STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265318	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Maryland Heights	2920 Fee Fee Road Maryland Heights, MO 63043

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to follow their Abuse Policy when they failed to notify the Department of Health and Senior Services (DHSS) following an allegation one resident was hit by a staff (Resident #1). The sample size was five. The census was 200. Review of the facility's policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, revised on 2/1/23, showed:-Definition: Abuse, Neglect, Misappropriation of Patient Property and exploitation, as hereafter defined, will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, visitor or any other individual in this center. The patient has the right to be free from abuse, neglect, misappropriation of patient property, and exploitation;-The facility administrator is responsible for assuring that patient safety, including freedom from risk of abuse or neglect, holds the highest priority;-Physical Abuse: includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment;-The facility will seek and accept complaints from patients, patient families and partners without reprisal;-Any patient event that is reported to any partner by patient, family, other partner or any other person will be considered an allegation of either abuse, neglect, misappropriation of patient property or exploitation if it meets a criteria, including this any instances of hitting, slapping, pinching, or kicking or other potentially harmful action;- Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect, misappropriation of patient property or exploitation must report the event immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in abuse or serious bodily injury;-All allegations of possible abuse, neglect, misappropriation of patient property or exploitation will be immediately assessed to determine the appropriate direction of the investigation;?-Patients will be protected from harm during an investigation;-Partner(s) suspected of taking actions that would cause potential harm to a patient or other patients will be immediately placed on administrative leave pending result of investigation. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/26/25, showed:-Severely impaired cognition;-No hallucinations or delusions;-Verbal behavioral symptoms directed toward others, occurred one to three days;-No rejection of care;-No wandering;-Impairment of both lower extremities;-Dependent on most activities of daily living (ADLs)-Diagnoses included heart disease, high blood pressure, diabetes, dementia, anxiety disorder, bipolar disorder, and Schizophrenia (a serious mental health condition that affects how people think, feel and behave); Review of the resident's progress notes dated 3/30/26 at 6:56 A.M., showed Registered Nurse (RN) E documented he/she was informed by the resident's assigned staff the resident bumped his/her face on the dresser while getting dressed. The resident wanted to sit up while in bed and hit his/her face on the dresser. There was a small red spot by right eye and dark purple bruise to under right eye. The resident's responsible party (RP) was notified and wanted the resident to be sent to the hospital. At 7:29 A.M., Licensed Practical Nurse (LPN) A's documentation showed the resident's RP said that the resident was not responding as he/she normally would when RP spoke with him/her on the phone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RP wanted the resident to be sent to the hospital for further evaluation related to the event that morning. Review of the hospital emergency room (ER) records, dated 3/30/26 at 10:52 A.M., showed the physician documented the resident presented to the ER after a report of a fall. The resident reported that he/she may have been assaulted and was reported to the state by nursing. The resident and his/her family were comfortable of returning to the facility. Review of the resident's progress notes dated 3/31/26 at 11:34 A.M., showed the Nurse Practitioner (NP) documented the following:-Resident wanting to sit up himself on the bed to get dressed, not being steady and subsequently falling over and hitting face on dresser on 3/30/26; -Resident family wanted him/her sent out thinking he was not responding as usual;-At ER (emergency room) the resident reported nurse punching him in the eye;-The resident returned to the facility and told staff someone in a red hat or having red hair hit him/her in the eye, then later told another staff member somebody poked him/her in the eye. During an interview with the Administrator and the Director of Nursing (DON) on 4/1/26 at 9:06 A.M., the Administrator said they did not report the incident because they knew what happened that caused the resident's bruising in the eye. It was not related to abuse. They did not receive a call from the hospital, but they had access to the hospital records. The DON showed the hospital records with documentation stating the hospital staff contacted the DHSS for possible abuse. The Administrator said the resident's family came to the facility on 3/31/26, during their care plan meeting with a police officer. After explaining the incident, the police officer left with no report filed. The Administrator and DON continued to claim it was not necessary to report an abuse allegation to DHSS because the resident's description of the staff who allegedly hit him/her did not match to any of the staff in the facility. Observation and interview on 4/1/26 at 10:15 A.M., showed the resident had bruising on the right eye. The resident said a night shift staff hit him/her in the eye. He/She did not know the name, but the staff was a white female with short, reddish black hair with red tint. The resident said he/she did not tell anyone except his/her daughter because he/she did not like when people talked too much about it. He/She liked the staff and living in the facility until the incident happened. He/she still felt safe at the facility, but he/she wanted to leave. During an interview on 4/1/26 at 10:28 A.M., Licensed Practical Nurse (LPN) A said on 3/30/26, he/she received a report from the night shift nurse the resident hit his/her right eye on the bedside dresser during care, when he/she leaned on the right where the dresser was located. LPN A did not suspect any abuse or anyone hitting the resident. During an interview on 4/1/26 at 10:46 A.M., Certified Nurse Assistant (CNA) B said he/she did not get report from the night shift at the time of the incident. He/She heard from other staff the resident hit his/her eye on something at the bedside. At 10:50 A.M., CNA C said when he/she asked the resident about the bruising on his/her right eye, the resident said he/she fell, then changed his/her statement and said somebody hit him/her. When CNA C asked the resident further, he/she said, Oh, maybe I fell. The CNA said he/she notified the nurse. During an interview on 4/1/26 at 12:20 P.M., the Administrator said CNA F was caring for the resident the morning of 3/30/26. The resident rolled to the side when the CNA tried to sit him/her up, then hit his/her head on the dresser. They started an investigation because they found out the hospital reported to DHSS but had no details of what the report was. When the resident's family arrived at the facility for the scheduled care plan meeting, they were surprised a police officer also arrived. The family was upset because the facility did not communicate well to them. The police officer did not file a report. The Administrator said there was no abuse incident and agreed that she should have at least called for an FYI (for your information) or did a facility-reported incident. During an interview on 4/1/26 at 12:47 P.M., the DON said he talked to the resident when he/she returned from the hospital. The resident told him he/she hit his/her head on the dresser. The DON again talked to the resident on 4/1/26 with the same statement. A staff told him on 4/1/26 the resident mentioned someone hitting him/her. When asked how he followed-up the staff's report, the DON said he would make sure the resident was safe. No mention of reporting the allegation to DHSS. At 12:57 P.M., the DON talked to the resident per surveyor's request. Observation showed the resident told the DON that he/she was hit by a staff and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated with the same physical description. At 1:04 P.M., the DON said it was the first time the resident told him that story. He said the resident did not feel threatened. During an interview on 4/1/26 at 2:28 P.M., RN E said on 3/30/26 at approximately 5:00 A.M., CNA F reported when he/she sat the resident on the side of bed while getting the dressed, the resident fell sideways and hit his/her face on the nightstand. There was a small nick above the right eye and slight bruising. The resident did not make any statements of someone hitting or punching him/her. The RN said the CNA had provided care to the resident for many weeks and never had allegations of any abuse. He/She did not think CNA F would hit or was capable of hitting the resident. If there's a suspicion of abuse, he/she would assess the residents and would report to the DON. He/She would then follow the DON's instructions on what to do next. During an interview on 4/1/26 at 2:39 P.M., CNA F said on 3/30/26 at approximately 6:15 A.M., he/she was getting the resident up. While putting his/her pants on, the resident was trying to get up. The CNA told the resident to stop multiple times, then the resident leaned to the right side and hit his/her head on the nightstand. The CNA said he/she never hit or abused any residents during the many years as a CNA. He/She would report to the nurse for any suspicion of resident abuse. The CNA added on 3/30/26, the DON asked him/her to write a statement regarding the incident because there was an allegation the nurse hit the resident. During an interview on 4/1/26 at approximately 3:30 P.M., the Administrator said she should have called or reported the incident to DHSS. 29682932968713