STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265341	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillars of North County Health & Rehab Center, The	13700 Old Halls Ferry Road Florissant, MO 63033

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure for the Abuse Prevention Program to ensure one resident's safety when staff failed to report an abuse allegation immediately to administration for one of four sampled residents (Resident #2). The census was 64.Review of facility policy and procedure for Abuse Prevention Program dated 9/29/22, showed: -Internal reporting requirements and identification of allegations;-Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator. Review of Resident #2's medical record, showed:-Diagnoses included dementia, heart failure, mood disturbance, anxiety and psychotic disturbance;-Admitting nursing assessment dated [DATE], resident is alert and oriented to person, place, and time. Review of facility's investigation of sexual abuse allegation for the resident, dated 9/4/25 at 9:00 P.M., showed the resident's family called police for allegations against Certified Nurse Assistant (CNA) G for sexual abuse. When police arrived the family member said she had called about a wellness check and was not aware of the sexual abuse allegation until CNA H brought it up after he/she called the police. The investigation showed the allegation happened on 9/3/25 and CNA G, CNA H, CNA I said they did not report it because they did not believe it happened. The resident was interviewed and denied the sexual abuse allegation. During an interview on 9/8/25 at 8:43 A.M., the Director of Nursing (DON) said they were not informed of the sexual abuse allegation until staff told the resident's family member, who is not the resident's Power of Attorney (POA), then family had called police. CNA H said the family member came up to the nursing desk and said he/she was calling the police about the resident. CNA H assumed it was in reference to the resident's allegation of sexual abuse from 9/4/25, but in fact the family member called police for a wellness check because he/she could not get staff to change him/her. The family member went outside to call the police and upon him/her reentering the facility, accompanied by the police, CNA H told the family member about the allegation from the day prior, and this was the first time the family heard anything about the allegation. Staff notified the Assistant Director of Nursing (ADON) who called the DON about the allegation. This was the first time administrative staff heard about the allegation. The DON said as soon as she was notified, she came to the facility. Upon arrival, the police, the resident, and the resident's family were present. The investigation started immediately, and the resident denied the allegation happened and said no one has ever touched him/her inappropriately. The resident's POA was notified, and he/she refused to have the resident sent to the hospital for evaluation. The investigation showed CNA G was assisting the resident to bed and the resident accused him/her of sexual assault. CNA G said as soon as the resident accused him/her, he/she walked out of the room and told CNA H and CNA I what the resident said, and they went into the resident's room and assisted him/her back to bed. When they asked the resident why he/she said CNA G sexually assaulted him/her, he/she said he/she did not like staff of the opposite sex taking care of him/her, so he/she made the allegation. The DON said she interviewed CNA G, CNA H, and CNA I separately and they all responded that they felt like the situation had been resolved and they knew nothing had happened. CNA G said, I just left the room and walked out, and they walked in, and I felt like it was over. The DON started the investigation immediately, reported the incident to the state and started education with staff on abuse reporting. She expected staff to have reported this incident immediately and not have waited over 24 hours to report the incident. During an interview on 9/8/25 at 10:01 A.M., the resident's family member said while he/she was visiting the resident, he/she called the police on 9/4/25 around 8:00 P.M. for a wellness check because the resident was soiled, and he/she had asked the staff several times to come and change the resident. When police arrived, CNA H told the resident's family member about the resident accusing CNA G of sexual abuse and it was not true. 2608912

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide services that meet professional standards when the facility failed to follow physician orders for one of four sampled residents (Resident #1). The facility did not provide adequate enteral gastrostomy tube (g-tube, a feeding tube inserted into the stomach for resident nutrition, fluids and medications) management, which led to resident weight loss. The census was 64Review of the facility's Enteral Nutrition Policy and Procedure, dated 3/28/25, showed: Adequate nutritional support through enteral feeding will be provided to residents as ordered;-If a resident has an enteral feeding tube placed prior to admission or returning to the facility, the Physician and interdisciplinary team (a team that consists of at least a physician, nursing and dietary), will review the rational for the placement of the enteral feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident;-The nursing staff and physician will monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia (low or high blood sugars), altered electrolytes. The nursing staff and physician will also monitor the resident for worsening of condition that place the resident at risk;-Staff caring for the residents with enteral feeding tubes will report complications associated with the insertion and/or use of the feeding tube such as: -Aspiration (inhalation of food or liquid into the airway and lungs); -Leaking and skin breakdown around insertion site; -Perforation of the stomach or small intestine leading to peritonitis (inflammation or infection of the peritoneum, the tissue lining the abdominal cavity); -Esophageal (throat) swelling, strictures (abnormal narrowing or constriction of a bodily passage or opening), fistulas (abnormal tunnel or connection that forms between two body parts); -Clogging of enteral feeding tube;-Staff caring for residents with enteral feeding tubes will recognize and report complications relating to the administration of enteral nutrition products, such as: -Nausea, vomiting, diarrhea and abdominal cramping; -Inadequate nutrition; -Metabolic abnormalities (condition when the body's chemical process, that creates and uses energy, is disrupted, leading to the accumulation or lack of the bodies essential substances that can cause harm to the body); -Interactions between feeding formula and medications; -Aspiration;-Risk of aspiration will be assessed by the nurse and physician and addressed in the individual care plan. Risk of aspiration may be affected by: -Diminished level of consciousness; -Moderate to severe swallowing difficulties; -Improper positioning of the resident during feeding; -Failure to confirm placement of enteral feeding tube prior to initiating the feeding;-No policy and procedures to check residual of enteral feeding, height of resident position during enteral tube feeding, how to confirm enteral feeding tube placement, and how often residual should be checked. Review of Resident #1's medical records, showed:-admitted to facility on 7/31/25 at 7:54 P.M.;-Medical history: cerebral infarction (stroke), hemiplegia of non-dominant left side (paralysis), aphasia (difficulty speaking), myocardial infarction (heart attack), severe protein-calorie malnutrition, gastrostomy status (g-tube);-Resident is alert and oriented to name, place and time;-Resident weight at hospital, prior to admitting to facility, 81 pounds (lbs). Review of the resident's progress notes, showed:-7/31/25 at 8:58 P.M., resident is alert and oriented to person, place, time, and event (A&O x 4), able to verbalize needs. Resident is nothing by mouth (NPO) currently, has a history of strokes and falls. Resident stated he/she was walking before a recent fall. Some discomfort noted during care this shift. Left hand edema noted, extremity elevated. Resident has a Foley catheter (drains and collect urine from the bladder when a person cannot urinate on their own), urine is draining to gravity. Incontinent of bowel and bladder. Last bowel movement 7/31/25. Bony prominence noted. Small pressure sore noted to sacrum/coccyx (lower back/bottom). Treatment is dry and intact. G-tube noted, no bleeding/redness. Other skin is dry and intact. Heels are soft and clear currently. Boots are being worn. Vitals taken and recorded. Medications sent to Medical Director for verification. Resident is in bed, head of bed (HOB) elevated, bed in low position, resident educated on use of call light, call light is within reach. -8/1/25 at 2:17 A.M., resident is a new admit. Resident is alert to self and location. Resident is NPO, g-tube patent and intact. No facial grimacing. No signs or symptoms of pain. Foley intact and draining with gravity. Assisted activities of daily living (ADLs), temperature (T) 97.4.-8/2/25 at 12:18 A.M., resident is alert and oriented and voices no complaints of pain or discomfort. He/She receives and tolerates continuous tube-feeding with no noted distress. Resident is resting well and tolerates being turned and reportioned every two hours with HOB up at 45 degrees. Review of the resident's physician orders, showed:-Order dated 8/5/25, resident diet, NPO;-Order dated 8/13/25, weekly weights to monitor resident weight due to g-tube feedings, scheduled for Wednesdays between 7:30 A.M. and 3:00 P.M.;-Order dated 8/13/25, g-tube, flush