

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Country Villa Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored safely, physician orders and care plans were updated, and medication administration was documented appropriately, in accordance with facility policy, for one resident of five residents reviewed for self-administration of medication (Resident #1). The census was 85. Review of the facility's Ordering Self Administration of Medications policy, dated 12/15, showed:-Facility responsibility: Individual residents may self-administer medication if the following criteria are met: --Must have physician order to self-administer each particular medication; --Charge nurse must complete the self-administration of medication assessment form; --The interdisciplinary team must determine that it is safe for the resident to self-administer drugs before the resident may exercise that right; --The interdisciplinary team must also determine who will be responsible (resident or staff) for storage and documentation of the drugs, as well as the location of the drug administration (e.g. resident room, nurse's station); --Appropriate notation of these determinations will be placed in the resident's care plan; --Ability to self-administer medication is accessed every six months in skilled facilities and every year in assisted living facilities and upon change in resident's status. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/21/26, showed:-admitted on [DATE];-Cognitively intact;-No behaviors or refusal of care;-Diagnoses included chronic congestive heart failure. Review of the resident's care plan, dated 05/23/26, showed:-Focus: Self administration of medications. The resident has orders to self-administer medication;-Interventions/Tasks: Certified Medication Technician (CMT) or nurse will prepare medications for resident to self-administer;-No documentation of where the resident's medications would be stored, how staff would ensure it was administered, or who would be responsible for documenting the medication was administered. Review of the resident's June 2026 electronic physician order sheet (ePOS), reviewed on 06/02/26, showed:-Trelegy Ellipta inhalation aerosol powder (used to treat breathing disorders) 200-62.5-25 microgram (mcg), one puff orally one time a day;-Adempas (used to treat cardiovascular disease) oral tablet 2 milligrams (mg), give one tablet by mouth, three times a day;-Macitentan oral tablet (used to treat cardiovascular disease), 10 mg, give one tablet by mouth, three times a day;-An order, dated 04/21/26, for resident may go out on leave of absence with meds;-An order, dated 04/21/26, for resident may not go out on leave of absence with meds;-No order for acetaminophen (used to treat pain)-No order for eyedrops;-No order for resident to self-administer any medications. Review of the resident's progress notes, showed:-On 05/06/26 at 1:11 A.M., staff documented the resident upset about medication times. Feels that it is being given at the wrong time every day. Has been reported meds are being hoarded and not taken as they should. Resident feels that he/she should be able to take meds on his/her own;-On 05/24/26 at 11:29 A.M., staff documented when the nurse went in to give the resident medication, he/she asked the nurse what he/she was supposed to do with them. The nurse stated they were the resident's morning meds to be taken at that time, and the resident poured the medication in his/her hand. The resident said he/she already took his/her meds from his/her backup stash, and the nurse would have to call the police to get them from him/her. The resident said he/she called State to report he/she did (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: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Country Villa Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not receive medication that day. The nurse told the resident those were the medications he/she just gave him/her. The nurse walked out of the room and the resident placed the medication in an unknown place. Nursing management was made aware of the incident. Review of the resident's self-administration evaluation completed by the Director of Nursing (DON), dated 05/27/26, showed:-Able to correctly document self-administration of medications including as needed (PRN) medication: Able;-Able to demonstrate secure storage for medication kept in room: Able;-Able to correctly state situations warranting administration of PRN medication: Able;-Able to correctly document the documentation of PRN medications: Able;-Additional comments: Resident states it is his/her right to safely self-administer medications for the following reason: No reason documented. Review of the resident's progress note, dated 05/27/26 at 7:45 AM., showed the resident stated he/she was ready to self-administer medications. Assessment completed. Resident capable of self-administration of medications. Review of physician's phone order, dated 06/02/26, showed it was okay to leave medications at bedside. The resident could self-administer medications independently. Observation on 06/02/26 at 12:00 P.M., the resident lay in bed with his/her bedside table next to him/her. There was an inhaler, one unopened box of brand-name acetaminophen 650 mg capsules, two unopened boxes of brand-name acetaminophen 500 mg capsules, and several individual packets of eyedrops on the table. During an interview, the resident said he/she wanted to decide when his/her own medication was administered because the staff were giving it to him/her outside the required timeframes. He/She was prescribed orphan drugs (pharmaceutical treatments developed specifically to treat rare medical conditions, known as orphan diseases), Adempas, and macitentan for treating his/her high blood pressure. The government paid for these prescriptions so they could not be billed to the facility. The resident sent them to another address, and someone brought them to the facility once they were received. The last time they were brought to the facility, the staff misplaced them, and he/she did not receive the medication for a few days. He/She was required to work with an agency paying for the medications and provided information about when he/she took it and how many pills were left in the bottles. The staff would refuse to tell him/her how many pills were left in the bottle and he/she felt like they were going to jeopardize the assistance paying for the medications. There were strict guidelines for when the medication had to be administered, and the staff would bring the medication outside those timeframes. He/She did not want to lose the assistance because the medication was very expensive, and they might stop prescribing it if these guidelines were not met. The staff gave him/her a hard time if he/she asked for acetaminophen. He/She did not like generic acetaminophen, and the facility would not provide the name brand, so he/she ordered it on-line. He/She sometimes needed his/her inhaler, and the staff would not get it for him/her immediately and this caused problems with his/her breathing. He/She did not tell the staff when he/she ordered medications because he/she did not want the medications coming up missing again. The staff had not offered him/her a safe place to lock up his/her medications so he/she just kept them where he/she could reach them in an emergency. He/She would be willing to lock them up if there was an area to do so. During an interview on 06/02/26 at 12:10 P.M., Licensed Practical Nurse (LPN) A said he/she stopped administering the resident's medication or going in his/her room because he/she did not feel comfortable with it because the resident hid his/her medication and the LPN A did not know if or when the resident was taking the medication. The resident often refused to take the medication when staff administered it and was known to hide it between his/her legs. The resident became threatening when he/she addressed about this behavior or if staff tried to remove the medications. The resident threatened to call the police and State on staff. LPN A had no idea what medications were in the resident's room because the resident ordered them and hid them. He/She knew the resident had an order to self-administer his/her medication, but the staff were supposed to store the medications and prepare them for him/her. It was his/her understanding that the resident's physician said it was okay for the resident to self-administer if the facility said there was a policy, and they were following their policy. LPN A did not know if the resident was documenting the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Country Villa Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration or if the staff were just supposed to leave the medication with resident and take his/her word. LPN A was concerned the resident would take too much of his/her medication. The resident did not lock up the medication and had it out where other residents might be able to get hold of it. Staff were not told what to do with the medications in the resident's room or how they could be safely stored outside the nurse's stations and carts. During an interview on 06/02/26 at 12:25 P.M., CMT E said he/she did not know the resident had an order to self-medicate. He/She did not see an order when he/she administered the resident's medication earlier. He/She was new at the facility and did not know the resident well. No one told him/her the resident might hide the medication or refuse to accept it. He/She saw the resident's inhaler in his/her room, but the resident told CMT E that he/she was allowed to keep it in there. CMT E had not been given any instruction regarding leaving the resident's medication in his/her room or what to do with medications found in the room. During an interview on 06/02/26 at 12:45 P.M., the Assistant Director of Nursing (ADON) said she knew the resident had an order to self-administer his/her medication, but staff were not supposed to leave the medication bottles in the resident's room. The staff were supposed to prepare the medication. The resident refused to take the medication sometimes when it was brought to him/her, and staff would leave it for him/her to take when he/she was ready. The ADON expected nursing staff to go back later and check with the resident to ensure he/she took the medication and documented they were administered. The staff had to trust the resident to take the medication as ordered. The resident ordered over-the-counter medications online. The ADON removed several bottles of acetaminophen from the resident's room. The resident just went online and ordered more. Staff did not know what medications the resident had in his/her room because the resident would not let them know what he/she ordered. They only had one delivery of the orphan drugs, and they had been delivered to the facility. The ADON did not know anything about a friend delivering the medication or that it had been misplaced for several days. The resident had been assessed to self-administer the medication, but there were questions about whether he/she was responsible enough to do this. During interviews on 06/02/26 at 1:00 P.M. and on 06/03/26 at 10:00 A.M., the DON said he could not give good answers about the resident's self-administration. The resident continually gave staff a hard time about his/her medications and yelled them if they did not do as he/she demanded. The resident did not like certain staff and refused to take medication from them. He/She wanted the medication prepared in front of him/her and sometimes refused it, even if he/she saw it poured from the bottles. The staff would hand him/her medication and he/she refused to take it, and then refused to give it back to the staff to be administered later. He/She yelled at staff and threatened to call the police or the State on them, stating it was his/her right to take the medication when he/she wanted it. The resident continually called the DON at all hours of the day and night to complain about staff and demand his/her medication immediately. He/She hid the medication in his/her room or on his/her person and refused to return it to the staff. The resident ordered over-the-counter medication online and did not tell staff it was delivered and refused to give the medication to nursing staff for storage. The staff have removed medication from the resident's room several times, but he/she kept getting more. The DON assessed the resident for the capability of being able to administer his/her own medications because he/she kept demanding it. The resident was cognitively able to answer the questions, but the DON had concerns about the resident's ability to be responsible for the medication. Staff were supposed to keep the medications stored at the nurse's station, prepare them for administration, and leave the medication with the resident to self-administer when he/she was ready to take it. Staff did not go back and check with the resident to see if he/she took the medication. They documented it as administered as soon as it was given to the resident. Staff took the resident's word it was being taken as ordered. Since the medication was supposed to be stored at the nurse's station, he did not think the resident needed to be provided with a locked area to keep the medication safe. The acetaminophen and eye drops should have been on the resident's physician's orders, but they did not know the resident ordered them him/herself. The DON (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Country Villa Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed the resident the prior week and got an order from the physician to self-administer but missed updating it in his/her medical record. He did not know the information about documentation and storage needed to be included in his/her care plan. They had not run into an issue like this before and thought the assessment showing the resident was knowledgeable about the medication and documentation was enough to meet the guidelines to self-medicate. During an interview on 06/03/26 at 10:00 A.M., the Administrator said he expected staff to follow the facility's policy on self-administration of medication. Staff should be following up with the resident to ensure he/she took his/her medication and there should be documentation it was taken properly. The resident should take the medication safely in his/her room. 3016857		