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	06/04/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow appropriate discharge procedures for one resident (Resident #6) when staff failed to re-admit the resident from the hospital following an immediate discharge order dismissal. The sample size was six. The census was 58. Review of the facility's Immediate Discharge Policy & Procedure Manual, revised November 2017, showed:-Residents would not be transferred or discharged unless permitted by federal and Missouri regulations. An immediate discharge occurred when the safety or health of the resident or others was endangered, when the facility could not meet the resident's needs, or when the resident's behavior presented an immediate threat;-Purpose: To ensure immediate discharges were conducted safely, consistently, and in compliance with survey requirements;-Criteria:-Immediate danger to self or others;-Violent, aggressive, or threatening behavior;-Repeated unmanageable behaviors;-Facility unable to meet the resident needs;-Medical or psychiatric emergency required another level of care;-Procedure: -Assessed resident condition; -Notified Administrator and Director of Nursing (DON); -Obtained physician notification/order when appropriate; -Notified resident and responsible party; -Arranged safe discharge destination; -Provided discharge instructions and medications as applicable; -Completed all required documentation;-Required documentation: -Immediate Discharge Notice; -Progress Notes; -Nursing Assessment; -Physician Notification; -Responsible Party Notification; -Transfer Documentation; -Agency Notifications (if applicable);-Discharge appeal rights: Residents would be informed of applicable rights and provided information regarding state agencies when required by regulation. Review of Resident #6's hospital referral assessment plan, dated 04/15/26, showed:-admitted on [DATE];-Active problems: Adjustment disorder with mixed disturbance of emotions and conduct, depression (a serious mood disorder that caused persistent feelings of sadness, emptiness, and a loss of interest in activities), anxiety (chronic, exaggerated worry and tension about everyday events, often with no obvious cause), history of substance use disorder, chronic lower extremity wounds and colostomy (surgical procedure that creates an opening, called a stoma, in the abdominal wall); -Psychiatry evaluated the resident on 04/05/26 and prescribed Remeron (antidepressant primarily used to treat major depressive disorder.) and Zoloft (antidepressant medication). The resident refused to take the medications. The medications were discontinued;-Case management assisted with discharge planning due to the resident's reported abuse at the nursing home. Nursing home staff reported threats from the resident and refused to take him/her back;-The resident was deemed incompetent in May 2024 and had a legal guardian;-Disposition: Pending placement. Review of the resident's progress notes, showed:-On 04/21/26 at 1:13 P.M., the resident arrived at the facility in a wheelchair. His/Her diagnoses included stasis ulcers (a shallow, slow-healing open wound that develops on the lower legs or ankles) and adjustment disorder with disturbance of emotions and conduct. At 2:30 P.M., the resident refused wound care. The physician was notified. Review of the resident's care plan, in use during survey, showed:-Problem: The resident was at risk for alteration in mood and/or psychosocial well-being due to being in a new facility and adjustment disorder with mixed disturbance of emotions and conduct (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(start date: 04/22/26);-Approach: Staff conducted one-to-one visits and/or bedside socialization/activities as needed, consulted with practitioner for changes in mood or psychosocial status, encouraged the resident to socialize with other residents and attend activities, observed changes in mood and sleep patterns, changes in behavior, weight loss, crying episodes, nervousness, and provided opportunities for expression of feelings;-Problem: The resident could not be discharged to the community. He/She required 24-hour care (start date: 04/22/26);-Approach: Staff provided one-to-one visits as needed, call light within reach while in room, assisted the resident's family and friends as needed. Review of the resident's progress notes, showed:-On 04/24/26 at 9:22 P.M., the resident was outside a female resident's room. He/She yelled I got something I can put in you that feels really good. Staff educated the resident on inappropriate behaviors and tried to redirect him/her. The resident continued to call female staff bitches. Staff left a message for the physician. The resident did not display violent behaviors or threatening gestures;-On 04/25/26 at 5:57 P.M., the resident was belligerent towards staff. He/She made demeaning statements and used profanity. Staff redirected the resident;-On 04/30/36 at 2:46 P.M., staff attempted to provide wound care to resident. The resident said, I'm getting the fuck out of here and propelled down the hall in his/her wheelchair. The physician was notified. No new orders given. Review of the resident's care plan, in use during survey, showed:-Problem: The resident was verbally abusive, socially inappropriate, disruptive and resisted care. He/She made inappropriate drawings of his/her penis and told staff he/she was going to fuck them in the butt. He/She made inappropriate sexual advances towards staff and residents. He/She was non-compliant with wound and dressing changes. He/She ejaculated in the dining room in front of other residents (start date: 05/01/26);-Approach: Staff encouraged family support and/or involvement, encouraged the resident to vent his/her feelings, fears, and frustrations as needed, encouraged him/her to participate in activities of choice, notified the physician as needed, observed involvement in activities, provided medications as ordered and monitored effectiveness, and consulted the psychiatrist as needed. Review of the resident's progress notes, showed on 05/02/26 at 10:45 A.M., the resident displayed erratic behaviors. He/She refused medications. He/She made inappropriate statements to female residents in the dining room. He/She argued with staff and other residents. Staff tried to redirect him/her and use one to one, with no effectiveness. The resident refused PRN (as needed) behavior medications. The physician gave an order to send the resident to the hospital for a psychiatric evaluation. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/03/26, showed:-The resident could not complete the cognitive assessment;-Displayed disorganized thinking;-Physical behaviors towards others;-Diagnoses: Pain and chronic venous insufficiency (occurred when the veins in the legs did not efficiently return blood to the heart);-No therapy services. Review of the resident's progress notes, showed:-On 05/03/26 at 5:59 P.M., the resident told staff and other residents Somebody is going to die in this bitch today. He/She removed his/her clothes in the dining room and swung his/her colostomy bag. He/She threatened to throw feces on staff and other residents. Staff redirected the resident with limited effectiveness. Staff modified the environment to reduce stimulation. No physical contact or injuries noted to others. Staff notified the supervisor, physician and guardian. The guardian did not answer. The physician gave an order to send to the hospital for psychiatric evaluation;-On 05/11/26 at 2:45 P.M., the resident returned to the facility. He/She was upset his/her room was changed;-On 05/12/26 at 12:10 P.M., the physician assessed the resident. The resident wanted to do his/her own wound treatments for his/he bilateral, lower leg wounds. The nurse educated the resident on how to complete wound treatments. The physician gave approval for the resident to do his/her own wound treatments;-On 05/17/26 at 12:24 A.M., the resident masturbated in the dining room. Staff asked him/her to go to his/her room. The resident was angry and yelled. The resident was provocative (to cause a strong emotional, mental, or physical reaction) and inappropriate with staff during the night shift. Staff were unable to redirect the resident. At 2:22 A.M., the resident yelled and threatened staff. He/She wrote explicit letters to staff. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She went into other residents' rooms while they slept. Staff were unable to redirect the resident. Staff notified the physician at 2:20 A.M. The resident was sent to the hospital for a psychiatric evaluation. Staff left a message for the resident's guardian. At 1:52 P.M., the resident returned to the facility with new medication orders. At 6:34 P.M., the resident propelled around the facility and yelled provocative and inappropriate things at staff and residents. Staff attempts to redirect the resident were unsuccessful. At 9:07 P.M., the resident was aggressive and verbally abusive towards staff. Staff attempts to redirect the resident were unsuccessful. The physician gave an order to send the resident to the hospital. The resident was transferred to the hospital for a psychiatric evaluation and treatment at 9:00 P.M.;-No documentation regarding the resident's discharge. Review of the Immediate Notice of Discharge, dated 05/17/26, showed:- The facility determined the resident's behaviors created concerns regarding the health, safety, and welfare of the resident and/or others. The facility was unable to meet the resident's needs safely at this level of care. Transfer to the hospital was necessary for further evaluation, treatment, and stabilization. The resident was transferred with available medical information and personal belongings as appropriate. Review of the Department of Health & Senior Services (DHSS) Appeals Unit Order of Dismissal, dated 05/22/26, showed:-The immediate discharge notice failed to contain: -The resident's right to appeal the transfer or discharge notice to the director of the DHSS or his/her designated hearing official within 30 days of the receipt of the notice; -That a request for hearing should be sent to the DHSS Appeals Unit, the Appeals Unit address, phone/fax number and email address; -The location to which the resident was being transferred or discharged ; -The name, address and telephone number of the designated regional long-term care ombudsman (an impartial, designated official or representative who investigated and helped resolve complaints between individuals and large institutions) office; -For Medicare and Medicaid certified facility residents with developmental disabilities, the mailing address and telephone number of the Missouri Protection and Advocacy Agency, or the current address and telephone number of the protection advocacy agency if it has changed; -The facility's discharge of the resident was dismissed due to inadequate notice. The resident could remain at the facility. If the resident was discharged , based upon the defective notice, the facility was directed to allow the resident to return to the facility; -A copy of the notice was sent to the resident, Administrator, ombudsman and hospital social worker. During an interview on 06/02/26 at 2:20 P.M., the hospital social worker said the resident was transferred to the hospital from another hospital. The resident's guardian filed an appeal of the discharge. The Appeals Unit dismissed the discharge. The facility refused to allow the resident to return. The facility said they would take the fine. The resident remained at the hospital. He/She was not aggressive but yelled racial slurs at staff. During an interview on 06/04/26 at 1:54 P.M., the Administrator, DON and Social Worker said they were not aware of the resident's behaviors prior to admission. The resident's medication was adjusted. The psychiatrist said the medication would not help the resident. They did not send any referrals prior to discharge. They did not contact the ombudsman for assistance. The Administrator typed the immediate discharge notice. Staff called him/her at home, and she quickly typed the letter. She was aware of the immediate discharge notice requirements. She received the order of dismissal. She did not take the resident back due to safety concerns for staff and residents. 3021042