STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265343	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Villa Wellness & Rehabilitation	850 Country Manor Lane Creve Coeur, MO 63141

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards of practice when staff failed to administer physician-ordered medications to 10 residents (Resident #8, #6, #4, #7, #17, #5, #9, #10, #2, and #3). The sample was 17. The census was 80.Review of the facility's Physician Orders policy, revised 6/2020, showed: -Purpose: This will ensure that all physician orders are complete and accurate;-Policy: The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary;-Procedure:--Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline;--Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the Medication Administration Record (MAR)/Treatment Administration Record (TAR). Review of the facility's General Guidelines for Medication Administration policy, revised 8/2020, showed:-Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-Administration: Medications are administered in accordance with written orders of the prescriber;-Documentation (including electronic):--The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications;--The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross-referenced to a full signature in the space provided;-- If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a starter dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If three consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response;--If an electronic MAR system is used, specific procedures required for resident identification, identification of medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	described in the system's user manual. These procedures should be followed and may differ slightly from the procedures for using paper MARs. Electronic systems also describe procedures for secure access, maintaining privacy of resident information, and for electronic signatures. Maintenance and support procedures for these systems are described in the system user manuals. Procedures will vary between the various electronic systems available. 1. Review of the facility's Resident Council Meeting Minutes, dated 2/19/26, showed resident concerns that they are not receiving medication timely and doses are being missed. 2 Review of Resident #8's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/6/25, showed:-Cognitively intact;-Diagnoses included heart failure, morbid obesity, anxiety, chronic pain syndrome, high blood pressure, muscle weakness, and right knee pain. Review of the resident's care plan, dated 12/9/25, showed:-Problem: Anticoagulant (blood thinning medication) use;-Goal: Resident will have not noted bleeding through the next review;-Approach: Administer medication as ordered. Review of the resident's February 2026 MARs, dated 2/1/26 through 2/24/26 showed:-An order, dated 4/20/25, for Eliquis (blood thinning medication) 5 milligrams (mg), twice daily;--MAR blank with no documentation that Eliquis was administered on morning of 2/10/26, 2/11/26, and 2/19/26, or at night on 2/2/26, 2/3/26, and 2/9/26;-An order, dated 12/28/25, for Lasix (used to treat excess fluid retention (swelling)) 20 mg, administer two tablets once in the morning, give 40 mg daily;--MAR blank with no documentation that Lasix was administered on 2/11/26, 2/17/26, 2/18/26, and 2/19/26;-An order, dated 11/21/25, for Vitamin B-12 500 micrograms (mcg), two tablets equaling 1,000 mcg once a day;--MAR blank with no documentation that Vitamin B-12 was administered on 2/5/26, 2/10/26, 2/11/26, 2/15/26, and 2/18/26;-An order, dated 3/10/26, for Vitamin D3 125 mcg, administer one tablet daily;--MAR blank with no documentation that Vitamin D3 was administered on 2/5/26, 2/10/26, 2/11/26, 2/15/26, and 2/18/26;-An order, dated 12/1/25, for potassium chloride extended release (ER) 10 milliequivalent (mEq), administer once daily for congestive heart failure;--MAR blank with no documentation that potassium chloride was administered on 2/5/26, 2/10/26, 2/11/26, 2/15/26, and 2/18/26;-An order, dated 1/8/26, for Aspercreme (lidocaine, pain reliever) adhesive patch, medicated; 4 percent (%), administer one patch twice a day, apply to left shoulder in the morning (AM) and off at hour of sleep (HS);--MAR blank with no documentation that Aspercreme adhesive patch was applied in AM on 2/10/26, 2/11/26, 2/17/26, 2/19/25, and 2/22/26, or removed HS on 2/2/26, 2/6/26, 2/8/26, 2/11/26, 2/15/26, and 2/22/26;-An order, dated 12/26/25, for famotidine (used to treat heartburn) tablet 20 mg, twice daily at AM and evening (PM);--MAR blank with no documentation that famotidine was administered in AM on 2/10/26 and 2/11/26, or at PM on 2/2/26 and 2/9/26;-An order, dated 11/20/25, for ondansetron (used to prevent nausea) hydrochloride (HCl) tablet 4 mg, administer twice daily, take one tab in AM and HS;--MAR blank with no documentation that ondansetron was administered in AM on 2/10/26 and 2/11/26, or at HS on 2/2/26, 2/9/26, 2/17/26, and 2/24/26;-An order, dated 3/10/25, for Senna Plus (sennosides-docusate sodium, laxative and stool softener) tablet; 8.6-50 mg, administer twice daily at AM and PM;--MAR blank with no documentation that Senna Plus was administered in AM on 2/10/26 and 2/11/26, or at PM on 2/2/26, 2/3/25, and 2/9/26;-An order, dated 4/5/25, for gabapentin (treats nerve pain) 200 mg, administer three times daily at 8:00 A.M., 2:00 P.M., and 10:00 P.M., order date 4/5/25;--MAR blank with no documentation that gabapentin was administered on:---8:00 A.M. on 2/10/26 and 2/11/26;---2:00 P.M. on 2/10/26, 2/11/26, 2/12/26, 2/15/26, and 2/17/26;---10:00 P.M. on 2/2/26, 2/3/26, and 2/9/26;-An order, dated 5/28/25, for artificial tears two drops (gtts), each eye four times daily at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M., order date 5/28/25;--MAR blank with no documentation that artificial tears were administered on:---8:00 A.M. on 2/10/26 and 2/11/26;---12:00 P.M. on 2/10/26, 2/11/26, 2/15/26, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/17/26, and 2/19/26;---4:00 P.M. on 2/2/26, 2/9/26, 2/10/26, and 2/17/26;---8:00 P.M. on 2/2/26 and 2/9/26;-An order, dated 5/28/26 Miralax (medication used to treat constipation) 17 gram (gm) once an evening;--MAR blank with no documentation that Miralax was administered on 2/2/26, 2/9/26, 2/10/26, 2/17/26, and 2/22/26;-An order, dated 11/20/25, for Tylenol 1000 mg at HS for chronic pain;--MAR blank with no documentation that Tylenol was administered on 2/2/26, 2/9/26, and 2/15/26. During an interview on 2/20/26 at 1:35 P.M., the resident said that he/she had not been receiving his/her medication as ordered. He/She has missed doses of his/her gabapentin and this caused him/her to have more pain in his/her feet. 3. Review of Resident #6's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes, stroke, hemiparesis (weakness or reduced motor function on one side of the body), hypertension (high blood pressure), and depression. Review of the resident's electronic physician order summary (ePOS) and paper MAR from 2/3/26 to 2/24/26, showed:-An order, dated 4/22/25, before meal blood sugars, scheduled for 7:30 A.M., 11:30 A.M. and 4:30 P.M., along with Novolog insulin (a rapid-acting insulin) to be given per sliding scale (a medication regimen where the dose of rapid-acting insulin is given, based on pre-meal blood glucose readings), was not documented as completed or given on:-2/5/26 at 4:30 P.M.;-2/6/26 at 11:30 A.M.;-2/13/26 at 4:30 P.M.;-2/15/26 at 7:30 A.M.;-2/15/26 at 11:30 A.M.;-2/17/26 at 11:30 A.M.;-2/24/26 at 4:30 P.M.;-An order, dated 11/5/25, for Tresiba FlexTouch U-100 insulin pen (a prefilled injectable pen, with degludec, a long-acting insulin), with 100 units/milliliter (ml), give 24 units subcutaneously (SQ, under the skin) every day between 7:00 A.M. and 11:00 A.M., not documented as given on:-2/4/26;-2/7/26;-2/15/26;-2/24/26;-An order, dated 1/18/26, for metformin 500 mg tablet, administer one tablet, twice daily, was not documented as given on:-2/12/26 at 7:15 P.M. to 11:00 P.M.;-2/14/26 at 7:15 A.M. to 11:15 A.M.;-2/15/26 at 7:15 A.M. to 11:15 A.M.;-2/18/26 at 7:15 P.M. to 11:00 P.M.;-2/19/26 at 7:15 A.M. to 11:15 A.M.;-2/21/26 at 7:15 P.M. to 11:00 P.M.;-2/22/26 at 7:15 P.M. to 11:00 P.M.; During an interview on 2/19/26 at 12:52 P.M., the resident said he/she had not received insulin for four days last week, never saw a nurse, and his/her blood sugar was high. When his/her blood sugar was eventually taken, it was over 200. This week, the nurse came in and took his/her blood sugar but gave no insulin. 4. Review of Resident #4's medical record, showed diagnoses included diabetes with diabetic neuropathy (a potentially serious complication of diabetes where high blood sugar damages nerve fibers, primarily in the legs and feet), chronic kidney failure, dementia, major depressive disorder with psychotic symptoms, and adult failure to thrive. Review of the resident's care plan, in use at the time of survey, showed:-Problem: Diabetes, at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar);-Goal: Resident will remain free of signs and symptoms of hypoglycemia and hyperglycemia through the next review;-Approaches included:--Administer medications as ordered;--Administer insulin as ordered;--Accuchecks (blood glucose monitoring with a machine that reads a small sample of blood that is obtained via a small skin prick) as ordered. Review of the resident's February 2026 MARs, dated 2/1/26 through 2/24/26 showed:-An order, dated 1/15/26, before meal blood sugars, at 8:00 A.M., 12:00 P.M. and 4:00 P.M., along with Novolog insulin, to be given per sliding scale;--The MAR blank with no documentation the accuchecks were completed and no documentation the insulin was administered on:--2/5/26 at 4:00 P.M.;--2/7/26 at 8:00 A.M.;--2/8/26 at 12:00 P.M.;--2/14/26 at 8:00 A.M.;--2/15/26 at 8:00 A.M.;--2/15/26 at 12:00 P.M.;--2/18/26 at 12:00 P.M.-An order, dated 1/15/26, for insulin glargine-yfgn (a long-acting) insulin 3 ml pen, with 100 units/ml, administer 18 units SQ at bedtime (7:15 P.M. to 11:00 P.M.);--MAR blank with no documentation the insulin administered on 2/13/26;-An order, dated 1/27/26, for metformin 500 mg tablet, administer one tablet, twice daily (7:15 A.M. to 11:15 A.M. and 3:15 P.M. to 6:45 P.M.);--MAR blank with no documentation the metformin (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was administered on:--2/12/26 at 3:15 P.M. to 6:45 P.M.;--2/18/26 at 3:15 P.M. to 6:45 P.M.;-An order, dated 1/15/26, for lidocaine adhesive medicated patch, apply one patch every morning, between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation the lidocaine adhesive medicated patch was applied on 2/15/26;-An order, dated 1/27/26, for buspirone (anti-anxiety) 10 mg tab, administer one tablet, three times daily, between 7:15 A.M. to 11:15 A.M, 3:15 P.M. to 6:45 P.M., and at bedtime between 7:15 P.M. to 11:00 P.M.;--MAR blank with no documentation buspirone was administered in the morning on 2/15/26;--MAR blank with no documentation buspirone was administered in the afternoon on 2/12/26;--MAR blank with no documentation buspirone was administered at bedtime on 2/12/26 and 2/22/26;-An order, dated 1/22/26, for hydroxyzine HCL (antihistamine), 25 mg tablet, administer one tablet, three times daily, at 8:00 A.M, 12:00 P.M., and 4:00 P.M., for generalized anxiety disorder:--MAR blank with no documentation hydroxyzine was administered in the morning on 2/10/26, 2/15/26, and 2/18/26;--MAR blank with no documentation hydroxyzine was administered at noon on 2/5/12, 2/10/26, 2/14/26, 2/15/26, 2/16/26, 2/17/26, and 2/18/26;--MAR blank with no documentation hydroxyzine was administered at 4:00 P.M. on 2/12/26;-An order, dated 1/15/26, for melatonin 3 mg tablet at bedtime;--MAR blank with no documentation melatonin was administered on 2/12/26;-An order, dated 1/18/26, for mirtazapine 15 mg tablet at bedtime;--MAR blank with no documentation melatonin was administered on 2/12/26;-An order, dated 1/15/26, for quetiapine (antipsychotic medication) 25 mg tablet, administer one tablet at bedtime:--MAR blank with no documentation melatonin was administered on 2/12/26, 2/14/26, and 2/22/26. 5. Review of Resident #7's admission MDS, dated [DATE], showed: -Moderate cognitive impairment;-Diagnoses included dementia, sepsis (blood infection), vitamin D deficiency, insomnia, multiple fractures of ribs, kidney disease, vitamin B12 deficiency anemia (body lacks enough healthy red blood cells due to insufficient B12), and gastroesophageal reflux disease (GERD). Review of the resident's February 2026 MARs, dated 2/1/26 through 2/24/26 showed:-An order, dated 1/29/26, for Aspirin 81 mg once daily for atrial fibrillation (increased heart rate);--MAR blank with no documentation that aspirin was administered on 2/1/26 and 2/17/26;-An order, dated 1/9/26, for Vitamin D3 25 mcg, administer two tablets daily;--MAR blank with no documentation that vitamin D3 was administered on 2/17/26;-An order, dated 1/9/26, for Vitamin B12 1,000 mcg daily;--MAR blank with no documentation that vitamin B12 was administered on 2/17/26;-An order, dated 1/9/26, for finasteride (shrinks the prostate gland) 5mg once daily;--MAR blank with no documentation that finasteride was administered on 2/17/26;-An order, dated 1/23/26 through 2/2/26, for ciprofloxacin HCl (antibiotic) 250 mg twice daily at AM and HS for urinary tract infection (UTI);--MAR blank with no documentation that ciprofloxacin HCl was administered 2/2/26 at HS;-An order, dated 1/9/26, for docusate sodium (stool softener) 100 mg twice daily at AM and HS;--MAR blank with no documentation that docusate sodium was administered on:---AM on 2/16/26 and 2/17/26;---HS on 2/2/26, 2/3/26, 2/4/26, and 2/16/26;-An order, dated 1/24/26, for metoprolol tartrate (used to treat high blood pressure) 25 mg twice daily at AM and HS-MAR blank with no documentation that metoprolol tartrate was administered on: ---AM on 2/16/26 and 2/17/26;---HS on 2/2/26, 2/3/26, 2/4/26, and 2/16/26;-An order, dated 1/9/26, for Senna Plus 8.6-50 mg twice daily at AM and HS;--MAR blank with no documentation that Senna Plus was administered on:---AM on 2/16/26 and 2/17/26;---HS on 2/2/26, 2/3/26, 2/4/26, 2/16/26, and 2/17/26;-An order, dated 1/14/26, for mirtazapine (antidepressant) 15 mg daily at HS;--MAR was blank with no documentation that mirtazapine was administered on 2/2/26, 2/3/26, 2/4/26, 2/16/26 and 2/18/26;-An order, dated 1/9/26, for trazodone (antidepressant) 50 mg daily at HS;-MAR blank with no documentation that trazodone was administered on 2/2/26, 2/3/26, 2/4/26, 2/9/26, 2/15/26, 2/16/26, 2/18/26, 2/21/26, 2/22/26, and 2/23/26. 6. Review of Resident #17's quarterly MDS, dated [DATE], showed:-Severe cognitive (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment;-Diagnoses included anemia, insomnia, chronic pain, high blood pressure, GERD, kidney disease, and rheumatoid arthritis (autoimmune disease). Review of the resident's February 2026 MARs, dated 2/1/26 through 2/16/26, showed:-An order, dated 9/29/25, for gabapentin 100 mg at 7:00 A.M., 2:00 P.M., and 10:00 P.M.;--MAR blank with no documentation that gabapentin was administered on 2/14/26 at 2:00 P.M.;-An order, dated 12/24/25, for Lasix 20 mg daily; --MAR blank with no documentation that Lasix was administered on 2/14/26 and 2/15/26;-An order, dated 9/29/25, for Vitamin B12 500 mcg once daily;--MAR blank with no documentation that vitamin B12 was administered on 2/14/26;-An order, dated 9/29/25, for iron 325 mg once daily;--MAR blank with no documentation that iron was administered on 2/14/26;-An order, dated 9/29/25, for folic acid (supplement) 400 mcg daily;--MAR blank with no documentation that folic acid was administered on 2/14/26;-An order, dated 9/29/25, for leflunomide (used to treat rheumatoid arthritis) 10 mg daily;--MAR blank with no documentation that leflunomide was administered on 2/14/26;-An order, dated 2/14/26, for lisinopril (used to treat high blood pressure) 20 mg daily;--MAR blank with no documentation that lisinopril was administered on 2/14/26;-An order, dated 9/29/25, for carvedilol (used to treat high blood pressure) 25 mg twice daily at 9:00 A.M. and 9:00 P.M;--MAR blank with no documentation that carvedilol was administered on 2/14/26 at 9:00 A.M. and on 2/15/26 at 9:00 P.M.;-An order, dated 9/29/25, for cholestyramine (used to lower high cholesterol) powder in packet 4 gram (g) once a day at noon;--MAR blank with no documentation that cholestyramine was administered on 2/14/26;-An order, dated 9/29/25, for mirtazapine 7.5 mg once daily at HS;--MAR blank with no documentation that mirtazapine was administered on 2/14/26. 7. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Memory problem;-Diagnoses included stroke, diabetes, seizure disorder, aphasia (a language disorder), bipolar disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from manic highs to depressive lows), peripheral vascular disease (a blood circulation disorder caused by narrowing, blockage, or spasms in blood vessels outside the heart and brain), and hypertension. Review of the resident's February 2026 MARs, dated 2/1/26 through 2/24/26 showed:-An order, dated 10/23/25, for carbamazepine (a mood-stabilizing medication used to treat seizures, nerve pain, and bipolar disorder) 100 mg tablets, administer 250 mg every 6 hours (12:00 A.M., 7:00 A.M., 12:00 P.M, and 7:00 P.M.), for unspecified convulsions (seizures);--MAR blank with no documentation the carbamazepine was administered at:---12:00 A.M on 2/14/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, and 2/21/26;---7:00 A.M. on 2/14/26;---12:00 P.M. on 2/14/26;---7:00 P.M. on 2/16/26, 2/17/26, and 2/20/26;-An order, dated 12/24/25, for Lasix 20 mg, administer one tablet once in the morning;--MAR blank with no documentation that Lasix was administered on 2/11/26, 2/17/26, 2/18/26, and 2/19/26;-An order, dated 11/1/25, for Eliquis 5 mg tablet, administer one tablet twice daily, in the morning and at bedtime;--MAR blank with no documentation the Eliquis was administered at bedtime on 2/7/26;-An order, dated 10/23/25, for Keppra (an anticonvulsant/seizure medication used to control seizures) 500 mg tablet, administer 500 mg twice daily, in the morning and at bedtime, for unspecified convulsions;--MAR blank with no documentation the Keppra was administered at bedtime on 2/7/26 and 2/21/26;-An order, dated 10/23/25, atorvastatin (medication used to lower cholesterol) 40 mg at bedtime;--MAR blank with no documentation the atorvastatin was administered at bedtime on 2/12/26;-An order, dated 2/18/26, for metformin 1000 mg by mouth, twice daily, with a start date of 2/18/26;--MAR blank with no documentation the metformin was administered in the morning on 2/19/26, 2/20/26, and 2/21/26;--MAR blank with no documentation the metformin was administered at bedtime on 2/19/26, 2/20/26, and 2/21/26. 8. Review of Resident #9's quarterly MDS, dated [DATE], showed:-Cognition intact;-Diagnoses included diabetes, heart failure, embolism of pulmonary artery (major blood vessel that carries deoxygenated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood from the right ventricle of the heart to the lungs for oxygenation), depression, high cholesterol, and hypertension. Review of the resident's February 2026 MARs, dated 2/1/26 through 2//24/26, showed:-An order, dated 10/9/25, for pantoprazole (used to treat GERD) 40 mg once every morning at 6:00 A.M.:--MAR blank with no documentation the pantoprazole was administered in the morning on 2/18/26;-An order, dated 10/9/25, for gabapentin 600 mg, administer three times daily at 7:00 A.M., 2:00 P.M., and 10:00 P.M.;--MAR blank with no documentation that gabapentin was administered at:---7:00 A.M. on 2/8/26;---2:00 P.M. on 214/26 and 2/15/26;---10:00 P.M. on 2/7/26, 2/16/26, and 2/21/26;-An order, dated 10/9/25, for allopurinol (drug that inhibits uric acid formation in the body) 100 mg tablet, give 200 mg (two tablets) once daily in the morning;--MAR blank with no documentation that allopurinol was administered on 2/14/26;-An order, dated 10/9/25, for Jardiance (drug used to lower blood sugar) 10 mg by mouth, once daily every morning:--MAR blank with no documentation that gabapentin was administered on 2/14/26;-An order, dated 10/9/25, for Miralax 17 gm once every morning between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation that Miralax was administered on 2/14/26;-An order, dated 10/9/25, for multivitamin tablet, take one tablet every morning between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation that multivitamin was administered on 2/14/26;-An order, dated 10/9/25, for oxybutynin chloride, extended release (ER) 5 mg tablet, once daily between 7:15 A.M. to 11:15 A.M.;---MAR blank with no documentation that oxybutynin was administered on 2/14/26;-An order, dated 10/21/25, for Eliquis 5 mg tablet, administer one tablet twice daily, in the morning and at bedtime, for chronic embolism and thrombosis of both lower extremities;--MAR blank with no documentation the Eliquis was administered in the morning on 2/14/26;--MAR blank with no documentation the Eliquis was administered at bedtime on 2/7/26, 2/16/26, 2/17/26, and 2/21/26;-An order, dated 12/8/25, for ferrous sulfate 325 mg tablet in the morning between 7:15 A.M. to 11:15 A.M and in the late afternoon/early evening between 3:15 P.M. to 6:45 P.M.;--MAR blank with no documentation ferrous sulfate was administered in the morning on 2/14/26;--MAR blank with no documentation ferrous sulfate was administered late afternoon/early evening on 2/21/26;-An order, dated 10/9/25, for PreserVision (supplement for the eyes) capsule twice daily in the morning between 7:15 A.M. to 11:15 A.M and in the late afternoon/early evening between 3:15 P.M. to 6:45 P.M.;--MAR blank with no documentation PreserVision was administered in the morning on 2/10/26, 2/14/26, and 2/15/26;--MAR blank with no documentation PreserVision was administered late afternoon/early evening on 2/7/26 and 2/21/26;-An order, dated 10/9/25, for atorvastatin 10 mg at bedtime;--MAR blank with no documentation the atorvastatin was administered at bedtime on 2/7/26, 2/14/26, 2/17/26, and 2/21/26;-An order, dated 10/9/25, for duloxetine (antidepressant) 20 mg once daily at bedtime;--MAR blank with no documentation the medication was administered at bedtime on 2/7/26, 2/14/26, 2/17/26, and 2/21/26. 9. Review of Resident #10's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included seizure disorder, repeated falls, dementia, Parkinson's disease (a progressive neurodegenerative brain disorder that affects the whole-body due to dopamine loss-movement disorders, loss of smell, constipation, mood disorders, fatigue, memory fog, and dementia in later stages), chronic obstructive pulmonary disease (COPD, lung disease) and stroke. Review of the resident's February 2026 MARs, dated 2/1/26 through 2/22/26, showed:-An order, dated 12/21/25, for metoclopramide (medication used to treat severe heartburn and diabetic gastroparesis or slow stomach emptying) 10 mg tablet once daily, at 6:00 A.M. before breakfast;--MAR blank with no documentation the metoclopramide was administered at 6:00 A.M. on 2/10/26;-An order, dated 8/26/25, amlodipine (a calcium channel blocker) 10 mg once daily between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation amlodipine was administered on 2/15/26, 2/16/26, and 2/19/26;-An order, dated 8/26/25, for aspirin 81 mg once daily between 7:15 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265343	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Villa Wellness & Rehabilitation	850 Country Manor Lane Creve Coeur, MO 63141

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 11:15 A.M.;--MAR blank with no documentation aspirin was administered on 2/15/26, 2/16/26, and 2/19/26;-An order, dated 8/2/25, hydrochlorothiazide (a diuretic/water pill used to treat high blood pressure and edema fluid retention) 12.5 mg once daily between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation aspirin was administered on 2/15/26, 2/16/26, 2/17/26, and 2/22/26;-An order, dated 9/1/25, for Klor-Con (potassium chloride) ER, 20 mEq once daily between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation medication was administered on 2/16/26;-An order, dated 12/16/25, for amantadine (medication used to treat Parkinson's disease) 100 mg capsule, one capsule twice daily between 7:15 A.M. to 11:15 A.M and in the evening between 7:15 P.M. to 11:00 P.M.;--MAR blank with no documentation amantadine was administered in the morning on 2/10/26 and 2/16/26;--MAR blank with no documentation amantadine was administered in the evening on 2/4/26, 2/5/26, 2/9/26, 2/10/26, 2/16/26, and 2/20/26;-An order, dated 3/21/25 for Budesonide-glycopyr-formoterol HFA aerosol inhaler (a prescription, fixed-dose combination medication used for the long-term maintenance treatment of COPD), administer 2 inhalation puffs twice daily between 7:15 A.M. to 11:15 A.M and in the late afternoon/early evening between 3:15 P.M. to 6:45 P.M.;--MAR blank with no documentation amantadine was administered in the morning on 2/15/26 and 2/16/26;--MAR blank with no documentation amantadine was administered in the late afternoon/early evening on 2/5/26, 2/9/26, 2/10/26, and 2/16/26;-An order, dated 3/21/25, for memantine (medication used to treat moderate to severe Alzheimer's disease and dementia) 5 mg, twice daily twice daily between 7:15 A.M. to 11:15 A.M and in the evening between 7:15 P.M. to 11:00 P.M.;--MAR blank with no documentation memantine was administered in the morning on 2/16/26;--MAR blank with no documentation memantine was administered in the evening on 2/9/26 and 2/16/26;-An order, dated 7/7/25, for carbidopa-levodopa (medication used to treat Parkinson's disease) 25-100 mg, administer 3.5 tabs, three times daily, between 7:15 A.M. to 11:15 A.M, 11:30 A.M. to 2:45 P.M., and in the evening between 7:15 P.M. to 11:00 P.M.;--MAR blank with no documentation carbidopa-levodopa was administered in the morning on 2/10/26 and 2/16/26;--MAR blank with no documentation carbidopa-levodopa was administered late morning to early afternoon on 2/10/26, 2/15/26, 2/16/26, 2/17/26, and 2/19/26;--MAR blank with no documentation carbidopa-levodopa was administered in the evening on 2/3/26, 2/9/26, 2/16/26, and 2/18/26;-An order, dated 3/21/25, for bisacodyl (a stimulant laxative), 5 mg tablets, take 2 tablets once daily at bedtime;--MAR blank with no documentation bisacodyl was administered on 2/4/26, 2/7/26, 2/9/26, 2/13/26, 2/16/26, and 2/18/26;-An order, dated 12/5/25, for melatonin 3 mg tablet at bedtime;--MAR blank with no documentation melatonin was administered on 2/3/26, 2/4/26, 2/9/26, 2/10/26, 2/13/26, 2/16/26, and 2/18/26. 10. Review of Resident #2's medical record, showed diagnoses included Parkinson's disease, diabetes, major depressive disorder, hypertension, hyperlipidemia, allergic rhinitis (environmental allergies), cerebrovascular disease (a group of conditions that impair blood flow to the brain, leading to oxygen deprivation, brain cell damage, and often stroke), and calculus (a solid, crystal-like mineral deposit) of the ureter (the narrow tube that carries urine from the kidney to the bladder). Review of the resident's February 2026 MARs, dated 2/1/26 through the morning on 2/18/26, showed:-An order, dated 11/25/24, for polyethylene glycol (laxative), 17 gm, once daily between 7:00 A.M. and 3:00 P.M.;--MAR blank with no documentation polyethylene glycol was administered on 2/8/26, 2/13/26, 2/14/26, 2/15/26, and 2/17/26;-An order, dated 7/2/25, for fluticasone propionate (nasal spray used to reduce inflammation and treat allergies, asthma, and COPD) spray, 50 mcg, administer one nasal spray, in each nostril, once daily in the morning;--MAR blank with no documentation fluticasone propionate was administered in the morning on 2/8/26, 2/16/26, 2/17/26, and 2/18/26;-An order, dated 8/8/23 for hydrochlorothiazide 12.5 mg once daily between 7:15 A.M. to 11:15 A.M.;--MAR blank with no documentation hydrochlorothiazide was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered on 02/15/26, 2/16/26, 2/17/26, and 2/18/26;-An order, dated 10/9/23 for metoprolol succinate ER) 25 mg once daily in the morning, for hypertension;--MAR was blank with no documentation that Metoprolol was administered on 02/15/26, 2/17/26, and 2/18/26;-An order, dated 1/22/25, for multivitamin tablet, take one tablet every morning between 7:15 A.M. to 11:15 A.M.:--MAR blank with no documentation that multivitamin was administered on 02/17/26 and 2/18/26;-An order, dated 8/8/23, for sertraline (antidepressant) 50 mg tablet, administer once daily in the morning;--MAR blank with no documentation sertraline was administered on 02/17/26 and 2/18/26;-An order, dated 8/8/23, for amantadine 100 mg capsule, one capsule twice daily between 7:15 A.M. to 11:15 A.M and between 3:15 P.M. to 6:45 P.M.;--MAR blank with no documentation amantadine was administered in the morning on 2/15/26, 2/17/26 and 2/18/26;--MAR blank with no documentation amantadine was administered between 3:15 P.M. to 6:45 P.M on 2/12/26 and 2/14/26;-An order, dated 5/20/25, for loteprednol etabonate eye drops (an ophthalmic corticosteroid used to treat eye inflammation, pain, and swelling), suspension 0.5 %, administer one drop, ophthalmic (eye), twice daily;--MAR blank with no documentation loteprednol etabonate eye drops was administered in the morning on 2/15/26, 2/16/26, 2/17/26 and 2/18/26;--MAR blank with no documentation loteprednol etabonate eye drops was administered in the afternoon on 2/14/26;-An order, dated 8/15/23, for metformin 1000 mg by mouth, twice daily;--MAR blank with no documentation the metformin was administered in the morning on 2/17/26 and 2/18/26;--MAR blank with no documentation the metformin was administered at bedtime on 2/14/26;-An order, dated 8/8/23, for carbidopa-levodopa 25-100 mg, administer three tabs, three times daily, at 8:00 A.M., 2:00 P.M., and 8:00 P.M.;--MAR blank with no documentation carbidopa-levodopa was administered in the morning on 2/17/26 and 2/18/26;--MAR blank with no documentation carbidopa-levodopa was administered at 2:00 P.M. on 2/6/26, 2/7/26, 2/14/26, and 2/15/26;-An order, dated 1/30/25, for ocean nasal spray (a non-medicated, 0.65% sodium chloride solution) 0.65%, administer two sprays into each nostril, twice daily;--MAR blank with no documentation ocean nasal spray was administered in the morning on 2/15/26 and 2/17/26;--MAR blank with no documentation ocean nasal spray was administered in the afternoon on 2/5/26 and 2/8/26. 11. Review of Resident #3's medical record, showed diagnoses included heart failure, COPD, moderate protein-calorie malnutrition, anxiety disorder, hypertension, spinal stenosis (a chronic, degenerative condition where the spinal canal narrows, putting pressure on the spinal cord and nerve), alcohol abuse, depression, hyperlipidemia, anxiety disorder, peripheral vascular disease, and GERD. Review of the residen[

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment in accordance with acceptable standards of practice when facility staff failed to complete and document neurological assessments (neuro checks) following unwitnessed falls for three residents (Residents #3, #10 and #15). The sample was 17. The census was 80.Review of the facility's Fall Evaluation and Prevention policy, dated 8/2020, showed:-Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents;-Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed;-Procedure:-Definition: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions;--An un-witnessed fall occurs when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there;-Following a fall the following steps should be undertaken:--Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. The evaluation should include vital signs and neurological (neuro) evaluation - pulse (P), respiration (R), and blood pressure (BP) measurements, assessment of pupil size and reactivity, and equality of hand grip strength) status;--If there was a loss of conscious or the fall was unwitnessed, neuro signs should be initiated and checked for at least 72 hours. 1. Review of Resident # 3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/8/25, showed:-Cognitively intact:-Falls since admission/entry or reentry or the prior assessment: No;-Diagnoses included high blood pressure, anxiety, restless leg syndrome (occurrence of uncomfortable sensations in the legs and the urge to move them to relieve the sensations), and pain in spine. Review of the resident's incident report, dated 2/6/26 at 3:40 A.M., showed:-Nursing description: Notified by aide that resident had an unwitnessed fall out of bed upon assessment resident was lying on her back flat on the floor, noted resident with skin tear to left elbow and bruising on left scapula (shoulder blade);-Resident description: Resident stated he/she was in a deep sleep and he/she just fell;-Was this incident witnessed: No;-Description: Full assessment of skin and vitals taken, vitals within normal limits (WNL) assessed bruising, cleaned and bandaged left elbow. As needed (PRN) pain medication given for pain. Notified Director of Nursing (DON) and left message with physician on file;-Injury Type: No Injuries observed at time of incident;-Level of pain: Seven out of 10;-People Notified: DON and physician;-Resident family/emergency contact not notified of fall. Review of resident's medical record, showed no documentation of neuro checks completed for the unwitnessed fall. 2. Review of Resident #10's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Falls since admission/entry or reentry or the prior assessment: No;-Diagnoses included dementia, Parkinson's disease (a progressive, chronic brain disorder that primarily affects movement), stroke, seizure, and repeated falls. Review of the resident's incident report, dated 2/16/26 at 12:30 P.M., showed:-Nursing description: Resident slid out of wheelchair onto floor in hallway;-Resident description: Resident unable to give (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description;-Was this incident witnessed: No;-Description: Vital signs obtained, hospice contacted, resident assisted to bed;-Injury type: Abrasion;-Injury location: Face;-People Notified: DON and physician;-Resident family/responsible party not notified of fall. Review of the resident's medical record showed, no neuro checks completed for the unwitnessed fall. 3. Review of Resident #15's annual MDS, dated [DATE], showed:-Severe cognitive impairment;-Falls since admission/entry or reentry or the prior assessment: Yes;-Number of falls: One;-Falls with no injury: One;-Falls with injury (except major): One;-Diagnoses included seizure, dementia, high blood pressure, sleep disorder, and osteoarthritis (joint disease, causing the protective cartilage on bone ends to break down, resulting in pain, swelling, and stiffness). Review of the resident's incident report dated 2/8/26 at 9:43 P.M., showed:-Nursing Description: Resident was trying to get in the bed and fell, resident did not hit his/her head. Family and physician aware no new orders. Denies any pain or discomfort at this time;-Resident Description: Resident Unable to give description;-Was this incident witnessed: No;-Injury type: No injuries observed at time of incident;-People Notified: None listed. Review of the resident's medical record, showed no neuro checks completed for the unwitnessed fall. 4. During an interview on 2/20/26 at 11:06 A.M., the Interim Director of Nursing (DON) and the Previous Administrator (PA) said they expected staff to be knowledgeable of and to follow facility policies and procedures. If a resident had a fall, they expected the nurse to complete a head to toe assessment, including obtaining vital signs and starting neuro checks if the fall was unwitnessed or if the resident hit their head. They expected notifications to be made to the physician, family/Resident Representative (RR) and the DON. They expected the notifications to be documented in the incident report and/or progress note. They expected post-fall monitoring to be completed for 72 hours after the fall. They expected documentation of the post fall monitoring to be completed in the resident's progress notes once per shift for 72 hours. They expected vital signs to be completed each shift if neuro checks were not being completed and for them to be documented in the progress note or placed in the resident's medical record under vital signs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify interventions to reduce the likelihood of another fall for four residents who had unwitnessed falls (Residents #3, #10, #1, and #15), and facility staff failed to notify the resident's family/resident representative (RR) of falls for two residents (Residents #3 and #10). In addition, the facility failed to ensure three staff performed an assisted transfer for one resident (Resident #8) as instructed by the resident's physician orders and care plan, and staff failed to document an incident report and to notify the resident's physician and RR when the resident was injured during a staff-assisted transfer. The sample was 17. The census was 80.Review of the facility's Fall Management Program Policy, undated, showed:-Purpose: To prevent resident falls and minimize complications associated with falls through the development of a fall management program;-Policy: The facility will provide the highest quality care in the safest environment for the residents residing in the facility. The facility has developed a fall management program that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation;-Procedure:-Post?Fall:--A. Following a resident's fall, the licensed nurse will complete an incident report and a Post?Fall Assessment & Investigation within 24 hours or as soon as practicable;--B. The licensed nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated;--C. The interdisciplinary team (IDT) committee will meet within 72 hours of a fall. The IDT committee will review and document:---i. Summary of event following a fall;---ii. Root cause analysis;---iii. Referrals, as necessary and;---iv. Interventions to prevent future falls; -Documentation:--A. Fall Risk Assessments will be maintained in the resident's medical record; --B. The IDT committee will document findings and recommendations in the resident's medical record. The IDT committee may use the IDT Minutes - Sub?Committee form for documentation purposes; --C. Nursing staff will document the resident's response to interventions being utilized in the resident's medical record;--D. The resident's care plan will be updated as necessary;-Resident/responsible party:--i. Education provided to the resident and/or responsible party will be documentedin the medical record;--ii. Both resident and family should be informed and understand fall risk factors andagree on strategies to prevent the resident from falling. Review of the facility's Fall Evaluation and Prevention Policy, dated 8/2020, showed:-Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents;-Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed;-Procedure:-Definition: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions; -An un-witnessed fall occurs when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there;-Root Cause Analysis;--Complete the Accident/Incident report and notify the physician and responsible party. Document the physician orders and/or response from the physician and responsible party;-If the fall was un-witnessed, initiate the investigation including witness statements (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from staff and residents. Try to determine who was the last person to see the resident prior to the fall and the resident's condition at that time;-The IDT team will review the plan of care and update the interventions as appropriate. 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/8/25, showed:-Cognitively intact:-Falls since admission/entry or reentry or the prior assessment: No;-Diagnoses included high blood pressure, anxiety, restless leg syndrome (occurrence of uncomfortable sensations in the legs and the urge to move them to relieve the sensations), and pain in spine. Review of the resident's incident report dated 2/6/26 at 3:40 A.M., showed:-Nursing description: Notified by aide that resident had an unwitnessed fall out of bed upon assessment resident was lying on her back flat on the floor, noted resident with skin tear to left elbow and bruising on left scapula (shoulder blade);-Resident description: Resident stated he/she was in a deep sleep and he/she just fell;-Was this incident witnessed: No;-Description: Full assessment of skin and vitals taken, vitals within normal limits (WNL) assessed bruising, cleaned and bandaged left elbow. As needed (PRN) pain medication given for pain. Notified Director of Nursing (DON) and left message with physician on file;-Injury Type: No Injuries observed at time of incident;-Level of pain: Seven out of 10;-People Notified: DON and physician;-Resident family/emergency contact not notified of fall. Review of resident's progress notes 2/6/26 through 2/8/26, showed no IDT committee meeting notes or interventions implemented following the resident's fall on 2/6/26. Review of the resident's care plan, in use at the time of survey, showed:-Problem: Resident is at risk for falls related to impaired mobility, anti-depression drug use, previous falls, and alcohol abuse;-Goal: Minimize the risk for falls and related injury through the next review;-Approaches, dated 8/27/24, included:--Despite decreased safety and recommended assist with mobility, resident chooses to remain as independent as possible and continues to self transfer. Staff to provide frequent checks and offer to assist with toileting and transfers;--Determine ability to understand use of call light and ability to utilize. Provide appropriate call light system;--Keep personal items and frequently used items within reach;--Occupational therapy (OT) to screen. Evaluation and treatment as indicated/ordered;--Physical therapy (PT) to screen. Evaluation and treatment as indicated/ordered;-No interventions identified following the resident's fall on 2/6/26. 2. Review of Resident #10's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Falls since admission/entry or reentry or the prior assessment: No;-Diagnoses included dementia, Parkinson's disease (a progressive, chronic brain disorder that primarily affects movement), stroke, seizure, and repeated falls. Review of the resident's incident report, dated 2/16/26 at 12:30 P.M., showed:-Nursing description: Resident slid out of wheelchair onto floor in hallway;-Resident description: Resident unable to give description;-Was this incident witnessed: No;-Description: Vital signs obtained, hospice contacted, resident assisted to bed;-Injury type: Abrasion;-Injury location: Face;-People Notified: DON and physician;-Resident family/responsible party not notified of fall. Review of resident's progress notes 2/16/26 through 2/18/26, showed no IDT committee meeting notes or interventions implemented following the resident's fall on 2/16/26. Review of the resident's care plan, in use at the time of survey, showed:-Problem: Resident has recent history of falls related to seizures and mobility;-Goal: No further incident of falls with/without injury through next review;-Approaches, dated 6/11/25, included: -Evaluate history/cause of past falls. Incorporate findings into care needs;-Keep call light within reach. Assess for ability to understand use of call light and ability to use;--Keep personal items and frequently used items within reach;--OT to screen. Evaluation and treat as indicated;--PT to screen. Evaluation and treat as indicated;--Transfer status independent;-No interventions identified following the resident's fall on 2/16/26. 3. Review of Resident #1's admission MDS, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Villa Wellness & Rehabilitation	850 Country Manor Lane Creve Coeur, MO 63141

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE], showed:-Severe cognitive impairment;-Falls since admission/entry or reentry or the prior assessment: No;-Diagnoses included dementia, high blood pressure, stroke, diabetes, and anxiety. Review of the resident's incident report, dated 2/6/26 at 8:35 P.M., showed:-Type of incident: Fall with injury;-Description of incident: Nurse heard resident screaming. Upon entering resident room observed resident on his/her left side. Resident left wrist was swollen and he/she complained of hip pain. Emergency medical services (EMS) called and resident was transferred to the hospital. Message left for resident family member. Physician and DON notified. Review of resident's progress notes 2/6/26 through 2/8/26, showed no IDT committee meeting notes or interventions implemented following the resident's fall on 2/6/26. Review of the resident's care plan, in use at the time of survey, showed:-Problem: Resident is at risk for falls related to impaired mobility, incontinent of bladder and anti-psychotic drug use;-Goal: Minimize the risk for falls and related injury through next review;-Approach, dated 12/11/25, for monitoring within monitoring, antithrust cushion (cushion that prevents forward sliding in chair);-Approaches, dated 12/3/25, included: --Despite decreased safety and recommended assist with mobility, the resident chooses to remain as independent as possible and continues to self transfer. Staff to provide frequent checks and offer to assist with toileting and transfers;--Determine ability to understand use of call light and ability to utilize. Provide appropriate call light system;--Keep personal items and frequently used items within reach;--OT to screen. Evaluation and treatment as indicated/ordered;--PT to screen. Evaluation and treatment as indicated/ordered,--No intervention identified following the resident's fall on 2/6/26. Review of the resident's medical record, showed no post fall risk evaluation completed for fall on 2/6/26. 4. Review of Resident #15's annual MDS, dated [DATE], showed:-Severe cognitive impairment;-Falls since admission/entry or reentry or the prior assessment: Yes;--Number of falls: One;--Falls with no injury: One;--Falls with injury (except major) skin tears, abrasions, lacerations, superficial bruises, hematomas (bruise that happens when an injury causes blood to collect and pool under the skin) and sprains: One;--Falls with major injury: None;-Diagnoses included seizure, dementia, high blood pressure, sleep disorder, and osteoarthritis (joint disease, causing the protective cartilage on bone ends to break down, resulting in pain, swelling, and stiffness). Review of the resident's incident report, dated 2/8/26 at 9:43 P.M., showed:-Nursing description: Resident was trying to get in the bed and fell, resident did not hit his/her head. Family and physician aware no new orders. Denies any pain or discomfort at this time;-Resident description: Resident unable to give description;-Was this incident witnessed: No;-Injury type: No injuries observed at time of incident;-People notified: None listed. Review of resident's progress notes, dated 2/8/26 through 2/10/26, showed no IDT committee meeting notes or interventions implemented following the resident's fall on 2/8/26. Review of the resident's care plan, dated 1/8/26, showed:-Problem: Resident has a recent history of falls related to poor safety awareness, impulsive, anti-depressant drug use, impaired mobility, and has a sleep disorder;-Minimize the risk for falls and related injury through next review;-Approach, dated 1/13/26, for resident has very poor safety awareness and is very forgetful. Will have staff assist him/her to bed after dinner;-Approaches, dated 1/6/26, included:--Despite decreased safety and recommended assist with mobility, the resident chooses to remain as independent as possible and continues to self transfer. Staff to provide frequent checks and offer to assist with toileting and transfers;--Despite frequent reminders, the resident does not remember to use call light to ask for assist. Staff to attempt to anticipate needs;--Ensure call light is in reach and educate on the use of the call light, if indicated;--Evaluate history/cause of past falls. Incorporate findings into care needs;--PT to screen. Evaluation and treatment as indicated/ordered;-No interventions identified following the resident's fall on 2/8/26. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer, CNA A and CNA B said only two people were needed for the Hoyer transfer. CNA A and CNA B said they were not aware that the resident's care plan showed three people were needed during the resident's transfers. During an interview on 02/26/26 at 3:09 P.M., the Interim DON and Current Administrator (CA) said if a resident obtained an injury during a staff-assisted transfer, they expected a nurse to do a head to toe assessment to evaluate the resident's skin. They expected an incident report and progress note to be completed with a description of the injury. They expected the physician, family/RR and DON to be notified and the notifications to be documented in the incident report/progress note. Any new orders should be entered onto the resident's physician order summary and the nurse should enter an order on the resident's treatment administration record (TAR) to monitor the site until healed if no treatment is needed. They expected staff to complete a progress note each shift for 72 hours after the incident. They expected the post-incident progress note to include observations of the resident and if there were any changes to the injury. They expected staff to follow the interventions listed in the resident's care plan. They expected physician orders to be followed. 273784727378382786977

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when staff failed to administer seizure medication as ordered for one resident who experienced increased seizures (Resident #10). The sample was 17. The census was 80. Review of the facility's Physician Orders policy, revised June 2020, showed:-Purpose: This will ensure that all physician orders are complete and accurate;-Policy: The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary;-Procedure: --Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline;--Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the Medication Administration Record (MAR)/Treatment Administration Record (TAR). Review of the facility's General Guidelines for Medication Administration policy, dated August 2020, showed:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-Preparation:-At a minimum, the Five Rights (right resident, right drug, right dose, right route, and right time) should be applied to all medication administration and reviewed at three steps in the process of preparation: --When medication is selected;--When the dose is removed from the container; --After the dose is prepared and the medication is put away;-Always employ the MAR during medication administration;--Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and the MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule;-If the medication cannot be located, after further investigation, the pharmacy is contacted or medication removed from the emergency kit;-Administration:-Medications are administered in accordance with written orders of the prescriber;-The person who prepares the dose for administration is the person who administers the dose;-A schedule of routine dose administration times is established by the facility and utilized on the administration records;-For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR is flagged. After completing the medication pass. the nurse returns to the missed resident to administer the medication;-Refusals of Medication:--Residents may actively refuse medications;--Medication refusal must be reported to the prescriber after three doses are refused, or in accordance with facility policy, and prescriber notification must be documented;-Documentation (including electronic):-The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given;-At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented;-In no case should the individual who administered the medication report off-duty without first recording the administration of any medications;--The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration.-When PRN medications are administered, the following documentation is provided:--a. Date and time of administration;--b. Dose;--c. Route of administration (if other than oral);--d. Injection site, if applicable;--e. Complaints or symptoms for which the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was given;--f. Results achieved from giving the dose and the time the results were noted;--g. Signature or initials of the person recording the effects, if different from the person administering the medication;-If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a starter dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled;--An explanatory note is entered on the reverse side of the record;--If three consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified;---Nursing documents the notification and physician response;-If an electronic MAR system is used, specific procedures required for resident identification, identification of medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user manual;--These procedures should be followed, and may differ slightly from the procedures for using paper MARs. Review of the facility's Seizure Precautions policy, dated June 2020, showed:-Purpose: To ensure the safety of residents during seizure activity;-Policy: The facility will provide preventative measures prior to and during seizure activity to prevent resident injury to the extent possible;-Procedure:-Residents considered at risk for seizures are those with a history of seizures and those withconditions that predispose them to seizures;-Determine the appropriate seizure precautions based on, included:--The kind of seizure has the resident had before;--Missed doses of anticonvulsants;--Whether the previous seizure was an acute episode or if it resulted from a chronic condition. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/29/26, showed:-Moderate cognitive impairment;-Diagnoses included seizure disorder, repeated falls, dementia, Parkinson's disease (a progressive neurodegenerative brain disorder that affects the whole-body), and stroke. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is at risk for seizures, due to diagnosis of seizure disorder;-Goal: Resident will decrease the number of seizures he/she has through the next review;-Approaches included administer medications as ordered. Review of the resident's physician order sheet, dated 1/1/26 to 1/31/26, showed:-An order, dated 8/11/25, to admit to hospice;-An order, dated 5/7/25, for Depakote (divalproex, anti-seizure medication) extended release (ER) 24-hour, 500 milligram (mg) tablet. Give two tablets, 1000 mg, oral once a day at morning medication pass (7:25 A.M. to 11:15 A.M.) for epilepsy (seizure disorder);-An order, dated 5/13/25, for divalproex tablet ER, 250 mg tablet. Give five tablets, 1,250 mg oral, once daily at bedtime (7:15 P.M. to 11:00 P.M.) for epilepsy;-An order, dated 9/1/25, for levetiracetam (anti-seizure medication) 1,000 mg tablet. Give one, 1,000 mg oral tablet, twice daily (at 07:15 AM to 11:15 AM and at 03:15 PM to 06:45 PM) for epilepsy;-An order, dated 9/30/25, for lacosamide (anti-seizure medication), 100 mg tablet. Give one tablet, 100 mg oral, twice daily (at 07:15 AM to 11:15 AM and at 03:15 PM to 06:45 PM) for localization-related (focal/partial) epilepsy;-An order, dated 12/5/25, for lorazepam (medication used to treat anxiety and active seizures) concentrate 2 mg per milliliter (mg/ml). Give 0.5 ml (1mg) oral, every 12 hours, at 9:00 A.M. and 9:00 P.M. Review of the resident's paper MAR, dated February 2026, showed:-Depakote ER 1,250 mg, scheduled for 7:15 P.M. to 11:00 P.M., not documented as given on 2/2/26, 2/4/26, 2/8/26, and 2/9/26;-Lacosamide 100 mg, scheduled for 3:15 P.M. to 6:45 P.M., not documented as given on 2/9/26;-Levetiracetam 1000 mg, scheduled for 3:15 P.M. to 6:45 P.M., not documented as given on 2/9/26. Review of the resident's paper Licensed Nurse MAR, dated February 2026, showed:-Lorazepam concentrate 2mg/ml, administer 0.5 ml (1 mg), scheduled for every 12 hours, not documented as given at 9:00 P.M. on 2/2/26, 2/3/26, 2/4/26, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/5/26, 2/6/26, and 2/9/26;Lorazepam concentrate 2mg/ml, administer 0.5 ml (1 mg), scheduled for every 12 hours, not documented as given at 9:00 A.M. on 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/7/26, 2/9/26, and 2/10/26. Review of the resident's electronic progress note, dated 2/10/26 at 2:10 P.M., showed Licensed Practical Nurse (LPN) F documented the 200-hall nurse reported the resident had a brief seizure, while visiting a resident on the 200 hall, and there was no injury. During an interview on 3/6/26 at 11:01 A.M., LPN F said in a progress note he/she wrote on 2/10/26, he/she documented the lorazepam was given because he/she must have looked at the resident's paper MAR at that time. When told the paper MAR had no documentation for 9:00 A.M. on 2/10/26, LPN F said he/she must have looked at the lorazepam-controlled count sheet, as some days the nurses were not signing off on the paper MARs because it was too much. The new facility owners were taking away the CMTs and the nurse could not pass the nursing medications (medications assigned to the licensed nurse only), do all the wound and skin treatments, and pass the hundreds of medications normally passed by the CMT. There were days when the resident's morning medications did not get passed until after lunch, because of this. He/She was aware the resident received three other anti-seizure medications, twice daily, but did not check to see if they were being given as ordered, because he/she could not keep up and there was too much going on and too much to do. The resident had not had a seizure for a couple of months, prior to 2/10/26. Further review of the resident's paper MAR, dated February 2026, showed:-Lacosamide 100 mg, scheduled for 7:15 A.M. to 11:15 A.M., not documented as given on 2/15/26 and 2/16/26;-Levetiracetam 1000 mg, scheduled for 7:15 A.M. to 11:15 A.M., not documented as given on 2/16/26;-Depakote/divalproex ER 1,000 mg, scheduled for 7:15 A.M. to 11:15 A.M., not documented (box blank/no staff initials) as given on 2/16/26;-2/16/26.-Lacosamide 100 mg, scheduled for 3:15 P.M. to 6:45 P.M., not documented as given on 2/10/25, 2/15/25, and 2/16/26;-Levetiracetam 1000 mg, scheduled for 3:15 P.M. to 6:45 P.M., not documented as given on 2/10/26 and 2/16/26;-Depakote/divalproex ER 1,250 mg, scheduled for 7:15 P.M. to 11:00 P.M., not documented as given on 2/13/26, 2/14/26, 2/15/26, and 2/16/26. Further review of the resident's paper Licensed Nurse MAR, dated February 2026, showed:-Lorazepam concentrate 2mg/ml, administer 0.5 ml (1 mg), scheduled for every 12 hours, at 9:00 A.M. and 9:00 P.M., not documented as given at 9:00 A.M. on 2/11/26, 2/12/26, and 2/13/26;-Lorazepam concentrate 2mg/ml, administer 0.5 ml (1 mg), scheduled for every 12 hours, at 9:00 A.M. and 9:00 P.M., not documented as given at 9:00 P.M. on 2/10/26, 2/11/26, 2/12/26, and 2/16/26;-A handwritten order, undated, for lorazepam concentrate 2mg/ml, administer 0.5 ml (1 mg), every 4 hours PRN (as needed). Time row listed PRN 1, PRN 2, PRN 3, and PRN 4;--In column for PRN 1, for 2/16/26, the time 10:00 A.M., was written in (no nurse initials);--In column for PRN 2, for 2/16/26, the time 10:05 A.M. was written in (no nurse initials);-A handwritten order, undated, for lorazepam concentrate 2 mg/ml, administer 1 ml (1 mg) now;--The time row had 10:15 A.M. written in;--LPN C's initials inside MAR box for 2/16/26;-A handwritten order, undated, for lorazepam concentrate 2 mg/ml, administer 1 ml every 5 minutes, times 3 doses, as needed for uncontrolled seizures;--Time row listed PRN 1, PRN 2, PRN 3, with blank MAR boxes. Review of the hospice company's Patient Care Order (Verbal Order) sheet, dated 2/16/26 at 10:16 A.M., showed:-Lorazepam 2mg/ml oral concentrate, administer 1 ml (1 mg) sublingually (under the tongue) every 5 minutes as needed for uncontrolled seizures, times 3 doses;-Lorazepam 2mg/ml oral concentrate, administer 1 ml (1 mg) sublingually stat (immediately) for anxiety. Review of the resident's electronic progress notes, dated 2/16/26, showed:-No progress note regarding the resident's seizure activity at approximately 10:00 A.M. that morning; -At 2:54 P.M., LPN E documented the resident was found lying on the left side, on the floor, in front of the wheelchair. A pea-size abrasion was noted to the left forehead above the eyebrow and resident was alert and oriented times 4 (oriented (continued on next page)

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Country Villa Wellness & Rehabilitation	850 Country Manor Lane Creve Coeur, MO 63141

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to person, place, time, and situation). During an interview on 3/5/26 at 3:05 P.M., Certified Medication Technician (CMT) D said he/she worked at the facility on 2/16/26 as a CMT. He/She did not recall anyone having any seizures at the facility. He/She recalled going into the resident's room and passing medications to the resident's roommate, but did not recall seeing the resident who lived on the right side of the room. CMT D signed out the medications on the paper MAR for the people to whom he/she passed medications. When asked why none of the resident's medications were signed out on the 2/16/26 day shift, he/she said maybe the resident's MARs were not in the binder. Some residents did not have MARs, but he/she did not know who they were, how many there were, or to whom he/she reported the issue. He/She went from room to room, passing the medications, and if a resident was not in their room at the time, he/she went back later to see if they were there. During an interview on 2/26/26 at 11:56 A.M., LPN E said an aide came to him/her on the morning of 2/16/26 to report the resident had a seizure in the dining room. LPN E went to the dining room and saw the resident have three seizures, each lasting about one minute, with maybe 30 seconds in between each one. He/She did not write a progress note because the resident often had seizures but LPN E could not say how often because he/she worked the other units. During an interview on 3/4/26 at 11:00 A.M., the resident's Hospice Registered Nurse (RN) said she was on her way to the facility on 2/16/26 when the Nurse Practitioner (NP) texted her, a little before 10:00 A.M., notifying her the resident had two seizures in less than 10 minutes. At 10:00 A.M., the NP called to notify her the resident had two more seizures, they had exhausted their lorazepam orders, and they needed immediate orders for more lorazepam. The Hospice RN called the Hospice Physician, who gave additional lorazepam orders at 10:09 A.M., including one stat (given immediately) dose of 1 mg and another order to give lorazepam 1 mg every 5 minutes, for three doses total, if needed, for recurrent seizures. Review of the resident's progress note, dated 2/20/26 at 9:00 A.M., showed LPN E documented the resident had a seizure in the dining room, was taken to his/her room, placed into the bed, and given his/her seizure medications and a pain pill. No further seizure activity noted. During an interview on 02/20/26 at 11:06 A.M., with the Interim Director of Nursing (DON) and the Previous Administrator (PA), they said they expected staff to be knowledgeable of and to follow facility policies. They expected when medication was administered by a nurse or a CMT, they should document that it was administered by initialing on the resident's MAR. If there was no documentation, then it was not done/administered. During an interview on 2/26/26 at 3:09 P.M., with the Interim DON and the Current Administrator (CA), they said they expected medication to be administered as ordered. The Interim DON said the risk of not receiving seizure medication as ordered would increase the possibility of the resident having a seizure. During an interview on 2/26/26 at 11:44 A.M., the resident's physician, Physician I, said the resident admitted to the facility over two years ago because he/she was having multiple uncontrolled seizures at home. He/She had been stable, until this month, which Physician I thought was due to missed seizure medications, because things were so messed up with the medication issue at the facility. The resident told Physician I that he/she had five seizures back-to-back. The DON notified Physician I about the resident's seizure activity on 2/20/26, but Physician I was not notified about the seizure activity on 2/16/26. There have been times when residents were not getting their medications until 1:00 P.M. The resident had missed one dose of a seizure medication about six or eight months ago and had an immediate seizure episode. This is how Physician I knew the resident could not miss any seizure medications. 2743991