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
	24227	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF RAYTOWN	9110 EAST 63RD STREET RAYTOWN, MO 64133

(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
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to provide protective oversight when Resident #1 became combative and verbally requested Medication Aide A (MA A) to get out of his/her room and MA A continued to provide care to the resident who was upset and combative out of five sampled residents. The facility census was 53 residents. Review of the facility's undated Abuse and Neglect policy and procedure showed: -The facility prohibits the abuse, neglect, and exploitation of residents by staff. -The Director will ensure no resident shall be subjected to verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion, neglect, or exploitation. -Each allegation of abuse, neglect, or exploitation shall be reported to the Director of the community as soon as staff are aware of the allegation and to the department within 24 hours. -The Director shall ensure that an investigation is started when they or the designee become aware of the allegation. -Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in process.	A4776		

Per acknowledgement of email receipts

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A4776	Continued From page 1 1. Review of Resident #1's undated face sheet showed he/she was admitted with diagnoses that included: -Hypertension(high blood pressure). -Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs). -Post Cerebral Vascular Accident (the period and effects after a stroke). Review of the resident's Medication Administration Record (MAR) dated December 2025 showed: -He/she was taking Aspirin enteric coated (EC) (a blood thinner) take one tablet every day. -He/she was taking Clopidogrel (Plavix an antiplatelet used to prevent blood clots in the blood) 75 milligram (mg) take one tablet every day. Review of the resident's Nurse's Notes dated June 2025 to 12/5/25 showed there was no documentation that showed any skin tears or bruising noted to the resident. Review of the resident's Nurses Notes dated 12/6/25 showed: -Staff reported bruising to both arms and skin tears to the left arm. -The resident was sent to the emergency room for evaluation. -The resident returned to the facility the same day with no new orders. -Family was notified. Review of the facility's Investigation dated 12/6/25 showed: -On 12/6/25 at approximately 2:00 A.M., MA A was making rounds and went into Resident #1's	A4776		

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A4776	Continued From page 2 apartment, while providing care to the resident, he/she noticed a skin tear to the resident's left forearm. -He/she cleaned and dressed the area with a dry dressing. -At approximately 6:00 A.M., when MA A went to get the resident ready for the day, he/she noted that the resident had bruises to his/her right forearm, as well as the bruises and skin tears he/she noted earlier to resident's left forearm. -At approximately 7:00 A.M., MA A brought MA B to the resident's apartment to show him/her the skin tears and bruising on the resident's arms during his/her shift. -At approximately 8:30 A.M. MA B overheard the resident tell a tablemate someone twisted his/her arm. -At approximately 8:50 A.M., MA B reported to the Regional Director of Operations (RDO), Regional Nurse Consultant (RNC) and Health Service Director (HSD) that the resident was observed with bruising to both forearms and two skin tears located close together on his/her left forearm. The posterior (further back in position) skin tear measured 1.5 centimeters (cm) x 2 cm x 0.1 cm and the distal (situated away from the center of the body) skin tear measured 1.7 cm x 2 cm x 0.1 cm. -Following completion of the investigation abuse was ruled out. -The resident was taking two medications that thinned the blood and was swinging his/her arms while care was being provided. -The staff member would no longer be employed for not following facility policy and for not leaving the resident alone when requested. Observation on 12/8/25 at 12:05 P.M., of the resident showed: -A brown ace bandage wrapped from the resident	A4776		

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A4776	Continued From page 3 left elbow to the mid forearm. -There was purple/red bruising on the resident's left and right arms. During an interview on 12/8/25 at 12:05 P.M., the resident said: -A female staff member came into his/her room to assist him/her. -He/she did not remember the staff member's name. -He/she told the staff member to get out of his/her room. -The staff member did not leave the room, he/she put a bandage on his/her arm because there was a small scratch on his/her arm, and came back to get him/her up for the day. During an interview on 12/8/25 at 2:09 P.M., MA B said: -At approximately 7:00 A.M., upon arrival for his/her scheduled day shift, MA A said the resident was combative, swinging his/her arms while he/she was providing cares and had skin tears and bruising to both his/her arms. -MA A continued to assist the resident while the resident was being combative. During an interview on 12/8/25 at 3:02 P.M., MA A said: -He/she was doing his/her rounds around 2:00 A.M. and noticed the resident had a small skin tear on his/her left arm. -He/she went out of the resident's room to get a bandage for the resident. -When he/she walked back in the resident's room, he/she noticed the resident was picking at the small skin tear. -He/she bandaged the small skin tear and then proceeded to change the resident's brief. -The resident became combative and began	A4776		

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A4776	Continued From page 4 swinging his/her hands and arms while he/she was providing cares.. -The resident's arms did not hit or make contact with anything while he/she was swinging them. -He/she worked his/her whole shift. During an interview on 12/9/25 at 8:52 A.M., the Regional Director of Operations said: -He/she was told by MA B that the resident had skin tears and bruising to both arms and was combative while MA A was providing care and he/she continued to work his/her shift. -If there was any form of altercation between a resident and a staff member, the staff member would be removed from the area and suspended pending an investigation. During an interview on 12/9/25 at 9:00 A.M., the Health Services Director said: -He/she was told by MA B that the resident had skin tears and bruising on both his/her arms and was combative while MA A was providing care and MA A continued working his/her shift. -He/she expected staff to follow the policy and let him/her know of any skin tears, bruising and resident's being combative during cares. -If there was any form of altercation between a resident and a staff member, the staff member would be removed from the area and suspended pending an investigation. During an interview on 12/9/25 at 2:36 P.M., MA A said: -The resident was being combative and swinging his/her arms while care was being provided. -He/she continued to change the resident's brief because he/she could not leave the resident without a brief on. -He/she left the room when he/she finished changing the resident's brief.	A4776		

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A4776	Continued From page 5 -He/she worked his/her whole shift. MO00259646 MO00259650	A4776		
A8025	19 CSR 30-88.010(25) Report A/N to DHSS/DMH When Needed If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been abused or neglected, the administrator or employee shall immediately report or cause a report to be made to the department. Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances that would reasonably result in abuse or neglect shall immediately report or cause a report to be made to the department and to the Department of Mental Health. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure staff immediately notified the Director of a resident who was combative during cares, had new skin tears and bruising on his/her arms for one sampled resident (Resident #1) out of five sampled residents. The facility census was 53 residents. Review of the facility's undated Abuse and	A8025		

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A8025	Continued From page 6 Neglect policy and procedure showed: -Each allegation of abuse, neglect, or exploitation shall be reported to the Director of the community as soon as staff is aware of the allegation and to the department within 24 hours. -The Director will ensure no resident shall be subjected to verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion, neglect, or exploitation. 1. Review of Resident #1's undated face sheet showed he/she was admitted with diagnoses that included: -Hypertension (high blood pressure). -Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs). -Post Cerebral Vascular Accident(the period and effects after a stroke). Review of the facility's Investigation dated 12/6/25 showed: -On 12/6/25 at approximately 2:00 A.M., Medication Aide A was making rounds and went into Resident #1's apartment, while providing care to the resident, he/she noticed a skin tear to the resident's left forearm. -He/she cleaned and dressed the area with a dry dressing. -At approximately 6:00 A.M., when MA A went to get the resident ready for the day, he/she noted that the resident had bruises to his/her right forearm, as well as the bruises and skin tears he/she noted earlier to resident's left forearm. -At approximately 7:00 A.M., MA A brought MA B to the resident's apartment to show him/her the skin tears and bruising on the resident's arms during his/her shift. -At approximately 8:30 A.M. MA B overheard the resident tell a tablemate someone twisted his/her	A8025		

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A8025	Continued From page 7 arm. -At approximately 8:50 A.M., MA B reported to the Regional Director of Operations (RDO), Regional Nurse Consultant (RNC) and Health Service Director (HSD) that the resident was observed with bruising to both forearms and two skin tears located close together on his/her left forearm. The posterior (further back in position) skin tear measured 1.5 centimeters (cm) x 2 cm x 0.1 cm and the distal (situated away from the center of the body) skin tear measured 1.7 cm x 2 cm x 0.1 cm. Observation on 12/8/25 at 12:05 P.M., of the resident showed: -An ace bandage wrapped from the resident's left elbow to the mid forearm. -There were purple/red bruises on the resident's left arm. -There were purple/red bruises on the resident's right arm. During an interview on 12/8/25 at 12:02 P.M., the resident said: -A female staff member came into his/her room to assist him/her. -He/she did not remember the staff member's name. -He/she told the staff member to get out of his/her room. -The staff member did not leave the room, he/she put a bandage on his/her arm because there was a small scratch on his/her arm. During an interview on 12/8/25 at 2:09 P.M., MA B said: -At approximately 7:00 A.M., upon arrival for his/her scheduled shift, MA A took him/her to the resident's apartment and showed him/her the resident's skin tears and bruises on both of the	A8025		

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A8025	Continued From page 8	A8025		

resident's arms.
-MA A said the resident was combative and swinging his/her arms while he/she was changing the resident's brief.
-At 8:56 A.M. he/she reported the skin tears and bruising to both of the resident's arms to the RDO, RNC and HSD.

During an interview on 12/8/25 at 3:02 P.M., MA A said:
-He/she was doing his/her rounds and found the resident had a small skin tear on his/her arm.
-He/she went out of the resident's room to go get a bandage for the resident.
-When he/she walked back in the resident's room, he/she noticed the resident was picking at the small skin tear.
-He/she bandaged the small skin tear and then changed the resident's brief.
-The resident became combative and began swinging his/her arms at him/her.
-During shift change he/she told MA B about the skin tears and bruising to the resident's arms.
-He/she did not tell the HSD, RNC, or the RDO about the skin tears and bruising.

During an interview on 12/9/25 at 8:52 A.M., the RDO said:
-He/she was told by MA B about the bruising and skin tears to the resident's arms.
-He/she immediately called the HSD at the facility to have him/her start an investigation.
-MA A should have reported immediately the skin tears and bruising to the resident's arms and the resident's combativeness.

During an interview on 12/9/25 at 9:00 A.M., the HSD said:
-He/she was told by the RDO about the skin tears and bruising on both of the resident's arms and to

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A8025	Continued From page 9 start an investigation. -He/she expected staff to follow the chain of command and facility policy for reporting all incidents, including finding skin tears and bruising. -MA A should have reported immediately the skin tears and bruising to the resident's arms and the resident's combativeness. -He/she expected staff to report if resident's were being combative during cares. -Reporting should be to management not another employee. During an interview on 12/9/25 at 2:36 P.M., MA A said: -He/she noticed skin tears and bruising to both of the resident's arms. -The resident was combative with him/her during cares. -He/she told MA B about the skin tears and bruising to both the resident's arms and that the resident had been combative during the shift while cares were being provided. -He/she did not tell the HSD or the RDO about the skin tears and bruising or that the resident was combative as he/she didn't think it was an issue. MO00259646 MO00259650	A8025		

Plan of Correction

Regulation: Protective oversight shall be provided twenty-four (24) hours a day.

Facility: Trustwell Living of Raytown

Survey Date: 12/10/2025

Trustwell Living at Raytown Place Assisted Living POC for December 10, 2025, Self report Investigation. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this plan of correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

19 CSR 30-86.047(35) Protective Oversight

(35) Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II (36) Residents shall receive

The facility acknowledges the findings related to protective oversight and has implemented corrective actions to ensure resident safety, staff accountability, and compliance with Missouri assisted living regulations regarding 24-hour protective oversight.

1. Corrective Action for Resident #1:

Immediately upon identification of the incident, Resident #1 was assessed by nursing staff for physical and psychosocial well-being. The resident's care plan and behavior interventions were reviewed and updated to include specific approaches for redirection, de-escalation, and notification procedures when behaviors escalate. Medication Aide A (MAA) received immediate counseling and retraining regarding abuse prohibition, resident rights, appropriate response to combative behaviors, and the requirement to obtain assistance when a resident becomes agitated or unsafe.

2. Identification of Other Residents at Risk:

The facility conducted an audit of current residents requiring behavioral monitoring, redirection, or dementia-related care to ensure individualized interventions and protective oversight measures are in place and being followed. Any identified gaps in care plans or behavior interventions were corrected immediately.

3. Systemic Changes Implemented:

- Staff, including Medication Aides, caregivers, nurses, and management, will receive mandatory re-education on:
    - Abuse and neglect prevention
    - Protective oversight requirements
    - Resident rights
    - Dementia care and de-escalation techniques
    - Appropriate staff response to combative or distressed residents
    - Reporting requirements and chain of command
- Education will include review of the facility Abuse and Neglect Policy and Missouri regulations related to protective oversight and resident safety.
- The facility has implemented a protocol requiring staff to immediately remove themselves from direct interaction and notify supervisory personnel if a resident becomes escalated and the staff member is unable to safely redirect the resident.
- Licensed nursing and management staff will conduct random weekly observations of resident interactions to ensure staff compliance with protective oversight expectations.
- The Executive Director or designee will review all incident reports involving resident behaviors weekly to identify trends and ensure appropriate interventions are implemented timely.

4. Monitoring to Ensure Continued Compliance:

- The Executive Director or designee will complete weekly audits of incident reports, behavior documentation, and staff interventions for four (4) weeks, then monthly thereafter for two (2) additional months.
- Any identified concerns will result in immediate corrective action and additional staff education.
- Audit findings will be reviewed during Quality Assurance meetings to ensure ongoing compliance and sustained corrective action.

5. Date of Compliance:
The facility alleges compliance on 12.6.2025.

19 CSR 30-88.010(25) Report Abuse/Neglect to DHSS/DMH When Needed

(25) If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been abused or neglected, the administrator or employee shall **immediately report or cause a report to be made to the department.**Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances that would reasonably result in abuse or neglect shall **immediately report or cause a report to be made to the department and to the Department of Mental Health**.

1. Corrective Action for Resident #1:
Upon identification of the concern, the resident was immediately assessed by nursing staff and the Executive Director/designee was notified. The allegation and observed bruising/skin tears were reviewed to determine appropriate reporting requirements. The incident was reported to the Missouri Department of Health and Senior Services and other required agencies per facility policy and state regulation. The resident's physician and responsible party were notified, and documentation was completed in the clinical record.

2. Identification of Other Residents at Risk:
The facility conducted a review of all incidents, bruises, skin tears, and injuries of unknown origin from the previous thirty (30) days to ensure appropriate reporting, investigation, documentation, and follow-up occurred timely. Any identified concerns were immediately addressed and reported as required.

3. Systemic Changes Implemented:

- Staff members, including administration, nursing, medication aides, and direct care staff, received mandatory re-education regarding:
    - Abuse, neglect, and exploitation prevention
    - Identification of injuries of unknown origin
    - Mandated reporter responsibilities
    - Immediate notification requirements to administration
    - Timeframes for reporting to DHSS/DMH
    - Documentation expectations following allegations or suspected abuse
- The facility Abuse and Neglect policy was reviewed and revised to clarify immediate reporting expectations and chain of command responsibilities.

- A new protocol has been implemented requiring supervisory review of all resident bruising, skin tears, combative incidents, and injuries before the end of each shift to determine if reporting criteria are met.
- Shift communication tools were updated to ensure significant incidents are escalated immediately to licensed nursing staff and administration.
- Staff were educated that reporting obligations apply whenever there is reasonable cause to suspect abuse or neglect. (FindLaw)

4. Monitoring to Ensure Continued Compliance:

- The Executive Director or designee will audit all incident reports, skin tear logs, bruising reports, and investigation documentation weekly for four (4) weeks, then monthly for two (2) additional months.
- Audits will verify:
    - Timely administrative notification
    - Appropriate reporting to state agencies
    - Physician and responsible party notification
    - Completion of investigations and follow-up documentation
- Any identified concerns will result in immediate corrective action and additional staff education.
- Results of audits will be reviewed during Quality Assurance and Performance Improvement meetings for ongoing compliance monitoring.

5. Date of Compliance:
The facility alleges compliance on 12.6.25.

Submitted By: Guinevere Driggers
Title: Interim Executive Director
Date: 5.12.26