An administrator signature on the 2567 & approved POC could not be found in file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A2206	19 CSR 30-86.022(2)(H) Combustibles Not Stored Under Stairways General Requirements. (H) Facilities shall not use space under stairways to store combustible materials. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure combustibles were not stored under the stairwell from F Hall and E Hall in the Assisted Living Facility (ALF) Section. This practice potentially affected 14 residents who resided in two out of eight smoke zones in the ALF. The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/20/24 at 9:07 A.M., showed numerous milk crates, one hydration cart with a chair and five boxes of foaming dispenser stored under the stairwell from E Hall. Observation on 8/20/24 at 9:32 A.M., showed 30 boxes of paper towel dispensers and two wooden tables were stored under the stairwell from F Hall. During an interview on 8/20/24 at 9:34 A.M., the Environmental Services (EVS) Director agreed that items should not be stored under the stairwells and he/she would have those items moved. Review of 2012 National Fire Protection Association (NFPA) 101 Chapter 7.2.2.5.3 showed: "Usable Space. Enclosed, usable spaces within exit enclosures shall be prohibited, including under stairs, unless otherwise permitted by 7.2.2.5.3.2.	A2206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2231	Continued From page 1	A2231		
A2231	19 CSR 30-86.022(7)(G) Stairways/Corridors Free of Obstructions Exits, Stairways, and Fire Escapes. (G) All stairways and corridors shall be easily negotiable and shall be maintained free of obstructions. II This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the staircase from the F Hall in the Assisted Living Facility (ALF) was maintained to be clear of all obstructions which partially blocked the stairwell to the lower floor from the ALF section. This practice potentially affected three residents who resided in one smoke zone (the F Hall) out of eight total smoke zones on the ALF. The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/19/24 at 1:44 P.M., showed the presence of a couch and a bed frame which partially blocked the stairwell from the F Hall exit door to that stairwell. During an interview on 8/19/24 at 1:46 P.M., the Environmental Services (EVS) Director said he/she was not sure how long those items had been stored at that location but those items should not be stored in a way to block the stairwell. Review of the 2012 National Fire Protection Association (NFPA) 101 Chapter: 7.1.10.1, showed the following: "Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency." 7.2.2.2.1.2 Minimum New Stair Width.	A2231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2231	Continued From page 2 (A) Where the total occupant load of all stories served by the stair is fewer than 50, the minimum width clear of all obstructions, except projections not more than 4 and 1?2 in. at or below handrail height on each side, shall be 36 in. (915 mm). (B)* Where stairs serve occupant loads exceeding that permitted by 7.2.2.2.1.2(A), the minimum width clear of all obstructions, except projections not more than 4 1?2 in. at or below handrail height on each side, shall be in accordance with Table 7.2.2.2.1.2(B) and the requirements of 7.2.2.2.1.2(C), 7.2.2.2.1.2(D), 7.2.2.2.1.2(E), and 7.2.2.2.1.2(F).	A2231		
A2249	19 CSR 30-86.022(9)(C) Fire Alarm System-Test/Maintain Complete Fire Alarm Systems. (C) All facilities shall test and maintain the complete fire alarm system in accordance with NFPA 72, 1999 edition. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure the vertical sliding door pass through between the kitchenette and the dining room in the Assisted Living Facility (ALF) section, was equipped to automatically close with fire alarm activation, to prevent the passage of smoke. This practice potentially affected at least 20 residents who used the dining room. This practice potentially affected 2 smoke zones (the dining room and G Hall area). The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/20/24 at 9:14 A.M., showed	A2249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2249	Continued From page 3 the vertical sliding door between the kitchenette and the dining room was not joined with the fire alarm system, to ensure that door closed upon fire alarm activation. During an interview on 8/20/24 at 9:16 A.M., the Environmental Services (EVS) Director said that door needed to be self-closing with the fire alarm system. Review of 2010 National Fire Protection Association (NFPA) 80 Chapter 10.4.1 through 10.4.2, showed: 10.4.1.1 Vertically sliding tin-clad, sheet metal, and sectional steel doors shall be equipped to close automatically at the time of fire. 10.4.1.2 Vertically sliding sectional doors shall close automatically upon operation of a fusible link or detector that releases the overhead sectional door, and the governor shall control the rate of descent.	A2249		
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	A2256		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2256	Continued From page 4	A2256		

is interconnected with the fire alarm system. When the sprinkler option is chosen, the areas 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:
Based on observation, interview and record review, the facility failed to ensure the doors to the following hazardous areas were self-closing or not damaged in the Assisted Living Facility (ALF): the door to the G Hall Activities' office; the door to vacant resident room C212; and the activities' storage room in the Administrative section of the ALF. This practice potentially affected three out of eight smoke zones in the ALF section. The facility census was 31 residents with a licensed capacity of 57 residents.

1. Observation on 8/20/24 from 9:16 A.M. to 11:38 A.M. with the Environmental Services (EVS) Director, showed:
-The door to the G Hall activities' office with numerous combustibles in it, was not self-closing.
-The door to vacant resident room C212 was not self- closing. The room had eight boxes of light fixture, three boxes of hand sanitizer gel, seven boxes of shampoo, and four boxes of cleaners.
-The door to the ALF Administrative section Activities' room was not self-closing and had numerous combustibles including boxes of holiday decorations, several dolls, and three plastic bins of decorations.

During an interview on 8/20/24 from 9:16 A.M. to 11:38 A.M. the EVS Director said the hand sanitizer and the shampoo had been in that room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A2256	Continued From page 5 for several months. Review of the 2012 National Fire Protection Association (NFPA) 101 Chapter 19.3.2 entitled Protection from Hazards, showed: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. 19.3.2.1.3 The doors shall be self-closing or automatic-closing. 19.3.2.1.4 Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (1220 mm) above the bottom of the door. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms. (2) Central/bulk laundries larger than 100 ft. 2 (9.3 m2). (3) Paint shops. (4) Repair shops. (5) Rooms with soiled linen in volume exceeding 64 gal (242 L). (6) Rooms with collected trash in volume exceeding 64 gal (242 L). (7) Rooms or spaces larger than 50 ft. 2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	A2256		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2263	Continued From page 6	A2263		
A2263	19 CSR 30-86.022(10)(H) Smoke Sections Protection from Hazards. (H) All facilities shall be divided into at least two (2) smoke sections with each section not exceeding one hundred fifty feet (150') in length or width. If the floor ' s dimensions do not exceed seventy-five feet (75') in length or width, a division of the floor into two (2) smoke sections will not be required. II This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that smoke barrier walls (a wall designed to resist the passage of smoke extending from outside wall to outside wall and from the floor to the roof) at the following areas in the Assisted Living Facility (ALF) were maintained free of openings, which could allow the passage of smoke through those smoke barrier walls: the East hall smoke barrier wall, the Smoke barrier wall close to the East stairwell wall, the smoke barrier wall close to A207; and the smoke barrier wall close to A202 in the section. This practice potentially affected all residents who resided in or used 8 smoke zones in the ALF. The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/19/24 from 1:33 P.M. to 2:43 P.M. with the Environmental Services (EVS) Director, showed the following with the smoke barrier walls in the ALF: -One opening with an orange cord installed through that penetration at the East barrier smoke wall. -There was a 4 inch (in.) long by 2 in. opening in the East stairwell smoke wall. -There were two small openings in the smoke	A2263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2263	Continued From page 7 barrier wall next to room A207. -There was one opening with a blue conduit, which passed through the smoke barrier wall next to resident room A202. During an interview on 8/19/24 from 1:33 P.M., to 2:43 P.M. the EVS Director said new cameras were installed in the hallways of the ALF about 4 months ago. Review of the 2012 National Fire Protection Association (NFPA) 101 Chapter 8.5 through 8.5.2.2, showed the following: -8.5.1* General. Where required by Chapters 11 through 43, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. -8.5.2.1 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. -8.5.2.2 Smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.5.6.3 Where walls or partitions are required to have a minimum 1-hour fire resistance rating, recessed fixtures shall be installed in the wall or partition in such a manner that the required fire resistance is not reduced, unless one of the following is met: (1) Any steel electrical box not exceeding 0.1 square feet (square ft) shall be permitted where the aggregate area of the openings provided for the boxes does not exceed 0.7 square ft in any 100 square ft. of wall area, and, where outlet boxes are installed on opposite sides of the wall, the boxes shall be separated by one of the following:	A2263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A2263	Continued From page 8 (a) Horizontal distance of not less than 24 in. (b) Horizontal distance of not less than the depth of the wall cavity, where the wall cavity is filled with cellulose loose-fill, rock wool, or slag wool insulation. (c)*Solid fireblocking. (d) Other listed materials and methods.	A2263		
A2268	19 CSR 30-86.022(11)(A) Complete Sprinkler System-NFPA 13 Sprinkler Systems. (A) Facilities licensed on or after August 28, 2007, or any section of a facility in which a major renovation has been completed on or after August 28, 2007, shall install and maintain a complete sprinkler system in accordance with NFPA 13, 1999 edition. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to maintain sprinkler heads free from paint or corrosion in the following areas: F204, E211, E210, E207, D203, in the Assisted Living Facility (ALF) section, and the dishwasher area of the main kitchen and the A Hall shower room. This practice potentially affected three smoke zones out of eight smoke zones in the ALF section. The facility census was 31 residents with a licensed capacity of 57 residents in the ALF. 1. Observation on 8/20/24 from 9:34 A.M. to 12:42 P.M. with the Environmental Services (EVS) Director showed: -Paint was present on the sprinkler head in resident room F204.	A2268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A2268	Continued From page 9 -Paint was present on the sprinkler head in resident room E211. -Paint was present on the sprinkler head in resident room E210. -Paint was present on the sprinkler head in resident room E207. -Paint was present on the sprinkler head in resident room D203. During an interview on 8/20/24 at 12:42 P.M., the EVS Director said any painting of the ceiling which caused some paint to splatter on some sprinkler heads, was completed before his/her tenure at the facility. Review of 2011 NFPA 25 Chapter 5.2 through Chapter 5.2.1.1.2, showed: -5.2.1.1 Sprinklers shall be inspected from the floor level annually. -5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). -5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage. (2) Corrosion. (3) Physical damage. (4) Loss of fluid in the glass bulb heat responsive element. (5) Loading. (6) Painting unless painted by the sprinkler manufacturer.	A2268		
A3201	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed	A3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A3201	Continued From page 10 and shall be maintained in good repair and in accordance with the construction and fire safety rules in effect at the time of initial licensing. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview and record review, the facility failed to ensure that smoke barrier walls (a wall designed to resist the passage of smoke extending from outside wall to outside wall and from the floor to the roof) at the following areas were maintained free of openings, which could allow the passage of smoke: the East hall smoke barrier wall, the Smoke barrier wall close to the East stairwell wall, the smoke barrier wall close to A207, the smoke barrier wall close to A202; the facility also failed to maintain corridor doors in the following areas to resist the passage of smoke: the door between the kitchenette and the ALF dining room; Social Service Designee (SSD) A's office door; and failed to ensure the facility was operated to minimize the possibility of a fire emergency in accordance with National Fire Protection Association (NFPA) 101 Chapter 19, by not ensuring that employees could readily access locked rooms such as the beauty shop, the old chaplains' office and the previous doctor's office. This practice potentially affected all residents. The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/19/24 from 1:33 P.M. to 2:43 P.M. with the Environmental Services (EVS) Director, showed the following with the smoke barrier walls in the ALF: -One opening with an orange cord installed through that penetration at the East barrier smoke wall. -There was a 4 inch (in.) long by 2 in. opening in	A3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A3201	Continued From page 11	A3201		

the East stairwell smoke wall.
-There were two small openings in the smoke barrier wall next to room A207.
-There was one opening with a blue conduit, which passed through the smoke barrier wall next to resident room A202.

During an interview on 8/19/24 from 1:33 P.M. to 2:43 P.M. the EVS Director said new cameras were installed in the hallways about 4 months ago.

Review of the 2012 National Fire Protection Association (NFPA) 101 Chapter 8.5 through 8.5.2.2, showed the following:
-8.5.1* General. Where required by Chapters 11 through 43, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.
-8.5.2.1 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof.
-8.5.2.2 Smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.
8.3.5.6.3 Where walls or partitions are required to have a minimum 1-hour fire resistance rating, recessed fixtures shall be installed in the wall or partition in such a manner that the required fire resistance is not reduced, unless one of the following is met:
(1) Any steel electrical box not exceeding 0.1 square feet (square ft) shall be permitted where the aggregate area of the openings provided for the boxes does not exceed 0.7 square ft in any 100 square ft. of wall area, and, where outlet boxes are installed on opposite sides of the wall,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A3201	Continued From page 12	A3201		

the boxes shall be separated by one of the following:
(a) Horizontal distance of not less than 24 in.
(b) Horizontal distance of not less than the depth of the wall cavity, where the wall cavity is filled with cellulose loose-fill, rock wool, or slag wool insulation.
(c)*Solid fireblocking.
(d) Other listed materials and methods. joined.

2. Observation on 8/20/24 at 9:09 A.M. with the EVS Director, showed:
-The door between the kitchenette and the ALF dining room was held open with a wedge.
-There was a 1-inch (in.) hole and another hole that was 1.5 in. diameter that would cause that door not to resist the passage of smoke if that door was closed.

During an interview on 8/20/24 at 9:11 A.M., the ALF kitchen server said:
-He/she had the door open with a wedge because the door was open while he/she brought items in and out of the kitchen.
-He/she was not bringing anything into the kitchen and he/she did not know how long the door had holes in it.

Observation on 8/20/24 at 11:26 A.M. with the EVS Director, showed the door to SSD A's office did not close when it was pulled shut because the overhang on the door was too thick.

During an interview on 8/20/24 at 11:31 A.M., SSD A said he/she placed that hanger on the door the week prior to the survey and he/she would have to change it.

Review of the following chapters of National Fire Protection Association (NFPA) 101, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A3201	Continued From page 13 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lb is applied at the latch edge of the door. 19.3.6.3.10* Doors shall not be held open by devices other than those that release when the door is pushed or pulled. 19.3.6.3.11 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas. 3. Observation on 8/20/24 at 9:26 A.M., showed the EVS Director did not have keys to the beauty shop nor the old chaplain's office located on the G Hall. Observation on 8/20/24 at 11:46 A.M., showed the EVS Director did not have keys to the former doctor's office. During an interview on 8/26/24 at 10:12 A.M., the EVS Director said: -The facility had three master keys for the ALF. -The master keys didn't open everything. -The Manager on Duty (MOD) had access to the keys in the Director of Hospitality office. Review of the following chapters of the National Fire Protection Association (NFPA), showed: NFPA 101 Chapter 19.1.1.3.2, showed the following: "Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement	A3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A3201	Continued From page 14 of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention procedures and planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building" NFPA 1, chapter 16.3.4 showed Access for Fire Fighting. 16.3.4.1 A suitable location at the site shall be designated as a command post and provided with plans, emergency information, keys, communications, and equipment, as needed. 16.3.4.2 The person in charge of fire protection shall respond to the location command post whenever fire occurs. 16.3.4.3 Where access to or within a structure or an area is unduly difficult because of secured openings or where immediate access is necessary for life-saving or fire-fighting purposes, the Authority Having Jurisdiction (AHJ) shall be permitted to require a key box to be installed in an accessible location. 16.3.4.4 The key box shall be an approved type and shall contain keys to gain access as required by the AHJ. * The higher classification merited due to the extent of the violation.	A3201		
A3214	19 CSR 30-86.032(13) Electrical Wiring, Maintained, Inspected In facilities that are constructed or have plans approved after July 1, 2005, electrical wiring shall be installed and maintained in accordance with	A3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A3214	Continued From page 15 the requirements of the National Electrical Code, 1999 edition, National Fire Protection Association, Inc., incorporated by reference, in this rule and available by mail at One Batterymarch Park, Quincy, MA 02269, and local codes. This rule does not incorporate any subsequent amendments or additions to the materials incorporated by reference. Facilities built between September 28, 1979 and July 1, 2005 shall be maintained in accordance with the requirements of the National Electrical Code, which was in effect at the time of the original plan approval and local codes. This rule does not incorporate any subsequent amendments or additions. In facilities built prior to September 28, 1979, electrical wiring shall be maintained in good repair and shall not present a safety hazard. All facilities shall have wiring inspected every two (2) years by a qualified electrician. II/III This regulation is not met as evidenced by: Class III Based on observation, interview and record review, the facility failed to prevent piggybacking(a continuous string of surge protectors (a portable device containing electrical outlets that protects equipment from an electrical surge) in resident room E207; to ensure an electrical outlet had a cover on it in the Human Resources Office; and to prevent the storage of combustibles closer than 3 feet (ft.) to an electrical panel in activities' room. This practice potentially affected two out of eight smoke zones. The facility census was 31 residents with a licensed capacity of 57 residents. 1. Observation on 8/20/24 at 9:57 A.M., with the Environmental Service (EVS) Director showed one extension cord with two appliances plugged	A3214		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A3214	Continued From page 16 into it in resident room E207. 2. Observation on 8/20/24 at 11:49 A.M. with the EVS Director showed the cover was missing from the electrical receptacle in the Human Resources Office. During an interview on 8/20/24 at 11:50 A.M., the Human Resources Officer said he/she did not know that outlet was missing a cover. 3. Observation on 8/20/24 at 11:53 A.M., with the EVS Director, showed the storage of numerous combustibles including nine plastic bins, two cardboard boxes, and assorted other items in a storage room, which were closer than 3 ft. from an electrical panel. During an interview on 8/20/24 at 12:14 P.M., the Director of Entertainment said he/she did not know he/she could not store items in that room. Review of the 2011 National Fire Protection Association (NFPA) 70 Chapter 400.8, showed the following: Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: 1) As a substitute for the fixed wiring of a structure 2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 3) Where run through doorways, windows, or similar openings 4) Where attached to building surfaces 5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings 6) Where installed in raceways, except as otherwise permitted in this Code 7) Where subject to physical damage.	A3214		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

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A3214	Continued From page 17 Review of the 2011 edition of the National Fire Protection Association (NFPA) 70, 210-23 showed, "In no case shall the load exceed the branch-circuit ampere rating. An individual branch circuit shall be permitted to supply any load for which it is rated. A branch circuit supplying two or more outlets or receptacles shall supply only the loads specified according to its size as specified in 210.23(A) through (D) and as summarized in 210.24 and Table 210.24. (A) A 15- or 20-ampere branch circuit shall be permitted to supply lighting units or other utilization equipment, or a combination of both. The rating of any one cord- and plug-connected utilization equipment shall not exceed 80 percent of the branch-circuit ampere rating. The total rating of utilization equipment fastened in place, other than lighting fixtures, shall not exceed 50 percent of the branch-circuit ampere rating where lighting units, cord- and plug-connected utilization equipment not fastened in place, or both, are also supplied. (1) Cord-and-Plug-Connected Equipment Not Fastened in Place. The rating of any one cord-and-plug-connected utilization equipment not fastened in place shall not exceed 80 percent of the branch-circuit ampere rating. (2) Utilization Equipment Fastened in Place. The total rating of utilization equipment fastened in place, other than luminaries, shall not exceed 50 percent of the branch circuit ampere rating where lighting units, cord-and-plug connected utilization equipment not fastened in place, or both, are also supplied." The Long Term Care (LTC) Bulletin - Volume 4, Issue 2, Winter 2006 (a publication by the Missouri Department of Health and Senior Services Section for Long Term Care and made available to all facilities) stated the following:	A3214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A3214	Continued From page 18 -Never plug more than one item into an extension cord; -All motorized equipment needs to be plugged directly into an electrical outlet. (This would include appliances or equipment with motors such as a refrigerator and an oxygen concentrator); -Extension cords can be no longer than six feet; -Extension cords or surge protectors that do not have a Underwriters Laboratories (UL) or Factory Mutuals (FM) acceptance tag or stamp cannot be used; -Extension cords in health care settings have an American Wire Gauge System (AWG) rating of 14 or less. Review of NFPA 70 Chapter 400.10, showed: "Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. Review of the 2011 Edition of the National Fire Protection Association (NFPA) 70, National Electrical Code, Article 406.6, showed, "Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the mounting surface." Section 110.26 showed the following: Spaces about Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment.	A3214		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4798	Continued From page 19 Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to ensure physician orders were being followed for two sampled residents (Resident #1 and #3) out of three sampled residents. The facility census was 31 residents. 1. Review of Resident #1's Face Sheet showed he/she admitted to the facility on 3/25/24 with the following diagnoses: -Chronic Obstructive Pulmonary Disorder (COPD-a disease process that decreases the ability of the lungs to perform ventilation). -Dependence on Supplemental Oxygen. Review of the resident's undated care plan showed: -There was no focus or intervention in place related to the resident's oxygen use. -There was no focus or intervention in place related to the resident's skin integrity. Review of the resident's Physician Order Sheet (POS) dated June 2024 showed: -An order for continuous oxygen via nasal cannula (a device that delivers extra oxygen through a tube into your nose) at 4 liters (L)/minute every shift. -An order for skin checks weekly every day shift every Monday.	A4798		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4798	Continued From page 20 Review of the resident's Treatment Administration Record (TAR) dated June 2024 showed: -The facility failed to document three out of four weekly skin checks. -The facility failed to document 23 out of 60 every shift oxygen checks. Review of the resident's POS dated July 2024 showed: -An order for continuous oxygen via nasal cannula at 4 L/minute every shift that ended on 7/12/24. -An order for continuous oxygen via nasal cannula at 3 L/minute every shift that started on 7/12/24. -An order for skin checks weekly every day shift every Monday. Review of the resident's TAR dated July 2024 showed: -The facility failed to document five out of five weekly skin checks. -The facility failed to document six out of 21 every shift oxygen checks at 4 L. -The facility failed to document nine out of 39 every shift oxygen checks at 3 L. Review of the resident's POS dated August 2024 showed: -An order for continuous oxygen via nasal cannula at 3 L/minute every shift. -An order for skin checks weekly every day shift every Monday. Review of the resident's TAR dated August 2024 showed: -The facility failed to document three out of three weekly skin checks. -The facility failed to document 15 out of 50 every shift oxygen checks.	A4798		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4798	Continued From page 21 2. Review of Resident #3's face sheet showed he/she admitted to the facility with the following diagnoses: -Urinary Tract Infections (UTI- an infection in any part of the urinary system). -Presence of Urogenital (relating to both the urinary and genital organs) implants (injections of material into the urethra to help control urine leakage caused by weak urinary muscle). Review of the resident's undated care plan showed: -The resident had an indwelling (inside the body) suprapubic (situated above the pubis (either of a pair of bones forming the two sides of the pelvis)) catheter (a surgically created connection between the urinary bladder and the skin, used to drain urine from the bladder). Review of the resident's POS dated June 2024 showed: -An order for staff to change the Suprapubic Catheter drainage bag weekly and Pro Re Nata (PRN- as needed), one time a day every Sunday for Suprapubic Catheter care. -An order for Suprapubic Catheter care every shift and PRN every shift. -An order for staff to change the Suprapubic Catheter once every three weeks for infection control and to maintain patency. Review of the resident's TAR dated June 2024 showed: -The facility failed to document three out of five weekly Suprapubic Catheter bag changes. -The facility failed to document 22 out of 60 every shift Suprapubic Catheter cares. -The facility failed to document one out of two Suprapubic Catheter changes.	A4798		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4798	Continued From page 22 Review of the resident's POS dated July 2024 showed: -An order for Suprapubic Catheter care every shift and PRN every shift. -An order for staff to change the Suprapubic Catheter once every three weeks for infection control and to maintain patency. Review of the resident's TAR dated July 2024 showed: -The facility failed to document one out of one Suprapubic Catheter changes. -The facility failed to document 16 out of 62 every shift Suprapubic Catheter cares. Review of the resident's POS dated August 2024 showed: -An order for staff to change the Suprapubic Catheter drainage bag weekly and PRN, one time a day every Sunday for Suprapubic Catheter care. -An order for Suprapubic Catheter care every shift and PRN every shift. -An order for skin checks weekly, every day shift, every Monday. Review of the resident's TAR dated August 2024 showed: -The facility failed to document three out of four weekly Suprapubic Catheter bag changes. -The facility failed to document 16 out of 50 every shift Suprapubic Catheter cares. -The facility failed to document three out of three weekly skin checks. 3. During an interview on 8/26/24 at 12:52 P.M. Certified Medication Technician (CMT) B said: -The Certified Nursing Assistants (CNAs) and CMTs were only responsible for informing the	A4798		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4798	Continued From page 23 charge nurse on the unit of any skin changes but were not responsible for any skin documentation. -As a CMT, he/she could document on any oxygen checks that he/she completed during his/her shift, as long as the order was on the TAR. -He/She was unsure if there was anyone assigned to ensure documentation was completed. During an interview on 8/26/24 at 1:04 P.M. Registered Nurse (RN) A said: -He/She noticed that the unit was having documentation issues and that there were multiple inconsistencies throughout the unit. -The nursing staff were to notify the charge nurse with any skin concerns or changes. -The CMTs could document on certain treatment orders including the monitoring of Resident #1's oxygen. -He/She would be the one responsible for auditing the staff's documentation to ensure completion. -He/She expected staff to complete all required documentation throughout the shift.	A4798		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of	A4837		

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	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4837	Continued From page 24	A4837		

medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III

This regulation is not met as evidenced by:
Based on interview and record review, the facility failed to maintain a record in the facility for each resident that included a monthly review of the residents' general conditions and needs for three sampled residents (Resident #1, #2, and #3) out of three sampled residents. The facility census was 31 residents.

1. Review of Resident #1's Face Sheet showed he/she admitted to the facility on 3/25/24 with the following diagnoses:
-Chronic Obstructive Pulmonary Disorder (COPD-a disease process that decreases the ability of the lungs to perform ventilation).
-Dependence on supplemental oxygen.
-Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).
-Hypertension (high blood pressure).

Review of the resident's undated care plan showed:
-The resident was at moderate risk for falls related to weakness and gait imbalance.
-The resident had an Activities of Daily Living (ADL) self-care performance deficit and limitations in physical mobility, activity intolerance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE BLUE SPRINGS, MO 64014

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A4837	Continued From page 25	A4837		

and impaired balance.
-The resident had an altered cardiovascular status related to hypertension.

Review of the resident's Electronic Medical Record (EMR) on 8/26/24 showed no monthly summaries could be found within the record.

The resident's monthly summaries were requested on 8/26/24 and not received at the time of exit.

2. Review of Resident #3's Face Sheet showed he/she admitted to the facility with the following diagnoses:
-Coronary Artery Disease (CAD-plaque build-up in the wall of the arteries that supply blood to the heart).
-Chronic Respiratory Failure (a condition that results in the ability to effectively exchange carbon dioxide and oxygen and induces chronically low oxygen levels).
-Nonrheumatic Aortic Valve Stenosis (thickening and narrowing of the valve between the heart's main pumping chamber and the body's main artery).

Review of the resident's undated care plan showed the resident:
-Had an ADL self-care performance deficit and limited physical mobility related to activity intolerance, fatigue, and impaired balance.
-Had an indwelling suprapubic catheter (a medical device that helps drain urine from the bladder).
-Was at risk for falls related to gait/balance problems and used a wheelchair.
-Had the potential for nutritional deficit and had a mechanically altered diet (any foods that could be blended, mashed, pureed, or chopped using a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A4837	Continued From page 26	A4837		

kitchen tool such as a knife, grinder, blender, or food processor).
-Had an altered cardiovascular status related to CAD and hypertension.

Review of the resident's EMR on 8/26/24 showed no monthly summaries could be found for the last 12 months.

The resident's monthly summaries were requested on 8/26/24 and not received at the time of exit.

3. Review of Resident #2's Face Sheet showed he/she admitted to the facility on 12/19/22 with the following diagnoses:
-Atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).
-Retention of urine.
-Hypotension (low blood pressure).
-Dementia (loss of cognitive functioning).

Review of the resident's undated care plan showed:
-The resident was at high risk for falls.
-The resident had an ADL self-care performance deficit.
-The resident had an altered cardiovascular status related to atrial fibrillation.
-The resident was on anticoagulation therapy.

Review of the resident's EMR on 8/26/24 showed no monthly summaries could be found within the record.

The resident's monthly summaries were requested on 8/26/24 and not received at the time of exit.

4. During an interview on 8/26/24 at 1:04 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13219D	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE SENIOR LIVING	111 MOCK AVENUE 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
A4837	Continued From page 27 Registered Nurse (RN) A said: -The nurses were responsible for documenting the monthly summaries. -He/She had noticed that they were not getting completed. -There was not a monthly summary form that auto-populated for the nurses to complete monthly. -He/She would expect to see a progress note related to the monthly summaries if the monthly summary form was unavailable.	A4837		