

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2025
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NAME OF PROVIDER OR SUPPLIER
TRUSTWELL LIVING OF RAYTOWN

STREET ADDRESS, CITY, STATE, ZIP CODE
**9110 EAST 63RD STREET
RAYTOWN, MO 64133**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL INFORMATION CONCERNING THE YINQ INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A2202	<p>19 CSR 30-86.022(2)(D) Inspection Rights, No Fire Hazard</p> <p>General Requirements. (D) The department shall have the right of inspection of any portion of a building in which a licensed facility is located unless the unlicensed portion is separated by two- (2-) hour fire-resistant construction. No section of the building shall present a fire hazard. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation and interview on May 20, 2025, the facility failed to ensure the department shall have the right of inspection of any portion of a building in which a licensed facility is located unless the unlicensed portion is separated by two (2) hour fire-resistant construction, and no section of the building shall present a fire hazard. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation at 11:25 A.M., showed dryer lint and socks in the back of the dryers and pipe in the laundry room. The excessive dryer lint in and out of the pipe causes a fire hazard.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "Will have this added to preventative maintenance check."</p>	A2202		
A2214	<p>19 CSR 30-86.022(5)(A) Fire Drill/Evacuation Plan, Consultation</p> <p>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</p>	A2214		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE _____ (X6) DATE
[Signature] 7-23-25

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

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A2214	<p>Continued From page 1</p> <p>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</p> <p>This regulation is not met as evidenced by: Class III</p> <p>Based on record review and interview on May 20, 2025, the facility failed to request consultation and assistance annually or provide documentation the consultation had been scheduled from the local fire unit for review of fire and evacuation plans. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Record review on May 20, 2025 at 12:57 P.M., showed no request for consultation with the local fire department or having one performed.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said,"I can't account for anything in 2024, but will work on getting it scheduled."</p>	A2214		
A2217	<p>19 CSR 30-86.022(5)(D) Fire Drill Requirements, Evacuation</p> <p>Fire Drills and Emergency Preparedness. (D) A minimum of twelve (12) fire drills shall be conducted annually with at least one (1) every three (3) months on each shift. At least four (4) of the required fire drills must be unannounced to residents and staff, excluding staff who are</p>	A2217		

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A2217	<p>Continued From page 2</p> <p>assigned to evaluate staff and resident response to the fire drill. The fire drills shall include a resident evacuation at least once a year. II/III</p> <p>This regulation is not met as evidenced by: Class III</p> <p>Based on record review and an interview on May 20, 2025, Facility failed to conduct one (1) fire drill every three (3) months on each shift and a full resident evacuation once a year. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Record review on May 20, 2025 at 12:57 P.M., showed only the following fire drills being conducted and recorded within the last twelve (12) months and no full evacuation:</p> <ol style="list-style-type: none"> 1. January 30, 2025 - 1st shift 2. February 28, 2025 - 2nd shift 3. March - None 4. April 4, 2025 - 1st shift 4. May 18, 2025 - 1st shift <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "I can't account for anything in 2024, but we are trying to get these address."</p>	A2217		
A2238	<p>19 CSR 30-86.022(8)(C) Exit Sign-Illumination</p> <p>Exit Signs. (C) All required exit signs and directional indicators shall be positioned so that both normal</p>	A2238		

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A2238	<p>Continued From page 3</p> <p>and emergency lighting illuminates them. II/III</p> <p>This regulation is not met as evidenced by: Class III</p> <p>Based on observation and interview on May 20, 2025, the facility failed to ensure all required exit signs and directional indicators shall be positioned so that both normal and emergency lighting illuminates them. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation at 10:34 A.M., showed an exit sign that failed to illuminate when pressing the test button, near the exercise/workout room.</p> <p>Observation at 10:38 A.M., showed an exit sign that failed to illuminate when pressing the test button, outside the sprinkler riser room.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We will get it fixed."</p>	A2238		
A2249	<p>19 CSR 30-86.022(9)(C) Fire Alarm System-Test/Maintain</p> <p>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</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation and interview on May 20, 2025, the facility failed to test and maintain the complete fire alarm system in accordance with</p>	A2249		

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A2249	<p>Continued From page 4</p> <p>NFPA 72, 1999 edition. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation at 11:27 A.M., showed a small circular ring missing from the bottom of a smoke detector in the laundry room's ceiling.</p> <p>Observation at 12:09 P.M., showed a residential smoke detector missing from its base in room 311.</p> <p>Record review on May 20, 2025 at 12:57 P.M., showed no record of a a semi-annual fire alarm inspection.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said,"I can't account for anything in 2024, but I will work on finding the paperwork or get it scheduled. I will also address smoke detector issues."</p> <p>Record review of the Nation Fire Protection Association (NFPA) 72 1999 Edition: 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer ' s recommendations, and shall verify correct operation of the fire alarm system.</p> <p>NFPA Standard: System defects and malfunctions shall be corrected. If a defect or malfunction is not corrected at the conclusion of system inspection, testing, or maintenance, the system owner, or the owner ' s designated representative shall be informed of the impairment in writing within 24 hours. 1999 NFPA 72, 7-1.1.2</p> <p>NFPA Standard: The owner or the owner ' s</p>	A2249		

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A2249	<p>Continued From page 5</p> <p>designated representative shall be responsible for inspection, testing, and maintenance of the system and alterations or additions to this system. The delegation of responsibility shall be in writing, with a copy of such delegation provided to the authority having jurisdiction upon request. 1999 NFPA 72, 7-1.2</p> <p>Record review of Nation Fire Protection Association (NFPA) 72 1999 Edition: 7-3 Inspection and Testing Frequency: 7-3.1* Visual inspection shall be performed in accordance with the schedules in Section 7-3 or more often if required by the authority having jurisdiction. The visual inspection shall be made to ensure that there are no changes that affect equipment performance.</p> <p>Table 7-3.1 Visual Inspection Frequencies Component for Semiannually:</p> <ol style="list-style-type: none"> 3. Batteries: Nickel-Cadmium Scaled Lead-Acid 4. Transient Suppressors: 5. Control Unit Trouble Signals: 7. Emergency Voice/ Alarm Communications Equipment: 8. Remote Annunciators 9. Initiation Devices: a. Air Sampling b. Duct Detectors c. Electromechanical Releasing Devices d. Fire-Extinguish System(s) or Suppression e. Fire Alarm Boxes f. Heat Detectors h. Smoke Detectors 10. Guard ' s Tour Equipment: 11. Interface Equipment: 12. Alarm Notification Appliances - Supervised: 13. Supervising Station Fire Alarm Systems -Transmitters 	A2249		

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A2249	<p>Continued From page 6</p> <ul style="list-style-type: none"> a. DACT b. DART c. McCulloh d. RAT <p>14. Special Procedures: 15. Supervising Station Fire Alarm Systems - Receivers</p> <ul style="list-style-type: none"> b. DARR* c. McCulloh Systems* d. Two-Way RF Multiplex* e. RASSR* f. RARS* g. Private Microwave* <p>7-3.2* Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic test is performed at least weekly by remotely monitored fire alarm control unit specifically listed for application, the manual testing frequency shall be permitted to be extended to annual.</p> <p>Table 7-3.2 Testing Frequencies Component for Semiannually:</p> <ul style="list-style-type: none"> 5. Batteries - Central Station Facilities <ul style="list-style-type: none"> a. Lead-Acid Type <ul style="list-style-type: none"> 1. Specific Gravity 6. Batteries - Fire Alarm Systems <ul style="list-style-type: none"> a. Lead-Acid Type <ul style="list-style-type: none"> 2. Discharge Test (30 minutes) 3. Load Voltage Test 4. Specific Gravity b. Nickel-Cadmium Type <ul style="list-style-type: none"> 3. Load Voltage Test d. Sealed Lead-Acid Type <ul style="list-style-type: none"> 3. Load Voltage Test 7. Batteries - Public Fire Alarm Reporting Systems Voltage test in accordance with Table 7-2.2, 7(a)- (f) 	A2249		

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A2249	Continued From page 7 a. Lead-Acid Type 4. Specific Gravity 15. Initiating Devices g. Radiant Energy Fire Detectors k. Waterflow Devices i. Valve Tamper Switches	A2249		
A2257	19 CSR 30-86.022(10)(B) Combustible Materials, Unnecessary Storage Of Protection from Hazards. (B) The storage of unnecessary combustible materials in any part of a building in which a licensed facility is located is prohibited. I/II This regulation is not met as evidenced by: Class II Based on observation and interview on May 20, 2025, The facility failed to ensure the storage of unnecessary combustible materials in any part of a building in which a licensed facility is located is prohibited. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observation at 11:45 A.M., showed several storage lockers with excess storage; walkway paths impeded by storage in the locker room. Several of the areas (lockers) have floor to ceiling storage of combustibles. During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We have already started on this issue and waiting on a roll-off dumpster."	A2257		
A2269	19 CSR 30-86.022(11)(B) Sprinkler System Maintenance/Testing	A2269		

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A2269	<p>Continued From page 8</p> <p>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</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation and interview on May 20, 2025 the facility failed to install and maintain a complete sprinkler system in accordance with NFPA 13, 1999 edition. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation on May 20, 2025 from 10:14 A.M. to 12:57 P.M., showed several sprinkler heads with foreign material and/or paint on them in the follow rooms and locations: Room 204 has two (2) covered with tape, Room 205 has two (2) covered with tape, Room 207 has six (6), Room 208 has one (1), Room 210 has two (2), Room 211 has two (2), Room 212 has two (2), Room 213 has five (5), Room 301 has one (1), Room 302 has two (2), Room 303 has six (6), Room 307 has four (4), Room 304 has three (3), Room 306 has two (2), One (1) outside the door to the internal Area of Rescue, Room 308 has one (1), Room 309 has five (5), Room 310 has one (1), Room 311 has one (1), Room 313 has one (1), Room 315 has one (1), Room 319 has two (2), Room 320 has eight (8), and Room 321 has two (2).</p> <p>Observation on May 20, 2025 at 10:42 A.M., showed a sprinkler head outside of room 204 with an open space between the escutcheon ring and</p>	A2269		

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A2269	<p>Continued From page 9</p> <p>the ceiling.</p> <p>Observation on May 20, 2025 at 11:01 A.M., showed boxes stored within eighteen (18") of a sprinkler head in the kitchen storage area.</p> <p>Observation on May 20, 2025 at 11:51 A.M., showed boxes stored within eighteen (18") of a sprinkler head in an office area.</p> <p>Observation on May 20, 2025 at 12:28 P.M., showed a sprinkler head in room 316 with a open space between the escutcheon ring and the ceiling.</p> <p>Observation on May 20, 2025 at 12:31 P.M., showed a sprinkler head in room 317 with a open space between the escutcheon ring and the ceiling.</p> <p>Observation on May 20, 2025 at 12:42 P.M., showed a sprinkler head outside of room 320 with a open space between the escutcheon ring and the ceiling.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "I didn't know because it wasn't in the last year's Statement of Deficiencies. But will be working to get the issues fixed."</p> <p>Record review of the Nation Fire Protection Association (NFPA) 25, 1992 Edition: 2-2.1.1* Sprinklers shall be visually inspected from floor level annually. Sprinklers shall be free of corrosion, obstructions of spray patterns, foreign materials, paint, and physical damage. Any automatic sprinklers shall be replaced that are painted, corroded, damaged, or loaded with foreign materials.</p>	A2269		

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A2269	<p>Continued From page 10</p> <p>Record review of the Nation Fire Protection Association (NFPA) 13, 1999 Edition. 5-5.5.3* Obstructions that Prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than eighteen (18") (457mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 5-5.5.3.</p> <p>5-5.6* Clearance to Storage. The clearance between the deflector and the top of storage shall be eighteen (18") (457 mm) or greater.</p> <p>Record review of the Nation Fire Protection Association (NFPA) 25, 1998 Edition. 2-2.1.1* The Sprinkler shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p>	A2269		
A2278	<p>19 CSR 30-86.022(12)(C) Emergency Lighting -Battery Powered, 1.5 hrs</p> <p>Emergency Lighting. (C) If battery-powered lights are used, they shall be capable of operating the light for at least one and one-half (1 1/2) hours. II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation and interview on May 20,</p>	A2278		

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(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
A2278	<p>Continued From page 11</p> <p>2025, the facility failed to ensure if battery-powered lights are used, they shall be capable of operating the light for at least one and one-half (1 1/2) hours. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation at 12:27 P.M., showed an emergency light that would not illuminate when pressing the test button near the 3rd floor interior stair case door.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We will get it fixed."</p>	A2278		
A2286	<p>19 CSR 30-86.022(15)(A) Wastebaskets, Metal/UL/FM-Requirements</p> <p>Trash and Rubbish Disposal. (A) Only metal or UL- or FM-fire-resistant rated wastebaskets shall be used for trash. II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observations and an interview on May 20, 2025, the facility failed to ensure all the wastebaskets were only metal or UL- or FM-fire-resistant rated wastebaskets. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observations on May 20, 2025 from 10:14 A.M. to 12:57 P.M., found the following rooms with unapproved wastebaskets; Room 203 has two (2), Room 208 has two (2), Room 209 has two (2), Room 210 has one (1), Hair Salon has two (2), Room 306 has one (1),</p>	A2286		

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A2286	Continued From page 12 Room 310 has two (2), Room 311 has one (1), Room 313 has two (2), Room 315 has one (1), Room 321 has one (1), Room 108 has one (1), Room 105 has two (2), Room 103 has one (1), Room 102 has three (3), Room 224 has six (6), and Room 220 has three (3). During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We just order a bunch of approved trash cans and can't explain how, but family bring the others in. We will make a contract for the residents to sign.	A2286		
A2298	19 CSR 30-86.022(17) Oxygen Storage Requirements Oxygen storage shall be in accordance with NFPA 99, 1999 Edition. II/III This regulation is not met as evidenced by: Class III Based on observation and interview on May 20, 2025, the facility failed to store portable oxygen cylinders in accordance with NFPA 99, 1999 Edition. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observation at 10:49 A.M., showed an oxygen cylinder setting next to a TV that was not in a holding device in room 110. Observation at 11:05 A.M., showed thirteen (13) oxygen cylinders in room 207. These oxygen cylinders are not stored properly and exceed the	A2298		

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A2298	<p>Continued From page 13</p> <p>amount/number of cylinders allowed outside of a proper oxygen storage area.</p> <p>Observation at 11:13 A.M., showed five (5) medium and one (1) large oxygen cylinders stored in the closet of room 209. These oxygen cylinders are not stored properly and exceed the amount/number of cylinders allowed outside of a proper oxygen storage area.</p> <p>Observation at 11:39 A.M., showed three (3) oxygen cylinders not in a holding device in room 302. These oxygen cylinders are not stored properly and exceed the amount/number of cylinders allowed outside of a proper oxygen storage area.</p> <p>Observation at 11:42 A.M., showed seven (7) oxygen cylinders not stored properly in the storage locker room. These oxygen cylinders are not stored properly and exceed the amount/number of cylinders allowed outside of a proper oxygen storage area.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "I will go to the nurse and have a discussion with the resident regarding the amount of spare oxygen cylinders that can be in each resident's room and the proper storage and requirements."</p> <p>Review of the following chapters of the 1999 National Fire Protection Association (NFPA) 99, showed: 8-3.1.11 Storage Requirements 8-3.1.11.2 Storage for non-flammable gases less than 3000 ft³ (85 m³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible</p>	A2298		

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A2298	Continued From page 14 construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases, such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or 3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	A2298		
A3201	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed 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 III Based on observation and interview on May 20, 2025, the facility failed to maintain the building in good repair. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observation at 10:47 A.M., showed an approximate three inch (3") by eight inch (8") hole	A3201		

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A3201	<p>Continued From page 15</p> <p>in the wall of the closet, by the sprinkler head, in room 206.</p> <p>Observation at 10:53 A.M., showed an approximate ten inch (10") by one foot (1') hole in the wall of the closet, by the sprinkler head in room 109.</p> <p>Observation between 10:56 A.M. and 10:59 A.M., showed the following in the facility's commercial kitchen: an approximate eight inch (8") by two and one-half foot (2-1/2') hole in the wall of a storage area; a ceiling tile out of place; a strip of door trim missing to the water heater area; and open spaces around pipes in the wall by water heater.</p> <p>Observation at 11:28 A.M., showed an approximate two and one-half foot (2-1/2') strip of drywall tape coming lose where the ceiling and wall meet in room 212.</p> <p>Observation at 11:36 A.M., showed an approximate two inch (2") by four inch (4") hole in the ceiling in the hair salon.</p> <p>Observation at 11:39 A.M., showed an approximate two and one-half foot (2-1/2') strip of drywall tape coming lose of the ceiling of room 302.</p> <p>Observation at 11:40 A.M., showed three (3) tiles with cut outs for wires and pipes to run through the ceiling in the first floor janitor's room.</p> <p>Observation at 11:49 A.M., showed an approximate two and one-half foot (2-1/2') strip of drywall tape coming lose from the ceiling and an approximate eighteen inch (18") by three inch (3") area where the drywall popcorn ceiling came</p>	A3201		

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A3201	<p>Continued From page 16</p> <p>down in an office.</p> <p>Observation at 12:24 P.M., showed several holes and penetrations in the maintenance room on the 3rd floor.</p> <p>Observation at 12:27 P.M., showed a horizontal crack in the wall at the seam where the drywall meets, outside of interior stairway on the 3rd floor near the door.</p> <p>Observation at 12:27 P.M., showed a broken ceiling tile in the near the fire place atrium.</p> <p>Observation at 12:06 P.M., showed a smoke detector not mounted flush against the ceiling in room 221.</p> <p>Observation at 12:21 P.M., showed a smoke detector not attached to the ceiling and hanging from it wires in room 216.</p> <p>Observation at 12:26 P.M., showed a smoke detector not attached all the way to the ceiling in room 214.</p> <p>Observation at 12:27 P.M., showed a smoke detector not mounted flush against the ceiling in the hallway near the mail boxes.</p> <p>Observation at 12:27 P.M., showed a smoke detector not mounted flush against the ceiling in hallway by the fire place atrium on the second floor.</p> <p>Observation at 12:28 P.M., showed a smoke detector not mounted flush against the ceiling in the hallway near room 224.</p> <p>Holes, cracks, missing tiles and penetrations will</p>	A3201		

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A3201	Continued From page 17 allow smoke, fire and toxic gases to travel to the unaffected portions of the building in the event of a fire. During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We will work on getting these issues fixed."	A3201		
A3211	19 CSR 30-86.032(10) Heaters-Approved Label, Venting, No Portable In newly licensed facilities or if a new heating system is installed in an existing licensed facility, the heating of the building shall be restricted to steam, hot water, permanently installed electric heating devices or a warm air system employing central heating plants with installation such as to safeguard the inherent fire hazard, or approved installation of outside wall heaters which bear the approved label of the American Gas Association or National Board of Fire Underwriters. The foregoing requirements are applicable to residential care facilities. In assisted living facilities, the heating of the building shall be restricted to steam, hot water, permanently installed electric heating devices or a warm air system employing central heating plants with installation such as to safeguard the inherent fire hazard, or approved installation of outside wall heaters which bear the approved label of the American Gas Association or National Board of Fire Underwriters. For all facilities, oil or gas heating appliances shall be properly vented to the outside and the use of portable heaters of any kind is prohibited. If approved wall heaters are used, adequate guards shall be provided to safeguard residents. I/II This regulation is not met as evidenced by:	A3211		

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A3211	Continued From page 18 Class II Based on observation and interview on May 20, 2025 the facility failed to ensure the use of portable space heaters was prohibited. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observation at 11:07 A.M., showed a portable electric heater sitting in the closet of Room 207. During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "We will take care of it."	A3211		
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 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	A3214		

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A3214	<p>Continued From page 19</p> <p>electrician. II/III</p> <p>This regulation is not met as evidenced by: Class II*</p> <p>Based on observations and an interview on May 20, 2025, the facility failed to install and maintain the electrical wiring in accordance with the requirements of the National Electrical Code, 1999 edition. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observations on May 20, 2025 at 10:52 A.M., showed a unsecured light switch located in a double receptacle box with electrical wire protruding from the junction box, without a cover plate in room 109. Testing with circuit tester/ hot stick indicated the light switch and wires were energized.</p> <p>Observations on May 20, 2025 at 10:53 A.M., showed the furnace power wire not secured to the furnace cabinet in room 109. At the time of discovery, the maintenance director stated, "every room is like this."</p> <p>Observations on May 20, 2025 at 10:55 A.M., showed a three (3) light switch junction box and outlet without cover plates, in room 108.</p> <p>Observations on May 20, 2025 at 10:57 A.M., showed a water heater with the power wires exposed from the junction panel, in the main kitchen.</p> <p>Observations on May 20, 2025 at 11:43 A.M., showed a lose outlet and junction box in the front wall of room 303.</p>	A3214		

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A3214	Continued From page 20 During an interview on May 20, 2025 at 2:22 P.M., the Executive director said, "The maintenance director is working on a list." *The higher classification merited due to the impact when combined with other deficiencies.	A3214		
A3219	19 CSR 30-86.032(18) Extension Cords/Duplex Receptacles If extension cords are used, they must be Underwriters ' Laboratory (UL)-approved or shall comply with other recognized electrical appliance approval standards and sized to carry the current required for the appliance used. Only one (1) appliance shall be connected to one (1) extension cord and only two (2) appliances may be served by one (1) duplex receptacle. If extension cords are used, they shall not be placed under rugs, through doorways or located where they are subject to physical damage. II/III This regulation is not met as evidenced by: Class III Based on observation and interview on May 20, 2025, the facility failed prevent the improper use of power strips, extension cords and the use of multi-plug adapters. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observations on May 20, 2025 from 10:14 A.M. to 12:57 P.M., found the following rooms with improper use of power strips, unapproved extension cords, multi-plug adapters, and appliances not approved to be plugged into power strips: Room 107 has a two (2), three (3) way adapters and a oxygen concentrator plugged into	A3219		

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A3219	<p>Continued From page 21</p> <p>a power strip. Room 207 has two (2) extension cords and one (1), three (3) way adapter. Room 105 has a unapproved three (3) plug extension cord daisy-chained into a power strip. Room 101 has a three (3) way adapter with three (3) appliances plugged into it, an extension cord with an appliance plugged into it, and a six (6) way adapter. Room 310 has a three (3) way adapter and an unapproved extension cord. Room 218 has three (3), three (3) way adapters. Room 313 has one (1), three (3) way adapter. Room 325 has one (1), three (3) way adapter.</p> <p>During an interview on May 20, 2025 at 2:22 P.M., the Executive director said,"We will get them removed and make a contract for the residents to sign."</p>	A3219		
A3220	<p>19 CSR 30-86.032(19) Elevator Requirements</p> <p>If elevators are used, installation and maintenance shall comply with local and state codes and the National Electric Code. II/III</p> <p>This regulation is not met as evidenced by: Class III</p> <p>Based on observation, record review, and interview on May 20, 2025, the facility failed to have a current approved elevator inspection certification under Missouri State Regulation, 11 CSR 40-5.065. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents.</p> <p>Observation at 11:34 A.M., showed one record located in the elevator dated as expired on December 10, 2023.</p>	A3220		

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A3220	Continued From page 22 Record review at 12:57 P.M., showed no current state elevator certificate documentation. During an interview on May 20, 2025 at 2:22 P.M., the Executive director said,"It has been inspected and have been trying to address it, but it started before I was hired in 2024."	A3220		
A3224	19 CSR 30-86.032(23) Rooms Neat, Orderly, Cleaned Daily Rooms shall be neat, orderly and cleaned daily. II/III This regulation is not met as evidenced by: Class III. Based on observation and interview on May 20, 2025, facility fails to keep rooms neat and orderly. The facility census was forty-seven (47). This affected forty-seven (47) of forty-seven (47) residents. Observation at 12:18 P.M., Show excessive clutter in resident room 314. This includes clothes, blankets, boxes and trash around the resident's room. Some of the exit pathways are approximately fifteen inches (15") , or less in width. The amount of clutter in this room would impede the resident's ability to exit in a timely manner during an emergency and creates an excessive fire load in the room. During an interview on May 20, 2025 at 2:22 P.M., the Executive director said,"We will address it with the resident."	A3224		

AMENDED PLAN OF CORRECTION

Provider Name:	Trustwell Living of Raytown	
Street Address, City, Zip:	9110 E. 63 rd St. Raytown, MO 64133	
Date of Survey:	May 20, 2025	
Provider number:	24227	
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	<i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</i>	
A2202	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Excess lint and socks were removed from the back of the dryers and pipe in the laundry room.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. A lint removal/visual check log has been added to the preventative maintenance binder.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Executive Director educated nursing staff and Maintenance Director on eliminating fire hazards due to lint build up in the laundry room.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit dryer usage weekly x4 weeks, and then bi-weekly for x2 months. The results of the audits will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2214	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p>	

	Executive Director scheduled a full evacuation drill - consultation with the Raytown Fire Department for July 2025.	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Education provided to Maintenance Director and preventative maintenance binder updated to include drill logs.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Maintenance Director educated on annual requirement of a fire drill consultation with participation from the fire department. Documentation for all drills will be kept in the preventative maintenance binder.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will routinely schedule a fire drill evacuation consultation with the local fire department annually. Feedback from monthly fire drills will be presented to the leadership team during the monthly Quality Improvement meeting and brought to the fire department for review during consultations.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2217	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Fire drills for the remainder of the year have been prescheduled so that each shift participates in a drill once per quarter.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Education provided to Maintenance Director and preventative maintenance binder updated to include detailed logs about fire drills.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Documentation for all drills will be kept in the preventative maintenance binder.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p>	

	Maintenance Director/designee will routinely schedule a fire drill once per month; ensuring that each shift participates once per quarter. Feedback from monthly fire drills will be presented to the leadership team during the monthly Quality Improvement meeting.	
	The corrective actions will be completed on or before:	09-03-2025
A2238	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Maintenance Director ordered 2 new emergency lights for the exit near the therapy room and the sprinkler room the week of June 9th.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Education provided to Maintenance Director and preventative maintenance binder updated to include emergency light testing.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Executive Director educated Maintenance Director on illumination requirements.</p> <p>Maintenance Director will routinely test and visually inspect emergency exit lights for proper illumination and maintain documentation of results in the preventative maintenance binder.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will test & inspect emergency exit lights 1x per month for 3 months and ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2249	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <ul style="list-style-type: none"> -Base of smoke detector was replaced in the laundry room. -Apartment 311 had a new smoke detector installed. -Fire alarm inspection was completed 01-20-2025. The semi-annual inspection will be completed in quarter 3 (July-Sept). 	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p>	

	All residents, staff and visitors have the potential to be affected by the alleged practice. Education provided to Maintenance Director and preventative maintenance binder updated to include inspection of smoke detectors and fire alarm inspection results.	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Maintenance Director will routinely test and visually inspect smoke detectors throughout the facility and maintain documentation of results in the preventative maintenance binder.</p> <p>Maintenance Director will coordinate semi-annual fire inspections with the fire vendor and maintain documentation of results in the preventative maintenance binder.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit smoke detectors 2x per month for 3 months then 1x per month ongoing. Maintenance Director/designee will also preschedule the semi-annual fire alarm inspection following the initial inspection each year. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2269	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>-Executive Director scheduled replacement of 63 sprinkler heads with 360 Fire Protection on 06/12/2025.</p> <p>-Top shelf storage in the kitchen and business office was removed.</p> <p>-Gaps in between sprinkler heads outside of 204 and 320 and inside 316 and 317 were filled with caulking.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Preventative maintenance binder was updated to include visual checks on sprinkler heads throughout the facility.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Maintenance Director/designee will routinely inspect sprinkler heads for proper installation and build up and ensure no objects are stored within 18" from the ceiling.</p> <p>Maintenance Director/designee will coordinate with construction vendors to ensure sprinkler heads are not sprayed, covered or painted on during renovations.</p>	

	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit sprinkler heads 1x per month for 3 months then 1x quarterly. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2257	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>A durable medical equipment vendor was called to properly dispose of the unused oxygen tanks in the locker area.</p> <p>Additional storage and unused items were removed from the locker area.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Preventative maintenance binder updated to include an indoor physical plant walkthrough.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>All staff educated not to store oxygen tanks in any area that is not labeled as oxygen storage. Residents will continue to store no more than two tanks inside their apartment.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2278	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>The bracket holding the emergency light near the stairway on the 3rd floor was adjusted to allow the test button to work properly.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p>	

	All residents, staff and visitors have the potential to be affected by the alleged practice. Preventative maintenance binder was updated to include an emergency lighting log.	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Executive Director educated Maintenance Director on illumination requirements.</p> <p>Maintenance Director will routinely test and visually inspect emergency exit lights for proper illumination and maintain documentation of results in the preventative maintenance binder</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will test & inspect emergency exit lights 1x per month for 3 months and ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A2286	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Non-fire rated wastebaskets in the following areas were removed: 203, 208, 209, 210, 306, 310, 311, 315, 321, 108, 105, 103, 102, 224, 220 and the beauty salon.</p> <p>Approximately 200 fire rated wastebaskets were distributed to all areas in quarter 1 of 2025. Families were notified that they may not replace our fire rated wastebaskets with plastic bins.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff, and visitors have the potential to be affected by the alleged practice. Families signed an addendum of prohibited items; including but not limited to wastebaskets.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Executive Director to educate families on prohibited items during admission.</p> <p>Staff will log in the work order book when non-fire-rated wastebaskets are in use.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results</p>	

	will be presented to the leadership team during the monthly Quality Improvement meeting.	
	The corrective actions will be completed on or before:	09-03-2025
A2298	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>A durable medical equipment vendor was called to remove the additional oxygen tanks from the lockers and apartments 110, 207, 209, and 302.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff, and visitors have the potential to be affected by the alleged practice. Families signed an addendum of prohibited items; including but not limited to oxygen storage.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>All staff were educated on the proper oxygen storage inside apartments.</p> <p>Staff will log in the work order book when oxygen storage inside the apartments exceeds two tanks and is without racks.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A3201	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <ul style="list-style-type: none"> -Holes in the wall, ceiling and near sprinkler heads in the kitchen storage, in closets of 206 and 109, beauty salon, office and door trim of water heater closet were covered with sheet rock and painted. -Missing ceiling tile in the kitchen, janitor's closet and near the fireplace on 2nd floor were replaced with new tile. -Open spaces around the pipes of the water heater were filled in with fire foam. -New drywall tape was put on cracks in 212, 302, bistro, and near stairway on 3rd floor. 	

	-Smoke detector mounting screws were tightened near 221, 216, 214, 224, near the fireplace and mailboxes.	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Preventative maintenance binder was updated to include a visual check of floors, walls, and ceiling (physical plant walkthrough).</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Executive Director implemented a physical plant walkthrough to observe and resolve findings.</p> <p>Staff will log repairs in the maintenance work order book.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance director/designee will visually inspect the physical plant (indoors) for holes and cracks in the floors, walls, and ceiling 1x weekly for 3 months and ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A3211	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>The electric heater inside the closet of apartment 207 was removed.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff, and visitors have the potential to be affected by the alleged practice. Families signed an addendum of prohibited items; including but not limited to electric heaters.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Staff will report to Maintenance Director/Executive Director for immediate removal or log in the work order book when extension cords/power cords are not properly used.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results</p>	

	will be presented to the leadership team during the monthly Quality Improvement meeting.	
	The corrective actions will be completed on or before:	09-03-2025
A3219	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Unapproved extension cords/power cords in apartments 207, 107, 105, 101, 310, 218, 313, and 325 were removed.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff, and visitors have the potential to be affected by the alleged practice. Families signed an addendum of prohibited items; including but not limited to extension cords.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Staff will report to Maintenance Director/Executive Director for immediate removal or log in the work order book when extension cords/power cords are not properly used.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
	The corrective actions will be completed on or before:	09-03-2025
A3320	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Re-inspection of the December 2024 inspection was delayed by ESSI. ESSI came out on 06-02-2025 and approved corrections for certification. Pending receipt of certificate.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>No residents have the potential to be affected by this alleged practice due to immediate correction, delayed certification and no defect with the cabin itself.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Business Office Manager/designee will keep a log of elevator certificate expiration dates and coordinate inspections accordingly.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p>	

	Executive Director will review certificate/license expiration log 1x per month for three months then monthly ongoing during the Quality Improvement Meeting.	
	The corrective actions will be completed on or before:	09-03-2025
A3224	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>At the time of inspection, the Executive Director informed the resident occupying #314 that must begin cleaning apartment with an emphasis on removing unnecessary combustibles to prevent hazardous injury to self and staff. Resident also received this notice in writing.</p>	
	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff and visitors have the potential to be affected by the alleged practice. Pathway to Safety & Neat and Orderly rooms was discussed with all residents during resident council. Education provided to all staff regarding pathway to safety inside apartments.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Staff will report to Maintenance Director/Executive Director or log in the work order book when furniture, boxes, shelving, etc. has become an obstruction that may impede a resident's path to safety in an emergency.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance Director/designee will visually audit apartments that is equal to 10% of the total occupied census, 2x for one month and 1x per month for 2 months then quarterly ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting.</p>	
AMENDED	The corrective actions will be completed on or before:	09-03-2025
A3214	<p>1) The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:</p> <p>Lose outlet in 303 was tightened so that it is fixed to the wall.</p> <p>Cover plates in 109 and 108 unoccupied apartments were replaced and wires pushed into junction boxes</p> <p>Furnace power wire has been secured to furnace cabinet in 109.</p> <p>Power wires are no longer exposed from the junction panel on water heater in kitchen.</p>	

	<p>2) The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:</p> <p>All residents, staff, and visitors have the potential to be affected by the alleged practice. All light switches have cover plates and wires are contained within junction boxes. Loose outlet plates were tightened.</p>	
	<p>3) Measures put into place to ensure that the deficient practice does not recur includes:</p> <p>Maintenance Director/Executive Director in-serviced all staff to log loose outlet covers and exposed wiring in the work order book to be addressed immediately.</p>	
	<p>4) The facility will monitor its performance to make sure the solutions are sustained by conducting the following:</p> <p>Maintenance director/designee will visually inspect the physical plant (indoors) for loose outlet plates and exposed wiring 2x for two months then 1x monthly ongoing. Results will be presented to the leadership team during the monthly Quality Improvement meeting</p>	
	<p>The corrective actions will be completed on or before:</p>	<p>09-03-2025</p>

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.