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
	30198	A. BUILDING: _____ B. WING _____	C 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BURLINGTON CREEK	6311 N COSBY AVENUE KANSAS CITY, MO 64151

(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
A4759	19 CSR 30-86.047(29)(A) Not Admit/Care For-Harm Self or Others The facility shall not admit or continue to care for a resident who: (A) Has exhibited behaviors that present a reasonable likelihood of serious harm to himself or herself or others; I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to ensure they did not continue to care for residents who exhibited behaviors with a reasonable likelihood of serious harm to himself/herself or others, when two sampled residents (Resident #1 and Resident #2) exhibited aggressive behaviors towards staff and other residents (Resident #3 and Resident #4) on multiple occasions and did not put interventions in place to protect the residents. The facility census was 73. Review of the facility's policy titled "Behaviors" dated 01/01/15 showed: -The purpose of the policy was to ensure behaviors were managed in a manner that maximized the safety of all individuals; -If behaviors escalated to the point of being dangerous to self or others staff were to take immediate measures for the safety of all residents; -If problem behaviors persisted, the physician was to be contacted, discussing approaches that had been tried, and discussion of a possible referral for behavioral health services; -Transfer to a psychiatric inpatient facility was the last resort generally only used when there was concern about danger to self or others.	A4759		

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A4759	Continued From page 1 1. Review of Resident #3's record showed diagnoses included Parkinson's (a progressive movement disorder of the nervous system), high blood pressure, glaucoma, and hallucinations. 2. Review of Resident #4's record showed diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), depression, and pain. 3. Review of Resident #1's record showed: -Diagnoses included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning; to such an extent that it interferes with a person's daily life and activities), anxiety, and depression. Review of Resident #1's Community Based Assessment and Service Plan dated 11/07/25 showed: -He/She was experiencing an increase in anxiety, agitation, and irritability; -He/She had frequent disruptive and/or aggressive behaviors both verbally and physically; -The resident's behaviors included pacing, hostility, yelling, crying, calling out, cursing, and smacking residents and staff; -No specific interventions were indicated beyond monitoring and reporting behavioral changes. Review of Resident #1's progress notes showed: -On 11/05/25 at 4:00 P.M. Certified Medication Technician (CMT) C witnessed Resident #1 pushing resident #4 in his/her wheelchair, when Resident #4 asked Resident #1 to stop, Resident #1 became upset and smacked Resident #4 in the face;	A4759		

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A4759	Continued From page 2 -Resident #1 was sent to the hospital but returned with inconclusive results explaining the aggressive behavior and placed on "alert charting"; -On 11/06/25 at 7:46 P.M. staff documented while providing cares, Resident #1 attempted to bite staff's neck, and then became aggressive, grabbing staff's arms and shirt, and scratching the staff member, staff member put Resident #1 to bed at which time Resident #1 kicked the staff member in the stomach; -On 11/07/25 the facility received an order from the resident's physician for inpatient treatment at a geriatric psychiatric facilty (geri psych) for aggression, anxiety, mood swings, and violent outbursts, however, the Resident's family refused geri psych treatment; -On 11/07/25 the resident's physician increased his/her Risperidone (medication used for behaviors) to 0.5 milligrams (mg); -On 11/10/25 at 1:12 P.M. CMT B witnessed Resident #1 walk up to another resident, grab their arm and refused to release. After CMT B's multiple attempts to get Resident #1 to let go of the other resident, Resident #1 did and the residents were separated; -On 11/10/25 at 3:32 P.M. CMT B witnessed Resident #1 approach another resident's family and when they asked the resident to leave, Resident #1 became aggressive and approached the other resident and began yelling in their face; -On 11/14/25 at 7:19 P.M. CMT B noted resident to be increasingly aggressive towards staff and residents, that the resident was sent to the hospital but later returned to the facility; -On 11/15/25 at 11:43 A.M. CMT B noted resident to be confrontational with other residents, and hitting staff, the resident was sent to the hospital for the safety of all residents, and returned to the facility on 11/17/25 after a stay with family over	A4759		

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A4759	Continued From page 3	A4759		

the weekend;
-On 11/18/25 at 2:41 A.M. Licensed Practical Nurse (LPN) A noted continued agitation, and standing closely to other residents trying to intimidate them;
-On 11/19/25 at 12:24 A.M. LPN A noted that the overnight care partner notified him/her that the resident hit her two times, and pulled his/her hair when trying to redirect the resident, resident continued to be agitated and difficult to redirect;
-On 11/19/25 at 6:10 P.M. CMT C witnessed Resident #1 slap Resident #3.

During an interview on 11/20/25 at 1:14 P.M. CMT D said:
-He/She was sitting right next to Resident #1 at dinner, but another resident was attempting to get up from the table in which he/she assisted with, and in the few seconds his/her back was turned to Resident #1 was when he/she slapped Resident #3;
-Prior to his/her shift on 11/19/25, he/she had been directed to keep Resident #1 in line of sight and provide constant redirection to prevent any further altercations to other residents;
-The line of sight monitoring did not appear to help Resident #1, as he/she was still experiencing agitation and behaviors;

During an interview on 11/20/25 at 1:40 P.M. Resident Assistant (RA) C and RA D said:
-They were not given any specific direction from management to keep Resident #1 on line of sight monitoring, they just did, so they knew where the two residents were at all times;
-Despite the line of sight monitoring they were doing, it did not seem to work with Resident #1 as he/she continued having behaviors towards staff and residents.

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A4759	Continued From page 4 During an interview on 11/19/25 at 1:49 P.M. the Memory Care Director said: -He/She was aware of Resident #1's aggressive behaviors and agitation, and staff were expected to keep him/her in their line of sight; -He/She did not know staff were not providing the line of sight care on 11/19/25; -Resident #1's physician recommended geri psych treatment, but family refused, therefore the physician increased the resident's Risperidone but it did not appear to be effective with the continued agitation towards staff and other residents; -He/She did not have anything documented regarding the interventions in place for Resident #1 to prevent further altercations. During an interview on 11/20/25 at 12:25 P.M. the AWD said: -Interventions in place for Resident #1 included "alert charting", which included one charting note daily, summarizing the resident's behaviors for the day; -Resident #1 was supposed to be in line of sight of staff at all times. During an interview on 11/20/25 at 2:30 P.M. the Executive Director said: -He/She was not certain what interventions were in place for Resident #1 but thought Resident #1 was on increased monitoring, he/she was unsure what that included; -He/She would expect different interventions to behaviors to be attempted, and not the same ones that did not appear to be working; -He/She was aware of Resident #1's continued behaviors and was unsure of what to do next as the resident's family refused the physician's order for geri psych; -He/She had begun discussing finding placement	A4759		

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A4759	Continued From page 5 for Resident #1 elsewhere and discharging, but had not secured anything or issued a discharge notice yet. 4. Review of Resident #2's record showed: -Diagnoses included Alzheimer's (the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain), depression, and anxiety. Review of Resident #2's Community Based Assessment and Service Plan dated 11/07/25 showed Resident #2 currently had occasional disruptive and/or aggressive behaviors both verbally and physically. Review of Resident #2's progress notes showed: -On 09/22/25 at 6:59 P.M. RA B witness Resident #2 throw a cup of water on another resident; -On 10/28/25 at 10:31 LPN A documented in an "alert charting" note, staff witnessed Resident #2 bend another resident's fingers backward earlier in the day, and at this time kicked LPN A in the abdomen; -On 11/02/25 at 12:26 P.M. CMT B witnessed Resident #2 hit Resident #3 on the head and walked away; -On 11/05/25 at 3:30 P.M. CMT C witnessed Resident #2 hit Resident #4 across the arm and walked away, resident was sent to the hospital and found to have a urinary tract infection (UTI), and returned to the facility with an antibiotic, and continued on "alert charting"; -On 11/09/25 at 3:35 P.M. CMT C documented that other staff witnessed Resident #2 walk up to Resident #4 and kick him/her in the left shin with a barefoot, Resident #2 was escorted to his/her room and monitored for the evening;	A4759		

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A4759	Continued From page 6 -On 11/20/25 at 11:05 A.M. the Assistant Wellness Director (AWD) documented that staff witnessed Resident #1 grab Resident #3's hands and start to shake them, upon staff attempting to separate the two residents, Resident #1 hit Resident #3 in the right shoulder. 5. During an interview on 11/20/25 at 8:05 A.M. CMT B said: -Staff had been directed to keep Resident #1 and Resident #2 on line of sight monitoring due to their recent behaviors; -No interventions in place were working to cub Resident #1's behaviors. During an interview on 11/20/25 at 1:14 P.M. CMT D said: -He/She was not aware of any increased monitoring or interventions in place for Resident #2 at the time he/she hit Resident #3. During an interview on 11/20/25 at 1:40 P.M. RA C and RA D said: -Resident #2 was not on any increased monitoring until after the incident today (11/20/25) where he/she slapped Resident #3, at which time he/she was placed on 1:1 with staff until he/she was taken to the hospital. During an interview on 11/19/25 at 1:49 P.M. the Memory Care Director said: -Resident #2's behaviors were exacerbated because of Resident #1, but thought Resident #2 had been doing well since finishing his/her antibiotic for the UTI; -Resident #2 was not on any increased monitoring as of 11/19/25 as he/she was not presenting with any further behaviors to his/her knowledge.	A4759		

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A4759	Continued From page 7 During an interview on 11/20/25 at 12:25 P.M. the AWD said: -Resident #2 was not on any increased monitoring after he/she finished his/her antibiotic for the UTI, and was no longer presenting behaviors to his/her knowledge. 6. During an interview on 11/20/25 at 2:30 P.M. the Executive Director said: -He/She expected interventions to be in place for any resident presenting potentially harmful behaviors to ensure the safety of all residents. MO259213, MO259420, and MO259430	A4759		
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 for two residents (Resident #3 and Resident #4) when two sampled residents (Resident #1 and Resident #2) displayed aggressive behaviors towards residents on multiple occasions and no protective interventions	A4776		

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A4776	Continued From page 8	A4776		

were put in place to prevent further harm to Resident #3 and Resident #4. The facility census was 73.

Review of the facility's undated policy titled "Protective Oversight" showed:
-Protective oversight meant providing ongoing supervision, awareness, and timely response to prevent injury, unsafe situations, or neglect;
-Employees were required to remain aware of resident's location, condition and needs at all times, never leaving residents along in any area where harm could occur;
-Employees were to immediately report any safety concerns or incidents.

1. Review of Resident #1's record showed:
-Diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety, and depression.

Review of Resident #1's Community Based Assessment and Service Plan dated 11/07/25 showed:
-Resident #1 was experiencing an increase in anxiety, agitation, and irritability;
-Resident #1 had frequent disruptive and/or aggressive behaviors both verbally and physically;
-Resident #1 current behaviors included pacing, hostility, yelling, crying, calling out, cursing, and smacking residents and staff;
-No specific interventions were indicated beyond monitoring and reporting behavioral changes.

2. Review of Resident #3's record showed diagnoses included Parkinson's (a progressive movement disorder of the nervous system), high

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A4776	Continued From page 9 blood pressure, glaucoma, and hallucinations. 3. Review of Resident #4's record showed diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), depression, and pain. 4. Review of Resident #1's progress notes showed: -On 11/05/25 at 4:00 P.M. Certified Medication Technician (CMT) C witnessed Resident #1 pushing resident #4 in his/her wheelchair, when Resident #4 asked Resident #1 to stop, Resident #1 became upset and smacked Resident #4 in the face, no injuries were noted by staff; -Resident #1 was sent to the hospital but returned with inconclusive results explaining the aggressive behavior and placed on "alert charting"; -On 11/07/25 the facility received an order from the resident's physician for inpatient treatment at a geriatric psychiatric facility (geri psych) for aggression, anxiety, mood swings, and violent outbursts, however, the Resident's family refused geri psych treatment; -On 11/07/25 the resident's physician increased his/her Risperidone (medication used for behaviors) to 0.5 milligrams (mg); -On 11/19/25 at 6:10 P.M. CMT C witnessed Resident #1 slap Resident #3. During an interview on 11/20/25 at 1:14 P.M. CMT D said: -He/She was sitting right next to Resident #1 at dinner, but another resident was attempting to get up from the table that was a fall risk in which he/she assisted with, and in the few seconds his/her back was turned to Resident #1 was when	A4776		

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he/she slapped Resident #3;
-Prior to his/her shift on 11/19/25, he/she had been directed to keep Resident #1 in line of sight and provide constant redirection to prevent any further altercations to other residents;
-Despite the line of sight monitoring, Resident #1 was still experiencing agitation and behaviors.

During an interview on 11/20/25 at 1:40 P.M. Resident Assistant (RA) C and RA D said:
-They were not given any specific direction from management to keep Resident #1 on line of sight monitoring, they just did, so they knew where the two residents were at all times;
-Despite the line of sight monitoring they were doing, it did not seem to work with Resident #1 as he/she continued having behaviors towards staff and residents.

During an interview on 11/20/25 at 8:05 A.M. CMT B said:
-Staff had been directed to keep Resident #1 with in line of sight due to increased behaviors;
-No interventions in place were working to curb Resident #1's behaviors.

During an interview on 11/19/25 at 1:49 P.M. the Memory Care Director said:
-He/She was aware of Resident #1's aggressive behaviors and agitation, and staff were expected to keep him/her in their line of sight;
-He/She did not know staff were not providing the line of sight care on 11/19/25;
-Resident #1's physician recommended geri psych treatment, but family refused, therefore the physician increased the resident's Risperidone but it did not appear to be effective with the continued agitation towards staff and other residents;
-He/She did not have anything documented

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A4776	Continued From page 11	A4776		

regarding the interventions in place for Resident #1 to prevent further altercations.

During an interview on 11/20/25 at 12:25 P.M. the AWD said:
-Interventions in place for Resident #1 included "alert charting", which included one charting note daily, summarizing the resident's behaviors for the day;
-Resident #1 was supposed to be in line of sight of staff at all times, because 1:1 supervision was not something the facility was typically able to accommodate.

During an interview on 11/20/25 at 2:30 P.M. the Executive Director said:
-He/She thought Resident #1 was on increased monitoring, but was unsure what that included as the facility did not typically provided 1:1 care;
-He/She was aware of Resident #1's continued behaviors and was unsure of what to do next as the resident refused the physician's order for geri psych;
-He/She had begun discussing finding placement for Resident #1 elsewhere and discharging, but had not secured anything or issued a discharge notice yet.

5. Review of Resident #2's record showed:
-Diagnoses included Alzheimer's (the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain), depression, and anxiety.

Review of Resident #2's Community Based Assessment and Service Plan dated 11/07/25 showed Resident #2 currently had occasional disruptive and/or aggressive behaviors both verbally and physically.

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	30198	A. BUILDING: _____ B. WING _____	C 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BURLINGTON CREEK	6311 N COSBY AVENUE KANSAS CITY, MO 64151

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A4776	Continued From page 12 Review of Resident #2's progress notes showed: -On 11/02/25 at 12:26 P.M. CMT B witnessed Resident #2 hit Resident #3 on the head and walked away; -On 11/05/25 at 3:30 P.M. CMT C witnessed Resident #2 hit Resident #4 across the arm and walked away, resident was sent to the hospital and found to have a urinary tract infection (UTI), and returned to the facility with an antibiotic, and continued on "alert charting"; -On 11/09/25 at 3:35 P.M. CMT C documented that other staff witnessed Resident #2 walk up to Resident #4 and kick him/her in the left shin with a barefoot, Resident #2 was escorted to his/her room and monitored for the evening; -On 11/20/25 at 11:05 A.M. the Assistant Wellness Director (AWD) documented that staff witnessed Resident #2 grab Resident #3's hands and start to shake them, upon staff attempting to separate the two residents, Resident #2 hit Resident #3 in the right shoulder. During an interview on 11/20/25 at 8:05 A.M. CMT B said: -Staff had been directed to keep Resident #2 on line of sight monitoring due to recent behaviors; -No interventions in place were working to curb Resident #2's behaviors. During an interview on 11/20/25 at 1:14 P.M. CMT D said: -He/She was not aware of any increased monitoring or interventions in place for Resident #2 at the time he/she hit Resident #3. During an interview on 11/20/25 at 1:40 P.M. RA C and RA D said: -Resident #2 was not on any increased monitoring until after the incident today (11/20/25)	A4776		

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A4776	Continued From page 13 where he/she slapped Resident #3, at which time he/she was placed on 1:1 with staff until he/she was taken to the hospital. During an interview on 11/19/25 at 1:49 P.M. the Memory Care Director said: -Resident #2's behaviors fed off resident #1, but thought Resident #2 had been doing well since finishing his/her antibiotic for the UTI; -Resident #2 was not on any increased monitoring as of 11/19/25 as he/she was not presenting with any further behaviors to his/her knowledge. During an interview on 11/20/25 at 12:25 P.M. the AWD said: -Resident #2 was not on any increased monitoring after he/she finished his/her antibiotic for the UTI, and was no longer presenting behaviors to his/her knowledge. 5. During an interview on 11/20/25 at 2:30 P.M. the Executive Director said: -He/She expected interventions to be in place for any resident presenting behaviors to ensure the safety of all residents. MO259213, MO259420, and MO259430	A4776		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the	A8023		

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A8023	Continued From page 14 Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review the facility failed to develop and implement written policies which required a report to be made to the Department of Health and Senior Services (DHSS) upon allegations of abuse or neglect. Failure occurred when Resident #2 hit Resident #3 on the head on 11/02/25, and kicked Resident #4 in the shin on 11/09/25 and no reports were made to DHSS. The facility census was 73. Review of the facility's Abuse and Neglect policy dated 10/02/19 showed: -All reports of suspected abuse would be investigated timely for the protection of all residents; -Physical abuse was the willful act of inflicting bodily injury which included but not limited to striking, slapping, pinching, choking, kicking, shoving, and prodding; -All staff were trained to report suspected abuse and neglect which included strategies for dealing with difficult and/or aggressive behavior and how and whom to report any allegations to; -Upon observation of a resident to resident incident, immediate action was to be taken to protect the safety of those involved, and reported to the Executive Director, Wellness Director, physician, and resident's responsible party within 24 hours; -Any allegations of abuse or neglect were to be reported to DHSS within the required timeframe.	A8023		

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A8023	Continued From page 15 1. Review of Resident #2's record showed diagnoses included Alzheimer's (the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain), depression, and anxiety. 2. Review of Resident #3's record showed diagnoses included Parkinson's (a progressive movement disorder of the nervous system), high blood pressure, glaucoma, and hallucinations. 3. Review of Resident #4's record showed diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), depression, and pain. Review of Resident #2's progress notes for November 2025 showed: -On 11/02/25 at 12:26 P.M. Certified Medication Technician (CMT) B witnessed Resident #2 hit Resident #3 in the head and walked away; -On 11/09/25 at 3:35 P.M. CMT C documented that other staff witnessed Resident #2 walk up to Resident #4 and kick him/her in the left shin with a barefoot, Resident #2 was escorted to his/her room and monitored for the evening. During an interview on 11/20/25 at 8:05 A.M. CMT B said: -On 11/02/25 he/she witnessed Resident #2 hit Resident #3 in the head with an open hand; -He/She documented the incident, and thought he/she reported the incident to the nurse on duty that day, which was what he/she had been trained and was expected to do. During an interview on 11/19/25 at 2:18 P.M.	A8023		

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A8023	Continued From page 16 CMT C said: -He/She recalled on 11/09/25 he/she was completing a medication pass and while standing at the medication cart in the television room, he/she heard a commotion; -Upon turning around he/she saw Resident #2 with a barefoot and being escorted away from the television room by a Resident Assistant; -The Resident Assistant informed him/her that Resident #2 had kicked Resident #4 in the shin with his/her barefoot; -He/She documented the incident, but was unsure if he/she reported the incident to management; -He/She was expected to report all resident to resident altercations to management. During an interview on 11/26/25 at 3:45 P.M. Resident Assistant B said: -He/She witnessed the incident on 11/09/25 of Resident #2 kicking Resident #4; -He/She reported to the CMT C, who he/she thought reported to the Memory Care Director (MCD); -He/She was expected to report all incidents immediately to the medication technician on shift, who would then report to management. During an interview on 11/19/25 at 1:49 P.M. the MCD said he/she did not recall the incident on 11/09/25 if it was reported to him/her. During an interview on 11/20/25 at 12:25 P.M. the Assistant Wellness Director (AWD) said: -He/She could not recall the incident on 11/02/25 between Resident #2 and Resident #3; -Upon looking at progress notes for Resident #2 it did not appear the incident on 11/02/25 was investigated or reported to DHSS otherwise would have been documented;	A8023		

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A8023	Continued From page 17 -He/She was unaware of the incident between Resident #2 and Resident #4 on 11/09/25. -He/She expected all staff to report all resident to resident incidents to the MCD, the AWD, or the Wellness Director, immediately. During an interview on 11/20/25 at 12:07 P.M. the Executive Director said: -He/She expected everything to be documented; -He/She expected any injuries to be documented and reported to clinical management which included the MCD, AWD, or Wellness Director, who would then report to him/her; -He/She would expect that a small slap from one resident to another could be redirected and not necessarily reported to management or DHSS; -He/She did not know any and all physical altercations between residents needed to be reported to DHSS. *The higher classification merited due to the extent of the violation. MO259213, MO259420, and MO259430	A8023		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III	A8030		

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A8030	Continued From page 18 This regulation is not met as evidenced by: Class II* Based on interview and record review, facility staff failed to provide proper and timely care for three of six sampled residents (Resident #5, #6, and #7) when they failed to answer residents call lights in a timely manner. The facility census was 73. The facility did not provide a policy regarding call lights. 1. Review of Resident #5's medical record showed: -Diagnoses included anxiety, heart disease, and bronchiectasis (a condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred, which causes coughing with a lot of mucus and frequent infections). Review of the facility's 11/09/25 - 11/19/25 call light report showed the following: -Resident #5 had a call light on for 19.3 minutes on 11/09/25 at 8:47 A.M.; -Call light on for 32.9 minutes on 11/09/25 at 9:50 A.M.; -Call light on for 27.6 minutes on 11/09/25 at 4:40 P.M.; -Call light on for 35.7 minutes on 11/10/25 at 6:49 A.M.; -Call light on for 38 minutes on 11/10/25 at 11:10 A.M.; -Call light on for 16.5 minutes on 11/11/25 at 12:22 P.M.; -Call light on for 16.4 minutes on 11/11/25 at 2:28 P.M.; -Call light on for 31.2 minutes on 11/12/25 at 6:20	A8030		

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A8030	Continued From page 19 A.M.; -Call light on for 20.3 minutes on 11/12/25 at 2:59 P.M.; -Call light on for 36.5 minutes on 11/13/25 at 8:41 A.M.; -Call light on for 30.1 minutes on 11/14/25 at 9:27 A.M.; -Call light on for 39.8 minutes on 11/14/25 at 11:03 A.M.; -Call light on for 20.9 minutes on 11/14/25 at 1:15 P.M.; -Call light on for 21.1 minutes on 11/14/25 at 2:45 P.M.; -Call light on for 18.2 minutes on 11/15/25 at 9:19 A.M.; -Call light on for 21.7 minutes on 11/15/25 at 3:04 P.M.; -Call light on for 26.7 minutes on 11/16/25 at 7:03 A.M.; -Call light on for 17.1 minutes on 11/17/25 at 6:58 A.M.; -Call light on for 34.4 minutes on 11/17/25 at 8:58 A.M.; -Call light on for 16.4 minutes on 11/17/25 at 2:02 P.M.; -Call light on for 34.3 minutes on 11/17/25 at 4:30 P.M.; -Call light on for 23.5 minutes on 11/18/25 at 2:57 P.M.; -Call light on for 26.3 minutes on 11/18/25 at 3:42 P.M.. During an interview on 11/19/25 at 1:04 P.M. Resident #5 said: -He/She used his/her call light for assistance grabbing things out of reach, or for assistance using the restroom; -It took staff a while to answer his/her call lights often; -It made him/her feel desperate when he/she had	A8030		

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A8030	Continued From page 20	A8030		

to wait long periods of time to answer the call light;
-Staff generally nice when they did answer the call light but they also hounded him/her for using the call light to much, which he/she did not appreciate;
-He/She would expect staff to answer the call lights within five minutes.

2. Review of Resident #6's record showed:
-Diagnoses included dysphagia (swallowing difficulties), macular degeneration (a condition in which there is a slow breakdown of cells in the center of the retina), and hyperlipidemia (your blood has too many lipids, or fats).

Review of the facility's 11/09/25 - 11/19/25 call light report showed the following:
-Resident #6 had a call light on for 24.3 minutes on 11/10/25 at 8:27 A.M.;
-Call light on for 21.5 minutes on 11/10/25 at 8:59 A.M.;
-Call light on for 20.4 minutes on 11/10/25 at 4:17 P.M.;
-Call light on for 28.9 minutes on 11/10/25 at 8:33 P.M.;
-Call light on for 16.8 minutes on 11/11/25 at 9:07 A.M.;
-Call light on for 19.3 minutes on 11/11/25 at 1:28 P.M.;
-Call light on for 26 minutes on 11/12/25 at 8:53 A.M.;
-Call light on for 27.1 minutes on 11/12/25 at 12:31 P.M.;
-Call light on for 24.8 minutes on 11/12/25 at 2:45 P.M.;
-Call light on for 33.3 minutes on 11/12/25 at 3:41 P.M.;
-Call light on for 31.3 minutes on 11/12/25 at 5:43 P.M.;

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A8030	Continued From page 21 -Call light on for 31.6 minutes on 11/12/25 at 6:56 P.M.; -Call light on for 29.5 minutes on 11/12/25 at 7:38 P.M.; -Call light on for 28.6 minutes on 11/13/25 at 6:59 A.M.; -Call light on for 48.9 minutes on 11/13/25 at 8:20 A.M.; -Call light on for 18.8 minutes on 11/14/25 at 9:13 A.M.; -Call light on for 59.4 minutes on 11/14/25 at 1:04 P.M.; -Call light on for 32.4 minutes on 11/15/25 at 6:48 P.M.; -Call light on for 24.1 minutes on 11/15/25 at 7:48 P.M.; -Call light on for 20.7 minutes on 11/16/25 at 5:35 A.M.; -Call light on for 54.4 minutes on 11/17/25 at 7:26 A.M.; -Call light on for 18.7 minutes on 11/17/25 at 7:03 P.M.; -Call light on for 37.5 minutes on 11/18/25 at 6:07 P.M.. During an interview on 11/19/25 at 1:29 P.M. Resident #6 said: -He/She had often pushed his/her call light when he/she needed help, as he/she required total assistance with most things; -He/She often had to wait a while for staff to come after pushing his/her call light; -Staff recently started telling him/her to just have bowel movements in his adult brief and they would then come in an change him/her, but knowing the response times were sometimes long, that was uncomfortable and hurt his/her dignity to sit in soiled briefs. 3. Review of Resident #7's record showed:	A8030		

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A8030	Continued From page 22 -Diagnoses included Parkinson's disease (a progressive neurodegenerative disorder that primarily affects the brain, causing problems with movement and other functions), spinal stenosis (happens when the space inside the backbone is too small often causing pain), neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), and repeated falls. Review of the facility's 11/09/25 - 11/19/25 call light report showed the following: -Resident #7 had a call light on for 34.9 minutes on 11/11/25 at 6:05 A.M.; -Call light on for 25.1 minutes on 11/11/25 at 7:15 A.M.; -Call light on for 20.5 minutes on 11/11/25 at 12:30 P.M.; -Call light on for 30.5 minutes on 11/11/25 at 2:19 P.M.; -Call light on for 26.6 minutes on 11/11/25 at 10:26 P.M.; -Call light on for 22 minutes on 11/12/25 at 10:35 A.M.; -Call light on for 28 minutes on 11/12/25 at 5:36 P.M.; -Call light on for 19.5 minutes on 11/13/25 at 8:17 P.M.; -Call light on for 28.9 minutes on 11/14/25 at 5:32 A.M.; -Call light on for 18.4 minutes on 11/14/25 at 12:45 P.M.; -Call light on for 19.8 minutes on 11/15/25 at 12:24 A.M.; -Call light on for 19.3 minutes on 11/16/25 at 1:36 P.M.; -Call light on for 62.3 minutes on 11/17/25 at 7:54 A.M.; -Call light on for 25.1 minutes on 11/17/25 at 5:45 P.M.;	A8030		

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A8030	Continued From page 23 -Call light on for 21.3 minutes on 11/18/25 at 4:31 P.M.. During an interview on 11/19/25 at 1:38 P.M. Resident #7 said: -He/She used the call light all the time because he/she could not walk; -He/She felt frustrated when he/she had to wait a long time before staff came. 4. During an interview on 11/26/25 at 1:26 P.M., Certified Medication Technician (CMT) A said: -He/She was expected to answer call lights within 5-7 minutes of alerting; -Some lights might go longer unanswered during their busier times in the morning and evening; During an interview on 11/26/25 at 1:43 P.M. Resident Assistant A said: -He/She was expected to answer call lights within five to nine minutes; -He/She did his/her best, but knew some went longer because some of the newer residents were requiring more extensive care and staff are in their room for 20 or more minutes, while also being the only one on the floor. During an interview on 11/19/25 at 11:35 A.M. the Assistant Wellness Director said: -All care staff were expected to answer call lights within 10 minutes; -He/She did not know call lights were not being answered timely. During an interview on 11/26/25 at 9:13 A.M. the Executive Director said: -Was not aware that call lights were not being answered timely; -He/She expected call lights to be answered within 10 minutes.	A8030		

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A8030	Continued From page 24 *The higher classification merited due to the violation's effect on the resident(s). MO259344	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	American House Burlington Creek Assisted Living and Memory Care
Street Address, City, Zip:	6311 N Cosby Ave Kansas City, Missouri 64151
Date of Survey:	11/26/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4759	Executive Director will issue a discharge as outlined in this regulation, to all current and future Residents exhibiting behaviors that present a reasonable likelihood of serious harm to themselves or others	12/15/2025
A4759	Wellness Director will ensure that adequate information is obtained and thoroughly reviewed pertaining to any potential in-coming Residents during the pre-admission assessment process, and will submit a request for denial for any potential resident that currently or has a history of behaviors that present a reasonable likelihood of serious harm to themselves or others to ensure compliance of this rule	11/27/2025
A4759	Wellness Director will in-service care team on Managing and responding to Residents within the community exhibiting behaviors	12/15/2025
A4776	Wellness Director will ensure that appropriate interventions are initiated and followed for all incidents reported within the community	12/01/2025
A4776	Executive Director and/or Regional Wellness Director will review all completed incident reports, ensuring that appropriate interventions have been put in place to prevent additional incidents from occurring	12/01/2025
A4776	Wellness Director will in-service all care staff on protective oversight as it pertains to their job specifications, as well as the importance of following the interventions put in place to prevent future occurrences	12/15/2025
A4776	Wellness Director will monitor on-going to ensure that interventions are being followed by community staff	12/01/2025
A8023	Executive Director and Regional Wellness Director will develop a policy outlining when incidents will be reported to DHSS as outlined in this regulation.	12/26/2025

A8023	Executive Director/Wellness Director will ensure that all occurrences are reviewed and reported, as appropriate, to Regional Wellness Director and DHSS to ensure compliance of this rule.	11/27/2025
A8023	Regional Wellness Director will review all new incident reports, and will immediately notify Executive Director and Wellness Director of any appropriate incidents that have not been reported to DHSS to ensure compliance of this rule	11/27/2025
A8023	Wellness Director will immediately in-service all care staff on the importance and expectation of reporting incidents to the Wellness Director/Assistant Wellness Director as they occur to ensure compliance of this rule	12/01/2025
A8030	Executive Director/Regional Wellness Director will develop a call light response policy to ensure compliance of this rule	12/15/2025
A8030	Wellness Director will in-service all care staff on call light response policy and expectations	12/15/2025
A8030	Executive Director will in-service concierge staff on monitoring the call light system on-going throughout each shift, alerting the care team of any call lights still alarming after the 5 minute mark, and will alert the Executive Director/Wellness Director of any call lights still alarming after 10 minutes to ensure compliance of this rule	12/15/2025
A8030	Executive Director will review the call light response 24-hour report daily and will investigate and address any call light responses with the care staff, not answered within a timely manner.	12/15/2025
A8030	Regional Wellness Director will review weekly average call light responses to ensure on-going compliance of this rule.	12/15/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.