AN ADMINISTRATOR SIGNATURE COULD NOT BE OBTAINED.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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. 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. Review of the facility's policy titled "Administration of Medications" dated October 2024 showed: -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). 1. Review of Resident #2's Admission Record	F 658	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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showed he/she admitted to the facility with the following diagnoses:
-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).

Review of the resident's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 4/21/25 showed the resident was cognitively intact.

Review of the facility's Medication Error Investigation dated 4/16/25 showed:
-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

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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).

Review of Resident #2's and Resident #14's medical record showed Resident #2 received the following un-ordered medication:
-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

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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.
-Senna-S (used to treat constipation) Capsule 8.6-50 mg, give two capsules by mouth twice a day for constipation.
-Acetaminophen (Tylenol- used as a pain and fever reliever) Oral Tablet 500 mg, give 1000mg by mouth three times a day for pain.
-Methocarbamol (used to treat muscle pain and spasms) Oral Tablet 500 mg, give 500 mg by mouth three times a day for muscle aches).
-Losartan Potassium (used to treat high blood pressure) Oral Tablet, give 100 mg by mouth one time a day for high blood pressure.

During an interview on 4/23/25 at 3:53 P.M. Registered Nurse (RN) C said:
-Interruptions during medication pass made for increased risk of medication errors.
-The nurses were sometimes interrupted by staff and other residents during medication pass.
-There could be a variety of problems or negative outcomes related to a resident receiving the wrong medication.
-The medication on the resident's MAR that stuck out the most to him/her that could cause a potential negative outcome was the Losartan Potassium.

During an interview on 4/24/25 at 10:16 A.M. the Director of Nursing (DON) said:
-RN B should have given the correct medications to the resident.
-There was potential for the resident to have a negative outcome which was why the resident was sent to the local hospital.
-The investigation conducted determined that

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F 658	Continued From page 4 interruptions during medication pass most likely caused the error. -The Losartan Potassium was the main medication that stuck out to him/her which could have caused the biggest negative outcome. During an interview on 4/24/25 at 11:25 A.M. RN B said: -He/She had been preparing both Resident #2's medications and Resident #14's medications at the same time. -He/She normally labeled the medication cups with the resident's names. -He/She accidentally grabbed the wrong cup and administered Resident #14's medications to Resident #2. -He/She realized immediately afterwards that the medication error had occurred. -Resident #2 had not questioned him/her when taking the medication. -He/She typically "pre-popped" resident's medications during medication administration. -The "pre-popping" method was not something taught to him/her by the facility, but was the best way for him/her to get through the medication pass at a faster pace. -He/She had started working at the facility earlier in the year and this incident was the first and only time a medication error had occurred. -The resident seemed lethargic and sleepy after the incorrect medications were given. -He/She was distracted during the medication pass. -He/She had a student with him/her and other residents were asking for pain medications. -He/She was very upset about the error as the error should not have occurred. -He/She should have given Resident #2 the correct medications.	F 658		

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F 689 SS=E	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, 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. 1. Review of Resident #3's Admission Record showed he/she admitted to the facility on 2/17/25 with the following diagnoses: -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,	F 689		

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and safety awareness).
-Need for Assistance with Personal Care.

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:
-The resident had moderately impaired cognition.
-The resident needed partial/moderate assistance (helper does less than half the effort) with toileting hygiene.

Review of an Un-Witnessed Fall Incident Report dated 3/8/25 at 8:50 A.M. completed by Registered Nurse (RN) A showed:
-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.
-The resident had an additional hematoma noted.

Review of the resident's skin observation dated 3/9/25 at 8:30 P.M. showed:
-The resident had a hematoma to his/her left front scalp.
-The resident had bruising to his/her left trochanter (a tubercle of the femur near its joint with the hip bone).
-The resident had a left lateral facial bruise.
-The resident had a bruise to his/her right top of

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his/her hand.

Review of a Fall Investigation dated 3/10/25 completed by the Administrator and Director of Nursing (DON) showed:
-The resident had an unwitnessed fall on 3/8/25.
-The licensed nurse heard a loud noise that came from the resident's room.
-The nurse went to the resident's room immediately and observed the resident in a left lateral position and asking for help to get up.
-The call light was not engaged at the time of the fall.
-Upon entry to the resident's room, the nurse noted that the resident's bathroom door was also on the floor.
-Nursing staff reported that the door did not fall on or hit the resident.
-The door was found lying next to the resident.
-The nurse performed a head to toe skin assessment, a passive range of motion (ROM) assessment, and a neurological assessment.
-It was noted that the resident had a hematoma to the left lateral side of his/her head.
-Later in the day the resident started to complain of pain.
-The facility received orders from the facility's provider for an X-ray of his/her head and left hip.
-The X-rays were completed on 3/8/25 and the X-ray reports were received on 3/9/25.
-The X-ray report showed that the resident had a left femoral neck fracture with minimal impaction and displacement.
-The X-ray report showed the resident's skull did not have any fractures.
-The facility's provider was then notified and the resident was sent to the local hospital for evaluation and treatment.
-The inter-disciplinary team met on 3/10/25 to

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discuss the resident's fall.
-The resident had been receiving antibiotics for a Urinary Tract Infection (UTI) prior to the fall and determined that the UTI was most likely the root cause of the fall.
-All previous fall and safety interventions were in place at the time of the fall.
-The Maintenance Director performed an audit to all the resident bathroom track doors in the facility to identify any concerns.
-No concerns were found upon completion of the audit.
-The inter-disciplinary team also determined that the secondary root cause of the fall was the resident's diagnosis of dementia.
-The fall was determined to be accidental and was not caused by any facility abuse or neglect.

Review of an Administrative Note dated 3/10/25 at 9:51 A.M. completed by the Administrator showed:
-On 3/8/25 around 8:50 A.M. nursing care staff heard a loud bang come from the resident's room.
-Nursing care staff responded immediately to the resident's room and found the resident on the floor on his/her left side asking for help.
-It was noted that the resident's track bathroom door was also on the floor.
-The resident had a hematoma to his/her left lateral part of head.

Review of an undated witness statement completed by RN A showed:
-The resident was found in his/her room lying on his/her left side between the two sides of the room.
-The resident was unable to explain what happened.

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-The resident was wearing non-skid socks at the time of the fall.
-The resident had gotten out of his/her wheelchair and the wheelchair was not near the resident or the door when the resident was found on the floor.
-The resident did not have any complaints at the time of the fall.
-The resident began to complain of pain about two hours after the fall occurred.

Review of an undated statement completed by Occupational Therapist (OT) A showed:
-OT A had not seen the resident prior to the resident's fall.
-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.
-The resident was wearing non-skid socks at the time of the fall.
-The resident stated, he/she "was trying to come out of the bathroom."
-OT A assisted the resident in setting up his/her breakfast and began to eat his/her food.

During an interview on 4/18/25 at 9:21 A.M. the Maintenance Director said:
-There is an online system that staff could use to put in work orders.
-Any staff person had access to the online system to put in work orders.
-He/She was unaware of any issues with the resident's track bathroom door prior to the resident's fall on 3/8/25.
-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.
-He/She was notified immediately after the resident's fall that the resident's bathroom track

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door had fallen off the track.
-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.
-He/She had not found anything wrong with the door or track system.
-He/She then completed an audit of all the resident bathroom doors on 3/8/25, and no other issues were found.
-All resident bathroom doors throughout the facility have the same door and track system.

During an interview on 4/18/25 at 12:11 P.M. the Maintenance Director said:
-The housekeepers complete a room flip checklist whenever a resident discharges.
-The facility has a high volume of discharges, so the housekeepers perform the room flip checklist frequently.
-The housekeepers were expected to let the Maintenance Director know of any issues once the room flip checklist had been completed.
-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.
-The bathroom track door could not be permanently removed from the track because the resident lived in a semi-private room with a roommate.
-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.
-None of the staff were able to report how the bathroom door came off the track when the resident fell on 3/8/25.
-If the door were to be bumped with enough

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leverage there would be a chance that the door could come off the track.

During an interview on 4/18/25 at 12:30 P.M. RN A said:
-He/She had not received any reports from the resident or resident's family about there being any issues with the resident's door.
-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.
-The door was not found on top or really near the resident when the resident fell.
-The resident was able to report to him/her that the door had not fallen on him/her.
-The resident did not seem to be injured at the time of the fall and seemed to be embarrassed by the whole situation.
-The resident had some scratches on his/her head and arms after the fall.
-The resident reported that he/she was in pain a few hours after the fall occurred.
-The resident's roommate at the time reported that the door had not hit or fallen on the resident when the resident fell.

During an interview on 4/18/25 at 12:47 P.M. Licensed Practical Nurse (LPN) A said:
-He/She had heard a crash and ran to the resident's room.
-When he/she got to the room OT A was helping the resident up from the floor.
-The resident's bathroom door was lying on the ground next to the resident.
-He/She was unsure if the door had hit the resident.

During an interview on 4/18/25 at 12:52 P.M. OT

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A said:
-He/She had been in a different resident's room when he/she heard a loud bang.
-He/She saw the resident lying on the ground on his/her left side with his/her feet towards the bathroom.
-The resident's bathroom track door was lying next to the resident to the left of the resident.
-With the way the track door was situated it did not appear that the door had hit or fallen on the resident.
-The resident had stated he/she was trying to use the bathroom at the time of the fall.
-The Maintenance Director came in to fix the bathroom track door afterwards.

During an interview on 4/18/25 at 12:59 P.M. Family Member A said:
-He/She had arrived at the facility around 9:25 A.M. on the morning of 3/8/25.
-The resident was by the nurse's station when he/she arrived at the facility.
-The resident had a bump and bruise on his/her head/face.
-He/she wheeled the resident back to his/her room.
-The resident's bathroom door was hanging on the track when he/she arrived at the resident's room.
-He/She had been told by RN A that the bathroom track door did not hit or fall on the resident.
-The door had been an issue prior to the incident.
-He/She had been in communication with RN A about the bathroom track door being an issue.
-He/She did not think that he/she had any additional conversations with other staff about the resident's bathroom track door.

During an interview on 4/18/25 at 1:27 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265880	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IGNITE MEDICAL RESORT BLUE SPRINGS	20511 E TRINITY PLACE BLUE SPRINGS, MO 64015

(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 689	Continued From page 13	F 689		

Resident #9 said:
-He/She had been roommates with Resident #3.
-The bathroom door was on the track prior to the incident.
-He/She thought his/her roommate fell against the door and knocked it down.
-He/She did not visualize the fall itself, only heard the resident and the door fall.
-There had not been any issues with the bathroom track door prior to the incident.
NOTE: Review of Resident #9's Prospective Payment System (PPS) five-day assessment showed the resident was cognitively intact.

During an interview on 4/18/25 at 2:25 P.M. RN A said:
-There had not been any issues with the resident's bathroom track door prior to the incident.
-He/She had not reported any issues to the Maintenance Director prior to the incident.
-He/She did not think the roommate visualized the incident but had been in the room at the time of the incident.
-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.

During an interview on 4/22/25 at 2:51 P.M. LPN C said:
-He/She had worked with the resident the day before the incident on 3/7/25.
-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.
-The resident's bathroom track door was usually open.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265880	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IGNITE MEDICAL RESORT BLUE SPRINGS	20511 E TRINITY PLACE BLUE SPRINGS, MO 64015

(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 689	Continued From page 14 During an interview on 4/22/25 at 3:49 P.M. LPN D said: -He/She had not remembered there being any issue with the resident's bathroom track door prior to the incident. -He/She felt like he/she would have noticed if there was anything wrong with the bathroom track door. -There had not been any reports of any issues with the resident's bathroom track door. -The resident's bathroom track door seemed to always be open. -He/She felt like if the bathroom track door was pushed/pulled hard enough, it could come off the track. Observation on 4/23/25 at 10:05 A.M. showed all residents had the same bathroom track doors. During an interview on 4/24/25 at 9:00 A.M. the Maintenance Director said: -He/She had only performed an audit of all resident bathroom track doors after the incident. -Nothing else needed to be done after that point in time. -He/She had never had an issue with any resident bathroom track door like what happened during the incident prior to the incident. -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. -No additional safety mechanisms were placed on the resident's bathroom track door prior to the incident. -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.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265880	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IGNITE MEDICAL RESORT BLUE SPRINGS	**20511 E TRINITY PLACE BLUE SPRINGS, MO 64015**

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F 689	Continued From page 15	F 689		

During an interview on 4/24/25 at 10:16 A.M. the DON said:
-He/She was unaware of any issues with the resident's bathroom track door prior to the incident.
-There had not been an issue with any other residents bathroom track doors like what happened during the this incident.
-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.

During an interview on 4/24/25 at 10:35 A.M. the Administrator said:
-The incident had been an isolated incident.
-He/She had not thought that what happened in the incident was even a possibility.
-The Maintenance Director did not have to fix anything with the bathroom track door or track system after the incident occurred.
-He/She was unaware of any issues with the resident's bathroom track door prior to the incident.
-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.

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.

MO00252789

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
	32246	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IGNITE MEDICAL RESORT BLUE SPRINGS	**20511 E TRINITY PLACE BLUE SPRINGS, MO 64015**

(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
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II 1. Refer to F689.	A4074		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

PLAN OF CORRECTION

Provider Name:	Ignite Medical Resort Blue Springs
Street Address, City, Zip:	20511 E Trinity Pl, Blue Springs MO 64015
Date of Survey:	4/24/2025
Provider number:	265880

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F000	**Survey Allegation of Compliance:** Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Ignite Medical Resort Blue Springs of the truth or findings alleged in this statement of deficiencies and plan of correction OR failure to follow applicable standards of care. This plan of correction is submitted to comply with state and federal law. This plan of correction serves as the allegation of compliance. **Compliance Statement:** For the deficiencies cited in this survey, this facility will develop and implement a facility wide system to assure correction and continued compliance with the regulations. We will provide a complete copy of the deficiencies and the plan of correction to our Quality Assurance and Performance Improvement (QAPI) Committee for review and appropriate action during our next scheduled QAPI Committee meeting and to ensure appropriate action is maintained thereafter.	6/6/2025

F689	**Corrective Action Taken:** On 3/8/25, Resident #3 was immediately assessed by nursing staff following the fall incident. X-rays were obtained which revealed a left femoral neck fracture. The resident was transferred to the hospital for evaluation and treatment. The bathroom track door was immediately inspected by the Maintenance Director on 3/8/25. The bump stops were tightened as a precautionary measure.. **Identify other residents having the potential to be affected by the same deficient practice will occur are as follows:** On 3/8/25, the Maintenance Director completed a facility-wide audit of all resident bathroom track doors to identify any potential safety concerns. No additional issues were identified during this audit. All residents who utilize bathrooms with track doors have the potential to be affected **Measures that will be put into place or systematic changes made to ensure that the deficient practice reoccur are as follows:** 1. The Director of Nursing (DON) provided in-service re-education to nursing staff regarding: Fall prevention by reviewing fall risk assessment to identify needed interventions based on patient's recent fall and habits. 2. The Maintenance Director provided in-service re-education to housekeeping staff regarding: Proper inspection of bathroom doors during room flip checks. Maintenance Director to complete monthly bathroom door inspections. 3. The facility is installing additional safety hardware/cables on all bathroom track doors. **QA/PI Plan:** 1. The DON or designee will review all fall incidents weekly for 4 weeks, then monthly for 2 months to ensure proper assessment and follow-up of interventions implemented. 2. The Maintenance Director or designee will conduct random weekly audits of bathroom doors tracks for proper function and safety for 4 weeks, then monthly for 2 months.	6/6/2025

	3. The Administrator or designee will conduct weekly audits of maintenance work orders and completion documentation for 4 weeks, then monthly for 2 months. Results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and recommendations. The QAPI Committee will determine the need for ongoing monitoring based on audit results. The Administrator is responsible for implementing this plan of correction.	

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.

PLAN OF CORRECTION

Provider Name:	Ignite Medical Resorts Blue Springs
Street Address, City, Zip:	20511 E. Trinity Place Blue Springs, MO 64015
Date of Survey:	4/24/25
Provider number:	265880

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4074	Refer to F689	6/6/2025

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.