

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/05/2025
NAME OF PROVIDER OR SUPPLIER  Garden View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Garden Path O Fallon, MO 63366	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Based on observation, interview and record review, the facility failed to ensure four residents (Resident #7, Resident #2, Resident #5 and Resident #10), in a review of eleven sampled residents, were free from sexual abuse. Resident #11 demonstrated a pattern of sexual behaviors with residents without the capacity to consent to sexual activity. Staff found Resident #11 in Resident #7's room with his/her hands down Resident #7's pants and in the resident's perineal area, Resident #11 touched and rubbed Resident #2's breasts, kissed Resident #5 on the mouth twice, and grabbed Resident #10 by his/her hands, pulled the resident to him/her and groped his/her breast. The facility census was 70. Review of the undated facility policy, Abuse Prevention Program, showed the following:-Policy Statement: Residents have the right to be free from abuse. This includes, but is not limited to, freedom from sexual abuse;-Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will:-Protect residents from abuse by anyone including, but not necessarily limited to other residents;-Develop and implement policies and procedures to aid our facility in preventing abuse;-Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, and handling verbally or physically aggressive resident behavior;-Identify and assess all possible incidents of abuse. Review of the facility policy, Abuse and Neglect, Clinical Protocol, revised November 2024, showed the following:-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish;-Sexual Abuse was defined as non-consensual sexual contact of any type with a resident;-Willful was defined and as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the undated facility policy, Capacity to Consent, showed the following:-Purpose: To ensure residents are evaluated for the capacity to consent; -The residents have the right to, and the facility must promote and facilitate resident self-determination through support of resident choice;-Residents have the right to engage in consensual sexual activity; however, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity; the facility must ensure the resident is evaluated for capacity to consent;-Residents without the capacity to consent sexual activity may not engage in sexual activity;-Policy: If a resident expresses the desire to engage in consensual sexual activity, the facility must evaluate the resident for the capacity to consent; This can be done by the following:-Physician evaluation;-Completion of the Capacity to Consent Assessment Form;-Indications of potentially diminished capacity are:-Diagnosis of Dementia/Alzheimer's or other related cognitive impairment; -Documentation in the medical record from a family member or person well acquainted with the resident that resident has symptoms of cognitive impairment or dementia;-Other psychiatric diagnosis that could impair resident's decision making ability;-Noted confusion, forgetfulness or difficulty communicating. 1. Review of Resident #11's undated face sheet showed the following:-admission date of 08/18/25;-The resident's family member was his/her personal representative;-Diagnoses included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking reasoning, and problem-solving) with agitation (a behavioral symptom characterized by feelings of emotional distress, restlessness, and difficulty staying calm, which can manifest as verbal or physical aggression) and mood disturbance, major depressive disorder (MDD) with psychotic symptoms (a severe form of depression characterized by the presence of psychotic symptoms such as delusions and hallucinations, in addition to the classic symptoms of depression) and manic episodes (a period of abnormally elevated mood, energy, and activity levels that lasts for at least one week). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/26/25, showed the following: -Significantly impaired cognition;-No documentation the resident exhibited any physical behavior directed toward others (e.g. sexual behaviors);-Used a wheelchair for mobility. Review of the resident's care plan, revised on 09/04/25, showed the following:-He/She can be overly friendly and affectionate to staff and/or residents of the opposite sex;-He/She was able to change position in bed by self; may require supervision to moderate assist to get to the edge for transfer;-He/She required supervision to moderate assistance by one staff for transfers as requested and as necessary; up to wheelchair; -His/Her family reports that he/she was a very loving person with a history of behaviors of trying to kiss other residents/staff; he/she loved to blow kisses, hold hands and sweet talk; the resident reported his/her favorite hobby is chasing the opposite sex; -He/She has a history of wandering in/out of other residents' rooms;-Staff to provide reminders to keep his/her hands to himself/herself if he/she attempted to kiss them.-If reasonable</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to report allegations of sexual abuse to the state agency for three residents (Resident #2, Resident #5, and Resident #10), in a review of 11 sampled residents when staff witnessed and documented sexual abuse. Resident #11 demonstrated a pattern of sexual abuse behaviors with residents without the capacity to consent to sexual activity. Staff witnessed Resident #11 rub Resident #2's breasts, kiss Resident #5 on the mouth twice, and grab Resident #10 by his/her hands, pull the resident to him/her and grope the resident's breast. Further review showed the facility did not report these incidents to the resident representatives for Resident #2, #5 or #10 as facility policy directed. The facility census was 70. Review of the undated facility policy, Abuse Prevention Program, showed the following:-Report any allegations of abuse within timeframes as required by federal requirements;-The Administrator has the overall responsibility for the coordination and implementation of our facility's abuse prevention program policies and procedures. Review of the facility policy, Abuse and Neglect, Clinical Protocol, revised November 2024, showed the following:-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish;-Sexual Abuse was defined as non-consensual sexual contact of any type with a resident;-Willful was defined and as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the undated facility policy, Freedom from Abuse, Neglect and Exploitation - Investigation and Reporting, showed the following:-At the facility, all reports of resident abuse shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported;-All personnel are to report any signs and symptoms of abuse to their supervisor or to the Director of Nursing Services immediately;-If the alleged abuse involves another resident, the accused resident's representative and attending physician will be informed of the alleged abuse incident and that there may be restrictions on the accused resident's ability to visit other resident rooms unattended;-Should the results indicate that abuse occurred, appropriate authorities will be notified;Reporting:-All alleged violations involving abuse will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:a. The State licensing/certification agency responsible for surveying/licensing the facility;c. The Resident's Representative of Record;-Suspected abuse will be reported within two hours;-Alleged abuse will be reported within two hours if the alleged events have resulted in serious bodily injury; a. If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours;-Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone;-Notices will include, as appropriate: a. The name of the resident; b. The number of the room in which the resident resides;c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.);d. The date and time the alleged incident occurred;e. The name(s) of all persons involved in the alleged incident; and f. What immediate action was taken by the facility. Review of the undated facility policy, Capacity to Consent, showed the following:-Purpose: -To ensure residents are evaluated for the capacity to consent; -The residents have the right to, and the facility must promote and facilitate resident self-determination through support of resident choice;-Residents have the right to engage in consensual sexual activity; however, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent;-Residents without the capacity to consent to sexual activity may not engage in sexual activity;-Policy: -If a resident expresses the desire to engage in consensual sexual activity, the facility must evaluate the resident for the capacity to consent; This can be done by the following:-Physician evaluation;-Completion of the Capacity to Consent Assessment Form;-Indications of potentially diminished capacity are:-Diagnosis of Dementia/Alzheimer's or other related cognitive impairment; -Documentation in the medical record from a family member or person well acquainted with the resident that resident has symptoms of cognitive impairment or dementia;-Other psychiatric diagnosis that could impair resident's decision making ability;-Noted confusion, forgetfulness or difficulty communicating. 1. Review of Resident #11's undated face sheet showed the following:-admission date of 08/18/25;-The resident's family member was his/her personal representative;-Diagnoses included: dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking reasoning, and problem-solving) with agitation (a behavioral symptom characterized by feelings of emotional distress, restlessness, and difficulty staying calm</p>		