

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 11/18/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</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
---	-------	-----------

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 11/18/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided met acceptable professional standards of care when staff failed to accurately document one resident's tube feedings (nutrition provided through a gastric tube (g-tube) a tube that is surgically inserted into the stomach) for one resident (Resident #8). In addition, staff failed to obtain and document a resident's blood pressure prior to the administration of Hydrochlorothiazide (used to treat high blood pressure) (Resident #14). The sample was 16. The census was 166. Review of the facility's Documentation in the Medical Record Policy, dated 8/1/25, showed:-Licensed staff and interdisciplinary team (IDT) members shall document all assessments, pertinent observations, and services provided in the resident's medical record in accordance with state law and facility policy;-Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 1. Review of Resident #8's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/23/25, showed:-Moderately impaired cognition;-Dependent on staff for all activities of daily living (ADL);-Tube Feeding, while a resident;-Diagnoses included: high blood pressure, diabetes, and traumatic brain injury (TBI, an injury to the brain caused by a bump, blow, jolt, or penetrating object to the head) Review of the resident's care plan in use at the time of survey, showed:-Focus: The resident has unplanned/unexpected weight loss related to poor food intake;-Goal: No significant weight loss of 5% in 30 days or 10% in 180 days;-Interventions included: Give the resident supplements as ordered. Alert nurse/dietitian if not consuming food on a routine basis. Review of the resident's progress notes showed on 8/1/25 at 8:14 P.M., g-tube flushed with 100 milliliters (ml) water every six hours and 240 ml bolus of Glucerna 1.5 (liquid nutrition) after meals if eats less than 50%. Will add Glucerna 1.5 at 40ml/hour daily from 7p-7a.; Review of the resident's treatment administration record (TAR) dated August 2025, showed:-A physician order for Glucerna 1.5 at 40 ml/hour to run 12 hours/day from 7 P.M. to 7 A.M. per g-tube. Start date 8/2/25, discontinued on 8/21/25: Documentation showed: At 6:00 A.M., six out of 20 opportunities, blank. At 6:00 P.M. seven out of 20 opportunities, blank. Review of the resident's progress notes, showed:-On 8/26/25 at 2:08 P.M., resident refusing tube feeding recently. The dietician emailed Director of Nursing (DON) to discuss ongoing plan of care regarding nutrition if resident continues to refuse tube feeding. Awaiting response;-On 8/28/25 at 6:29 P.M., the Certified Nurse Aide on duty reported to the nurse the resident kept disconnecting his/her tube feeding. The nurse provided education;-No other documentation the resident refused his/her tube feeding, what the tube feeding was not documented as ordered, or why the treatment was not documented/administered. Review of the resident's TAR dated September 2025, showed a physician order to flush g-tube with 100 ml of water every 4 hours, start date 9/6/25. Documentation showed nine out of 53 opportunities, blank. Review of the resident's progress notes, showed:-On 9/6/25 at 4:04 P.M., tube feeding: Glucerna 1.5 at 50ml/hour x 23 hours daily with 150 ml water flush every 4 hours. Resident will refuse at times;-No documentation to show why the tube feeding flushes that were left blank were not documented/administered. During an interview on 10/29/25 at 9:39 A.M., the Registered Dietician (RD) said she knew the resident was refusing to eat and refusing his/her tube feedings by checking the administration records. If there was a blank on the TAR she would not know if the resident received his/her tube feeding or not. If he/she was refusing, it should be documented. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included high blood pressure. Review of the resident's care plan, dated 9/17/25 and in use at the time of the investigation, showed:-Focus: Resident has hypertension (HTN, high blood pressure);-Goal: Resident will remain free from signs and symptoms of HTN;-Interventions: Avoid taking blood pressure reading after physical activity or emotional distress. Give anti-hypertensive medications as ordered monitor for side effects such as orthostatic hypotension (condition where the blood pressure drops suddenly upon position change) and increased heart rate and effectiveness. Review of the resident's electronic Physician's Orders Sheet (ePOS), dated October 2025, showed an order dated 9/20/25, Hydrochlorothiazide oral tablet 12.5 mg. Give one tablet my mouth one time a day for hypertension. Do not give if systolic blood pressure (pressure in the arteries when the heart contracts) less than 100. Review of the resident's Medication Administration Record (MAR), dated September 2025, showed an order, dated 9/20/25, Hydrochlorothiazide oral tablet 12.5 mg. Give one tablet my mouth one time a day for hypertension. Do not give if systolic blood pressure less than 100. On 9/21/25 through 9/30/25</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 11/18/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</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 11/18/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADLs) received personal hygiene assistance in accordance with their personal needs by not providing baths/showers for two residents (Residents #13 and #12). In addition, the facility failed to ensure staff had enough towels and linen to assist residents timely with personal care as needed when staff and residents reported a towel and linen shortage. The resident sample was 16. The census was 166.1. Review of the facility's Resident Rights policy, dated 9/1/24, showed:-The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents;-The resident has the right to a dignified existence;-The resident has the right to be treated with respect and dignity, including the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. 2. Review of the facility's 6-month Linen Purchase History dated 4/28/25 through 10/28/25, showed the following items were ordered:-120 flannel blankets;-10 dozen bath towels, 24 x 50;-10 dozen bath towels, 22 x 44;-124 dozen bath towel, 24 x 48;-33 dozen flat sheets;-40 dozen under pads;-34 dozen contour sheets;-18 dozen pillow cases;-280 dozen wash clothes. 3. Review of Resident #13's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 8/14/25, showed:-Cognitively intact;-No rejection of care;-Required substantial/maximal assist (helper does more than half the effort) for toilet hygiene, shower/bath and personal hygiene;-Always incontinent of bowel and bladder;-Diagnoses included: high blood pressure, diabetes, generalized muscle weakness and difficulty walking. Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has an Activity of Daily Living (ADL) self-care performance deficit activity intolerance;-Goal: the resident will maintain/level of functioning;-Interventions: Toileting hygiene, shower/bath, personal hygiene: substantial/max. Toilet use: The resident requires (extensive assistance) by staff for toileting. During an interview on 10/24/25 at 2:05 P.M., the resident said he/she did not receive his/her shower yesterday. He/She just wanted to clean his/her arm pits and pee pit. They do not always have wash clothes/towels to do it. The last time he/she had a shower was 10/10/25. 4. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Moderately impaired cognition;-No rejection of care;-Dependent on staff for toilet hygiene, shower/bath self and personal hygiene;-Occasionally incontinent of bowel and bladder;-Diagnoses included: heart failure, high blood pressure and cerebral palsy (a disorder of movement, muscle tone or posture). Review of the resident's care plan, in use at the time of survey showed:-Focus: resident has an ADL self-care performance deficit related to cerebral palsy;-Goal: will maintain current level of function through the review date;-Interventions: Requires dependent assistance of one staff member to provide bath/shower twice weekly and as necessary, provide sponge bath when a full bath or shower cannot be tolerated. Personal hygiene: requires dependent assistance of one staff member. Toilet use: requires total dependence. During an interview on 10/23/25 at 9:18 A.M. the resident said he/she always had to wait to get his/her shower because there was a towel shortage. 5. Review of the Daily Census sheet for the Memory Care unit, dated 10/23/25, showed 33 residents resided on the unit. Observation and interview on 10/23/25 at 9:50 A.M., Registered Nurse (RN) P attempted to open the linen closet on the Memory Care Unit but was unable to. He/She did not know the code. Observation and interview on 10/23/25 at 9:52 A.M., Certified Nursing Assistant (CNA) BB said the night shift is responsible for ensuring the day shift has enough linen and towels. Whatever is not used from the cart that is brought to the unit, it put in the linen closet. The day shift is responsible for ensuring the night shift has enough as well so it should be restocked by 7:00 P.M. CNA BB opened the linen closet to the Memory Care Unit. There were three cloth pads, two sheets, and a bag of gowns. No towels and no washcloths. CNA BB said they have not come yet with the cart, but they will start showers after the linen arrives. 6. Review of the Daily Census sheet for the 500-hall, dated 10/23/25, showed 43 residents resided on the hall. Observation and interview on 10/24/25 at 7:15 A.M., showed the 500-hall clean linen closet had no towels or wash clothes. There was one fitted sheet and a trash bag with clean gowns on the shelf. There was one fitted sheet on the ground. Certified Medication Technician (CMT) H said they are no longer stocking the linen rooms. They used a linen cart. Their linen cart was downstairs in the laundry being restocked. The cart was usually returned to the floor around 12:00 P.M. If they needed supplies, they would go downstairs to get them. 7. Review of the Daily Census sheet for the rehab hall, dated 10/23/25, showed 32 residents resided on the unit. Observation on</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 11/18/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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 11/18/2025
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice when staff failed to transcribe new treatment orders timely and failed to accurately document treatments for three sampled residents (Resident #7, #3, and #8). Staff failed to obtain a physician order for a wound vacuum (wound vac, medical device that used suction to promote wound healing) for one resident (Resident #7). Staff failed to identify a deep tissue injury (DTI, persistent non-blanchable deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters caused by damage to the underlying soft tissues), upon admission for one resident (Resident #3). The sample was 16. The census was 166. Review of the facility's Wound Treatment Management Policy, dated 5/1/25, showed:-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;-In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse;-Treatments will be documented on the Treatment Administration Record (TAR). Review of the facility's Documentation in the Medical Record Policy, dated 8/1/25, showed:-Licensed staff and interdisciplinary team (IDT) members shall document all assessments, pertinent observations, and services provided in the resident's medical record in accordance with state law and facility policy;-Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 1. Review of Resident #7's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/4/25, showed:-Moderately impaired cognition and no rejection of care;-Diagnoses included: diabetes, stroke, high blood pressure and anemia (decrease in number of red blood cells);-One stage 2 pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, may also present as an intact or open/ruptured blister). Review of the resident's progress notes dated 5/7/25 at 7:56 P.M., showed, upon removal of right sock resident noted to have open area to right heel. Medical Doctor (MD) was contacted. Review of the resident's care plan in use at the time of survey, showed:-Focus: resident has a stage 2 on his/her right heel related to impaired mobility;-Goal: pressure injury will show signs of healing;-Interventions included: administer treatment per orders. Review of the resident's May 2025 TAR showed an order to cleanse the right heel with normal saline/wound cleanser. Pat dry, apply collagen (protein needed for new tissue growth), and dry dressing every 24 hours for wound healing. Start date: 5/6/25, discontinued on 5/12/25. Documentation showed: two out of seven opportunities were blank. Review of the wound doctor's note, dated 5/9/25, showed right heel stage 2. Treatment: cleanse wound with wound cleanser, apply Medi honey gel (provides a moist healing environment and fights bacteria), cover with dry dressing every 24 hours and as needed. Review of the resident's May 2025 TAR showed an order to cleanse right heel with normal saline/wound cleanser. Pat dry, apply Medi honey and dry dressing every 24 hours every dayshift for wound healing, start date 5/13/25. Documentation showed: three out of 18 opportunities were blank. Review of the resident's May 2025 progress notes showed no documentation as to why the treatment of Medi honey was not started until 5/13/25, four days after ordered by the wound doctor. Review of the resident's October 2025 progress notes, showed:-On 10/18/25 at 6:27 P.M., resident had an appointment for surgery for right stump on Tuesday 10/21/25.-On 10/23/25 at 5:10 P.M., resident arrived back from the hospital for below the knee amputation revision. During an interview on 10/24/25 at 12:10 P.M., the resident said he/she had a wound vacuum on his/her right leg stump (end of the leg where the bottom part of the leg had been amputated). Observation showed clear tubing visible from the resident's pant leg and attached to a small pump. Observation on 10/28/25 at 11:32 A.M., showed the resident sat at a table in the main dining room with his/her wound vacuum pump on the table next to him/her. He/She said the nurse was going to change the cannister today, but he/she did not know if the dressing was due to be changed or not. Review of the resident's TAR dated October 2025, showed:-A physician order to cleanse wound to right stump with wound cleanser, apply wet to dry dressing and wrap with kerlix everyday and when soiled, start date 10/3/25.--Documentation showed: Six out of 25 opportunities blank;-No physician orders a wound vac. During an interview on 10/24/25 at 12:50 P.M., Corporate Nurse F said she would expect staff to follow physician orders, and she would expect staff to document appropriately. A blank on the Medication Administration Record (MAR)/TAR meant there was an omission. If something was not</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 11/18/2025
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</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 11/18/2025
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to monitor a resident's nutritional status and effectiveness of interventions when staff failed to obtain admission weights and weekly weights as ordered for one resident with a diagnosis of severe protein calorie malnutrition upon admission (Resident #14). The sample was 16. The census was 166. Review of the facility's Weight Monitoring policy, dated 9/1/25, showed:-Based on the resident's comprehensive assessment, the facility will ensure all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;-Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period time) may indicate a nutritional problem;-The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes Identifying and assessing each resident's nutritional status and risk factors. Evaluating/analyzing the assessment information. Developing and consistently implementing pertinent approaches. Monitoring the effectiveness of interventions and revising them as necessary;-A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. Assessments should include the following: General appearance, height, weight, food and fluid intake, fluid loss or retention, laboratory/diagnostic evaluation;-Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible: Identified causes of impaired nutritional status. Residents' personal goals and preferences Resident specific interventions. Timeframe and parameters for monitoring. Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective, or a new cause of nutrition-related problems are identified;-Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the residents' assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status;-A weight monitoring schedule will be developed upon admission for all residents: Weights should be recorded at the time obtained. Newly admitted residents: Monitor for 4 weeks. If clinically indicated, monitor weekly or daily as recommended by the dietician or physician. All others- monitor weight monthly;-The newly recorded weight should be compared to the previous recorded weight. A significant change in weights is defined as: 5% change in one month (30 days); 7.5% change in 3 months (90 days); 10% change in 6 months (180 days);-The physician should be informed of a significant change in weight and may order nutritional interventions;-The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss;-The registered dietician or dietary manager should be consulted to assist with interventions. Actions are recorded in the nutrition progress notes;-Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate;-The interdisciplinary plan of care communicates care instructions to staff. Review of Resident #14's hospital record, showed:-Resident was alert and oriented to his/her name, has history of vascular dementia with behavioral disturbance;-Nutritional diagnoses: Severe chronic malnutrition related to dementia as evidenced by severe fat loss, severe muscle wasting, and less than 75% of estimated needs = 1 month (severe chronic);-Intervention/recommendations: Continue general diet. Provide Ensure high protein three times a day (TID);-On 8/22/25, resident seen for follow-up. By mouth intake is variable, overall less than 50% meals but consuming most Ensure as ordered. Weight decreased 2 pounds/1.7% since admission;-On 8/19/25, the resident weighed 111 pounds (lbs);-discharged on 8/26/25. Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 8/28/25, showed:-Resident was not able to complete the Brief Interview for Mental Status (assessment used to determine the cognition of residents);-No behaviors;-Set up or clean-up assistance required for eating;-Diagnoses included high blood pressure, non-Alzheimer's dementia, and malnutrition;-Weight: 114 lbs;-Nutritional approaches: Therapeutic diet. Review of the resident's care plan, in use at the time of the investigation, showed:-Focus: Resident has a potential nutritional problem related to his/her disease process related to his/her diagnosis of dementia. He/She is on a regular diet with thin liquids;-Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition;-Interventions: Monitor meal intakes and offer meal replacement if 50%.</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 11/18/2025
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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</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 11/18/2025
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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to provide the necessary behavioral health care services for one resident (Resident #14). The resident was admitted with a diagnosis of vascular dementia (type of dementia caused by damage to the blood vessels in the brain) with behavioral disturbances. The facility failed to administer the resident's psychotropic medications as ordered and accurately document the administration of the medication or refusal. In addition, the facility failed to code the resident's behaviors accurately by documenting no behaviors even though there were reports of behaviors such as refusals, hitting, and attempting to walk without assistance. The sample was 16. The census is 166. Review of the facility's Behavior Management policy, revised 8/1/25, showed: -Residents who exhibit behavioral concerns may require a behavior management care plan to ensure they are receiving appropriate services and interventions to meet their needs. The interdisciplinary team, including the family members, should develop a behavioral plan for each resident with identified behaviors through the Resident Assessment Instrument (RAI) process; -A behavior management plan can include a schedule of daily life events, which addresses the individuality of the resident. The plan should reflect the resident's personal preferences and usual routine, to the extent possible. The plan should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being; -Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions; -Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care; -The plan of care and behavior management plan should be reviewed at least quarterly for continued need of behavior management and appropriate interventions. Review of the facility's Use of Psychotropic Medication policy, revised 4/23/25, showed: -Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications; -The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis; -The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. Review of the facility's Medication Administration Policy, revised 2/7/24, showed: -Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection; -Report to the physician any medication side effects, or medications that are life sustaining or time critical that were not delivered within the allowable physician order parameters prior to administration of the next dose. Document in the progress notes any conversation with physician. Review of Resident #14's hospital record, for hospital admission date of 8/16/25, showed: -History of present illness: Resident was alert and oriented to his/her name, has history of vascular dementia with behavioral disturbance. When asked why he/she was brought to the hospital, resident replied, I like these puppies. Resident stated he/she lives with his/her mother and father. Staff stated they knew resident had violent tendencies, resident exhibits explosive behavior at night and he/she becomes paranoid and delusional. Staff stated the resident ripped the air conditioning unit off the wall last night and he/she was given Haloperidol (Haldol, antipsychotic medication) and then slept all night. Staff stated resident was squirting condiment bottles all over everyone, punched a couple of residents in the head, and punched a staff member in the throat. Staff stated resident was throwing objects taking objects off the wall and waving around a heavy cross with nails that was on the wall. Staff stated resident destroyed his/her room. Staff stated nothing was calming the resident down and he/she got an order for intramuscular (IM) Clonazepam (used to treat panic disorder), but they were not going to have this on hand until tomorrow. Staff stated resident was dangerous and very aware of his/her actions; -Behavioral Health progress note, dated 8/25/25, showed: -Primary Diagnosis: Severe vascular dementia with psychotic disturbance; -Assessment and Plan: Diagnostically unchanged. Depakote (medication used to treat seizures and can be used to treat psychosis) level returned to 37.7 (Normal range 50-125 micrograms). However, given his/her stability, I am not inclined to change the dose at this time. Improving overall. Has not required recent behavioral IM as needed medication. Continues to require 1:1 for patient safety due to frequently forgetting he/she has had</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 11/18/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 11/18/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection control when staff failed to use Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing) as recommended by the Centers for Disease and Prevention (CDC) and required by Centers for Medicare and Medicaid Services (CMS) for two out of two residents observed for wound care (Resident #2 and Resident #1) and when one resident's catheter drainage bag (a medical device that collects urine from a urinary catheter) lay on the floor (Resident #2). In addition, staff failed to cover food when transporting a cart of plated food onto the elevator. The sample was 16. The Census was 166. Review of the facility's Enhanced Barrier Precautions Policy, dated 4/13/25, showed:-An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/or indwelling medical devices (e.g. urinary catheters (a thin, flexible tube inserted into the bladder to drain urine) even if the resident is not known to be infected or colonized with a MDRO;-Implementation of EBP:-Make gowns and gloves available immediately near or outside of the resident's room; -PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room; -The infection preventionist (IP) will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.-High-contact resident care activities included transferring and wound care: any skin opening requiring a dressing. Review of the Facility's Catheter Policy, dated revised 8/1/25, showed:- Privacy bags will be available and catheter drainage bags will be covered at all times while in use;- Ensure drainage bag are located below the level of the bladder to discourage backflow of urine. 1. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/6/25, showed:-Cognitively intact;-Indwelling catheter;-Diagnoses included neurogenic bladder (the bladder does not empty properly due to a neurological condition), paraplegia (impairment in motor or sensory function of the lower extremities) and pressure ulcer (injury to the skin and/or underlying tissue, as a result of pressure or friction);-Other open area of the foot. Review of the care plan, in use at the time of survey, showed:-Focus: resident required EBP for indwelling catheter;-Goal: EBP will reduce the risk of transmission (spread) of known or unknown MDROs;-Interventions included:-EBP includes the use of gowns and gloves during high-contact resident care;-EBP to remain in place for the duration of the resident's stay or until resolution of the wound or removal of the indwelling medical device;-EBP will be utilized during high-contact resident care activities including but not limited to wound and/or indwelling device care. Review of the order summary report, dated 10/28/25, showed a physician order for EBP for indwelling medical device and wound. Gown and Gloves required for high-contact resident care activities every shift for isolation precautions, indwelling catheter, and wounds. Observation on 10/23/25 at 11:10 A.M., showed an EBP sign on the door. The resident lay in a low bed, with his/her catheter drainage bag touching the floor. Licensed Practical Nurse (LPN) B entered the resident's room, performed hand hygiene and put on gloves. Then he/she raised the bed and removed the resident's protective boot from his/her left foot and performed wound care. LPN B then assisted the resident to roll onto his/her side and performed wound care to the buttocks and back of his/her thighs. No gown was worn. Observation on 10/23/25 at 3:50 P.M., showed the resident lay in his/her low bed. The catheter drainage bag lay on the floor, parallel to the bed. Observation and interview on 10/24/25 at 9:08 A.M., showed the resident lay in his/her low bed. The catheter drainage bag was half full, and lay on the floor. Certified Nurse Aide (CNA) I said the drainage bag should not be sitting on the floor and it should be in a privacy bag. He/She was not sure where the privacy bags were located. During an interview on 10/24/25 at 2:55 P.M., Certified Medication Technician (CMT) Q said catheter drainage bags should not touch the floor. Central supply had privacy bags. During an interview on 10/24/25 at 3:15 P.M., LPN E said catheter drainage bags should not sit or lie on the floor. If the drainage bag was touching or lying on the floor, it could be pulled or ran over. Also, there could be a risk for infection. During an interview on 10/24/25 at 3:25 P.M., the Director of Nursing (DON) said if a catheter drainage bag was touching the floor, staff should place it in a wash basin. 2. Review of Resident #1's quarterly MDS, dated [DATE], showed:-Short and long-term memory loss;-Dependent on staff for all activities of daily living (ADL) and transfers;-Indwelling catheter;-Diagnoses included obstructive</p>		