Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25482	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE VILLAGE SENIOR LIVING COMMUNITY	103 BERNARD DRIVE BELTON, MO 64012

(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) COMPLETE DATE
A2213	19 CSR 30-86.022(4)(C) Range Hood Certification Range Hood Extinguishing Systems. (C) The range hood and its extinguishing system shall be certified at least twice annually in accordance with NFPA 96, 1998 edition. II/III This regulation is not met as evidenced by: Class II Based on observation and interview during the fire safety inspection process, the facility failed to certify a hood extinguishing system in accordance with NFPA 96. The facility census was sixty-seven. This deficiency affects sixty-seven of sixty-seven residents. Observation revealed the kitchen hood suppression system has not been inspected or tagged. (Kitchen Hood Suppression Systems are required to be inspected twice a year, per NFPA 96). During the exit interview on July 31, 2024 at 1115, the maintenance director stated he would have the system inspected and tagged.	A2213		
A2238	19 CSR 30-86.022(8)(C) Exit Sign-Illumination Exit Signs. (C) All required exit signs and directional indicators shall be positioned so that both normal and emergency lighting illuminates them. II/III This regulation is not met as evidenced by: Class III Based on observation and interview during the fire safety inspection process, the facility failed to ensure all exit signs were illuminated under	A2238		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tawnia Brooke Wickler RN | TITLE: Administrator | (X6) DATE: 8/12/24

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A2238	Continued From page 1 normal and emergency conditions. The facility census was sixty-seven. This deficiency affects sixty-seven of sixty-seven residents. Observation revealed the exit sign in the main lobby leading out through the patio was an unapproved exit sign, as it was unable to be illuminated under normal and emergency conditions. Observation revealed the exit signs at the base of the three emergency exit stairwells are unapproved exit signs, as they are unable to be illuminated under normal and emergency conditions. During the exit interview on July 31, 2024 at 1120, the maintenance director stated he would install the appropriate exit signs.	A2238		
A2256	19 CSR 30-86.022(10)(A) Hazardous Area Requirements Protection from Hazards. (A) In assisted living facilities and residential care facilities licensed on or after November 13, 1980, for more than twelve (12) beds, hazardous areas shall be separated by construction of at least a one- (1-) hour fire-resistant rating. In facilities equipped with a complete fire alarm system, the one- (1-) hour fire separation is required only for furnace or boiler rooms. Hazardous areas equipped with a complete sprinkler system are not required to have this one- (1-) hour fire separation. Doors to hazardous areas shall be self-closing and shall be kept closed unless an electromagnetic hold-open device is used which is interconnected with the fire alarm system. When the sprinkler option is chosen, the areas	A2256		

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A2256	Continued From page 2 shall be separated from other spaces by smoke-resistant partitions and doors. The doors shall be self-closing or automatic-closing. Facilities formerly licensed as residential care facility I or II, and existing prior to November 13, 1980, shall be exempt from this requirement. II This regulation is not met as evidenced by: Class II Based on observation and interview during the fire safety inspection process, the facility failed to maintain smoke partitions which separate the kitchen area from the dining area. The facility census was sixty-seven. This deficiency affects sixty-seven of sixty-seven residents. Observation revealed an air vent from the kitchen to the dining room that provided no fire/smoke protection. Observation revealed the fire/smoke door of the kitchen propped open with a chair. (Chair removed during inspection) During the exit interview on July 31, 2024 at 1125, with the maintenance director stated he would see that the kitchen staff keeps the door closed and will install a magnetic hold tied into the fire alarm system. He will also have a smoke damper installed in the open vent.	A2256		
A2273	19 CSR 30-86.022(11)(E) Sprinkler System, Res. Impaired, Multilevel Sprinkler Systems. (E) Multi-level assisted living facilities that provide care to one (1) or more residents with a physical, cognitive, or other impairment that prevents the	A2273		

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A2273	Continued From page 3 individual from safely evacuating the facility with minimal assistance shall install and maintain an approved sprinkler system in accordance with NFPA 13, 1999 edition. I/II This regulation is not met as evidenced by: Class II Based on observation and interview during the fire safety inspection process, the facility failed to install a complete sprinkler system in accordance with NFPA 13, 1999 edition. The facility census was sixty-seven. This deficiency affects sixty-seven of sixty-seven residents. Observation revealed no sprinkler heads in the bathrooms of rooms 123, 204, 306 and 306. During the exit interview on July 31, 2024 at 1130, with the maintenance director he stated he would wait until I researched whether the bathrooms require sprinkler heads or not. Follow-up phone conversation on August 1, 2024 at 1500, the maintenance director advised he had contacted the sprinkler designer and he came to the same conclusion as I had, that the 4 bathrooms require sprinkler heads. He has the sprinkler company coming next week to correct the situation.	A2273		
A2286	19 CSR 30-86.022(15)(A) Wastebaskets, Metal/UL/FM-Requirements Trash and Rubbish Disposal. (A) Only metal or UL- or FM-fire-resistant rated wastebaskets shall be used for trash. II This regulation is not met as evidenced by:	A2286		

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A2286	Continued From page 4 Class III Based on observation and interview during the fire safety inspection process, the facility failed to ensure only metal or UL- or FM-fire-resistant rated wastebaskets were being used for trash. The facility census was sixty-seven. This deficiency affects sixty-seven of sixty-seven residents. Observation revealed unapproved wastebaskets in use throughout the facility, in nearly every resident room and many common spaces. There were so many unapproved waste baskets, that removal at time of discovery was not a practical solution. During the exit interview on July 31, 2024 at 1135, the maintenance director stated he has received misinformation regarding wastebaskets. He now has a clear understanding and will remove and replace all of the unapproved wastebaskets throughout the facility.	A2286		

PLAN OF CORRECTION

Provider Name:	CARNEGIE VILLAGE ASSISTED LIVING
Street Address, City, Zip:	103 Bernard Drive Belton Mo 64012
Date of Survey:	7/31/24
Provider number:	25482

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This serves as the allegation of compliance for Carnegie Village Assisted Living. Carnegie Village Assisted Living asserts that all corrections described on this Plan of Correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our plan of action. **The staff of Carnegie Village Assisted Living is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Carnegie Village Assisted Living is in substantial compliance as set forth below, and we are confident that we will be found in substantial compliance with regulations upon re-survey. The statements made on the Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.** **Carnegie Village Assisted Living has completed the following interventions because of the findings from the survey exiting on 7/30/24.**	
A2213	**Immediate actions taken for the resident found to have been affected include:** During the survey it was stated that a company should have conducted a semi-annual inspection. All State Fire Equipment Midwest was dispatched on 8/7/24 to complete semiannual inspection of Range Hood Extinguishing System at 1:00pm **Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:**	9/14/24

	Monthly reoccurring follow ups between the Administrator and Maintenance Director to ensure all inspections have been scheduled and completed prior to the due date. **How the corrective actions will be monitored to ensure the practice will not recur:** The QA committee will review this plan of correction quarterly or at least 180 days until such time consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
A2238	**Immediate actions taken for the resident found to have been affected include:** Illuminated Exit Signs were added to main lobby exit out to patio, and all three emergency exit stairwells. This was done on 8/5/2024. All four exit signs after addition were tested for ninety minutes immediately followed by a thirty second test to ensure proper illumination duration of exit signs back up battery functions. **Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Monthly checks of emergency light placement and functions. This will be an ongoing action to ensure the facility remains compliant by the Maintenance Director. **How the corrective actions will be monitored to ensure the practice will not recur:** The QA committee will review this plan of correction quarterly or at least 180 days until such time consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	9/14/2024
A2256	**Immediate actions taken for the resident found to have been affected include:** The corrective action for the kitchen door being propped open with a chair is to add an aluminum electromagnetic door holder wall mounted that is tied into the fire panel. This was completed 8/7/2024 The Corrective action for air vent between kitchen and dining room is to have Fagan install the fire/smoke damper, and	9/14/2024

	for the Electronic Contract Company to run wire, connect, and program damper into fire panel. **Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Staff education provided to all staff on 8/1/24 by the Maintenance Director on ensuring that all doors aren't being propped open. Fagan will be out to community on 8/28/24 to install. Electronic Contracting Company will be out to community on 8/30/24 to program to fire panel. This will be accomplished by having the kitchen door and damper logged and monitored for proper functions during all monthly tests, and fire drills performed by the Maintenance director. **How the corrective actions will be monitored to ensure the practice will not recur:** The QA committee will review this plan of correction quarterly or at least 180 days until such time consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
A2273	**Immediate actions taken for the resident found to have been affected include:** National Fire Suppression will add one head in the bathrooms of rooms 123, 204, 305, and 306. National Fire Suppression will drain the system, and branch off the closest existing head in each room. Upon completion National Fire Suppression will reengage the system. The Maintenance Director will follow behind and make all necessary repairs to walls that had been affected during the installation. Completion date is 8/16/24. **Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential for being affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Maintenance Director will perform monthly rounds on all sprinkler heads to confirm continued cleanliness and functionality.	9/14/2024

	How the corrective actions will be monitored to ensure the practice will not recur: The QA committee will review this plan of correction quarterly or at least 180 days until such time consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
A2286	**Immediate actions taken for the resident found to have been affected include:** Corrective action is to replace all non-fire rated waste baskets with approved wastebaskets. This will take place throughout the facility. All non-approved wastebaskets will be removed and replaced with all metallic or UL listed fire rated wastebaskets. This began upon exit of interview and will be completed by 8/19/2024. **Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Adding policies during admission process regarding bringing trash cans into the facility. The Maintenance Director will add it to monthly safety rounds to monitor any waste baskets that have been brought in from family members that don't meet requirements. **How the corrective actions will be monitored to ensure the practice will not recur:** The QA committee will review this plan of correction quarterly or at least 180 days until such time consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	9/14/2024
