

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility staff failed to ensure one of five sampled residents was free from physical abuse (Resident #1). Resident #1 had diagnoses including dementia, restlessness, agitation, cognitive communication deficit, and other abnormalities of gait and mobility. On 6/6/25 at approximately 5:00 P.M., certified medication technician (CMT) C told the resident he/she was nasty when the resident coughed or pretended to cough on CMT D's neck. CMT C began arguing with the resident, used profanity, and they threatened each other. CMT C pushed the resident and the resident pushed back. CMT C swung at the resident, hitting the resident around the face and neck, and the resident was pushed back against the wall. Staff intervened and pulled the resident away, causing him/her to fall to the ground. The CMT continued to try and strike the resident before staff pulled him/her away. The resident sustained visible injuries to his/her neck and hand. The facility census was 158.</p> <p>The Administrator was notified on 6/11/25 at 2:00 P.M., of an immediate jeopardy (IJ) which began on 6/6/25. The IJ was removed on 6/10/25 as confirmed by surveyor on-site verification.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy revised 8/22/22, showed:</p> <p>-Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property;</p> <p>-Definition:</p> <p>--Abuse: Means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology;</p> <p>--Willful: Means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm;</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265001
		If continuation sheet Page 1 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Verbal abuse: Means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend or disability;</p> <p>--Physical abuse: Includes but is not limited to, slapping, punching, biting and kicking. It also includes controlling behavior through corporal punishment;</p> <p>--Mistreatment: Means inappropriate treatment or exploitation of a resident;</p> <p>-Policy Explanation and Compliance Guidelines:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a. Prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property;</p> <p>b. Establish policies and procedures to investigate any such allegations;</p> <p>2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspect abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law;</p> <p>3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written;</p> <p>-Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation that achieves:</p> <p>--Identifying, correcting and intervening in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms;</p> <p>--The identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect;</p> <p>--Providing residents, representatives and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution and providing feedback regarding the concerns that have been expressed;</p> <p>--Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors;</p> <p>-Identification of Abuse, Neglect and Exploitation;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations;</p> <p>--Possible indicators of abuse include, but are not limited to:</p> <p>--Resident, staff or family report of abuse;</p> <p>--Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body;</p> <p>--Verbal abuse of a resident overheard;</p> <p>--Physical abuse of a resident observed;</p> <p>--Psychological abuse of a resident observed;</p> <p>-Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:</p> <p>--Responding immediately to protect the alleged victim and integrity of the investigation;</p> <p>--Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;</p> <p>--Increased supervision of the alleged victim and residents;</p> <p>--Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;</p> <p>--Protection from retaliation;</p> <p>--Providing emotional support and counseling to the resident during and after the investigation, as needed;</p> <p>--Revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse;</p> <p>--Assuring the reporters are free from retaliation or reprisal;</p> <p>--Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the state survey agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 5/9/25, showed:</p> <ul style="list-style-type: none"> <li>-Adequate hearing and vision;</li> <li>-Sometimes understands others and is sometimes understood;</li> <li>-Moderately cognitively impaired;</li> <li>-No behaviors or rejection of care noted;</li> </ul> <p>-Diagnoses included dementia, bladder cancer, generalized anxiety disorder, degenerative disease of the nervous system, restlessness and agitation, lack of coordination, other abnormalities of gait and mobility, elevated blood pressure and muscle weakness.</p> <p>Review of the resident's care plan dated 6/6/25, showed:</p> <ul style="list-style-type: none"> <li>-Focus: Resident rights are guaranteed by the Federal 1987 Nursing Home Reform Law. The law requires Skilled Nursing Facilities to promote and protect the rights of each resident, placing emphasis on individual preferences, dignity, and self-determination;</li> <li>-Interventions: The resident has the right to be treated with consideration, respect, and dignity, to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and to be free from restraint (physical or chemical);</li> <li>-Focus: Resident is verbally aggressive related to dementia, ineffective coping skills and mental /emotional illness;</li> <li>-Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Assess resident's coping skills and support system. Give the resident as many choices as possible about care and activities;</li> <li>-Focus: Resident is resistive to care. Resident will sometimes refuse to get blood sugar checked:</li> <li>-Interventions: Allow the resident to make decisions about treatment regime, to provide sense of control. Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care. Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to and as they occur during each contact. If resident resists with activities of daily living (ADLs), reassure resident, leave and return five to ten minutes later and try again. Praise the resident when behavior is appropriate;</li> <li>-Focus: Resident will have behaviors when he/she gets agitated;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet resident's needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Provide a program of activities that is of interest and accommodates residents status;</p> <p>-Focus: Resident has dementia;</p> <p>-Interventions: Ask yes/no questions in order to determine the resident's needs. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. Cue, reorient and supervise as needed;</p> <p>-Focus: The resident has a communication problem related to dementia;</p> <p>-Interventions: Anticipate and meet needs. Ensure/provide a safe environment: Call light in reach, Adequate low glare light, bed in lowest position and wheels locked. Avoid isolation.</p> <p>Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed.</p> <p>Review of the resident's progress notes, showed:</p> <p>-On 6/6/25 at 5:25 P.M., per staff on duty (CMT C, CMT D, certified nurse aide (CNA) E, CNA F and CNA G), CMT C asked the resident to cover his/her mouth when coughing by CMT D. The resident became irate yelling profanity, increased agitation, and upset. The resident charged CMT C, striking him/her in the face and grabbing him/her. Staff had to get in between the resident and CMT C so the CMT could be allowed to get to safety. The nurse assessed the resident with findings as follows: No visible bruising or open areas. Resident stated he/she hates the sight of the CMT C. At 6:33 P.M., the nurse called the resident's physician and informed him/her of resident aggression towards staff. The physician sent an as needed (PRN) order for Trazodone (used to treat anxiety) 50 milligrams twice a day as needed. At 6:45 P.M., the nurse informed the resident's daughter about new order obtained PRN for agitation/anxiety. The resident's family member returned phone call, and this nurse informed him/her of the resident's aggression towards staff.</p> <p>Review of the resident's skin assessment dated [DATE], showed no new skin issues.</p> <p>Review of the resident's care task record dated 5/13/25 through 6/9/25, showed:</p> <p>-Task: Behavior monitoring and interventions:</p> <p>-On 6/6/25 at 2:00 P.M., no behaviors observed;</p> <p>-No other documentation of behaviors for 6/6/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's June 2025 physician's order sheet, showed:</p> <ul style="list-style-type: none"> <li>-Pain monitoring every shift;</li> <li>-Aspirin, 81 milligrams (mg) tablet, give one tablet by mouth one time a day for high blood pressure;</li> <li>-Citalopram Hydrobromide, 20 mg tablet, give one tablet by mouth, one time a day for depression;</li> <li>-Quetiapine fumarate, 25 mg, give one tablet one time a day for generalized anxiety disorder, restlessness and agitation;</li> <li>-Memantine hydrochloride (HCl), 500 mg, give one tablet by mouth two times a day for depression;</li> <li>-Trazodone HCl, 50 mg, give 50 mg by mouth two times a day related to anxiety disorder.</li> </ul> <p>Review of the resident's June 2025 electronic Medication Administration Record, showed:</p> <p>-On 6/6/25:</p> <ul style="list-style-type: none"> <li>-Aspirin, 81 mg, at 8:00 A.M., drug refused;</li> <li>-Citalopram Hydrobromide 20 mg, at 8:00 A.M., drug refused;</li> <li>-Quetiapine Fumarate, 25 mg, at 8:00 A.M., drug refused;</li> <li>-Memantine HCl, 5 mg, at 8:00 A.M. and at 5:00 P.M., drug refused;</li> <li>-Trazodone HCl, 50 mg, at 8:00 A.M. and at 5:00 P.M., drug refused;</li> </ul> <p>-On 6/7/25, a 10 recorded for pain monitored on the day shift.</p> <p>During an interview on 6/9/25 at 11:30 A.M., the resident said he/she got beat a few days ago by the second in command behind the nurse (CMT C). This was the third time the resident had been assaulted by him/her. The staff member was throwing punches at him/her. The staff member continually insulted him/her and told him/her he/she would never get out of the facility. Other staff were there and saw it happen. The staff member beat him/her good. The resident was injured in the incident when the staff member hit him/her in the face and scratched his/her neck. The nurse told the resident he/she would take care of it, but he/she did not do anything. The nurse was never around when things happened. The resident no longer felt safe in the facility and did not trust the staff to help him/her.</p> <p>Observations of the resident on 6/9/25 between 11:30 A.M. and 5:00 P.M., showed a scratch on the right side of his/her neck, a scratch on the left side of his/her neck and a scratch on his/her right hand.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/25 at 4:30 P.M., the wound nurse said he/she measured the resident's wounds on this date and found the wound on the left side of the neck measured 3 centimeters (cm), the wound on the right side of the neck measured 0.3 cm width on the top and 0.5 cm length at the bottom. The wound on the resident's left wrist measured 0.3 cm in width by 0.5 cm in length.</p> <p>Review of the resident's trauma informed care form, dated 6/10/25, showed: Physical assault: Happened to me.</p> <p>During an interview on 6/9/24 at 12:25 P.M., Registered Nurse (RN) J said on 6/6/24, he/she was on his/her way home from working at the facility and CNA G called and told him/her Resident #1 had assaulted CMT C. He/She called the DON and reported the allegation and the DON told RN J he/she needed to return to the facility to get statements from all of the staff who were working. The resident was still agitated when he/she got back to the facility and said he/she wanted a fair fight. He/She never said he/she was assaulted. RN J did not ask him/her if he/she was assaulted, only if he/she was in pain and if he/she felt safe. He/She assessed the resident and did not see any injuries at the time. The staff interviewed who were working (CMT C, CMT D, CNA E, CNA F and CNA G) reported the resident attacked CMT C, and the other staff (CMT D, CNA E, CNA F and CNA G) had to get him/her off him/her. The resident allegedly coughed on CMT D and when CMT C told him/her to cover his/her mouth, the resident ran towards him/her and the staff (CMT D, CNA E, CNA F and CNA G) had to pull the resident off him/her. All of the staff (CMT C, CMT D, CNA E, CNA F and CNA G) who were present wrote statements indicating this is what happened. He/She did not interview the staff individually about what happened, just asked them to write out statements. The resident had never physically assaulted anyone before, but there were certain staff he/she did not like. He/She did not like CMT C, because he/she often had to redirect him/her, and the resident did not like that. The resident told the nurse he/she did not want to be there with CMT C anymore. The RN did not know if the resident received his/her medication on 6/6/25 because CMT C did not tell him/her the resident refused his/her medications and he/she did not administer it that day.</p> <p>Review of a written statement by CMT C dated 6/6/25, provided by the DON on 6/9/24, showed the resident walked behind him/her and CMT D, and the resident coughed. CMT C told the resident to cover his/her mouth, and the resident turned around and charged him/her, attacking him/her.</p> <p>During an interview on 6/9/25 at 1:55 P.M., CMT C said he/she and CMT D were at the nurse's station and the resident walked by and coughed on CMT D's neck. CMT C told the resident to cover his/her mouth. The resident does not like CMT C and always has an attitude. CMT C asked the resident why he/she coughed on CMT D, and the resident became enraged, rushed towards CMT C and grabbed his/her arms. The CMT started struggling trying to get free and grabbed at the resident trying to get loose. The other staff (CMT D, CNA E, CNA F and CNA G) pulled the resident back away from him/her, but the resident kept trying to attack him/her. He/She never struck the resident, and he/she did not fall to the ground. CMT C did not know why the resident did not like him/her. The resident would get angry with him/her when he/she found the resident in the wrong. CMT C usually just ignored the resident's behavior when he/she got angry. CMT C did not know who administered the resident's medication on 6/6/25 because he/she often would refuse to take medication from him/her, and he/she would have to get the nurse to administer it.</p> <p>Review of a written statement by CMT D dated 6/6/25 and provided by the DON on 6/9/25, showed the resident walked behind him/her and coughed on his/her neck. CMT C told him to cover his/her mouth, and then the resident charged at him/her while the staff tried to get him/her off CMT C.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/25 at 1:45 P.M., CMT D said the incident started because the resident walked by and coughed on him/her. CMT C let the resident know not to do that, and the resident got really aggressive, and they had to restrain him/her. The resident got angry so fast. It was out of nowhere. He/She charged at CMT C and the staff had to restrain him/her. CMT C grabbed the resident's arms to try and prevent him/her from hitting him/her. CMT D did not usually work on the memory care floor, so did not know if the resident and CMT C had prior problems with each other.</p> <p>Review of a written statement by CNA G dated 6/6/25 and provided by the DON on 6/9/25, showed CMT C was talking to CMT D and the resident walked by and coughed on CMT D's neck. CMT C asked the resident why he/she coughed on CMT D's neck. That is when he/she saw the resident walk towards CMT C. CMT C told the resident not to get up in his/her face, and then the resident pushed CMT C and called him/her a bitch.</p> <p>During interviews on 6/9/25 at 2:20 P.M. and at 3:30 P.M., CNA G said he/she was in the dining room on the day of the incident and heard Resident #1 and CMT C yelling at each other. The resident had coughed on CMT D's neck and CMT C asked the resident why he/she coughed on his/her neck. CMT C told the resident he/she could not believe he/she coughed on his/her neck. CNA G thought they were joking at first, but then the resident got angry and walked towards CMT C. CMT C told the resident not to walk up on him/her, and then the resident charged at CMT C. The resident fell, and CNA E got him/her in a headlock. The resident was on the ground and CNA E had his/her arm around the resident's neck. CNA F grabbed CMT C and attempted to pull him/her away from the resident. CNA G yelled at CNA D to let the resident go and helped him/her up from the ground. The resident was bleeding from his/her neck and hand. CNA G took the resident into the dining room and tried to get him/her to eat dinner. The resident was very upset and asked if CNA G saw what happened. CNA G wrote the statement about the staff member being attacked because he/she was afraid he/she would lose his/her job.</p> <p>Review of a written statement by CNA E dated 6/6/25 and provided by the DON on 6/9/25, showed he/she heard CMT C ask Resident #1 to cover his/her mouth, and then the resident charged at the CMT. CMT D grabbed CMT C's neck until they could pry the resident's hands from his/her neck.</p> <p>During interviews on 6/9/25 at 2:10 P.M. and on 6/11/25 at 8:50 A.M., CNA E said he/she was in the dining room on the night of the incident, at the back of the room and did not see what started the problem. He/She heard Resident #1 and CMT C yelling at each other about the resident covering his/her mouth. CNA E had to finish passing out the tray he/she was holding and got there at the end of it. No one was on the floor. CMT D, CNA E, CNA F, and CNA G were standing between the resident and CMT C. The resident was up against the wall. It was chaos and everybody was everywhere. The resident had been upset and agitated all day. He/She did not know if the resident got his/her medication that day. Residents can get agitated if they do not get their medication. The resident did not like to be redirected by CMT C. The resident told CNA E all the staff jumped on him/her except for him/her. He/She did not report it, because he/she believed the resident was restrained to prevent him/her from assaulting CMT C.</p> <p>Review of a written statement by CNA F dated 6/6/25 and provided by the DON on 6/9/25, showed the resident walked by CMT C and CMT D, and the resident coughed on CMT D's neck. CMT C asked the resident why he/she would do that and to cover his/her mouth. The resident then got mad and charged at CMT C. CNA F, CMT D, CNA E and CNA G had to get the resident off CMT C.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 6/9/25 at 2:05 P.M., and on 6/11/25 at 8:15 A.M., CNA F said he/she was in the dining room serving trays on the night of the incident. Resident #1 walked by the nurse's station and he/she playfully coughed on CMT D, and CMT C turned around and started yelling at him/her. CMT C told the resident he/she was nasty. They started arguing back and forth, and then the resident threatened to hit him/her. CMT C said he/she wished the resident would hit him/her. The resident then walked closer to CMT C, and he/she pointed his/her finger in the resident's face and said, You better get the f**k out of my face. The resident stepped closer, and then the CMT pushed him/her back. The resident pushed the CMT and then the CMT started swinging at the resident. CMT C was hitting the resident around the face and neck, and the resident was pushed back against the wall. CNA E got behind the resident and attempted to pull him/her away from the CMT and he/she fell on him/her. CNA F was trying to pull CMT C away from the resident and was telling him/her it was not worth losing his/her job. CMT C continued to yell, I told your ass and tried to swing on the resident again while he/she was on the ground. They were finally able to get CMT C away from the resident and behind the nurse's station. The resident was bleeding from wounds on his/her face and neck. CNA F wrote two statements. The first one was the night of the incident. RN J came in and told all of the staff to write statements about what they witnessed. This was done in front of all of the staff, and CNA F did not feel comfortable writing one. The nurse told him/her the resident attacked the staff, and the staff restrained him/her to protect the CMT and asked if that is what he/she witnessed. The nurse read everyone's statement out loud to ensure they all matched up and then left. CNA F thought about it overnight and then called the DON the next day to tell him/her what really happened, and he/she wanted to change his/her statement. The DON came to the facility on 6/7/25, and CNA F gave him/her a new statement and told him/her CMT C had assaulted the resident. The DON told him/her since they were past the time to report the incident it would look bad if the CNA changed his/her story and he/she would be perceived as a liar. The DON told him/her they were going to go with the original statements and he/she would be back in on 6/11/25 to further investigate the incident. The CNA had a copy of the second statement and had recorded the conversation between him/her and the DON.</p> <p>Review of the second written statement by CNA F dated 6/7/25, sent to DHSS on 6/11/25 at 8:32 A.M., showed he/she and CNA E were in the dining room the night of the incident, passing trays for dinner. Resident #1 walked by CMT C and CMT D and playfully coughed on CMT D. CMT C told the resident he/she was nasty and why would he/she do that. The resident started getting agitated and they began arguing back and forth. The resident told CMT C he/she would hit him/her, and the CMT told the resident he/she wished he/she would hit him/her. The resident walked up to CMT C, and CMT C said, You better get the f**k out of my face and pushed the resident. The resident pushed the CMT back, and CMT C started swinging on the resident and grabbed him/her down to the floor. CMT D, CNA E and CNA F tried to break up the fight. CNA E got the resident away from the CMT, and CNA F pulled CMT C away. CMT C kept yelling I told your ass! They got the resident to calm down, but he/she would get agitated again every time he/she saw CMT C. RN J called and said he/she was on his/her way back to the building and wanted statements. CNA F felt coerced to write the statement the RN told him/her to write. The resident had visible scratches on both sides of his/her neck.</p> <p>Review of a recorded interview between the DON and CNA F, provided by CNA F on 6/11/25 at 8:35 A.M., showed:</p> <p>-The resident was in front of the nurse's station on the night of the incident. He/She was in a playful mood and acted like he/she was going to cough on CMT D;</p> <p>-CMT C started to yell at the resident, saying he/she saw what he/she did, and it was nasty;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident argued he/she had not done this, but CMT C kept saying he/she did, and the resident started to get agitated;</p> <p>-The resident and the CMT had words earlier in the day when the resident thought he/she had taken his/her cereal;</p> <p>-The resident told CMT C he/she would hit him/her, and he/she told the resident he/she wished he/she would hit him/her;</p> <p>-The resident was on his/her way to the dining room and turned around and came back when the CMT said this to him/her;</p> <p>-CMT C pointed his/her finger in the resident's face and said, You better get the f**k out of my face;</p> <p>-The resident took another step closer to the CMT, and CMT C pushed the resident back;</p> <p>-The resident then pushed the CMT back;</p> <p>-CMT C then started swinging at the resident and pushed him/her into the wall;</p> <p>-CMT C was grabbing at the resident's clothes with one hand and swinging with the other;</p> <p>-CMT C hit the resident on the side of his/her head. The resident was not swinging back;</p> <p>-The resident fell to the ground;</p> <p>-CNA F grabbed CMT C by the arms and tried to pull him/her back away from the resident while another staff member was trying to get the resident away. CNA E attempted to pull the resident away and the resident fell on him/her;</p> <p>-CMT C continued to try and swing on the resident while he/she was on the floor and yelled, I told you not to get in my face;</p> <p>-The resident was on the ground screaming, This is going to be a lawsuit;</p> <p>-The staff were finally able to get the CMT to go behind the nurse's station and the resident to the dining room.</p> <p>During an interview on 6/9/25 at 2:50 P.M., CNA I said he/she was not working the night of the incident but came in the next morning and heard CNA F and CNA H talking about the resident getting jumped on by staff the night before. The resident had visible scratches on both sides of his/her neck, and the resident said they hurt. CNA I did not report this to anyone, because he/she thought they already knew about it.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/9/25 at 4:30 P.M., CNA H said when he/she came to work on 6/7/25, CNA F told him/her the resident had been jumped on by staff the night before. CNA H told CNA F he/she should do the right thing and report it. Resident #5 told CNA H, he/she saw a staff member put Resident #1 in a choke hold. He/She did not report it, because he/she did not witness it and thought CNA F reported it.</p> <p>Review of Resident #5's quarterly MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Moderately cognitively impaired;</li> <li>-Adequate hearing and vision;</li> <li>-Usually understands others and makes self understood.</li> </ul> <p>During an interview on 6/9/25 at 4:05 P.M., Resident #5 said he/she was in the dining room the night of the incident and heard Resident #1 and CMT C yelling at each other. Then the yelling stopped, and the staff started running out of the dining room, so he/she went out to see what was happening. Resident #1 was on the floor, and a staff member had a reverse choke hold (a choke hold applied from behind the person, typically with one arm wrapped around the neck) on him/her. The resident had stopped yelling at this time.</p> <p>During interviews on 6/9/25 at 1:00 P.M. and on 6/11/25 at 11:35 A.M., the DON said she received a call on 6/6/25 around 5:00 P.M. from RN J stating Resident #1 had assaulted CMT C. She directed the RN to return to the facility to take statements from the staff. The staff told the DON the resident became agitated at CMT C after he/she asked the resident not to cough on CMT D and the resident charged at him/her. Staff had to restrain the resident so CMT C could get to safety. The DON removed CMT C as he/she was a trigger for the resident and asked him/her not to return until 6/9/25 so she could investigate the incident further. The DON planned to come back in to the facility on 6/7 and start an investigation. The DON told the staff to keep an eye on the resident. The DON returned to the facility on 6/7/25 after receiving a call from from CNA F regarding the incident. The DON assessed the resident and did not see any injuries. The resident did not allege he/she was abused. The DON did not specifically ask the resident if he/she was assaulted. The first night the resident told CNA E he/she was jumped by six staff members. The DON thought he/she was just confused from being restrained by the staff members. The DON would have expected the staff to document these allegations so they could have been investigated. The DON ensured a referral for a psychiatric evaluation was made for the resident and his/her physician was contacted to get an order for an as needed medication in case he/she got agitated again. The DON knew the resident did not like the CMT but believed it was because the CMT brought in food for the residents who behaved well, and he/she often did not get the food, and it made him/her angry. The DON did not remove the staff member from the unit prior to the incident, because he/she believed the resident just did not like being redirected. No one told the DON, CMT C had expressed he/she did not like the resident. RN J told her the witness statements verified the resident attacked the staff member. The DON suspended CMT C because he/she admitted calling the resident nasty and this was not an appropriate reply, until she could meet with CMT C on 6/9/25 to discuss appropriate behavioral responses. No one told the DON the resident was alleging he/she was abused or they witnessed the resident being abused. If staff had notified her about this, she would have immediately started an investigation and reported the allegations.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 6/9/25 at 5:30 P.M. and on 6/11/25 at 3:00 P.M., the Administrator said he is the abuse/neglect coordinator and staff, residents or family can report allegations to him at anytime. He expects staff to report all al[TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to thoroughly investigate an altercation between Resident #1 and several staff members which resulted in the resident sustaining scratches on both sides of his/her neck and on his/her left hand. A registered nurse asked for written statements from the staff members involved and then read each others statements in front of each other. The next day, Certified Nurse Aide F reported to the Director of Nursing his/her statement was not correct and provided a new statement of events alleging CMT C had assaulted the resident. The DON did not investigate the incident further, including interviewing the resident and other staff members privately regarding the incident or advise the Administrator of the revised statement. This deficient practice affected one out of five sampled residents. The census was 158.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy revised 8/22/22, showed:</p> <p>-Policy Explanation and Compliance Guidelines:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a. Prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property;</p> <p>b. Establish policies and procedures to investigate any such allegations;</p> <p>-Investigation of Alleged Abuse, Neglect and Exploitation:</p> <p>--An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur;</p> <p>--Written procedures for investigations include:</p> <p>1. Identifying staff responsible for the investigation;</p> <p>2. Exercising caution in handling evidence that could be used in a criminal investigation;</p> <p>3. Investigating different types of investigations;</p> <p>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations;</p> <p>5. Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and cause and;</p> <p>6. Providing complete and thorough documentation of the</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>investigation;</p> <p>-Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:</p> <ul style="list-style-type: none"> <li>--Responding immediately to protect the alleged victim and integrity of the investigation;</li> <li>--Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;</li> <li>--Increased supervision of the alleged victim and residents;</li> <li>--Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;</li> <li>--Protection from retaliation;</li> <li>--Providing emotional support and counseling to the resident during and after the investigation, as needed;</li> <li>--Revision of the resident's care plan if the resident's medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse;</li> </ul> <p>-Reporting/Response: The facility will have written procedures that include:</p> <ul style="list-style-type: none"> <li>--Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes:</li> <li>---Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or;</li> <li>---Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury;</li> <li>--Assuring the reporters are free from retaliation or reprisal;</li> <li>--Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the state survey agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint;</li> <li>--Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service;</li> <li>--Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following:</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>---Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;</p> <p>---Defining how care provision will be changed and/or improved to protect residents receiving services;</p> <p>---Identification of staff responsible for implementation of corrective actions.</p> <p>Review of Resident #1's progress notes, showed on 6/6/25 at 5:25 P.M., per five staff (Certified Medication Technician (CMT) C, CMT D, Certified Nurse Aide (CNA) E, CNA F and CNA G), the resident was asked by CMT C to cover his/her mouth when coughing. The resident became irate yelling profanity, increased agitation, and upset. The resident charged CMT C, striking him/her in the face and grabbing him/her. CMT D, CNA E, CNA F, and CNA G had to get in between the resident and CMT C so the CMT could be allowed to get to safety. The nurse assessed the resident with findings as follows: No visible bruising or open areas. Resident stated he/she hates the sight of CMT C. At 6:33 P.M., the nurse called the resident's physician and informed him/her of resident aggression towards staff. The physician sent an as needed (PRN) order for Trazodone (used to treat anxiety) 50 milligrams twice a day as needed. At 6:45 P.M., the nurse informed the resident's daughter about the new order obtained PRN for agitation/anxiety. The resident's family member returned the phone call and this nurse informed him/her of the resident's aggression towards staff.</p> <p>Review of the resident's skin assessment dated [DATE], showed no injuries.</p> <p>During an interview on 6/9/25 at 11:30 A.M., the resident said he/she got beat a few days ago by the second in command behind the nurse (CMT C). This was the third time the resident had been assaulted by him/her. The staff member was throwing punches at him/her. The staff member continually insulted him/her and told him/her he/she would never get out of the facility. Other staff were there and saw it happen. The staff member beat him/her good. The resident was injured in the incident when the staff member hit him/her in the face and scratched his/her neck. The nurse told the resident he/she would take care of it, but he/she did not do anything. He/She was never around when things happened. The resident no longer felt safe in the facility and did not trust the staff to help him/her.</p> <p>Observations of the resident on 6/9/25 between 11:30 A.M. and 5:00 P.M., showed a scratch on the right side of his/her neck, a scratch on the left side of his/her neck and a scratch on his/her right hand.</p> <p>During an interview on 6/11/25 at 4:30 P.M., the wound nurse said he/she measured the resident's wounds on this date and found the wound on the left side of the neck measured 3 centimeters (cm), the wound on the right side of the neck measured 0.3 cm width on the top and 0.5 cm length at the bottom. The wound on the resident's left wrist measured 0.3 cm in width by 0.5 cm in length.</p> <p>Review of the resident's trauma informed care form, dated 6/10/25, showed: Physical assault: Happened to me.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/9/24 at 12:25 P.M., Registered Nurse (RN) J said on 6/6/24, he/she was on his/her way home from working at the facility and CNA G called and told him/her Resident #1 had assaulted CMT C. RN J notified the DON about the allegation and she said RN J needed to return to the facility to get statements from all of the staff who were working. The resident was still agitated when he/she got back to the facility and said he/she wanted a fair fight. The resident never said he/she was assaulted. RN J did not ask him/her if he/she was assaulted, only if he/she was in pain and if he/she felt safe. He/She assessed the resident and did not see any injuries at the time. The staff (CMT C, CMT D, CNA E, CNA F and CNA G) reported the resident attacked CMT C, and the other staff (CMT D, CNA E, CNA F and CNA G) had to get him/her off him/her. The resident allegedly coughed on CMT D and when CMT C told him/her to cover his/her mouth, the resident ran towards him/her and the staff had to pull the resident off him/her. All of the staff (CMT C, CMT D, CNA E, CNA F and CNA G) who were present wrote statements indicating this is what happened. He/She did not interview the staff individually about what happened, just asked them to write out statements. He/She placed the statements in the nursing office. He/She was off the next two days and when he/she returned, the statements had been removed from his/her office. The resident had never physically assaulted anyone before, but there were certain staff he/she did not like. He/She did not like CMT C, because he/she often had to redirect him/her, and the resident did not like that. The resident told the nurse he/she did not want to be there with CMT C anymore.</p> <p>Review of the facility's investigation provided on 6/9/24, showed:</p> <ul style="list-style-type: none"> <li>-Five written statements by CMT C, CMT D, CNA E, CNA F and CNA G;</li> <li>-No documentation of any interviews done with residents.</li> </ul> <p>Review of a written statement by CMT C dated 6/6/25, showed the resident walked behind him/her and CMT D, and the resident coughed. CMT C told the resident to cover his/her mouth, and the resident turned around and charged CMT C, attacking him/her.</p> <p>During an interview on 6/9/25 at 1:55 P.M., CMT C said he/she and CMT D were at the nurse's station and the resident walked by and coughed on CMT D's neck. CMT C told the resident to cover his/her mouth. The resident does not like CMT C and always has an attitude. CMT C asked him/her why he/she coughed on CMT D, and the resident became enraged, rushed towards CMT C and grabbed his/her arms. CMT C started struggling, trying to get free and grabbed at the resident trying to get loose. CMT D, CNA E, CNA F and CNA G pulled the resident back away from him/her, but the resident kept trying to attack him/her. CMT C never struck the resident, and he/she did not fall to the ground. CMT C usually just ignored the resident's behavior when he/she got angry. CMT C wrote a statement about what happened the night of the incident.</p> <p>Review of a written statement by CMT D dated 6/6/25, showed the resident walked behind him/her and coughed on his/her neck. CMT C told the resident to cover his/her mouth, and then the resident charged at CMT C while CMT D, CNA E, CNA F and CNA G tried to get him/her off the CMT.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/25 at 1:45 P.M., CMT D said the incident started because the resident walked by and coughed on him/her. CMT C let the resident know not to do that, and the resident got really aggressive and they had to restrain him/her. The resident got angry so fast. It was out of nowhere. The resident charged at CMT C, and CNA E, CNA F, CNA G, and CMT D had to restrain him/her. CMT C grabbed the resident's arms to try and prevent him/her from hitting him/her. CMT D wrote a statement the night it happened.</p> <p>Review of a written statement by CNA G dated 6/6/25, showed CMT C was talking to CMT D, and the resident walked by and coughed on CMT D's neck. CMT C asked the resident why he/she coughed on CMT D's neck. That is when the resident walked towards CMT C. CMT C told the resident not to get up in his/her face and then the resident pushed CMT C and called him/her a bitch.</p> <p>During interviews on 6/9/25 at 2:20 P.M. and at 3:30 P.M., CNA G said he/she was in the dining room on the day of the incident and heard Resident #1 and CMT C yelling at each other. The resident had coughed on another staff member's neck, and CMT C asked the resident why he/she coughed on his/her neck. CMT C told the resident he/she could not believe he/she coughed on his/her neck. CNA G thought they were joking at first, but then the resident got angry and walked towards the CMT. CMT C told the resident not to walk up on him/her, and then the resident charged at him/her. The resident fell and CNA E got him/her in a headlock. The resident was on the ground and CNA E had his/her arm around his/her neck. CNA F grabbed CMT C and attempted to pull him/her away from the resident. CNA G yelled at CNA E to let the resident go and helped him/her up from the ground. The resident was bleeding from his/her neck and hand. CNA G took the resident into the dining room and tried to get him/her to eat dinner. The resident was very upset and asked if he/she saw what happened. CNA G wrote the statement about the staff member being attacked because he/she was afraid he/she would lose his/her job.</p> <p>Review of a written statement by CNA E dated 6/6/25, showed he/she heard CMT C ask Resident #1 to cover his/her mouth, and then the resident charged at the CMT. CMT D grabbed CMT C's neck until they could pry the resident's hands from his/her neck.</p> <p>During interviews on 6/9/25 at 2:10 P.M. and on 6/11/25 at 8:50 A.M., CNA E said he/she was in the dining room on the night of the incident at the back of the room and did not see what started the problem. He/She heard Resident #1 and CMT C yelling at each other about the resident covering his/her mouth. CNA E was passing out trays and could not run out immediately. He/She got there at the end of the incident, and no one was on the floor. CMT D, CNA E, CNA F and CNA G were standing between the resident and CMT C. The resident was up against the wall. It was chaos and everybody was everywhere. The resident did allege the staff jumped on him after the incident, but CNA E did not report it because he/she believed it was from restraining the resident to prevent him/her from assaulting CMT C.</p> <p>Review of a written statement by CNA F dated 6/6/25 and provided by the DON on 6/9/25, showed the resident walked by CMT C and CMT D and coughed on CMT D's neck. CMT C asked the resident why he/she would do that and to cover his/her mouth. The resident then got mad and charged at CMT C. CNA F and CMT D, CNA E and CNA G had to get the resident off CMT C.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 6/9/25 at 2:05 P.M., and on 6/11/25 at 8:15 A.M., CNA F said he/she was in the dining room serving trays on the night of the incident. Resident #1 walked by the nurse's station and he/she playfully coughed on CMT D, and CMT C turned around and started yelling at him/her. CMT C told the resident he/she was nasty. They started arguing back and forth, and then the resident threatened to hit him/her. CMT C said he/she wished the resident would hit him/her. The resident then walked closer to the CMT and he/she pointed his/her finger in the resident's face and said, You better get the f**k out of my face. The resident stepped closer, and then CMT C pushed the resident back. The resident pushed the CMT, and then CMT C started swinging at the resident. CMT C was hitting the resident around the face and neck, and the resident was pushed back against the wall. CNA E got behind the resident and attempted to pull him/her away from the CMT, and he/she fell on him/her. CNA F was trying to pull CMT C away from the resident and was telling him/her it was not worth losing his/her job. CMT C continued to yell, I told your ass and tried to swing on the resident again while he/she was on the ground. They were finally able to get the CMT away from the resident and behind the nurse's station. The resident was bleeding from wounds on his/her face and neck. CNA F wrote two statements. The first one was the night of the incident. RN J came in and told all of the staff to write statements about what they witnessed. This was done in front of all of the staff, and CNA F did not feel comfortable writing one. The nurse told CNA F the resident attacked the staff, and the staff restrained him/her to protect the CMT and asked if that is what he/she witnessed. CNA told him/her that is not what happened, but the nurse expected him/her to write that. The nurse read everyone's statement out loud to ensure they all matched up and then left. CNA F thought about it overnight and then called the DON the next day to tell her what really happened and he/she wanted to change his/her statement. The DON came to the facility on 6/7/25, and CNA F gave the DON a new statement and told her CMT C had assaulted the resident. The DON told CNA F since they were past the time to report the incident, it would look bad if the CNA changed his/her story, and he/she would be perceived as a liar. The DON told CNA F they were going to go with the original statements, and she would be back in on 6/9/25 to further investigate the incident. CNA F had a copy of the second statement and had recorded the conversation between him/her and the DON.</p> <p>Review of the second written statement by CNA F dated 6/7/25 sent to DHSS on 6/11/25 at 8:32 A.M., showed he/she and CNA E were in the dining room the night of the incident passing trays for dinner. Resident #1 walked by CMT C and CMT D and playfully coughed on CMT D. CMT C told the resident he/she was nasty and why would he/she do that. The resident started getting agitated and they began arguing back and forth. The resident told CMT C he/she would hit him/her and the CMT told the resident he/she wished he/she would hit him/her. The resident walked up to CMT C, and CMT C said, You better get the f**k out of my face and pushed the resident. The resident pushed the CMT back, and he/she started swinging on the resident and grabbed him/her down to the floor. CMT D, CNA E and CNA F tried to break up the fight. CNA E got the resident away from the CMT, and CNA F pulled CMT C away. CMT C kept yelling I told your ass! They got the resident to calm down, but he/she would get agitated again every time he/she saw CMT C. RN J called and said he/she was on his/her way back to the building and wanted statements. CNA E felt coerced to write the statement the RN told him/her to write. The resident had visible scratches on both sides of his/her neck.</p> <p>Review of a taped conversation on 6/7/25 between the DON and CNA F, sent to DHSS on 6/11/25 at 8:35 A. M., showed:</p> <p>-CNA reported the resident was in front of the nurse's station on the night of the incident. He/She was in a playful mood and acted like he/she was going to cough on CMT D;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CMT C started to yell at the resident saying he/she saw what he/she did, and it was nasty;</p> <p>-The resident argued he/she had not done this, but CMT C kept saying he/she did, and the resident started to get agitated;</p> <p>-The resident and the CMT had words earlier in the day when the resident thought he/she had taken his/her cereal;</p> <p>-The CMT's behavior was nothing new to anyone. He/She has a personal problem with the resident and does not like working with the resident;</p> <p>-The resident told CMT C he/she would hit him/her, and he/she told the resident he/she wished he/she would hit him/her;</p> <p>-The resident was on his/her way to the dining room and turned around and came back when the CMT said this to him/her;</p> <p>-CMT C pointed his/her finger in the resident's face and said, You better get the f**k out of my face'</p> <p>-The resident took another step closer to CMT C, and CMT C pushed the resident back;</p> <p>-The resident then pushed CMT C back;</p> <p>-CMT C then started swinging at the resident and pushed him/her into the wall;</p> <p>-CMT C was grabbing at the resident's clothes with one hand and swinging with the other;</p> <p>-CMT C hit the resident on the side of his/her head. The resident was not swinging back;</p> <p>-The resident fell to the ground;</p> <p>-CNA F grabbed CMT C by the arms and tried to pull him/her back away from the resident while another staff member was trying to get the resident away. CNA E attempted to pull the resident away and the resident fell on him/her;</p> <p>-CMT C continued to try and swing on the resident while he/she was on the floor and yelled, I told you not to get in my face;</p> <p>-The resident was on the ground screaming, This is going to be a lawsuit;</p> <p>-The staff were finally able to get the CMT to go behind the nurse's station and the resident to the dining room;</p> <p>-Another staff member told CNA F, the nurse was on his/her way back into the building to take their statements;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA F did not want to get involved because all of the staff are close out there and the nurse asked him/her to write the statement out in front of all the other staff;</p> <p>-The nurse told him/her it sounded like the resident charged at the CMT and the staff had to pull him/her off and did the CNA agree with that statement. Since this was being said in front of everyone the CNA agreed to write the statement. He/She did tell the nurse that he/she did not agree with what they were writing because they all knew the resident did not charge at the staff member. He/She felt coerced into writing the statement. He/She had written a new statement about what really happened and wanted to turn it in;</p> <p>-The DON said the problem was everyone turned in statements that got reported to him/her as the resident assaulted the staff member. The regulations said when there was an allegation of abuse, the facility was supposed to report it. If this was not done, the facility would get cited;</p> <p>-Since CNA F's statement was conflicting with the other statements it would look as if he/she lied when it was investigated. If they found out the other staff wrote out false statements then all of the staff would look like they lied. The DON did not want to turn this into a staff versus staff problem. If the resident told staff six people jumped on him/her, then it looked like they had six liars down there. Since the time had passed to report the abuse allegation, the original statements were going to stand;</p> <p>-The DON would come in on 6/9/25 and do a more thorough investigation.</p> <p>During an interview on 6/9/25 at 2:50 P.M., CNA I said he/she was not working the night of the incident, but came in the next morning and heard CNA F and CNA H talking about the resident getting jumped on by staff the night before. The resident had visible scratches on both sides of his/her neck and told CNA I they hurt. He/She did not report this to anyone, because he/she thought they already knew about it.</p> <p>During an interview on 6/9/25 at 4:30 P.M., CNA H said when he/she came to work on 6/7/25, CNA F told him/her the resident had been jumped on by staff the night before. He/She did not report it, because he/she did not witness it and thought CNA F reported it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 6/9/25 at 1:00 P.M. and on 6/11/25 at 11:35 A.M., the DON said she received a call on 6/6/25 around 5:00 P.M. from RN J stating Resident #1 had assaulted CMT C and she directed RN J to return to the facility to take statements from the staff. The staff told the DON the resident became agitated at CMT C after he/she asked him/her not to cough on another staff member and charged at him/her. Staff had to restrain the resident so the CMT could get to safety. The DON removed the CMT as he/she was a trigger for the resident and asked him/her not to return until 6/9/25 so the DON could investigate the incident further. The DON planned to come back in to the facility on 6/7 and start an investigation. The DON told the staff to keep an eye on the resident. The DON returned to the facility on 6/7/25 after receiving calls from staff who were looking for a particular outcome and were trying to influence the resident. The DON assessed the resident and did not see any injuries. The resident did not allege he/she was abused. The DON did not specifically ask the resident if he/she was assaulted because he/she did not want to put that thought in his/her head. There was a certain employee who was trying to get the resident to claim he/she was assaulted and this was confusing to him/her and he/she did not understand what was happening. The first night the resident told staff he/she was jumped by six staff members. The DON thought the resident was just confused from being restrained by the staff members. The DON would have expected the staff to document these allegations so they could have been investigated. The DON ensured a referral for a psychiatric evaluation was made for the resident and his/her physician was contacted to get an order for an as needed (PRN) medication in case he/she got agitated again. The DON knew the resident did not like the CMT, but believed it was because the CMT brought in food for the residents who behaved well, and he/she often did not get the food, and it made him/her angry. The DON did not remove the staff member from the unit prior to the incident because he/she believed the resident just did not like being redirected. No one told the DON the CMT had expressed he/she did not like the resident. RN J told the DON the witness statements verified the resident attacked the staff member. The DON suspended CMT C because he/she admitted calling the resident nasty and this was not an appropriate reply, until she could meet with him/her on 6/9/25 to discuss appropriate behavioral responses. No one told the DON the resident was alleging he/she was abused or they witnessed the resident being abused. If they had notified her about this, she would have immediately started an investigation and reported the allegations.</p> <p>During interviews on 6/9/25 at 5:30 P.M. and on 6/11/25 at 3:00 P.M., the Administrator said he is the abuse/neglect coordinator and staff, residents or family can report allegations to him at anytime. He expects staff to report all allegations of abuse immediately. The DON notified him of the incident on the night it happened. He was told the resident attempted to assault the staff member. The incident was witnessed and all of the staff statements showed the resident was the aggressor, and the staff tried to deescalate the situation. If the staff had reported the resident alleged he/she was abused they would have immediately started an investigation and called the police. He expected the staff to report exactly what happened, and anyone who failed to report would be suspended or fired. The DON told him the resident had been assessed and had no injuries. He did not know why the DON did not investigate the allegations and report them the night it happened or when the staff member reported them to her the next day. He did not know the staff member wrote a second statement. The DON should have provided the statement to him. The DON should have immediately notified him of the allegations and started an immediate investigation.</p> <p>MO00255497</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to provide necessary medications as ordered by the physician for one of seven sampled residents (Resident #5). The facility failed to provide twice daily anti-seizure medication to the resident nine out of ten times over a five-day period. Facility staff also failed to notify nursing management and the physician of the medication errors. The facility census was 158.</p> <p>1. Review of the Facility's Medication Administration Policy, revised 9/1/22, showed:</p> <ul style="list-style-type: none"> <li>-Medication carts should be stocked with adequate supplies of medications;</li> <li>-If expired medications are noted and cannot be administered, the nurse manager should be notified;</li> <li>-Any adverse side effects or refusals of medications should be documented and reported;</li> <li>-Discrepancies with orders or supplies of medication should be corrected and reported to the nurse manager.</li> </ul> <p>Review of the Facility's e-kit (Emergency Kit, a standard stock of commonly prescribed life-saving medications to be used in an emergency situation) Inventory on 6/12/25, showed:</p> <ul style="list-style-type: none"> <li>-A minimum of four tablets of Levetiracetam (an anticonvulsant medication used to treat seizures and epilepsy, commonly known as Keppra) 250 milligrams (mg) are always kept on hand in the e-kit for emergency situations, and the e-kit will hold a maximum of eight tablets of Levetiracetam 250 mg for emergency situations.</li> </ul> <p>Review of Resident #5's facility medical record, showed:</p> <ul style="list-style-type: none"> <li>-An admission date of 6/23/22;</li> <li>-Medical diagnoses included diabetes, history of stroke, and Moyamoya Disease (a rare disorder causing the blood vessels to the base of the brain to become narrowed and reduce blood flow);</li> <li>-An active physician order dated 10/14/22 for Levetiracetam 500 mg tablets to be given twice daily;</li> <li>-Progress notes entered on 6/1/25 at 8:28 A.M. and 9:08 P.M., showed the resident's Levetiracetam was not given as the medication was on order and not available to staff. The note did not indicate the resident's physician or the Director of Nursing (DON) was made aware of the missed medication;</li> <li>-Progress notes entered on 6/3/25 at 11:46 A.M. and 7:32 P.M., showed the resident's Levetiracetam was not given as the medication was on order and not available to staff. The note did not indicate the resident's physician or the DON was made aware of the missed medication;</li> <li>-Progress notes entered on 6/4/25 at 9:33 A.M. and 8:19 P.M., showed the resident's Levetiracetam was not given as the medication was on order and not available to staff. The note did not indicate the resident's physician or the DON was made aware of the missed medication;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Progress notes entered on 6/5/25 at 8:32 A.M. and 8:19 P.M., showed the resident's Levetiracetam was not given as the medication was on order and not available to staff. The note did not indicate the resident's physician or the DON was made aware of the missed medication.</p> <p>Review of the resident's medication administration record for June 2025, showed only one dose of Levetiracetam administered to the resident between 6/1/25 and 6/5/25, resulting in a total of nine out of 10 doses not administered to the resident as ordered.</p> <p>During an interview on 6/11/25 at 8:53 A.M., the resident said last week he/she had gone without seizure medication for almost a week, and during that time the resident was fearful that he/she would have another seizure. The resident was newly diagnosed with a seizure disorder that led to a heart attack, and worries often that he/she will have another seizure that he/she won't live through. The resident asked for the medication multiple times from 6/1/25 to 6/5/25 and was given various reasons why it was not available, including pharmacy delivery delays and staff inability to obtain the medication.</p> <p>During an interview on 6/11/25 at 10:58 A.M., the resident's family member said he/she had been notified of the first missing dose of the resident's seizure medication on 6/1/25 by the resident and called the facility to see what was being done to rectify this. The family member was told by facility staff that they were working on it, but was not given any specifics. The facility did not provide the resident his/her necessary seizure medication until 6/6/25, and the family member was never given a reason why the resident went without the medication for almost ten doses in a row.</p> <p>During an interview on 6/11/25 at 12:10 P.M., Pharmacist T, a representative of the facility's pharmacy partner, said the last delivery made to the facility was on 5/21/25, when a 30-day supply of the resident's needed seizure medication Levetiracetam was sent to the facility. The facility then sent a request for delivery of the medication on 6/6/25 and reported the medication had been missing. The pharmacy obtained approval for delivery of the missing medication and delivered the medication to the facility the same day, as the medication is high-priority for the resident's condition. It is important for the resident to take this on a routine, consistent basis in order to prevent further seizure-like activity.</p> <p>During interview on 6/11/25 at 12:21 P.M. Licensed Practical Nurse (LPN) U said he/she had heard the resident had gone without seizure medication for a few days. LPN U said staff are expected to immediately re-order necessary medications like Keppra if noted missing or unable to be found, and the facility's e-kit does have a small supply of Keppra on hand for emergency situations like this. The e-kit is accessible by any member of the nursing staff at the facility.</p> <p>During interview on 6/11/25 at 3:21 P.M., Regional Nurse Consultants (RNC) V and W said they would expect staff to immediately re-order necessary medications and to notify the Director of Nursing once noted to be missing. Potentially life-saving medications like Keppra are kept in the facility's e-kit and should be used in the event the medication cannot be located or re-ordered in a timely manner. RNC V and RNC W would expect staff to check the e-kit for the medication and to use the e-kit supply until the necessary medication is located or delivered to the facility. All residents in the facility should be administered medications timely and as ordered by the physician to reduce the negative impact of each resident's unique medical condition.</p> <p>MO00255283</p>		