident began to lose her balance and fell up against the wall and the CNA assisted resident to the floor. The nurse assessed resident, and no injuries were noted. R34 has had three falls in the last 60 days. The provider and family were notified. The provider ordered labs to be completed and a urinalysis (UA). Upon review of the fall investigations for the above falls, it was noted that the investigations lacked a root cause analysis for each fall. On 09/16/2026 at 07:45 AM, R34 was seated at the dining table eating breakfast. On 09/17/2026 at 12:55 PM, Licensed Nurse (LN) H stated that after each fall any witness made a statement then the IDT would have a meeting to determine new interventions and the cause of the fall. LN H stated she was not certain if the root			F0689			

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F0689 SS = D	Continued from page 15 cause was always noted for each fall. On 09/17/2026 at 01:30 PM Administrative Nurse D stated that after each fall a resident had that the IDT would meet to discuss the fall and the best interventions to put in place. A root cause should be included in the investigation. Administrative Nurse D stated that she would make sure that each fall investigation would include the root cause from here on out. The "Incident Reporting and Investigations" policy dated December 2025 documented the facility staff should initiate an incident report for falls. The policy did not go into detail about what needed to be reported or documented regarding falls.			F0689			
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment			F0690			

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F0690 SS = D	Continued from page 16 and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide Resident (R) 3 with sanitary indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) care, who had frequent urinary tract infections (UTIs- an infection in any part of the urinary system) and frequent need for antibiotic (a class of medications to treat infections) treatment. Findings included: - R3's Electronic Medical Record (EMR) included diagnoses of delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) disorder, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hemiplegia (paralysis of one side of the body) 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) affecting the right dominant side, urinary tract infection, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and obstructive and reflux uropathy (blockage stops or slows the normal flow of urine through the urinary tract). R3's "Quarterly Minimum Data Set" (MDS), dated 06/21/2026, documented R3 had intact cognition and rejection of evaluation of care, which occurred four to six days during the look-back period. R3 had functional range of motion impairment on one side of the upper and lower extremities. R3 required partial/moderate assistance with personal hygiene, rolling left to right, sit to lying, lying to sitting, sit to standing, and chair/bed-to-chair transfers and was dependent with toileting hygiene. The MDS further documented R3 had an indwelling catheter and colostomy. R3 also received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), antibiotic (a class of medications used to treat infections), diuretic (a			F0690			

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F0690 SS = D	Continued from page 17 medication to promote the formation and excretion of urine), hypoglycemic (a class of medications used to treat elevated blood sugar), and anticonvulsant. R3's "Care Plan" initiated on 12/17/2025 documented R3 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) with a diagnosis of BPH (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with obstructive uropathy. The plan directed staff to administer medications as ordered and provide catheter care every shift, and to change the catheter bag and tubing every four weeks. PPE (Personal Protective Equipment) is required for high resident contact care activities for suprapubic catheters. The plan further directed staff to monitor/record pain, signs and symptoms of urinary tract infections, and obtain and monitor lab/diagnostic work as ordered. The "Physician Orders" dated 09/04/2025 directed staff to provide catheter care every shift and change the catheter drainage bag weekly, change the suprapubic catheter every month, and document output every shift. The physician orders included Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high-contact care) for high resident contact care activities. The "Physician Order" dated 08/24/2026 directed staff to administer levofloxacin (antibiotic) 500 milligrams once a day for three days for urinary tract infection. Review of the EMR revealed R3 was treated for a urinary tract infection 03/19/2026, 04/19/2026, 05/30/2026, 06/12/2026, 06/29/2026, 07/16/2026, and 08/24/2026. On 09/16/2026 at 08:10 AM, Licensed Nurse (LN) G donned gloves and a gown. LN G assisted R3 onto the bed. She cleansed the catheter tubing with an alcohol pad and the area around the insertion site on his lower abdomen. LN G then placed a split gauze around the tube and taped the gauze with paper tape. LN G failed to change gloves following the cleaning of the tubing and before placing a clean sponge at the insertion site.	F0690					

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F0690 SS = D	Continued from page 18 On 09/16/2026 at 09:58 AM, LN G verified she should have changed gloves after she cleansed the tubing and placed a new split gauze at the insertion site. On 09/17/2026 at 01:30 PM, Administrative Nurse D stated LN G should have changed gloves after cleaning the catheter and before applying a clean gauze to the insertion site. The facility's "Catheter Care, Indwelling" policy, dated 12/2025, stated it is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed for soiling. The purpose is to promote hygiene, comfort, and decrease the risk of infections for catheterized residents. The policy lacked specifics related to EBP standards of practice.	F0690					
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 29 was	F0692					

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F0692 SS = D	Continued from page 19 offered adequate hydration. Findings included: - R29's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN-elevated blood pressure), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), protein calorie malnutrition, 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), and cognitive communication deficit. The "Annual Minimum Data Set" (MDS) for R29 dated 08/28/2026 recorded a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R29's MDS documented R29 was independent with eating. R29's "Care Plan" documented: 12/12/2025-boost supplement. Independent with eating. 12/31/2025-at risk for communication related to language barrier, primary language of Laotian. 09/01/2026- diet as ordered by physician, regular diet, regular texture, and nectar thick consistency. On 09/15/2026 at 12:10 PM, R29 sat at the dining room table. R29 had a cup of coffee in a brown mug, and a glass of water. R29 drank all his drinks and was not offered any more fluids. On 09/16/2026 at 03:40 PM, R29 was at the hydration counter. R29 was pulling on the beverage handles to get fluids. R29 was unable to get fluids from the hydration counter. He was able to open a liquid creamer. He placed the coffee stir straw in the cup of liquid creamer and tried to suck up the creamer. Dietary Staff BB came from the kitchen, picked up the tray of condiments, and took the cart back to the kitchen. Dietary Staff BB did not communicate with R29. R29 remained at the hydration counter. Dietary Staff BB took the dirty laundry cart out of the dining room and did not make the nursing staff aware that R29 was seeking fluids. On 09/17/2026 at 12:36 PM, Certified Nursing Aide (CNA) N stated R29 did not get fluids in his room.			F0692			

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F0692 SS = D	Continued from page 20 She stated staff needed to monitor him with fluids and food. CNA N stated dietary offered him fluids at meals. She stated R29 wheeled himself and could go to the dining room and dietary would get him drinks. On 09/17/2026 at 12:55 PM, Licensed Nurse (LN) G stated it was all nursing staff's duty to provide drinks to the residents. She stated residents should be offered drinks throughout the day, and not just at meals. LN G stated staff pass ice to residents in the afternoon and should provide fluids to all residents. On 09/17/2026 at 01:29 PM, Administrative Nurse D stated staff should offer all residents fluid throughout the day. She stated if R29 wanted a drink, the kitchen staff who noticed should have reported to nursing. She stated CNAs passed ice and water throughout the day, and they should be offering all residents fluids. The facility's "Nutrition and Hydration" policy dated 12/2025 documented It was the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional and hydration status, consistent with their comprehensive assessment, clinical condition, and preferences.			F0692			
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to assess and identify trauma-based triggers related to Resident (R)14's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) when staff failed to implement individualized interventions to prevent re-traumatization to R14. Findings included:			F0699			

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F0699 SS = D	Continued from page 21 - R14's Electronic Medical Record (EMR) documented diagnosis of PTSD, dementia (a progressive mental disorder characterized by failing memory and confusion), and attention-deficit/hyperactivity disorder (ADHD- a lifelong neurodevelopmental brain disorder marked by ongoing patterns of inattention, hyperactivity, and impulsivity that interfere with daily functioning). R14's "Admission Minimum Data Set (MDS)" dated 09/04/2026 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R14's Section I6100 was marked for an active diagnosis of PTSD. R14's "Functional Abilities Care Area Assessment" dated 09/08/2026 documented he had a self- care performance deficit related to a 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), multiple other comorbidities including PTSD. He was able to perform cares with partial/moderate assistance. R14's "Care Plan" initiated on 08/28/2026 and revised on 09/08/2026, directed staff he was at risk for impaired cognitive function or impaired thought process. Staff were directed to identify themselves at each interaction. The plan directed staff that social services were to provide psychosocial support as needed. Staff were directed to engage R14 in simple, structured activities that avoid overly demanding tasks. R14's "Care Plan" lacked a care area and staff direction to address his PTSD or any possible triggers that may cause re-traumatization. A "Social Services Assessment/Evaluation" in the EMR dated 08/29/2026 at 09:28 AM recorded in section III – Cognitive Patterns, Mood and Behavior Assessment an answer of "No" for question B "Experience of trauma or history of trauma". Question Ba. If yes, indicate the type (s) of trauma, option c. was not marked for PTSD. The Summary of the assessment documented resident has a Bims score of 11. The resident was able to let staff know his needs and wants, he stated he was depressed. The resident was in an okay mood that day. The resident had not had a behavior at that time. On 09/16/2026 at 10:34 R14's "Trauma Informed Care" assessment was requested from Administrative Staff A via email. Administrative Staff A's response was, "upon admission during social services assessment the resident denied trauma. The resident is to be seen by our psych group on			F0699			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/17/2026	
NAME OF PROVIDER OR SUPPLIER WILLOW POINT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE , KANSAS CITY, Kansas, 66104			
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F0699 SS = D	Continued from page 22 09/18/2026 due to his new admission". On 09/16/2026 at 09:50 AM, R14 self-propelled his wheelchair from the outside patio down the hall back to his room. When asked about any PTSD, R14 declined to discuss the trauma or possible triggers. On 09/17/2026 at 01:30 PM, Administrative Nurse D stated that upon R14's admission, a more thorough assessment should have been completed by social service to address his diagnosis of PTSD and ask about any triggers for possible re-traumatization. Administrative Nurse D stated that R14's care plan should also address the PTSD and should have interventions to direct staff of possible triggers for re-traumatization. The facility's "Procedure Trauma Informed Care" policy dated 12/01/2025 documented the facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.			F0699			