STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265595	A. BUILDING _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SPRINGS WELLNESS & REHABILITATION	930 NE DUNCAN ROAD BLUE SPRINGS, MO 64014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandy Braswell	Administrator	12/21/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265595	A. BUILDING _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SPRINGS WELLNESS & REHABILITATION	930 NE DUNCAN ROAD BLUE SPRINGS, MO 64014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the floors of the following rooms in a clean condition in resident rooms 204, 105, 101, 304, 310, 514, 504, 501, 411, 406, and 407. This practice potentially affected 12 residents. The facility census was 68 residents. 1. Observation on 12/2/24 with the Housekeeping Supervisor showed: - At 12:59 P.M., there was a buildup of cobwebs along the floor and wall area next to the refrigerator in resident room 204. - At 1:01 P.M., there was a buildup of cobwebs in the corners of room 101. - At 1:04 P.M., there was a buildup of dust and debris along the wall in resident room 304. - At 1:05 P.M., there was a buildup of hair and dust along the wall in resident room 310. - At 1:08 P.M., there was a buildup of dust under the bed in resident room 514. - At 1:10 P.M., there was a buildup of dust and cobwebs behind the bed and long the walls at the floor level in resident room 504. - At 1:15 P.M., there was a buildup of dust cobwebs behind the dresser in resident room 501. - At 1:17 P.M., there were dead insects under the bed and hairs on the floor in resident room 406. - At 1:19 P.M., there was a buildup of cobwebs behind the dresser in resident room 407. During an interview on 12/2/24 at 1:20 P.M., the Housekeeping Supervisor said the housekeepers are not pulling furniture out from the walls so they can get behind those areas.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265595	A. BUILDING _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SPRINGS WELLNESS & REHABILITATION	930 NE DUNCAN ROAD BLUE SPRINGS, MO 64014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 During an interview on 12/2/24 at 1:22 P.M., Housekeeper A said he/she cleaned the rooms daily, but sometimes it was difficult to pull the furniture out from the walls. MO00245581.	F 584		

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
	00677	A. BUILDING: _____ B. WING _____	C 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SPRINGS WELLNESS & REHABILITATION	930 NE DUNCAN ROAD BLUE SPRINGS, MO 64014

(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
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: 1. Refer to F584. MO00245581	A6012		

PLAN OF CORRECTION

Provider/Supplier Name:	Blue Springs Wellness and Rehabilitation Center
Street Address, City, Zip:	930 NE Duncan Road Blue Springs, MO. 64014
Date of Survey:	12/02/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	00677

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F584 **SS=E**	**F 584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.** This **REQUIREMENT** is not met as evidenced by: Based on observation and interview: • The facility allegedly failed to maintain the floors of the following rooms in a clean condition in resident rooms **204, 105, 101, 304, 310, 514, 504, 501, 411, 406**, and **407.** This practice potentially affected 12 residents. **Corrective Action for Affected Residents** • The Housekeeping Director and Housekeeping staff removed the buildup of cobwebs along the floor and wall area next to the refrigerator in resident **room 204.**	**1/15/25**

Missouri DHSS Department of Health and Senior Services

Plan of Correction

PLAN OF CORRECTION	
Provider Name:	Blue Springs Wellness and Rehabilitation
Street Address, City, Zip:	930 NE Duncan Road Blue Springs, MO. 64014
Date of Survey:	12-02-24
Provider number:	00677

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
A6012	**19 CSR 30-87.020(12) Floor Surfaces** This regulation is not met as evidenced by: Class II* 1. **Refer to F584.** **MO00245581.**	**1-15-25**

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.