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
	29519	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGEGROVE AT TIFFANY SPRINGS	5901 NW 88TH STREET KANSAS CITY, MO 64154

(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
A4508	19 CSR 30-86.045(3)(A)(6)(C) Individual Evacuation Plan - Evaluate General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 6. At a minimum the evacuation plan shall include the following components: C. The plan shall evaluate the resident for his or her location within the facility and the proximity to exits and areas of refuge. The plan shall evaluate the resident, as applicable, for his or her risk of resistance, mobility, the need for additional staff support, consciousness, response to instructions, response to alarms, and fire drills; II This regulation is not met as evidenced by: Class II Based on interview and record review the facility failed to ensure individual evacuation plans (IEP) for five of five residents (Residents #1, #2, #3, #4, and #5) whom required more than minimal assistance to safely exit the building, included a plan that evaluated the resident's location within the facility and proximity to exits and areas of refuge, the resident's risk for resistance, mobility, need for additional staff support, consciousness, response to instructions, alarms, and fire drills. Additionally the IEP's did not include instructions for how staff were to assist the resident in safely exiting the building. The facility census was 56. The facility did not provide a policy 1. Review of Resident #1's record showed diagnoses included: Seizure disorder, anxiety,	A4508		

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A4508	Continued From page 1 and stroke. Review of the resident's undated IEP showed: -The resident was unable to exit the community with three verbal prompts and one physical prompt and therefore required assistance from staff with exiting the community in the case of an emergency; -No specific details on what assistance the resident required from staff; -No details on how to get the resident to the nearest exit or area of refuge; -No specific details on the resident's risk for resistance, mobility, consciousness, response to instruction, alarms, and fire drills; -No detail on the need for additional staff support. 2. Review of Resident #2's record showed diagnoses included: Encephalopathy and confusion. Review of the resident's undated IEP showed: -The resident was unable to exit the community with three verbal prompts and one physical prompt and therefore required assistance from staff with exiting the community in the case of an emergency; -No specific details on what assistance the resident required from staff; -No details on how to get the resident to the nearest exit or area of refuge; -No specific details on the resident's risk for resistance, mobility, consciousness, response to instruction, alarms, and fire drills; -No detail on the need for additional staff support. 3. Review of Resident #3's record showed diagnoses included: Cognitive communication deficit, respiratory failure, general weakness.	A4508		

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A4508	Continued From page 2 Review of the resident's undated IEP showed: -The resident was unable to exit the community with three verbal prompts and one physical prompt and therefore required assistance from staff with exiting the community in the case of an emergency; -No specific details on what assistance the resident required; -No details on the resident's location in the facility and proximity to the nearest exit or area refuge and how to get there; -No detail on the resident's risk for resistance, mobility, consciousness, response to instruction, alarms, and fire drills; -No detail on the need for additional staff support. 4. Review of Resident #4's record showed diagnoses included high blood pressure and glaucoma. Review of the resident's undated IEP showed: -The resident was unable to exit the community with 3 verbal prompts and 1 physical prompt and therefore required assistance from staff with exiting the community in the case of an emergency; -No specific details on what assistance the resident required; -No details on the resident's location in the facility and proximity to the nearest exit or area refuge and how to get there; -No detail on the resident's risk for resistance, mobility, consciousness, response to instruction, alarms, and fire drills; -No detail on the need for additional staff support. 5. Review of Resident #5's record showed diagnoses included dementia, weakness, anxiety, and failure to thrive	A4508		

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A4508	Continued From page 3 Review of the resident's undated IEP showed: -The resident was unable to exit the community with three verbal prompts and one physical prompt and therefore required assistance from staff with exiting the community in the case of an emergency; -No specific details on what assistance the resident required; -No details on the resident's location in the facility and proximity to the nearest exit or area refuge and how to get there; -No detail on the resident's risk for resistance, mobility, consciousness, response to instruction, alarms, and fire drills; -No detail on the need for additional staff support. During an interview on 04/09/26 at 1:30 P.M. the Administrator said: -He/She was unclear on what details an IEP needed to include; -Corporate was still working to finalize the details of a new IEP form.	A4508		
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 4/9/2026, the facility failed to ensure oxygen storage shall	A2298		

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A2298	Continued From page 4 be in accordance with NFPA 99, 1999 Edition when there was no signage on the door indicating oxygen was being stored inside. The facility census was 56. Observation on 4/9/2026 at 10:50 A.M. showed an oxygen concentrator in use in room 218. However, no signage was on or near the room door advising that oxygen is being used inside. During an interview on 4/9/2026 at 1:30 P.M., the Executive Director said he/she was unaware that there was not proper signage on or near the resident's room door. NFPA 99, chapter 9.4.4.1 states, "a precautionary sign readable from a distance of 5 feet, shall be displayed on each door or gate of the storage room or enclosure." Further, chapter 9.6.3.2.1. states, "precautionary signs readable from 5 feet shall be conspicuously displayed wherever supplemental oxygen is in use."	A2298		
A4708	19 CSR 30-86.047(10) Care to Meet Resident Needs or Discharge The facility shall not admit or continue to care for residents whose needs cannot be met. If necessary services cannot be obtained in or by the facility, the resident shall be promptly referred to appropriate outside resources or discharged from the facility. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review the facility failed to provide care to one (Resident #1) of six sampled residents when the	A4708		

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A4708	Continued From page 5	A4708		

resident required a mechanical soft diet and feeding assistance and the facility did not provide it. The facility census was 56.

Review of the facility's resident handbook dated 05/01/24 showed the facility offered a nutritionally balanced regular diet. A low concentrated sweets diet or no salt added diet was available if recommended by a physician.

1. Review of Resident #6's medical file showed:

-Admit date was 08/07/25;
-Diagnoses included: Seizure disorder;
-He/She went to the hospital on 02/19/26 and was admitted for a stroke:
-He/She was readmitted to the facility and hospice services were started on 03/11/26.

Review of the resident's Community Based Assessment (CBA) dated 03/11/26 showed:
-The resident was totally dependent for personal care including bathing, dental/mouth care, hair care, and toe and fingernail care;
-The resident needed assistance with meal preparation and eating;
-He/She was dependent on staff for all mobility needs;
-The resident was dependent on staff for housekeeping needs;
-The administrator added a note to the comments section stating "Resident was accepted back on hospice services. If a change for improvement they would need to consider a higher level of care."

During an interview on 04/09/2026 10:15 A.M. the resident's private caregiver said:
-He/She had been sitting with the resident eight hours each day three days each week since she

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A4708	Continued From page 6 returned to the facility on 03/11/26 after having a stroke; -The resident's family member sat with the resident on the other days when he/she was not there; -While there, he/she assisted the resident with feeding, positioning, or anything else the resident might need. During an interview on 04/09/26 at 11:20 A.M., the resident's responsible party said: -The resident had not been able to feed him/herself since his/her stroke in February; -The resident returned to the facility on 03/11/26 with hospice services; -The resident was supposed to receive a mechanical soft diet; -The hospice physician ordered a mechanical soft diet when he/she was admitted to hospice services on 03/11/26; -The facility asked him/her to provide a caregiver everyday for feeding assistance. Review of the resident's Individualized Service Plan (ISP) last updated on 03/24/26 showed: -The resident required full assistance with dining for all three meals each day; -Staff were to assist the resident in ordering food that was soft in texture and then place the order in the refrigerator and the resident's daughter/caregiver would assist the resident when he/she arrived. During an interview on 04/15/26 at 2:00 P.M. the resident's hospice nurse said: -The resident was not able to feed himself/herself since returning to the facility on 03/11/26; -The resident initially had an order for a puree diet when he/she was admitted to hospice on 03/11/26, but the order was changed to a	A4708		

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A4708	Continued From page 7 mechanical soft diet a couple of weeks ago. Review of the resident's physician's orders on 04/09/26 did not show he/she had an order for a special diet. During an interview on 04/09/26 at 1:05 P.M. CMT A said: -The facility did not provide feeding assistance for the resident; -The resident's family provided a one on one caregiver to provide feeding assistance; -The facility did not accommodate special diets; -Staff assisted the resident in choosing softer foods but his/her family or private caregiver fed him/her. During an interview on 040/9/2026 at 1:30 P.M., the Executive Director said: -The resident required feeding assistance with all three meals each day which the family was providing; -The facility did not offer a mechanical soft diet or feeding assistance but the resident was being served soft foods; -If the family did not provide the caregiver daily the facility would not be able to meet the resident's needs.	A4708		
A4724	19 CSR 30-86.047(19) TB Screen Residents & Staff The facility shall screen residents and staff for tuberculosis as required for long-term care facilities by 19 CSR 20-20.100. II This regulation is not met as evidenced by: Class II	A4724		

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A4724	Continued From page 8 Based on interview and record review, the facility staff failed to ensure the required two step tuberculosis (TB, a communicable disease that affects the lungs characterized by fever, cough, and difficulty in breathing) screening test was administered upon hire for four of five sampled employees (Caregiver A, Caregiver B, Caregiver C, and Medication Technician (Med Tech) A). The facility census was 56. Long Term Care Employees and Volunteers. All new long-term care facility employees and volunteers who work ten (10) or more hours per week are required to obtain a Mantoux Purified Protein Derivative (PPD) (Mantoux, TB skin test, tuberculin skin test, and PPDs are often used interchangeably. Mantoux refers to the technique for administering the test. Tuberculin (also called PPD) is the solution used to administer the test) two (2)-step tuberculin test within one (1) month prior to starting employment in the facility. If the initial test is zero to nine millimeters (0-9 mm), the second test should be given as soon as possible within three (3) weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one (1) subsequent annual test within the past two (2) years. It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status. (E) Employees and volunteers with an initial zero to nine millimeters (0-9 mm) Mantoux PPD two (2)-Step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record. Review of the facility's policy titled, "Associate and Volunteer Screening for Tuberculosis," dated 01/22/25 showed: -All newly hired employees were to be screened	A4724		

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A4724	Continued From page 9	A4724		

for TB after being offered a position and before their first shift on duty;
-If a newly hired employee had no previous documented TB screening a two step TB test would be completed;
-If a newly hired employee had one previous documented TB screening, a TB risk assessment and a one step TB test would be completed;
-If a newly hired employee had two or more previous documented negative TB tests within the last 12 months, an annual screening was to be completed.

1. Review of Caregiver A's record showed:

-He/She was hired on 03/05/26;
-First step was administered on 03/10/26 and read on 03/13/26;
-No second step was found.

2. Review of Caregiver B's record showed:

-He/She was hired on 03/05/26;
-A first step was administered on 02/17/25 and read on 02/19/25;
-A second step was administered on 02/26/25 and read on 02/28/25;
-No annual screening was found since hire.

3. Review of Caregiver C's record showed:

-He/She was hired on 03/23/26;
-The first step was administered on 03/09/26 and read on 03/11/26;
-No second step was found.

4. Review of Med Tech A's record showed:

-He/She was hired on 03/23/26;
-The first step was administered on 03/31/26 and

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A4724	Continued From page 10 read on 04/02/26; -No second step was found. During an interview on 04/09/26 at 1:26 A.M. the Director of Nursing said: -He/She would expect all newly hired staff to be in compliance with TB screening; -He/She did not know Caregiver A, Caregiver B, Caregiver C, and Med Tech A were not in compliance with their TB screenings. During an interview on 04/09/26 at 1:30 P.M. the Administrator said: -All newly hired staff should have a two step screening prior to starting on the floor; -He/She had no process in place to distinguish a staff members hire date from the first date on duty; -He/She was unaware Caregiver A, Caregiver B, Caregiver C, and Med Tech A were not in compliance with their TB screenings.	A4724		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class III Based on observation, interview, and record review the facility failed to ensure no treatment was administered without an order when the facility failed to obtain an order for Resident #1 to use oxygen. The facility census was 56.	A4798		

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A4798	Continued From page 11 Review of the facility policy titled "Medication Administration." dated 02/16/17 showed that facility staff would only administer medications and treatment for which they have a physicians order for. 1. Review of Resident #1's record showed: -He/She admitted to the facility on 08/27/25; -Diagnoses included seizure disorder. Observation on 04/09/26 at 11:15 A.M. showed the resident wearing an oxygen nasal canulla. During an interview on 04/09/2026 at 11:15 A.M. the resident said: -He/She had been on oxygen since he/she had returned from a rehabilitation facility and was admitted to hospice on 03/11/26. Review of the resident's March 2026 physician's order sheet (POS) showed no order for oxygen. During an interview on 04/15/26 at 2:00 P.M. the resident's hospice nurse said: -The resident required five Liters of oxygen 24 hours each day and was ordered on 03/11/2026 when he/she was admitted to hospice services. During an interview on 4/15/26 at 2:30 P.M. the Executive Director said: -He/She was aware the resident was on oxygen but was not aware that there was not an order for it on his/ her POS.	A4798		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility	A4837		

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A4837	Continued From page 12 for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III This regulation is not met as evidenced by: Class II* Based on record review and interview, the facility failed to maintain on record a monthly review of each resident's general condition, needs, and significant incidents for four of five sampled residents (Resident #1, #6, #7, and #8). The facility census was 56. Review of the facility's undated policy titled, "Monthly Summary," showed staff should monitor the condition of each resident and document this evaluation on a "Monthly Summary Form" monthly. 1. Review of Resident #1's medical chart showed: -Diagnoses included seizure disorder;	A4837		

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A4837	Continued From page 13 -No monthly summaries were found for February or March 2026. 2. Review of Resident #6's record showed: -Diagnoses included dementia (a general term for a syndrome-a group of related symptoms-characterized by the progressive decline of brain function, severely impacting memory, thinking, language, and behavior); -No monthly summaries were found for February or March 2026. 3. Review of Resident #7's record showed: -Diagnoses included: High blood pressure, and history of a stroke: -No monthly summaries were found for February and March 2026. 4. Review of Resident #8's record showed: -Diagnoses included dementia; -No monthly summaries were found for February and March 2026. During an interview on 04/09/26 at 1:30 P.M., the Executive Director said: -His/Her corporate office said they did not need to complete monthly summaries. *The higher classification merited due to the extent of the violation.	A4837		
A6005	19 CSR 30-87.020(5) Toxic Material Storage Poisonous or toxic materials consist of the following categories: insecticides and rodenticides; disinfectants, sanitizer and related	A6005		

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SAGEGROVE AT TIFFANY SPRINGS	5901 NW 88TH STREET KANSAS CITY, MO 64154

(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
A6005	Continued From page 14 cleaning or drying agents; and caustics, acids, polishes and other chemicals. Each of these three (3) categories set forth shall be stored and physically located separate from each other. All poisonous or toxic materials shall be stored in locked cabinets or in a similar physically separate place used for no other purpose which is not accessible to residents. II This regulation is not met as evidenced by: Class II Based on observation and interview the facility failed to ensure all poisonous or toxic materials were stored in locked cabinets or in a similar physically separate place used for no other purpose. The facility census was 56. The facility did not provide a policy regarding storage of poisonous or toxic materials. 1. Observation in the kitchen on 04/09/26 at 10:00 A.M. showed: -There was a crate of cleaners/chemicals on the lower shelf of a metal table underneath the toaster; -The crate included oven cleaner, window cleaner, degreaser, and other cleaning chemicals. During an interview on 4/9/2026 at 2:30 P.M. the Executive Director said he/she expected all toxic materials to be kept separate from each other, away from food, and locked away for safety.	A6005		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor	A6012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29519	A. BUILDING: _____ B. WING _____	04/09/2026

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SAGEGROVE AT TIFFANY SPRINGS	5901 NW 88TH STREET KANSAS CITY, MO 64154

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A6012	Continued From page 15 coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: Class III Based on observation, record review and interview the facility failed to ensure all floors were kept clean and in good repair when the floors in the kitchen were dirty, in addition to piece of tile baseboard were fallen off. The facility census was 56. Review of the facility's policy titled, "Cleaning" dated 02/27/15 showed the floor of the kitchen was to be swept and mopped daily and mopped after each spill or contamination. 1. Observation of the kitchen on 04/09/26 at 10:25 A.M. showed: -The gray floor under, behind, and in front of the stove and grill area, covered in brown and black build up and debris; -Two pieces of tile baseboard under the hand washing sink in the dishwashing area fallen off exposing drywall, glue, and uncleanable surfaces; -The gray floor beneath the dishwasher with black residue and buildup near the drain. During an interview on 04/09/26 at 1:30 P.M. the Administrator said:	A6012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29519	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
A6012	Continued From page 16 -He/She expected all floors in the kitchen to be cleaned as much as needed to keep them clean; -He/She expected all surfaces to be kept in good repair and was unaware of the tile baseboard pieces that had fallen off.	A6012		
A7050	19 CSR 30-87.030(48) Food Contact Surfaces-Cast Iron/Threads Food-contact surfaces shall be easily cleanable, smooth and free of breaks, open seams, cracks, chips, pits and similar imperfections and free of difficult-to-clean internal corners and crevices. Cast iron may be used as a food-contact surface only if the surface is heated, such as in grills, griddle tops and skillets. Threads shall be designed to facilitate cleaning; ordinary " V " type threads are prohibited in food-contact surfaces, except that in equipment such as ice makers or hot oil-cooking equipment and hot oil-filtering systems, these threads shall be minimized. III This regulation is not met as evidenced by: Class III Based on observation, interview, and record review the facility failed to ensure food-contact surfaces were free of chips when plates that had just been used to serve breakfast had chips in them. This had the potential to affect all residents. The facility census was 56. The facility did not provide a policy regarding damaged dishware. 1. Observation on 04/09/26 at 10:20 A.M. showed: -13 used ceramic plates stacked on a black cart;	A7050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29519	A. BUILDING: _____ B. WING _____	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7050	Continued From page 17 -Five of the thirteen plates had a chip on them. During an interview on 04/09/26 at 10:21 A.M. Dietary Aide A said: -Kitchen staff continued to use plates and dishware with chips in them, as long as the chip was not too bad; -Kitchen staff discarded any that had significant chipping; -He/She could not identify what he/she would consider significant chipping. During an interview on 04/09/26 at 1:30 P.M. the Administrator said: -He/She expected all dishware, glasses, and plates to be free from chipping; -He/She expected staff to discard and replace any dishware with chipping to prevent contamination.	A7050		

PLAN OF CORRECTION

Provider/Supplier Name:	SageGrove at Tiffany Springs
Street Address, City, Zip:	5901 NW 88th St Kansas City MO, 64154
Date of Survey:	4-9-2026

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
A4508		The Executive Director (ED) has updated the policy and procedure on Individual Evacuation Plans.	5-30-26
		The ED and/or designee reviewed and revised the Individual Evacuation Plans (IEPs) for the five cited residents. Each revised IEP now includes: the resident's specific location within the facility, proximity to the nearest exits and areas of refuge, step-by-step staff assistance instructions, and an individualized evaluation of the resident's risk for resistance, mobility limitations, need for additional staff support, level of consciousness, and response to instructions, alarms, and fire drills.	
		The Facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents requiring more than minimal assistance to safely evacuate have the potential to be impacted by the deficient practice.	
		The Facility ED and/or designee will implement a new IEP form and review all current residents' IEP needs to ensure that all regulatory requirements are met at move-in, at any change of condition, and updated semi-annually.	
		The facility ED and/or designee will provide education and training to all staff regarding the IEP policy and procedure. Training components to include:	
		- Evaluate the residents' location within the facility and proximity to exits and areas of refuge.	
		- Evaluate the resident's risk of resistance, mobility, need for additional staff support, consciousness, response to instructions, alarms, and fire drills.	
		- Document specific step-by-step staff instructions for assisting each resident in safely exiting the building.	
		- Completion and sign-off of the IEP form by the ED and/or designee.	
		The facility ED will monitor this process in monthly meetings and review a random sample of IEPs quarterly to ensure the deficient practice does not reoccur.	
		Corrective action will be completed by 5-30-26.	

A2298		The ED has updated the policy and procedure on Oxygen Storage Requirements to meet NFPA 99, 1999 Edition requirements.	5-30-26
		The facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The facility ED and/or designee completed an immediate audit of all resident rooms and common areas and ensured that a precautionary sign readable from a distance of 5 feet is displayed on the door or near the entrance of any room or enclosure where supplemental oxygen is in use or stored, in accordance with NFPA 99 chapters 9.4.4.1 and 9.6.3.2.1.	
		The facility ED and/or designee will conduct weekly audits to ensure proper signage is displayed wherever supplemental oxygen is in use.	
		The facility ED and/or designee will monitor this process in the weekly Spotlight meetings to ensure the deficient practice does not reoccur.	
		Corrective action will be completed by 5-30-26.	
A4708		The ED updated the policy and procedure on Care to Meet Resident Needs or Discharge.	5-30-26
		The ED immediately coordinated with the hospice provider to ensure a physician's order for a mechanical soft diet was obtained and documented in Resident #6's Physician Order Sheet. The facility implemented a plan to provide direct staff feeding assistance for Resident #6 at all three meals daily, effective immediately, so that the resident is no longer dependent on a family-provided private caregiver for this basic care need. A family meeting was held on April 10, 2026 and reviewed resident status as above the needs and a 30-day notice was provided.	
		The facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The facility ED and/or designee will audit all current residents' Individualized Service Plans (ISPs) and physician orders to ensure that each resident's dietary and physical care needs, including feeding assistance and therapeutic diet requirements, are being met by facility staff as required.	
		The facility ED will ensure that at admission and at each change of condition, a clinical assessment is completed to determine whether the facility can meet the resident's needs. If the facility cannot meet a resident's needs, the resident will be promptly referred to appropriate outside resources or discharged in accordance with 19 CSR 30-86.047(10).	
		The facility ED and/or designee will provide training to all staff on the obligation to meet residents' dietary and care needs and the process for identifying when a higher level of care or discharge is required.	
		The facility ED and/or designee will monitor this process in the weekly Spotlight meetings to ensure the deficient practice does not reoccur.	

		Corrective action will be completed by 5-30-26.	
A4724		The ED updated the policy and procedure on TB screening for residents and staff.	5-30-26
		The ED and/or designee reviewed the TB screening status of all four cited employees identified. Caregiver A, Caregiver C, and Med Tech A had their second-step PPD administered and read as required. Caregiver B received the required annual TB screening. Any employee not yet in compliance was removed from direct care duties until compliance was achieved.	
		The facility will identify any other employees having the potential to be affected by this deficient practice.	
		The ED and/or designee conducted a full audit of all employees' and volunteers' TB screening documentation to ensure all are in compliance with the two-step PPD requirement or have documented prior screening history as required by 19 CSR 20-20.100.	
		The facility notes each employee's hire date from their first date on duty, to ensure the two-step TB screening process is completed within the required timeframes before or immediately upon the start of employment.	
		The DOH or Health Services Coordinator will review TB screening status at hire and will flag any employee without a completed second step before they are permitted to work on the floor.	
		The ED and/or designee will conduct monthly compliance checks to ensure all employee TB screenings and documentation are current.	
		The facility ED and/or designee will monitor this process at hire, at move-in, and in monthly meetings.	
		Corrective action will be completed by 5-30-26.	
A4798		The ED updated the policy and procedure on Physician Orders.	5-30-26
		The ED immediately contacted Resident #1's hospice provider to obtain and document a valid physician's order for oxygen use (5 liters/24 hours) on the resident's Physician Order Sheet. This order was obtained and placed in the resident's record.	
		The facility will identify any other residents who have the potential to be affected by this deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The facility ED and/or designee conducted an immediate audit of all current residents' Physician Order Sheets to verify that all medications, treatments, and dietary orders in use are supported by a current, documented physician's order.	
		The facility ED and/or designee will implement a reconciliation process at each hospital discharge, hospice admission, or change of condition to ensure all orders are transferred and documented in the facility's records before treatment begins.	
		The facility ED and/or designee will provide training to the nursing department on the policy and procedure for medication, treatment, and diet orders, including the requirement to verify and document physician orders for all hospice-ordered treatments upon readmission.	

		The facility ED and/or designee will monitor this process in the weekly Spotlight meetings to ensure the deficient practice does not reoccur.	
		Corrective action will be completed by 5-30-26.	
A4837		The ED updated the policy and procedure on Resident Condition/Medication Review.	5-30-26
		The ED and/or designee immediately ensured that retroactive monthly summaries were completed for the February and March 2026 review periods for all four cited residents (Residents #1, # 6, #7, and #8), to the extent clinically possible. Going forward, monthly summaries will be completed for all residents without exception.	
		The ED addressed and corrected the prior misunderstanding communicated by corporate that monthly summaries were not required. The ED confirmed with corporate leadership that monthly summaries are required under Missouri state regulation 19 CSR 30-86.047(58)(B) and will be completed for all residents every month.	
		The facility will identify any other residents who have the potential to be affected by this deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The ED and/or designee will ensure that all staff are educated on the requirements for monthly summary completion. Summary notes must include:	
		- General condition and needs	
		- Medication review and daily administration logging	
		- Monthly weight	
		- Record of outside services	
		- Record of any resident incidents including behaviors presenting a risk of serious harm.	
		The facility ED will monitor monthly summary completion in weekly Spotlight meetings and conduct a monthly audit of all resident records to verify completion.	
		Corrective action will be completed by 5-30-26.	
A6005		The ED has updated the policy and procedure on Toxic Material Storage.	5-30-26
		The facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The facility ED immediately removed all toxic/cleaning materials from the kitchen crate and placed them in locked storage, with each category (insecticides/rodenticides, disinfectants/sanitizers, and caustics/acids/polishes) stored physically separate from one another and from food preparation areas.	
		The facility ED and/or designee will conduct staff training on Hazard Communication standards, proper chemical storage protocols, and the regulatory requirement to keep all poisonous	

		or toxic materials locked, separate storage not accessible to residents.	
		The facility ED and/or designee will conduct weekly inspections of all storage areas to monitor compliance.	
		Corrective action will be completed by 5-30-26.	
A6012		The ED has updated the policy and procedure on cleaning and maintaining floor surfaces.	5-30-26
		The facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		The facility has scheduled and will complete the repair and replacement of the fallen tile baseboard pieces under the hand-washing sink in the dishwashing area by 5-15-26. Upon repair, all exposed drywall and uncleanable surfaces will be covered and restored to a smooth, cleanable condition per regulatory requirements.	
		The facility ED and/or designee will ensure dining and kitchen staff are retrained on the requirement for all floors to be swept and mopped daily, mopped after each spill or contamination, and that all floor surfaces and baseboards be always maintained in good repair.	
		The facility ED and/or designee will conduct weekly inspections of the kitchen floor, drain areas, and baseboard tiles to ensure cleanliness and structural integrity.	
		Corrective action will be completed by 5-30-26.	
A7050		The facility ED has updated the policy and procedure for Food Contact Surfaces.	5-30-26
		The facility will identify any other residents having the potential to be affected by the deficient practice.	
		All current residents have the potential to be impacted by the deficient practice.	
		All chipped plates identified on 4/9/26 were immediately discarded. The facility ordered replacement dishware, which was received by 4-10-26. All kitchen staff were directed to discard any dishware with any chips, cracks, or damage — regardless of severity — immediately upon identification.	
		The ED and/or designee will establish a formal dishware inspection protocol. Staff will inspect dishware before each meal service and after each dishwashing cycle. Any chipped or damaged dishware will be discarded immediately.	
		The ED and/or designee will conduct weekly audits of dishware stock to ensure an adequate, chip-free supply is maintained for all residents.	
		The ED and/or designee will train all dietary staff on the hazards of chipped dishware and the zero-tolerance policy for use of damaged food-contact surfaces.	
		Corrective action will be completed by 5-30-26.	

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.