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
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2210	19 CSR 30-86.022(3)(D) Fire Extinguishers UL/FM, Maintain/Check Fire Extinguishers. (D) All fire extinguishers shall bear the label of the Underwriters ' Laboratories (UL) or the Factory Mutual (FM) Laboratories and shall be installed and maintained in accordance with NFPA 10, 1998 edition. This includes the documentation and dating of a monthly pressure check. II/III This regulation is not met as evidenced by: Class III Based on observation, interview, and record review, the facility failed to ensure that all Class K fire extinguisher(s) (K extinguishers offer improved fire control for cooking fires by minimizing the splash hazard, forming a soapy foam on the surface of the hot cooking oil, holding in the vapors and steam, and smothering the fire) were installed with an appropriate, visible instructional placard above them to avoid confusion by a staff member and/or delay the response in the event of a fire, in accordance with State of Missouri rules and National Fire Protection Association (NFPA) standards and codes. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility census was 60 residents with a total capacity of 72 residents at the time of the survey. 1. Observation on 10/30/25 between 10:47 A.M. and 11:32 A.M. during the initial fire safety walk-through inspection with the Interim Plant Operation Director (IPOD) showed the following:	A2210		

Stacy Russell 11/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2210	Continued From page 1 -The instructional placard over the Class K extinguisher in the MCU (Memory Care Unit) kitchenette was blocked by two 8 ½ inch (") by 11" resident diet sheets. -In the Demo Kitchen there was a Class K extinguisher with no instructional sign. During interviews on 10/30/25 between 10:47 A.M. and 11:32 A.M. the IPOD said those sheets probably should not be there like that. Review of the facility's last professional 2-page Portable Fire Extinguisher Inspection Report, dated 9/9/25 and provided by the IPOD, showed the following: -Three Class K extinguishers were listed, one in the main kitchen, the kitchenette, and the Demo Kitchen. -Their instructional Class K extinguisher placards were not addressed. Review of the 2010 Edition of NFPA 10, Standard for Portable Fire Extinguishers, under Chapter 5, Selection of Portable Fire Extinguishers, at Section 5.5, Selection for Specific Hazards, subsection 5.5.5* Class K Cooking Media Fires, showed: -Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. -5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher. And, at Annex A, Explanatory Material, showed: - A.5.5.5.3 Figure A.5.5.5.3(a) and Figure A.5.5.5.3(b) show the recommended wording for	A2210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2210	Continued From page 2 the Class K placard. Recommended size is 7 5?8 in. × 11 in. (193 mm × 279 mm). (Note: The placard illustrated in A.5.5.5.3(a) showed the wording of a typical Class K placard with instructions in English and Spanish.)	A2210		
A2214	19 CSR 30-86.022(5)(A) Fire Drill/Evacuation Plan, Consultation Fire Drills and Emergency Preparedness. (A) All facilities shall have a written plan to meet potential emergencies or disasters and shall request consultation and assistance annually from a local fire unit for review of fire and evacuation plans. If the consultation cannot be obtained, the facility shall inform the state fire marshal in writing and request assistance in review of the plan. An up-to-date copy of the facility ' s entire plan shall be provided to the local jurisdiction ' s emergency management director. II/III This regulation is not met as evidenced by: Class III Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan that was not limited to, an annual review by their EP committee and complete policies and procedures for all emergencies as outlined in their facility and community-based Hazard Vulnerability Assessment (HVA) utilizing an all-hazards approach, with rankings of their risk potential and probability of each occurrence for specific disasters or emergencies, for the health, safety, and security needs of the resident	A2214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2214	Continued From page 3 population, visitors, volunteers, and staff in the event of limitations or cessation of operations, and/or to maintain the continuity of services to facility patients in those emergency or disaster situations. This deficient practice had the potential to affect everyone residing, visiting, using, or working in the facility. The facility census was 60 residents with a licensed capacity for 72 residents at the time of the survey. 1. Observation on 10/31/25 at 8:33 A.M. showed the facility was located in the city of Lee's Summit in Jackson County and Cass County, Missouri, United States. It is a suburb of the Kansas City metropolitan area. As of the 2020 census, the population was 101,108. Review of the facility's EP plan in a binder entitled, "Emergency Actions Binder," undated and provided by the Administrator, showed the following: -There was no signed and dated sheets for the documentation of yearly reviews. -The 7-page "Table of Contents" had dozens of separate headings of policies and procedures for various types of contingencies and emergencies with their respective page numbers, but none of the pages in the binder appeared to be numbered. -At "EVAC - Other than Hurricane," under types of evacuation, the second bullet point referenced section 3.2.2, but 3.2.2 could not be found. -At section 3.04, Fire Prevention/Life Safety Training, on the 3rd page it referenced section 3.2, but 3.2 could not be found. During interviews 10/7/25 between 10:59 A.M. and 11:32 A.M. the Interim Plant Operation	A2214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2214	Continued From page 4 Director (IPOD) said the following: -He/She thought the disaster manual was complete. -They did not know anything was missing. During an interview on 10/30/25 at 1:08 P.M. the Administrator said the emergency binder contained their whole disaster manual.	A2214		
A2216	19 CSR 30-86.022(5)(C) Plan Accessible/Evacuation Diagram Posted Fire Drills and Emergency Preparedness. (C) The written plan shall be accessible at all times and an evacuation diagram shall be posted on each floor in a conspicuous place so that employees and residents can become familiar with the plan and routes to safety. II/III This regulation is not met as evidenced by: Class III Based on observation, interview, and record review, the facility failed to adequately display evacuation route maps that sufficiently addressed all of the requirements in a conspicuous place along all egress paths, in accordance with State of Missouri rules and National Fire Protection Association (NFPA) standards and codes. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. This facility had a census of 60 residents with a licensed capacity of 72 residents at the time of the survey. 1. Observation on 10/30/25 between 10:47 A.M. and 11:32 A.M. during the initial fire safety	A2216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2216	Continued From page 5 walk-through inspection with the Interim Plant Operation Director (IPOD) showed the following: -The evacuation route map by resident room #105 had no outside designated assembly areas marked for the residents to go to in an emergency, or a compass rose (a circular diagram that shows the cardinal directions: North, East, South, West) with which the map user could orient themselves. -The east hallway between rooms #110 - 113 had no evacuation map. -The northwest hall evacuation map had no assembly areas or compass. -In the MCU (Memory Care Unit) there was no evacuation map in the hall with rooms #14 - 16 and the map across room #9 had no assembly areas or compass. -There was no evacuation map on the hall with rooms #1 - 4. -On the hall with resident rooms #136 - 139 there was no evacuation route map and the map by room #147 had no assembly areas or compass. During interviews on 10/30/25 between 10:47 A.M. and 11:32 A.M. the IPOD said the following: -He/She did not know if they had any extra evacuation route maps. -There should be one on every hall. Review of the facility's EP plan in a binder entitled, "Emergency Actions Binder," undated and provided by the Administrator, showed the following: -At "EVAC - Other than Hurricane," under types of evacuation, the second bullet point read that "external" meant to the exterior of the facility. -At section 3.04, Fire Prevention/Life Safety Training, it stated on the 3rd page to "Evacuate	A2216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2216	Continued From page 6 residents according to evacuation guidelines (3.2) to designated areas other than parking lots," but did not explain where those areas were located. During an interview on 10/30/25 at 1:08 P.M. the Administrator said that binder contained their whole disaster manual. Review of the 2012 Edition of NFPA 101, Life Safety Code, Under Chapter 7, Means of Egress, at Section 7.10, Marking of Means of Egress, showed: -7.10.8.5* Evacuation Diagram. Where a posted floor evacuation diagram is required in Chapters 11 through 43, floor evacuation diagrams reflecting the actual floor arrangement and exit locations shall be posted and oriented in a location and manner acceptable to the authority having jurisdiction. And, at Chapter Annex A, Explanatory Materials, showed: -A.7.10.8.5 Egress paths with multiple turns can often be confusing with respect to which exit route will lead to the closest exit door. Floor evacuation diagrams can eliminate the guesswork by giving the occupant a point of reference by the YOU ARE HERE symbol. The entire floor plan should be shown with the primary and secondary exit routes, exit stairs, and elevators clearly identified. For further information, see American Society for Testing and Materials (ASTM) E 2238, Standard Guide for Evacuation Route Diagrams.	A2216		
A2269	19 CSR 30-86.022(11)(B) Sprinkler System Maintenance/Testing	A2269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2269	Continued From page 7 Sprinkler Systems. (B) Facilities that have a sprinkler system installed prior to August 28, 2007, shall inspect, maintain, and test these systems in accordance with the requirements that were in effect for such facilities on August 27, 2007. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review the facility failed to ensure that all fire sprinkler head types used in the facility had spare replacement heads located within each sprinkler head box, in accordance with State of Missouri rules and National Fire Protection Association (NFPA) standards and codes. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility census was 60 residents with a total licensed capacity for 72 residents at the time of the survey. 1. Observation on 10/7/25 between 10:59 A.M. and 11:32 A.M. during the initial fire safety walk-through inspection with the Interim Plant Operation Director (IPOD) showed the following: -The sprinkler head cabinet by the fire sprinkler risers (a vertical pipe or assembly that connects the main water supply to a fire sprinkler system within a building) in the Fire Alarm Control Room contained no horizontal sidewall sprinkler heads with large, flat top deflectors. -In the east hallway there was 1 sidewall sprinkler head with a large, flat deflector by resident room #113. -There were 2 such sprinkler heads at the north end of the west hall.	A2269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2269	Continued From page 8 -There were sidewall sprinkler heads in the Storage Room by Exit #5, in the Spa, and in the Storage Room in the Spa. -The electrical room by the south entrance to the Assisted Living Facility (ALF) had a sidewall sprinkler head with a large, flat deflector and there was also one in the fitness room and two in the ALF Bistro. During interviews 10/7/25 between 10:59 A.M. and 11:32 A.M. the IPOD said the following: -The sprinkler risers and spare head cabinet in the Fire Alarm Control Room is for both the ALF and the Memory Care Unit (MCU). -He/She did not know what (spare) heads needed to be in there. Review of the facility's last 3-page professional fire sprinkler inspection, dated 8/26/25 and provided by the IPOD, showed there was no mention of any of the various fire sprinkler head types in the facility or the spare heads' cabinet and its contents. Review of the 2012 Edition of NFPA 101, Life Safety Code, under Chapter 9, Building Service and Fire Protection Equipment, at Section 9.7, Automatic Sprinklers and Other Extinguishing Equipment, showed: -9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Review of the 2011 Edition of the NFPA 25, Standard for the Inspection, Testing, and	A2269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32762	A. BUILDING: _____ B. WING _____	C 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON SENIOR LIVING THE	1701 S E OLDHAM PARKWAY LEES SUMMIT, MO 64081

(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
A2269	Continued From page 9 Maintenance of Water-Based Fire Protection Systems, under Chapter 5, Sprinkler Systems, at Section 5.4, Maintenance, sub-section 5.4.1, Sprinklers, showed: -5.4.1.4* A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. -5.4.1.4.1 The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. -5.4.1.4.2 The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100°F (38°C). -5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers-no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	A2269		

PLAN OF CORRECTION

Provider Name:	The Princeton Senior Living
Street Address, City, Zip:	1701SE Oldham Parkway
Date of Survey:	10/30/25-10/31/25
Provider number:	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
A2210	**Correction of Cited Deficiency:** All Class K fire extinguishers have an appropriate, visible instructional placard above them. **Assessment to Identify other Residents that may be affected:** The alleged deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, and worked in the facility. **Procedure to ensure on-going compliance:** The Culinary Director (CD) will audit three times weekly for x4 weeks, then weekly x 8 weeks to ensure the Class K placards remain in place and visible to staff. Memory Care staff was inserviced about ensuring that there is nothing blocking the placecard instructions. The Executive Director (ED) will conduct random audits weekly x12 weeks to verify appropriate placement and visibility of placards. **Monitoring for on-going compliance:** The results of the audits will be taken to the monthly Quality Assurance meeting (the first department head meeting of the month) monthly for 3 months and reviewed and revised as indicated.	11/25/25
A2214	**Correction of Cited Deficiency:** The facility Emergency Preparedness Committee conducted a review and revision of the Emergency Preparedness Plan/Binder. All pages in the Table of Contents have been numbered and	11/25/25

	correspond appropriately with the indicated topics. The annual review of the Emergency Preparedness binder has been completed and signed by the Executive Director. **Assessment to Identify other Residents that may be affected:** The alleged deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, and worked in the facility. **Procedure to ensure on-going compliance:** The Executive Director (ED)/Designee will review the Emergency Preparedness Binder at least annually and as indicated. **Monitoring for on-going compliance:** The Emergency Preparedness Binder will be reviewed in the monthly Quality Assurance meeting (the first department head meeting of the month) monthly for 3 months and reviewed and revised as indicated. **Correction of Cited Deficiency:** The Executive Director (ED)/Designee has contacted Lee's Summit Emergency Manager to request a review/consultation of the facility fire and evacuation plans. The facility has provided Lee's Summit Emergency Manager with a copy of the facility's Emergency Preparedness Plan. **Assessment to Identify other Residents that may be affected:** The alleged deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, and worked in the facility. **Procedure to ensure on-going compliance:** The ED/Designee will communicate with Lee's Summit Emergency Manager annually for a review/consultation of the facility fire and evacuation plans. **Monitoring for on-going compliance:** The results of the communication with Lee's Summit Emergency Manager will be taken to the monthly Quality Assurance meeting monthly for three months and reviewed and revised as indicated.	
A2216	**Correction of Cited Deficiency:** The evacuation map by resident room #105 has been updated to include shelter in place for the residents to go in the event of an emergency. The compass rose has been added to the map for users to orient themselves to their location and direction. An evacuation map has been placed in the East hallway between rooms #110-113. The Northwest Hall map has been revised to include the shelter in place and compass. An evacuation map has been placed on the Memory Care Unit between rooms #14-16. The evacuation map across from room #9 has been revised to include the shelter in place and compass. An evacuation map has been placed in the hall between rooms	11/25/25

	#1-4. An evacuation map has been placed in the hall between rooms #136-139. The evacuation map by room #147 has been revised to include the shelter in place and compass. **Assessment to Identify other Residents that may be affected:** The alleged deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, and worked in the facility. **Procedure to ensure on-going compliance:** The Plant Operations Director will audit five evacuation maps weekly for 12 weeks to ensure the maps remain in place and contain the required information. The Executive Director (ED)/Designee will randomly audit two evacuation maps weekly for 12 weeks to ensure maps remain in place and contain the required information. **Monitoring for on-going compliance:** The results of the audits will be taken to the monthly Quality Assurance meeting for review and revision as indicated.	
A2269	**Correction of Cited Deficiency:** Spare fire sprinkler heads have been ordered to ensure replacement sprinkler heads that included the large, flat deflector were available when needed. **Assessment to Identify other Residents that may be affected:** The alleged deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, and worked in the facility. **Procedure to ensure on-going compliance:** An audit of the two fire boxes was conducted to ensure there were at least six replacement sprinkler heads available. The Executive Director/Designee educated the interim Plant Operations Director on the types of replacement sprinkler heads that are to be available in the facility. The Plant Operations Director/Designee will audit both fire boxes weekly for 4 weeks then monthly for 2 months to ensure all required sprinkler head replacements are available. The Executive Director/Designee will conduct random audits on both fireboxes monthly for 3 months. **Monitoring for on-going compliance:** The results of the audits will be taken to the monthly Quality Assurance meeting for review and revision as indicated.	11/25/25