

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 09/29/2026	
NAME OF PROVIDER OR SUPPLIER WILLOW POINT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE , KANSAS CITY, Kansas, 66104			
(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 complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS) on behalf of the Centers for Medicare and Medicaid Services (CMS) on 09/29/2026. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.			F0000			
F0689 SS = SQC-J	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 observations, interviews, and record review, the facility failed to ensure Resident (R) 1 remained free from preventable accidents related to smoking when staff failed to reassess R1's ability to smoke safely after he was readmitted to the facility with oxygen. The facility failed to identify and implement adequate interventions and smoking supervision which addressed the risks associated with R1's history of noncompliance with the smoking rules and failed to ensure all smoking materials were accounted for and safely stored per R1's plan of care. On 09/04/2026, R1 readmitted to the facility wearing oxygen via nasal cannula, but staff did not reassess the resident's ability to smoke safely. On 09/19/2026, R1 lit a cigarette, which he had stowed in his pocket after staff provided it to him, inside his room. R1 was wearing his oxygen via nasal cannula at the time. The oxygen combusted, melted the nasal cannula, and caused third-degree facial burns and second-degree burns to R1's hand and leg. The facility's failure to assess risks related			F0689			

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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F0689 SS = SQC-J	Continued from page 1 to smoking and failure to ensure safekeeping of all smoking materials placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), nicotine dependence, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and tremors. R1's "Admission Minimum Data Set (MDS)" dated 05/26/2026 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1's MDS documented no behaviors. R1 had no impairment in his upper and lower extremities. The MDS documented R1 required setup or clean-up assistance with shower/bathing himself, and supervision or touching assistance with walking 10 feet on an uneven surface. R1 was independent with all other activities of daily living (ADLs). R1's "Quarterly MDS" dated 08/26/2026 documented a BIMS score of 13, which indicated intact cognition. R1 had verbal behavioral symptoms directed towards others. The MDS documented R1 was independent with all of his ADLs. R1's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 05/26/2026 triggered but lacked analysis. R1's "Psychotropic Drug Use CAA" dated 05/26/2026 triggered but lacked analysis. R1's "Smoking Care Plan" dated 06/30/2026 directed staff to complete smoking assessments as needed. R1's plan of care also directed staff to maintain smoking materials at the nurses' station or other designated areas. Staff were to monitor for possession of smoking paraphernalia as ordered and monitor to assess compliance with facility smoking policy/individual plan. R1's "Oxygen Therapy Care Plan," revised 09/10/2026, directed staff that R1 had oxygen at two	F0689					

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F0689 SS = SQC-J	Continued from page 2 to four liters per minute (L/min) via non-rebreather or nasal cannula as needed for shortness of breath (SOB), respiratory distress, cyanosis (bluish discoloration of the skin), and/or labored breathing. The plan of care also directed staff to administer R1 oxygen as ordered per the medical director's (MD) orders. R1's "Behaviors Care Plan," revised on 06/18/2026, documented he had a history of manipulative behavior related to the smoking policy. R1's plan of care directed staff to monitor and document behaviors and residents' responses to interventions. R1's "Smoking Evaluation Assessment" dated 08/23/2026 documented that he could light his own cigarette and did not utilize oxygen. He safely lit and held his smoking materials and disposed of his smoking materials appropriately. The evaluation documented R1 was educated on the risks of smoking, safe smoking practices, and he was educated on and identified the location of designated smoking areas. The "Nursing Note" dated 08/04/2026 at 06:57 AM documented R1 went outside the front door and smoked "weed" two times on that shift, redirection was not effective. R1 discharged to the hospital on 08/27/2026 and readmitted to the facility on 09/04/2026 with a new order for oxygen. The "Orders" tab revealed a "Physician's Order" dated 09/04/2026 for oxygen to be applied at two L/min via nasal cannula as needed for SOB, respiratory distress, cyanosis, and/or labored breathing. The "Nursing Note" dated 09/19/2026 at 01:00 PM documented at approximately 12:35 PM, Certified Medication Aide (CMA) R requested assistance in R1's room. Upon entering, staff observed R1 seated in his wheelchair; his face was black, and his room smelled like cigarette smoke, but there was no smoke seen in the air or in the room. The oxygen concentrator was still on in the room, so staff immediately turned it off. The oxygen tubing was found on R1's bed, wrapped in a bandana. R1 was alert and talking, requesting his medications. R1			F0689			

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F0689 SS = SQC-J	Continued from page 3 reported having no pain in his face. Staff obtained a new oxygen nasal cannula to provide oxygen to R1 to raise his oxygen saturation level above 90 %. R1's oxygen saturation improved to 93% on four L/min with his nasal cannula. Staff contacted Emergency Medical Services (EMS), who then arrived at R1's room and assessed R1's face. R1 had burns to his face and nasal passage per EMS's assessment. R1 had a cigarette in his shirt pocket and a lighter in his possession. R1 denied smoking in his room and refused at first to go to the emergency room (ER) and stated that he knew what burns were and did not think he was burned. EMS insisted R1 go to the ER to be evaluated and treated, and R1 eventually agreed to go and was transported to the ER. The "Interact Situation, Background, Assessment, Recommendation (SBAR) Summary for Providers Situation Note" dated 09/19/2026 at 03:39 PM documented R1 was smoking in his room with oxygen on, and it caught on fire and burned his face. R1's Primary Care Provider ordered R1 to be sent to the ER. CMA R's unnotarized "Witness Statement" dated 09/19/2026 documented CMA R went to R1's room and observed R1 in the bathroom washing black stuff off his face. She asked R1 to sit and sent for Licensed Nurse (LN) G and Administrative Staff A to come and help. LN G's unnotarized "Witness Statement" dated 09/19/2026 documented CMA R notified her she needed assistance in R1's room. Upon entering the room, R1 was seated in his wheelchair, and his face was black. LN G stated the room smelled like smoke, but no smoke was seen in the air or room. LN G turned the oxygen concentrator off. LN G documented R1 was alert, talking, and asked for his pain and anxiety medication. She documented R1 answered questions appropriately. LN G obtained new oxygen tubing because R1's oxygen saturation was below 90 percent. R1's oxygen saturation immediately improved to 93% on four L/min. LN G documented the fire department arrived and assessed R1, who was found to have burns to his face and nasal passages. LN G documented R1 handed over a cigarette and lighter from his shirt pocket but denied smoking in his room and initially refused to go to the ER. The paramedics insisted the resident go to the ER based on their assessment, and R1 transferred to the ER via EMS.			F0689			

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F0689 SS = SQC-J	Continued from page 4 Administrative Staff A's unnotarized "Witness Statement" dated 09/19/2026 documented she was notified of the incident with R1 while on the premises. Administrative Staff A documented entering R1's room and saw R1's face was black and there was black on the ground area by his bed. R1 was encouraged to sit down to ensure he was calm and alert. Administrative Staff A documented she asked R1 if he smoked with his oxygen on, to which R1 stated he was not smoking. Administrative Staff A asked if R1 had any prohibited items in his room, and R1 gave Administrative Staff A his lighter and cigarette that he had in his pocket. R1's "Skin and Wound Note" dated 09/23/2026 documented R1 had second-degree burns to his right middle finger and right posterior (back) knee, and third-degree burns to his face. On 09/29/2026 at 11:00 AM, R1 sat on his bed eating. R1 had scabs at the start of his left eyebrow, on the side of his left eye, leading down the left side of his nose. The scabs appeared to span from his nose approximately an inch in width, from there, the scabs reached across the top of his lip diagonally past the right side of his lip. R1 had scabbing around his mouth and then two small round areas on the right side of his chin. R1 stated he had a burned area on his right leg that had just been treated and an area on the right middle finger that appeared to be a rough circular shape close to the size of a quarter. R1 revealed the wound went up his left nostril and it was painful. On 09/29/2026 at 11:15 AM, R1 stated that he was able to get the cigarette when he went out for the scheduled smoke break. R1 stated it was easy to keep a cigarette from what was passed out by the staff because the staff did not really pay attention to whether or not both cigarettes were smoked. R1 stated he would just take one of the two cigarettes that were passed out and slip it into his shirt pocket. R1 revealed that he would take that saved cigarette out front and smoke it whenever he wanted another cigarette. R1 reported that a visitor gave him the lighter. R1 stated he did not want to get anyone in trouble throughout the conversation, and then stated when he caught fire, that was the first time he had ever attempted to smoke in his room. R1 stated it was stupid, and it was painful when he was burned.			F0689			

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F0689 SS = SQC-J	Continued from page 5 On 09/29/2026 at 12:00 PM. Certified Nursing Assistant (CNA) M stated she saw R1 sitting in front of the building when she arrived for work around 06:00 AM. CNA M could not recall witnessing R1 smoking out front but stated that she was usually focused on getting in to work, clocking in, and starting her shift. CNA M stated that all the residents shared lighters amongst themselves. On 09/29/2026 at 11:55 AM, Administrative Staff B stated R1 would go smoke in front of the building and she had seen it a few times. Administrative Staff B stated she always reported it to Administrative Staff A, and then she and Administrative Staff A would go talk to R1 about smoking out in front of the building. Administrative Staff B stated that Administrative Staff A was the only one who could get the lighter away from R1. On 09/29/2026 at 12:11 PM, Activity Z stated that she had seen R1 smoking in front of the building a couple of times, but it was usually early in the morning before everyone got into work. Activity Z reported that she did not know where R1 obtained the lighter. On 09/29/2026 at 12:17 PM, Administrative Nurse D stated she never saw R1 smoking out in front of the building, but she did not think it had been happening for a long time. Administrative Nurse D stated she could not say why those incidents were not charted or care planned. She stated she expected it to be documented and R1's non-compliance to be care planned. Administrative Nurse D stated she did not feel the smoking assessment needed to be redone when R1 returned with oxygen ordered because he only wore oxygen in his room as it was as needed. On 09/29/2026 at 12:22 PM, Administrative Staff A stated she saw R1 smoking in the front of the building when she first got to the building in the morning. Administrative Staff A stated R1 was only known to smoke out front either really early in the morning or late at night, and it had only been going on for a few weeks. She stated he would usually not smoke in the front of the building during business hours. The team would meet with him and talk about the policy and the expectations, redirect him, and they had actually started the 30-day discharge process, but then he went out (to the hospital) and had a change in condition. She stated that the			F0689			

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F0689 SS = SQC-J	Continued from page 6 behaviors should have been charted and it should have been care planned. Administrative Staff A said the burns to R1's hands and his leg were from the debris of the melted nasal cannula. She stated staff had never been able to find out where the lighter came from, and she stated that she had completed interviews. The facility's "Smoking Policy/E-cigarettes/chewing tobacco" policy, updated 01/01/2026, documented that it was the policy of the facility to provide the residents a smoke-free and nicotine-free environment. It is also the policy to provide those residents who choose to smoke a means in which to do so that does not jeopardize their safety or the safety of others residing in the facility. The policy documented that the facility would immediately confiscate smoking materials visible in a resident's room or on their person and place them in the secure storage area for these items. The facility may exercise the option to search a resident's room, with the resident's or resident representative's permission, if smoking materials are suspected to be with the person. On 09/29/2026 at 03:38 PM, Administrative Staff A, Administrative Staff C, Administrative Nurse D, and Consultant GG received the "Immediate Jeopardy [IJ] Template" and were informed that the facility's failure to assess risks related to smoking and failure to ensure the safekeeping of all smoking materials placed R1 in immediate jeopardy. The facility submitted an acceptable IJ removal plan on 09/29/2026 at 05:01 PM, which included the following corrective actions: Immediate Actions taken – all immediate staff in the building at midnight on 09/19/2026 were in-serviced on the smoking policy and residents with smoking paraphernalia in their rooms. Staff coming on the morning shift of 09/20/2026 were also in-serviced. An all-staff meeting was held on 09/24/2026, and the smoking policy and the incident were reviewed with the staff in attendance. On 09/29/2026, when the IJ was called, all residents who smoke were reassessed for safety, and any changes to their regimen were input into the care plan. All residents who smoke were counselled about the			F0689			

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F0689 SS = SQC-J	Continued from page 7 safety of smoking and not keeping smoking paraphernalia on their person at any time in the building, and the new policies and procedures. This was completed by Administrative Staff A on 09/29/2026 at 04:30 PM. All staff will be in-serviced by the end of the day on 09/30/2026 at 03:00 PM, and any as-needed staff will be in-serviced prior to their next scheduled shift. The Medical Director was notified of the incident on 09/20/2026, and the facility Nurse Practitioner. Notification with follow-up was sent to the State Agency. Implementation of the corrective actions and the removal of the immediate jeopardy was verified on-site on 09/29/2026. The deficient practice remained at a scope and severity of "G" (actual harm, isolated).			F0689			