| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265534 | A. Building<br>B. Wing | 03/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heritage Care Center | 4401 North Hanley Road<br>Saint Louis, MO 63134 |

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 0553<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>Based on observation, interview and record review, the facility failed to allow one resident (Resident #4) to participate in his/her own plan of care, when the resident was placed in a secured/locked unit based solely on his/her history of justice involvement. This failure did not support the resident's goals, choices, and preferences. This practice affected one resident who was admitted into the facility and immediately placed on the secured unit due to his/her status as a sex offender (Resident #4). The resident was described as being visibly upset when he/she got to the facility. The resident stated he/she did not want to come to this facility, and no one asked or provided him/her any paperwork. The resident stated he/she didn't do anything and didn't know why he/she was locked up in this place. The sample was 5. The census was 111.<br><br>Review of the facility's Sex Offender (Resident) Policy, revised 12/1/22, showed:<br><br>-Purpose: Establish policy and protocol to develop good risk management practices regarding the decision to admit registered sex offenders; Establish procedure for assessing where residents will reside in facility; Protecting all residents from abuse while abiding by anti-discrimination laws to protect prospective and current residents from unfair treatment or discrimination;<br><br>-Procedure:<br><br>-The facility that maintains housing of a sex offender must provide appropriate supervision commensurate with the risk posed by the resident. This entails an obligation to analyze the risk posed by the resident's placement on the registry, in determining the level of supervision and assistive devices required to monitor the resident;<br><br>-The facility will check all resident referrals evenly to abide by Medicare and Medicaid anti-discrimination laws to protect prospective and current residents from unfair treatment or discrimination, because of race, color, national origin, disability, age, sex (gender), or religion;<br><br>-The Interdisciplinary Team (IDT) admission team will determine if they can meet the residents' needs taking into consideration the following:<br><br>-Analyze and assess the residents for abusing other residents;<br><br>-Ensure the following criteria for sex offenders is also met for admission to the facility:<br><br>(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 0553<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The resident must not have displayed sexually aggressive and/or sexually abusive behaviors towards another resident residing in any other nursing facility within the past twelve months;<br><br>-The resident must agree to register the facility address as their own in the sexual offender registry;<br><br>-A sexually violent predator refers to a person who has been adjudicated guilty of a sex offense or acquitted on the grounds of mental disease or defect of a sex offense that makes the person likely to engage in predatory sex offenses;<br><br>-Notify admitting physician and Medical Director that the resident is a sex offender;<br><br>-The treating physician must be informed of a resident's status on the registry and input solicited as to the physician's assessment of the resident's risk for committing abuse;<br><br>-Immediately address any sexually inappropriate behaviors with all offending residents;<br><br>-Discharge Restrictions:<br><br>-A resident's status on the sex offender registry, by itself, does not give a facility the right to seek involuntary discharge of the resident;<br><br>-Federal and state laws relating to discharge require showing that a resident's behaviors have negatively impacted other residents;<br><br>-For example, Federal certification regulations applicable to nursing facilities allow a discharge if the safety of individuals in the facility is endangered.<br><br>Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/14/25, showed:<br><br>-admission date: 3/26/25;<br><br>-Cognitively intact;<br><br>-Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): Behavior not exhibited;<br><br>-Upper/Lower extremities: Impairment on one side;<br><br>-Cane/Crutch;<br><br>-Diagnoses included diabetes, seizure disorder or epilepsy, cerebrovascular accident (CVA, stroke), and hypertension.<br><br>Review of the resident's Discharge Planning Review Social Services, dated 3/29/25 at 1:43 P.M., showed:<br><br>(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 0553<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Description: Quarterly;<br><br>-Select one for resident's overall goal established during assessment process: Expects to be discharged to another facility;<br><br>-What determination was made by the resident and the care planning team regarding discharge to the community? Determination not made;<br><br>-Treatment care/needs: Left blank. No response;<br><br>-Overall summary of potential for discharge: Resident is a sex offender.<br><br>-Resident is his/her own responsible party.<br><br>Review of the resident's care plan, in use at the time of the investigation, showed no documentation regarding placement on the secured unit. The care plan and physician orders in the resident's medical records were sent with him/her from the previous facility and were dated 2024. Nothing was documented for 2025. The medical record did not contain documentation related to communication with the resident regarding the transfer to the facility or assessments completed to ensure the facility could provide necessary care and treatment.<br><br>Review of the resident's medical record notes, showed:<br><br>-3/27/25 at 6:14 P.M., adjusting well. No behaviors noted;<br><br>-3/26/25 at 6:41 P.M., Clinical admission, mood and behavior, mood is pleasant, no unwanted behaviors witnessed;<br><br>-3/26/25 at 6:33 P.M., Skilled evaluation, mood and behavior, no unwanted behaviors witnessed;<br><br>-No documentation related to previous or current sexual abuse behavior towards other residents;<br><br>-No documentation related to medical risk assessments of sexual abuse towards other residents determined and/or completed.<br><br>Observation and interview on 4/23/25 at 11:36 A.M., showed the resident on the secured unit. He/She sat on the edge of his/her bed with the door open. The resident said he/she was at the sister facility (another skilled nursing facility owned by the same corporation). He/She didn't want to come here. His/Her voice raised a little louder and said again that he/she didn't want to be here. The resident was shaking his/her head no, while he/she spoke about not wanting to be at the facility. He/She didn't know how he/she had gotten over here. He/She just ended up here. No one asked him/her if he/she wanted to come here and nobody gave him/her any papers about coming here. The resident told the facility that he/she didn't want to be here. He/She wanted to go back to his/her previous facility. He/She didn't know why he/she was in the locked unit. No one told him/her. He/She didn't do anything and doesn't know why he/she was locked up in this place. He/She didn't like being locked in here. He/She felt bad because he/she couldn't come and go in the facility. He/She didn't do anything. He/She wanted to go back where he/she came from.<br><br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 4/22/25 at 11:54 A.M., the Social Service Director (SSD) said the resident had been sent over from their sister facility. The resident was a sex offender, and she guessed that facility couldn't host him/her. The resident was pretty upset when he/she got to the facility. Sex offenders can only go to certain facilities, this is one of them. She thought there was a miscommunication about the types of residents the sister facility could have. She called corporate and told them the resident didn't want to be here. By the look on the resident's face, he/she didn't know he/she was coming to this facility. The resident didn't know why he/she came here. The SSD expected the sister facility and the admission Coordinator to have asked the resident where he/she wanted to go. The resident should have options. The admission Coordinator facilitated the resident's transfer. The transfer was not done correctly. The resident was on a locked unit because that's the policy for sex offenders at the facility. The SSD didn't want to put him/her on the locked unit. She didn't know the resident didn't know he/she was coming. The resident wasn't given transfer/discharge paperwork. He/She didn't have any of his/her belongings. She expected the resident to be asked where he/she wanted to live and for referrals to have been placed to give him/her options.<br><br>During an interview on 4/23/25 at 12:10 P.M., the Regional Nurse Director of Operations (RNDO) said the resident was transferred/discharged improperly. She said the sister facility did an improper discharge, and this facility had an improper admission. The resident wasn't given any paperwork related to the transfer. He/She was just swapped from the sister facility. She thought the resident was going back to the sister facility within a day or so. The resident would be given the 30-day notice, asked where he/she may want to live, and they would complete referrals based on what the resident said. The RNDO said the resident was on the locked unit because he/she was a sex offender and sex offenders went to the locked unit, per the facility policy. The RNDO said she was not aware the resident could not be put on a locked unit based on sex offender status. Per their policy, the resident had to go on a locked unit because he was a sex offender.<br><br>MO00252881 |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>Based on interview and record review, the facility failed to facilitate residents' rights to have reasonable reliable access to and privacy in their use of electronic communications such as email and video communications, for internet research and to watch television when the facility failed to provide WiFi services. This had the potential to affect all residents at the facility. The sample was 7. The census was 106.<br><br>Review of facility's Internet Provider documentation, showed:<br><br>-Notice of Material Breach:<br><br>-The facility was sent notification on/or around 9/16/24 by the Internet Provider that detailed the facility's violation of their Acceptable User Policy and the agreement. The facility shared its business/office only internet with the residents living at the facility. The residents then hooked up their personal devices to the business/office only internet. The facility allowed the continued use of the business/office only internet by the residents even after multiple Internet Provider notifications. The facility was given a timeframe to add a resident internet service package before the facility's internet was suspended and/or terminated due to unacceptable user policy violations. At the time of the on-site investigation, some residents still didn't have access to internet.<br><br>During an interview on 6/25/25 at 9:27 A.M., Resident #1 said he/she had gotten his/her TV mounted up on the wall in his/her new room. He/She needed the internet for watching TV. He/She said the internet didn't always work. There was no internet service. It had been out a while, but resident couldn't say how long.<br><br>During an interview on 6/25/25 at 10:58 A.M., Resident #13 said he/she couldn't listen to music or watch TV because the facility didn't have internet for a while. He/She was upset about the facility not having internet. The resident didn't have internet access and he/she didn't know why. He/She could not say how long how long he/she had been without internet access.<br><br>During an interview on 6/25/26 at 12:43 P.M. and 1:00 P.M., the Administrator said they found out the Internet Provider disconnected their internet service from the letter dated in 3/07/25. The Administrator thought the apartment building across the street from the facility got a hold of the WiFi password because some of the facility staff live there. The Internet Provider said there was extreme usage. That's why the internet was turned off/disconnected. The facility needed an encrypted code for the internet but she not sure how they would get the code to each resident device. The Administrator said the facility didn't have the right internet account. They were supposed to have a sharing account. She said the Business Manager was on the phone at that time trying to see how to get a shared internet account.<br><br>During a telephone interview on 6/25/24 at 1:10 P.M., an Internet Provider representative said the facility had a business internet line for office use only. They were letting the residents use that internet to hook up their personal devices, which was what got them the violation.<br><br>(continued on next page) |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a telephone interview on 6/26/25 at 11:47 A.M., an Internet Provider representative said the most recent notices that were sent to the facility were dated 5/11/25 and 5/28/25. The facility internet services were suspended for two unacceptable use violations. A representative from the Property Theft Department said the facility was in breach of the agreement because it shared the password with residents. The account the facility had was for office/business use only and not for any other purpose. A bulk service package needed to be added to accommodate resident use. He/She said the facility had originally promised not to share the internet services.<br><br>During an interview on 6/26/25 at 12:53 P.M., the Regional Nurse Consultant (RNC) said the facility just provided WiFi to the residents and didn't know the facility was required to provide residents with WiFi.<br><br>During an interview on 6/26/25 at 10:51 A.M., the Administrator said she didn't know the internet issue had been going on since 9/2024. She only thought it had been an issue since 03/2025. She expected the residents to have access to the WiFi.<br><br>During an interview on 6/26/25 at 2:53 P.M., the Administrator said they went through the facility's corporate Internet Technology (IT). Corporate IT was supposed to work on anything IT related in the building. The facility contacted its company's IT to provide resident internet after the complaint investigation exit.<br><br>MO00255664 |

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| F 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).<br><br>Based on observation, interview, and record review, the facility placed one resident (Resident #4) on a secured/locked unit within the facility, without clinical justification and an assessment of whether the individual met the criteria for admission on to a secured unit. The facility placed the resident, who was cognitively intact and their own responsible person, on the secured unit- based solely on his/her status as a registered sex offender. The resident stated he/she did not want to come to this facility, and no one asked or provided him any paperwork. The resident stated he/she didn't do anything and didn't know why he/she was locked up in this place. The sample was 5. The census was 111.<br><br>Review of the facility's Sex Offender (Resident) Policy, revised 12/1/22, showed:<br><br>-Purpose: Establish policy and protocol to develop good risk management practices regarding the decision to admit registered sex offenders; Establish procedure for assessing where residents will reside in facility; Protecting all residents from abuse while abiding by anti-discrimination laws to protect prospective and current residents from unfair treatment or discrimination;<br><br>-Procedure:<br><br>-The facility that maintains housing of a sex offender must provide appropriate supervision commensurate with the risk posed by the resident. This entails an obligation to analyze the risk posed by the resident's placement on the registry, in determining the level of supervision and assistive devices required to monitor the resident;<br><br>-The facility will check all resident referrals evenly to abide by Medicare and Medicaid anti-discrimination laws to protect prospective and current residents from unfair treatment or discrimination, because of race, color, national origin, disability, age, sex (gender), or religion;<br><br>-The Interdisciplinary Team (IDT) admission team will determine if they can meet the residents' needs taking into consideration the following:<br><br>-Analyze and assess the residents for abusing other residents;<br><br>-Ensure the following criteria for sex offenders is also met for admission to the facility:<br><br>-The resident must not have displayed sexually aggressive and/or sexually abusive behaviors towards another resident residing in any other nursing facility within the past twelve months;<br><br>-The resident must agree to register the facility address as their own in the sexual offender registry;<br><br>-A sexually violent predator refers to a person who has been adjudicated guilty of a sex offense or acquitted on the grounds of mental disease or defect of a sex offense that makes the person likely to engage in predatory sex offenses;<br><br>-Notify admitting physician and Medical Director that the resident is a sex offender;<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The treating physician must be informed of a resident's status on the registry and input solicited as to the physician's assessment of the resident's risk for committing abuse;<br><br>-Immediately address any sexually inappropriate behaviors with all offending residents;<br><br>-Discharge Restrictions:<br><br>-A resident's status on the sex offender registry, by itself, does not give a facility the right to seek involuntary discharge of the resident;<br><br>-Federal and state laws relating to discharge require showing that a resident's behaviors have negatively impacted other residents;<br><br>-For example, Federal certification regulations applicable to nursing facilities allow a discharge if the safety of individuals in the facility is endangered.<br><br>Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/14/25, showed:<br><br>-admission date: 3/26/25;<br><br>-Cognitively intact;<br><br>-Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): Behavior not exhibited;<br><br>-Upper/Lower extremities: Impairment on one side;<br><br>-Cane/Crutch;<br><br>-Diagnoses included diabetes, seizure disorder or epilepsy, cerebrovascular accident (CVA, stroke), and hypertension.<br><br>Review of the resident's Discharge Planning Review Social Services, dated 3/29/25 at 1:43 P.M., showed:<br><br>-Description: Quarterly;<br><br>-Select one for resident's overall goal established during assessment process: Expects to be discharged to another facility;<br><br>-What determination was made by the resident and the care planning team regarding discharge to the community? Determination not made;<br><br>-Treatment care/needs: Left blank. No response;<br><br>-Overall summary of potential for discharge: Resident is a sex offender.<br><br>(continued on next page) |

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|---|---|
| F 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Resident is his/her own responsible party.<br><br>Review of the resident's care plan, in use at the time of the investigation, showed no documentation regarding placement on the secured unit.<br><br>Review of the resident's medical record notes, showed:<br><br>-3/27/25 at 6:14 P.M., adjusting well. No behaviors noted;<br><br>-3/26/25 at 6:41 P.M., Clinical admission, mood and behavior, mood is pleasant, no unwanted behaviors witnessed;<br><br>-3/26/25 at 6:33 P.M., Skilled evaluation, mood and behavior, no unwanted behaviors witnessed;<br><br>-No documentation related to previous or current sexual abuse behavior towards other residents;<br><br>-No documentation related to medical risk assessments of sexual abuse towards other residents determined and/or completed.<br><br>Observation and interview on 4/23/25 at 11:36 A.M., showed the resident on the secured unit. He/She sat on the edge of his/her bed with the door open. The resident said he/she had been at a sister facility (another skilled nursing facility owned by the same corporation). He/She didn't want to come to this facility. His/Her voice raised a little louder and said again that he/she didn't want to be here. The resident was shaking his/her head no, while he/she spoke about not wanting to be at the facility. He/She didn't know how he/she had gotten over here. He/She just ended up here. No one asked him/her if he/she wanted to come here and nobody gave him/her any papers about coming here. The resident told the facility that he/she didn't want to be here. He/She wanted to go back to his/her previous facility. He/She didn't know why he/she was in the locked unit. No one told him/her. He/She didn't do anything and doesn't know why he/she was locked up in this place. He/She didn't like being locked in here. He/She felt bad because he/she couldn't come and go in the facility. He/She didn't do anything. He/She wanted to go back where he/she came from.<br><br>During an interview on 4/22/25 at 11:54 A.M., the Social Service Director (SSD) said the resident had been sent over from their sister facility. The resident was a sex offender, and she guessed that facility couldn't host him/her. The resident was pretty upset when he/she got to the facility. Sex offenders can only go to certain facilities, this is one of them. She thought there was a miscommunication about the types of residents the sister facility could have. She called corporate and told them the resident didn't want to be here. By the look on the resident's face, he/she didn't know he/she was coming to this facility. The resident didn't know why he/she came here. The SSD expected the sister facility and the admission Coordinator to have asked the resident where he/she wanted to go. The resident should have options. The admission Coordinator facilitated the resident's transfer. The resident was on a secured unit because that's the facility policy for sex offenders. The SSD didn't want to put him/her on the locked unit. She didn't know the resident didn't know he/she was coming. The resident wasn't given transfer/discharge paperwork. He/She didn't have any of his/her belongings. She expected the resident to be asked where he/she wanted to live and for the resident to be given options.<br><br>(continued on next page) |

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|---|---|
| F 0603<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 at 12:10 P.M., the Regional Nurse Director of Operations (RNDO) said the resident was transferred/discharged improperly. She said the sister facility did an improper discharge, and this facility had an improper admission. The resident wasn't given any paperwork related to the transfer. He/She was just swapped from the sister facility. She thought the resident was going back to the sister facility within a day or so. The resident would be given the 30-day notice, asked where he/she may want to live, and they would complete referrals based on what the resident said. The RNDO said the resident was on the locked unit because he/she was a sex offender and sex offenders went to the locked unit, per the facility policy. The RNDO said she was not aware the resident could not be put on a locked unit based on sex offender status. Per their policy, the resident had to go on a locked unit because he was a sex offender.<br><br>MO00252881 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>Based on interview and record review, the facility failed to ensure before the facility transferred or discharged a resident, they notified the resident, who was his/her own responsible party, of the transfer or discharge and the reasons for the move in writing. The facility failed to ensure the notice of transfer or discharge was made by the facility at least 30 days before the resident was transferred or discharged , and that the discharge or transfer notice included the reason for transfer or discharge, effective date, location in which the resident would be discharged , and the resident's right to appeal for one resident (Resident #5). The sample was 5. The census was 111.<br><br>Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave policy, revised 5/14/24, showed:<br><br>-Purpose: Establish policy and procedure regarding the transfer/discharge of residents;<br><br>-Definitions:<br><br>-Facility Initiated Transfer or discharge: A transfer or discharge which the resident objects to, which did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences;<br><br>-Consent to or agreement with the discharge or transfer means that the resident or their legally authorized representative has consented to or agreed with the transfer or discharge;<br><br>-Consent or agreement of the resident means that resident, with sufficient mental capacity to fully understand the effects and consequences of the transfer or discharge, consents to or agrees with the transfer or discharge;<br><br>-Legally authorized representative means a duly appointed guardian or attorney-in-fact (POA, power of attorney) who has current and valid power to make health care decisions or the resident;<br><br>-Any consent shall be documented in the medical record;<br><br>-Transfer and discharge:<br><br>-Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility;<br><br>-Specifically, transfer refers to the movement of a resident form a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility;<br><br>-Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected;<br><br>(continued on next page) |

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| | 265534 | A. Building<br>B. Wing | 03/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heritage Care Center | 4401 North Hanley Road<br>Saint Louis, MO 63134 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Documentation in electronic medical record:<br><br>-When a resident is discharged or transferred the interdisciplinary team (IDT) Discharge Summary (recapitulation) must be completed in the electronic medical record (EMR);<br><br>-Notice of discharge or transfer:<br><br>-Who must receive notice:<br><br>-Before any resident is transferred or discharged under a facility-initiated transfer or discharge, the facility must:<br><br>-Notify the resident and the resident representative the reason for the transfer or discharge in writing in a manner they understand;<br><br>-Notify a representative of the Office of the State Long-Term Care Ombudsman;<br><br>-A copy of the discharge/transfer notice shall be sent to the Ombudsman at least 30 days in advance of the discharge or as soon as possible;<br><br>-The written notice shall include the following information:<br><br>-The reason for the transfer or discharge;<br><br>-Effective date of the transfer or discharge;<br><br>-Location to which the resident is being transferred or discharged , including specific address;<br><br>-Resident's right to appeal the transfer or discharge notice to the Department of Health and Senior Services within 30 days of the receipt of the notice and the address to which the request shall be sent;<br><br>-That if the resident files an appeal, they can remain in the facility unless and until a hearing official finds otherwise;<br><br>-The name, address, e-mail, and telephone number of the designated regional long-term care ombudsman office;<br><br>- If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable one the updated information becomes available;<br><br>-The Administrator, Social Service Manager or their designee is responsible for drafting the transfer/discharge letter. This letter shall be sent to the Reliant Care Management Company Chief Compliance Officer for review. The legal review will ensure that the letter meets all the legal requirements, but the decision to discharge the resident and where to discharge the resident is fully the facility's decision;<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -When the facility transfers or discharges the resident to another care facility or provider, the following information (at a minimum) shall be provided to the new facility or provider:<br><br>-Contact information of the physician responsible for the care of the residents;<br><br>-The resident's representative;<br><br>-Advance Directive information;<br><br>-All special instructions or precautions for ongoing care, as appropriate;<br><br>-Comprehensive care plan goals;<br><br>-All other necessary information, including a copy of the resident's discharge summary, to ensure a safe and effective transition of care;<br><br>-In order to provide the information above, the facility shall complete the transfer/discharge summary. This summary will be sent with the resident as it contains the information required above;<br><br>-Orientation for transfer/discharge:<br><br>-The facility shall provide sufficient preparation and orientation to ensure that the resident has a safe and orderly transfer or discharge. This includes informing the resident where he or she is going and taking steps to minimize anxiety;<br><br>-Orientation may include explaining to a resident whey they are going to other location or leaving the facility;<br><br>-Orientation could include working with family or resident's representative to assure that the resident's possessions are not left behind or lost;<br><br>-Orientation should be documented in the medical record including the resident's understanding regarding the transfer or discharge.<br><br>Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, target date 2/25/25, showed:<br><br>-Cognitively intact;<br><br>-Diagnoses included, depression, diabetes, and multidrug resistant organism (MDRO);<br><br>-Participation in goal setting and assessment:<br><br>-Resident's overall goal: blank;<br><br>-Referral: Has a referral been made to the local contact agency (LCA): No.<br><br>Review of the resident's medical record, showed the resident was his/her own responsible party.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's care plan, in use at the time of the investigation, showed:<br><br>-Problem:<br><br>-Resident at risk for signs/symptoms of Resident Relocation Stress Syndrome (RRSS, a set of symptoms that occur when an individual moves from one environment to another, particularly those who are seniors that could include any of the following: confusion, dependency, anger, depression, withdrawal, behavioral changes);<br><br>-Desired Outcome: Resident will not have any signs/symptoms of RRSS prevented/mitigated. Revision: 11/30/24;<br><br>-Interventions included:<br><br>-Identify the resident's past coping techniques and, if indicated determine a plan for using those in the current relocation situation. Date initiated: 11/27/24;<br><br>-Monitor the resident for any changes in behavior related to the relocation process. Date initiated: 11/27/24;<br><br>-Monitor the resident for any changes in physical status. Date initiated: 11/27/24;<br><br>-Update the interdisciplinary assessment/individual service plan to reflect the resident's desire and needs for consideration in relocation. Dated initiated: 11/27/24;<br><br>-No updated documentation related to the resident's desire and needs for consideration in relocation to sister facility.<br><br>Review of the Social Services (SS) discharge planning review, dated 3/25/25 at 11:24 A.M., showed:<br><br>-Description: Quarterly;<br><br>-Anticipated length of stay: Sister Facility;<br><br>-As stated by whom: Resident;<br><br>-One overall goal established during assessment process: Expects to be discharged to another facility;<br><br>-What determination was made by the resident and the care planning team regarding discharge to the community? Determination not made;<br><br>-Treatment care/needs: Potential Treatment Needs: left blank;<br><br>-Overall summary of potential for discharge: left blank.<br><br>Review of the resident's progress note, showed:<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -3/25/25 at 9:17 A.M., SS spoke with the resident for the second time about relocating as he/she wanted to be in a facility closer to the city and there is availability at our sister facility. He/She will be relocated to the facility today;<br><br>-No documentation of communication with the resident related to relocating to the sister facility and/or any other facility.<br><br>Review of the resident's progress notes, showed:<br><br>-3/26/25 at 8:25 A.M., discharge summary: resident discharged to another facility. Alert and oriented when discharged . discharged with all belongings, skin free of all breakdowns Licensed Practical Nurse (LPN) M;<br><br>-No documentation of facility referral inquiries;<br><br>-No documentation of conversations with the resident and/or prospective facilities related to referrals and/or transfers from 12/1/24 through 3/26/25;<br><br>-No documentation of written discharge notification;<br><br>-No documentation of family notification;<br><br>-No documentation of physician notification;<br><br>-No documentation of medication reconciliation;<br><br>-No documentation of Ombudsman notification;<br><br>-No documentation of appeal information.<br><br>During an interview on 4/22/25 at 11:54 A.M., the SS Director said the resident wanted to be in the city. He/She wanted to be somewhere else. She went over the discharge process with the resident. She didn't do the referrals, Admissions did that. The Admissions staff took another position, so moving forward, she would be more involved with this process. She expected there to be documentation related to discharge communications and referrals for the resident. She expected the facility's policy to be followed.<br><br>During an interview on 4/25/25 at 11:10 A.M., the Regional Nurse Director of Operations (RNDO) said they didn't follow the process for the resident's discharge. She said the guardian was called and gave the facility permission for the discharge to a sister facility. The resident wasn't offered any other places to live. They were just swapping residents with another facility. They should have documented discussing the resident's move with the family to the other facility and should have documented asking the resident if he/she wanted to go. She expected the facility to follow its discharge policy, the resident to have been offered other options, and for staff to have documented the communications.<br><br>MO00252881 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on interview and record review, the facility failed to meet professional standards when staff did not clarify the instructions on one resident's discharge paperwork with the eye clinic after his/her eye appointment, which resulted in his/her eye surgery not being scheduled (Resident #6). The sample was 5. The census was 111.<br><br>Review of the facility's Transcription of Orders/Following Physician's Order policy, revised 5/18/24, showed:<br><br>-Purpose: The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;<br><br>-Procedure: Clarification of physician's orders will be obtained if the order is either unclear or the nurse is uncomfortable in implementation of the physician's orders.<br><br>Review of Resident #6's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, target date 2/26/25, showed:<br><br>-Cognitively intact;<br><br>-Wheelchair;<br><br>-Diagnoses included, diabetes, thyroid disorder (any condition that causes the thyroid gland to produce too much or too little thyroid hormone or that affects the structure or function of the thyroid gland), and Schizophrenia (a serious mental illness that affects a person's ability to think feel, and behave clearly).<br><br>Review of the resident's care plan, in use at the time of the investigation, showed:<br><br>-Problem: Resident has hyperthyroidism and is at risk for cardiac complications/chest pain, revised 2/28/24;<br><br>-Desired outcome: Resident will have no complications related to hyperthyroidism through the review date, target date 3/16/25;<br><br>-Interventions included: Keep lighting adequate but glare free and as low as tolerated for safety to prevent eye irritation.<br><br>Review of the resident's Optometry order form, dated 2/10/25, showed: Referral: Refer to Ophthalmologist for cataract surgery (removal of the natural lens of the eye that has developed a cataract, an opaque or cloudy area), both eyes.<br><br>Review of the resident's progress notes, showed:<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -2/10/25 at 3:38 P.M., resident was seen by the eye doctor today in the facility and was given a referral to be seen by another eye doctor for possible cataract surgery. The eye center was called and appointment was set for Wednesday, 2/19/25 at 2:00 P.M.;<br><br>-2/19/25 at 3:02 P.M., resident appointment was rescheduled for the eye center on 3/19/25 at 2:00 P.M.<br><br>Review of the resident's health status note, dated 3/19/25 at 4:19 P.M., showed the resident had a doctor appointment. No new orders.<br><br>Review of the resident's eye center after visit summary, dated 3/19/25, showed: Instructions from Ophthalmologist: Return for cataract evaluation.<br><br>During an interview on 4/23/25 at 11:15 A.M., the resident said he/she went to the eye center about his/her eyes at least one time. He/She didn't know about the surgery. He/She didn't know if he/she wanted the surgery or not.<br><br>During an interview on 4/22/25 at 1:33 P.M., the eye center receptionist said the resident's appointment on 2/19/25 was rescheduled due to the weather. The resident was seen in the eye center on 3/19/25. The facility was supposed to bring the resident back so the surgeon could evaluate the resident and then the cataract surgery would have been scheduled.<br><br>During an interview on 4/23/25 at 10:15 A.M., Licensed Practical Nurse (LPN) E said he/she knew the resident. When discharge paperwork came back, the assigned nurse was supposed to review it. He/She said there was nothing on the resident's discharge summary to tell the nurse what to do. The receiving nurse wouldn't have done anything because there was not a date/location/procedure documented on the paperwork. There was not a number on the discharge paperwork to call about the evaluation. The paperwork just said return for evaluation. LPN E said at the very least, the nurse should have called to clarify what they meant by return for evaluation.<br><br>During an interview on 4/23/25 at 9:59 A.M., the Medical Records staff said the nurse was responsible to make medical appointments for residents. She handled transportation, but tried to help them keep up with the appointments. When residents brought back discharge paperwork from appointments, she received the paperwork and uploaded it to the resident's EMR. The nurse was responsible to look at the discharge paperwork. The nurse made follow-up appointments. Sometimes she made the appointment and made the nurse aware. She didn't know the resident was supposed to go back to the eye center to see the surgeon.<br><br>During an interview on 4/23/25 at 10:07 A.M., LPN F, said the nurse was responsible to follow the instructions on the resident's discharge paperwork. If the discharge paperwork came back with the resident, the nurse was supposed to follow-up, make an appointment, if necessary, and then give the information to Medical Records.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 at 10:42 A.M., the Administrator and Director of Nursing (DON) both said they expected the receiving nurse, at the very least, to have called the eye center and clarify the instructions on the resident's discharge summary. They both expected nursing to go through the discharge paperwork, make appointments, and put the information on the report so someone could follow-up the next day. They expected the physician, family, and DON to be notified of the resident's return to the facility.<br><br>During an interview on 4/25/25 at 11:10 A.M., the Administrator and Regional Nurse Director of Operations both expected at the very least for staff to have verified the resident's discharge paperwork. They expected the charge nurse and DON to follow-up with the discharge paperwork instructions/recommendation.<br><br>During an interview on 4/24/25 at 8:42 A.M., the Nurse Practitioner said the resident was her patient. If the discharge paperwork said return, staff should have called and found out what to do. The staff needed to follow-up. The DON should have known to do that. Staff needed to ask questions.<br><br>During an interview on 4/24/25 at 10:06 A.M., the Medical Director said there wasn't enough information on the resident's discharge after visit paperwork for the staff to know what to do. According to the discharge instructions, from an accountability perspective, he expected the eye center to call the facility with instructions. From a clinical perspective, he would think if no one called the facility from the eye center with instructions, someone from the facility should have called the eye center to make another appointment. They should know to call to get clarification. The nurse should have wondered what return for evaluation meant.<br><br>MO00252604 |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to complete a comprehensive discharge summary for one discharged resident record reviewed (Resident #5). The sample was 5. The census was 111.<br><br>Review of the facility's Nursing Discharge Summary policy, revised 5/14/24, showed:<br><br>-Purpose: It is the policy of this facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies;<br><br>-Definitions:<br><br>-Anticipated discharge means that the discharge is planned and not due to the resident's death or an emergency;<br><br>-Continuing care provider means the entity or person who will assume responsibility for the resident's care after discharge. This includes licensed facilities, agencies, physicians, practitioners, and/or other licensed caregivers;<br><br>-Recapitulation of stay means a concise summary of the resident's stay and course of treatment in the facility;<br><br>-Reconciliation of medications means a process of comparing pre-discharged medications to post-discharge medications by creating an accurate list of both prescription and over the counter medication that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care;<br><br>-Policy: This discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plan of care after discharge. It must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualize care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another.<br><br>Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave policy, revised 5/14/24, showed:<br><br>-Purpose: Establish policy and procedure regarding the transfer/discharge of residents;<br><br>-Documentation in Electronic Medical Record (EMR): When a resident is discharged or transferred the Interdisciplinary Discharge Summary (recapitulation) must be completed in the medical record system.<br><br>Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, target date 2/25/25, showed:<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Cognitively intact;<br><br>-Toileting, upper/lower body dressing: Partial to moderate assistance;<br><br>-Diagnoses included, depression and diabetes;<br><br>-Participation in goal setting and assessment:<br><br>-Resident's overall goal: blank, unanswered;<br><br>-Referral: Has a referral been made to the local contact agency (LCA): No.<br><br>Review of the resident's physician order sheet, showed no discharge order.<br><br>Review of the resident's closed medical record, showed;<br><br>-Initial admission: [DATE], re-entry: 2/5/25;<br><br>-3/26/25 at 8:25 A.M., the resident discharged to a skilled nursing facility on 3/26/25;<br><br>-The record did not contain a complete discharge summary, which would include a final summary of the resident's status, a reconciliation of all pre and post discharge medications and a post-discharge plan of care.<br><br>During an interview on 4/22/25 at 1:00 P.M., the Director of Nursing said when a resident discharged to another care facility, the resident's medical record should have a discharge summary from all the other departments. The summary should include the medications, recapitulation of stay, if home health was ordered and what company, list of medications and how many were sent with the resident, and any follow up appointments.<br><br>MO00252881 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1), with a known history of suicidal ideation, high risk of suicide and frequent self-harming behavior received adequate supervision. The facility determined the resident required close supervision, defined as supervision from three to five feet, to ensure the resident's safety and well-being. Per the resident's care plan, the resident was to receive 1:1 monitoring. On 3/3/25, staff assigned to provide 1:1 supervision for the resident were reassigned to other duties and left the resident unsupervised in his/her room with the door closed. The resident broke the window in his/her room and used the glass to cut himself/herself resulting in multiple deep cuts requiring medical intervention. The sample size was eleven. The census was 106.<br><br>The Administrator was notified on 3/13/25 at 2:20 P.M., of an Immediate Jeopardy (IJ) which began on 3/3/25. The IJ was removed on 3/13/25, as confirmed by surveyor onsite verification.<br><br>Review of the facility's Supervision Types, no date, showed: Close Supervision: Supervise resident from a distance of three to five feet.<br><br>Review of the facility's Accidents and Supervision Policy, revised 5/18/24, showed:<br><br>-Purpose: Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:<br><br>-Implementing interventions to reduce hazard(s) and risk(s);<br><br>-Monitoring for effectiveness and modifying interventions when necessary;<br><br>-Definitions:<br><br>-Hazards: Elements of the resident environment that have the potential to cause injury or illness;<br><br>-Risk: Any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident;<br><br>-Supervision/Adequate Supervision: Intervention and means of mitigating risk of an accident;<br><br>-Implementation of Interventions: Using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes:<br><br>-Communicating the interventions to all relevant staff;<br><br>-Assigning responsibility;<br><br>-Providing training as needed;<br><br>-Ensuring that the interventions are put into action;<br><br>(continued on next page) |

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| | 265534 | A. Building<br>B. Wing | 03/14/2025 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Interventions are based on the results of the evaluation and analysis of information about hazards and risks;<br><br>-Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully;<br><br>-Monitoring and Modification: Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: Ensuring that interventions are implemented correctly and consistently;<br><br>-Supervision: Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision:<br><br>-Defined by type and frequency;<br><br>-Based on the individual resident's assessed needs and identified hazards in the resident environment.<br><br>Review of the facility's Suicide Prevention policy, revised 5/14/24, showed:<br><br>-Purpose: It is the policy of this facility to assess residents for suicidality. Additionally, it is the policy of this facility to act quickly and appropriately if a resident expresses thoughts of suicide;<br><br>-Definitions:<br><br>-Protective Factors: Personal and environmental characteristics that help protect people from suicide. It's important to note that protective factors may not counteract significant suicidal risk;<br><br>-Suicidal Ideation: Self-Reported thoughts about engaging in suicide-related behaviors;<br><br>-Suicidality: The tendency of a person to commit suicide;<br><br>-Suicide Prevention: The resident will not be left alone. One on one care will be provided until arrangements can be made for the resident to receive emergency psychiatric care, or until the resident's physician determines that the risk of suicide is no longer present.<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/22/24, showed the following:<br><br>-Cognitively intact;<br><br>-Used wheelchair;<br><br>-No impairment to upper extremities;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Diagnoses included: major depressive disorder (Serious mental health condition characterized by persistent sadness, hopelessness, and loss of interest or pleasure in activities), anxiety disorder (mental heal disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), post-traumatic stress disorder (PTSD, a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events, or set of circumstances).<br><br>Review of the resident's care plan, initiated on 1/29/25 and revised on 2/05/25, showed:<br><br>-Problem: The resident's Columbia Suicide Severity Rating Scale (C-SSRS, suicide risk assessment tool) assessment deems the resident is at high risk for suicide;<br><br>-Desired outcomes included: To keep the resident in a safe protective environment. To provide proper tools and coping skills to reduce suicidal ideation. To reduce the amount of times resident experiences suicidal ideation;<br><br>-Interventions included: Begin behavior monitoring. Begin 1:1 monitoring. Remove items from room that could be used in his/her plan. Safety Planning Interventions:<br><br>-Safety Planning Intervention:<br><br>-Warning Signs for impending crisis: left blank;<br><br>-Internal coping strategies or Activities that distract from suicidal ideations (specify);<br><br>-Person or place that helps distract them from suicidal thoughts: left blank;<br><br>-Identify person that they can talk to (specify);<br><br>-Unique hopes for the future and reason for living: left blank;<br><br>-Seek professional help from counselor or psychologist.<br><br>Review of the resident's physician order sheet in use at the time of the investigation, showed an order, dated 12/23/24, for: Behaviors, Monitor for the behaviors of binging and purging, every shift related to personal history of suicidal behavior.<br><br>Review of the resident's medical record, showed:<br><br>-On 1/12/25 at 11:01 P.M., staff documented they were made aware of the resident trying to self-harm. The resident had two sharpened pieces of a can lid. The resident said he/she was trying to cut himself/herself;<br><br>-Mental Status Exam, Date of service: 1/16/25. History from nursing/family. On 1/12/25, resident attempted to self-harm with two sharpened pieces of a can lid, attempting to cut himself/herself. Resident stated if he/she didn't get a cigarette he/she would find something else to do it with it;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -On 1/20/25 at 9:22 P.M., staff documented the resident said he/she cut himself/herself because his/her anxiety pushed him/her to it. The resident had blood on his/her pants and sleeves, but refused to let staff assess the wound. The resident claimed to have stopped the bleeding. The resident clutched an object in his/her hand. Emergency Medical Services (EMS) was called. EMS arrived with the police. After speaking with the resident, the officer was able to get the piece of glass the resident used to self-harm.<br><br>Review of the resident's C-SSRS assessment, dated 1/29/25, showed:<br><br>-Scoring is as follows: low risk 0-4, moderate risk 5-10, high risk 11-50;<br><br>-Category: High Risk;<br><br>-Score: 43.0;<br><br>-In the past month, have you wished you were dead or wished you could go to sleep and not wake up, Yes;<br><br>-In the past month, have you had any thoughts about killing yourself, Yes;<br><br>-Have you been thinking about how you might kill yourself, Yes;<br><br>-Have you had these thoughts and had some intention of acting on them, Yes;<br><br>-Have you started to work out or worked out the details of how to kill yourself, Yes;<br><br>-Do you intend to carry out this plan, No;<br><br>-Have you ever done anything, started to do anything, or prepared to do anything to end your life, Yes.<br><br>Review of the resident's progress notes, showed on 2/4/25 at 8:33 A.M., staff documented they found the resident with a laceration to his/her left arm. The resident said he/she was in his/her room and up all night having emotional issues. The resident wanted to cut himself/herself to release emotional pain. The resident said this helped him/her cope. The resident used glass from a bottle of make-up<br><br>Review of the resident's Psychosocial Post-Incident Impact Questionnaire, dated 2/4/25, showed:<br><br>-Description: Incident;<br><br>-Why were you trying to hurt yourself or others: Patient stated he/she was angry with himself/herself. He/She stated cutting helps him/her cope with emotional and physical pain;<br><br>-What do you feel the facility can do or change to allow your coping skill to be more effective: Patient stated he/she needs himself/herself back. He/She does not do good with sitting alone. He/She feels like he/she is a burden.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the resident's C-SSRS assessment, dated 2/10/25, showed:<br><br>-Category: High Risk;<br><br>-Score: 46.0;<br><br>-In the past month, have you wished you were dead or wished you could go to sleep and not wake up, Yes;<br><br>-In the past month, have you had any thoughts about killing yourself, Yes;<br><br>-Have you been thinking about how you might kill yourself, Yes;<br><br>-Have you had these thoughts and had some intention of acting on them, Yes;<br><br>-Have you started to work out or worked out the details of how to kill yourself, Yes;<br><br>-Do you intend to carry out this plan, Yes;<br><br>-Have you ever done anything, started to do anything, or prepared to do anything to end your life, Yes.<br><br>Review of the resident's mental status exam, showed:<br><br>-Date of service, 2/13/25;<br><br>-An order was placed for Abilify (medication used to treat schizophrenia (a chronic mental health condition that affects a person's thoughts, feelings, and behaviors)) 400 milligrams intramuscular (IM, administration directly into the muscle tissue) every 28 days for the management of schizophrenia, and the patient agreed to the treatment plan. Additionally, an order was given for 15-minute safety checks to closely monitor him/her well-being and intervene promptly if needed. They patient will continue to be observed for any changes in symptoms, mood, or behavior;<br><br>Review of the resident's progress notes, showed:<br><br>-On 3/1/25 at 9 P.M., staff documented it was reported to this LPN (Licensed Practical Nurse) C that resident stated he/she was very upset, and he/she had been self-harming himself/herself. Body inspection done. The resident has what appeared to be cuts on his/her arms and legs. His/her roommate said that the resident had been doing this for a couple of days. Resident called his/her family. Resident stated to other staff members that he/she was going to keep cutting himself/herself. Ambulance called;<br><br>-On 3/3/25 at 12:48 A.M., the resident broke the window in his/her room and cut his/her left arm with a piece of glass. The door to the resident's room was closed at that time. Staff discovered the resident cut himself/herself while doing rounds. The resident told staff the act of cutting takes the pain away.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 3/3/25 at 9:04 A.M., the Director of Nursing (DON) said on 3/3/25 at 12:48 A.M., the resident broke the window in his/her room and cut his/her left arm with a piece of glass. The door to the resident's room was closed at that time. Staff discovered the resident cut himself/herself while doing rounds. The resident told staff the act of cutting takes the pain away.<br><br>During an interview on 3/10/25 at 2:35 P.M. and on 3/11/25 at 4:50 P.M., the resident said he/she was on 1:1 supervision on 3/3/25. The resident said they took the 1:1 staff away because the facility was short staffed. He/She took advantage of the opportunity and broke the window. The resident said he/she was without his/her 1:1 staff for maybe 15 to 20 minutes. He/She was able to bust the window out within the 15-20 minutes the 1:1 staff was gone. He/She tried to use his/her hairbrush, but that didn't work. Then he/she wrapped a towel over his/her hand and hit the window in the corner. Most of the window broke when he/she hit the glass. The glass fell out in different size pieces. The glass fell inside the room. He/She used a medium size piece. He/She held up both index fingers, pulled them apart to approximately 5 inches to represent the medium size piece of glass used to cut his/her right arm. He/She got steri-strips on his/her right arm.<br><br>During a telephone interview on 3/11/25 at 2:28 P.M., Activity Aide (AA) F said he/she was assigned to a different resident for 1:1 on 3/3/25. He/She saw the resident's door was shut. AA F opened the door to the resident's room and saw the resident was shaking. AA F told LPN G the resident had cut himself/herself. He/She saw the resident's arm bleeding. LPN G wrapped the resident's arm up. The resident was taken to the nurse's desk to wait for the ambulance.<br><br>During an interview on 3/11/25 at 10:41 A.M., and 5:59 P.M., LPN G said he/she reassigned the 1:1 staff that was with the resident to help clean other residents due to short staffing. He/She didn't remember the name of the 1:1 staff. LPN G was going to be the 1:1 staff for the resident. LPN G and AA F went back to the resident's room. LPN G said he/she was only gone 5 minutes or less from the resident. He/She said the resident was on his/her phone playing games when he/she first went into his/her room. The resident had on long sleeves, so he/she didn't see the blood at first. After LPN G raised the resident's sleeve, he/she saw blood on the resident's right arm. He/She said the resident's arm looked like [NAME] or [NAME] Scissor Hands cut the resident's arm up. LPN G said it was horrible. LPN G said a couple of the cuts were so deep, he/she thought the resident would need stitches.<br><br>During an interview on 3/12/25 at 3:13 P.M., Certified Medication Technician (CMT) B said staff were never supposed to leave a 1:1 resident unattended. If staff needed to go to the bathroom, lunch, break, or anything else, they had to pass the 1:1 supervision to another staff member.<br><br>During an interview on 3/12/25 at 3:20 P.M., LPN N said staff should never leave a 1:1 resident. The resident should be within arm's reach. If the assigned staff had to leave, they must get a relief staff member.<br><br>During an interview on 3/12/24 at 3:32 P.M., LPN C said staff should never leave an assigned 1:1. If he/she had to do something, he/she would take the assigned 1:1 resident with him/her. It has happened before but it was easy to get a replacement.<br><br>During an interview on 3/11/25 at 5:13 P.M., the Social Service Director said she thought the 1:1s gave the resident personal attention. She knew the resident was 1:1s when he/she broke the glass, but she wasn't aware of the particulars.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 3/12/25 at 11:01 A.M. and 11:17 A.M., the Administrator said she expected the resident to have more opportunities to participate in activities and for family to be more involved. She expects staff to listen, pay attention, ask questions, provide help, and be 1:1 companion for the resident when he/she was having thoughts of self-harm. The Administrator expected staff to be within arm's length of resident's who needed 1:1s. She expected staff to stand outside of the bathroom door during toileting. She expected staff to be with their assigned 1:1 resident at all times. The Administrator said she didn't think the resident was on 1:1s when he/she broke the window. Both the Administrator and Assistant Director of Nursing (ADON) said they didn't know the resident had a 1:1 staff assigned to him/her or that the 1:1 staff had been removed due to short staff. Both said having a 1:1 staff member assigned to the resident would reduce opportunities for self-harm. The Administrator expected staff to find coverage for the resident if they have some other task to do.<br><br>During a telephone interview on 3/12/25 at 11:43 A.M., the Medical Doctor (MD) said he had planned to stop by to see the resident today. He read from the resident's psych note, dated 2/15/25, which said the resident was experiencing depression and anxiety. Due to being a high risk of suicide, other precautions were necessary. The resident had a conscious desire to inflict harm. The resident scored 46.0 on the suicide evaluation assessment and was considered high risk. The MD said 1:1 staff should never leave the resident alone; especially based on the psych note showing high risk of self-harm. He said the resident was 1:1 until he/she could be reassessed this month. The MD said 1:1 removal left the resident unattended, and if the resident committed self-harm, it would not be noticed right away, and more damage can be done.<br><br>Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.<br><br>At the time of the exit, the deficiency was lowered to the D level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s).<br><br>MO00250594<br><br>MO00250414 |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.<br><br>Based on interview and record review, the facility failed to ensure there were sufficient and competent staff to care for one resident who required 1:1 staff supervision for safety and behaviors (Resident #1). Staff failed to follow the resident's care plan intervention of avoiding power struggles when the resident wanted to go to bed but was told there was not enough staff to take him/her. This contributed to the resident's escalated aggressive behavior which resulted in the resident being sent out to the hospital via ambulance. The sample was 8. The census was 106.<br><br>Review of the facility's Sufficient Staff policy, revised 5/18/24, showed:<br><br>-Purpose: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment;<br><br>-Policy:<br><br>-The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;<br><br>-Except when waived, licensed nurses; and<br><br>-Other nursing personnel, including but not limited to nurse aides;<br><br>-The facility must ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care;<br><br>-Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's need;<br><br>-The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents needs, as identified through resident assessments, and described in the plan of care;<br><br>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/4/25, showed:<br><br>-Cognitively in tact;<br><br>-Wheelchair;<br><br>-No upper extremity impairment;<br><br>-Lower extremity impairment, both sides;<br><br>(continued on next page) |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Anxiety disorder (Intense, excessive, and persistent worry and fear about everyday situations) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life).<br><br>Review of the resident's care plan in use at the time of the investigation, showed:<br><br>-Date initiated/revised: 11/25/24;<br><br>-Problem: Resident at risk for nervousness related to the diagnosis of anxiety;<br><br>-Desired outcome: Resident will have decrease signs and symptoms of the diagnosis of anxiety;<br><br>-Interventions:<br><br>-Closely watch him/her for signs of anxiety and act before he/she loses control;<br><br>-Do not get into a power struggle with him/her;<br><br>-Don't get too close and remember his/her personal space;<br><br>-Problem:<br><br>-Revision 11/22/24;<br><br>-Resident has a long history of mental illness and frequent psychiatric hospital admissions per Pre-admission Screening and Resident Review (PASSR, a federally mandated process required for individuals seeking admission to a Medicaid-certified nursing facility);<br><br>-Desired Outcome: Stabilization of mental illness. With treatment regime ordered by physician and implementation of behavior management, revised 11/30/24;<br><br>-Interventions:<br><br>-Behavior modification program as needed;<br><br>-1:1 interventions as needed, revised 11/22/24;<br><br>-Problem: Resident is at risk for high/low emotions related to bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs);<br><br>-Desired outcome: Resident will have decrease signs and symptoms of the diagnosis of bipolar;<br><br>-Interventions:<br><br>-Be consistent. Keep routine as much as possible;<br><br>-Decrease stimulation around me when he/she display signs of anxiety;<br><br>(continued on next page) |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Do not get into a power struggle with him/her.<br><br>Review of the resident's progress notes, showed:<br><br>-5/24/25 at 12:16 A.M., resident attacked staff. Resident became upset that his/her supervision was late and that he/she had to sit at the front desk with the nurse. Resident attempted to leave nurse supervision. Nurse attempted to stop the resident. Resident attacked nurse. Resident scratched and swung at nurse. Resident threw a pitcher of water at the nurse. Resident reached for a pill crusher and fell from chair. 911 called. Two police officers and fire department Emergency Medical Services (EMS) arrived. Resident given his/her cellphone and was taken to hospital. Guardian notified. Management notified. Medical Doctor (MD) notified;<br><br>-5/24/25 at 4:05 A.M., resident returned from hospital. No new orders (NNO). 1:1 supervision continued.<br><br>Review of the facility's staffing assignment sheet for 5/23/25, showed:<br><br>-Evening shift 3:00 P.M. to 11:00 P.M.:<br><br>-D-Hall: Licensed Practical Nurse (LPN) C assigned as Nurse and Certified Medication Technician (CMT) assignment<br><br>-Two Certified Nurse Assistants (CNA) assigned odd/even rooms. One of the CNA's name had a line drawn through the name;<br><br>- CNA E left at 7:00 P.M.;<br><br>-Night shift from 11:00 to 7:00 A.M.,<br><br>-D-Hall, Split:<br><br>-Two CNAs assigned odd/even rooms;<br><br>-One staff showed up at 11:00 P.M., and was assigned to C-Hall;<br><br>-CNA G assigned to do 1:1, WNBI (will not be in);<br><br>-C-Hall:<br><br>-CNAs A and B assigned odd/even rooms. At 3:30 A.M., CNA A assigned to do 1:1;<br><br>-A-Hall, Split: Two CNAs assigned to the top and back of the hall.<br><br>Review of the facility's Staff Investigation Statements, showed:<br><br>(continued on next page) |

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| | 265534 | A. Building<br>B. Wing | 03/14/2025 |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -LPN C's statement, reported on 5/23/25: On 5/23/25 at 11:45 P.M., the resident was sitting with nurse at the nurse station. Resident stated he/she was tired and wanted to go to his/her room. Nurse reminded resident that he/she was on 1:1 monitoring and that he/she needed to wait for the person that was to be monitoring him/her. Resident stated that the nurse could monitor him/her. Nurse explained that he/she was doing an important task and could not leave at that moment. Resident became very angry and started yelling threats. Resident wheeled himself/herself away from nurse supervision. Resident made sudden stops while trying to flee from nurse in order to hit and scratch the nurse. Resident wheeled from the hallway to the dining area yelling threats of harming the nurse and himself/herself. Nurse stayed close behind the resident to keep from him/her from injury. Resident reached for a water pitcher on the medication cart and flung it at the nurse. He/She then reached forward again to grab another object from the cart and fell forward. Nurse called 911 for assistance. Two police officers and two Emergency Medical Technicians (EMT) arrived. Resident was taken to hospital via ambulance. Guardian notified. Psychiatric MD notified;<br><br>-On 5/25/25, CNA B said LPN C explained to the resident that the resident could not be in his/her room until his/her 1:1 arrived. LPN C was holding his/her wheelchair and started to lean the resident back. The resident started punching and scratching LPN C. CNA B and LPN C asked the resident to stop but he/she kept swinging. The resident also knocked a pitcher of water off the medication cart;<br><br>-Additional information provided related to CNA B's statement via telephone interview by Director of Nursing (DON). CNA B said LPN C held the wheelchair so that the resident could not go back to his/her room without 1:1 supervision. CNA B never observed LPN C tilting the resident's wheelchair backwards in any fashion;<br><br>-On 5/26/25, CNA A said he/she was on his/her hall and heard yelling. He/She came out and asked LPN C what was going on. LPN C said the resident had to sit at the nurse's station with him/her until the resident's 1:1 came. The resident started to scream and yell, saying he/she wasn't sitting up there. He/She was going to his/her fucking room. The resident proceeded to roll (towards his/her room). LPN C told the resident he/she couldn't let the resident go to his/her room. The resident continued to go to his/her room. LPN C tried to redirect the resident. That's when the resident started holding his/her wheels on the wheelchair. LPN C told the resident to stop punching and scratching him/her. CNA A left and went back to his/her hall but said he/she didn't feel comfortable leaving LPN C. CNA A walked back in and there was water all over the place. The resident grabbed everything off the nurse's cart and threw it all over the room.<br><br>During an interview on 6/25/25 at 9:27 A.M., the resident said the LPN C didn't push him/her out of the wheelchair. It started when the evening 1:1 staff had to leave. The resident had to sit up at the nurse's desk while the night 1:1 staff wasn't there. LPN C told the resident that he/she had to stay at the nurse's desk until a relief came or all night, if one didn't come. That's when the resident tried to leave the nurse's desk to go back to his/her room. The resident scratched and swung at LPN C because he/she was trying to stop him/her from going to his/her room.<br><br>(continued on next page) |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 6/26/25 at 10:13 A.M., LPN C said he/she was with the resident because they were extremely short staffed. The person that had the resident on evening shift had to leave, so the resident had to come to the nurse station while LPN C was working. The resident said he/she wanted to go to his/her room. The resident told LPN C he/she was tired. LPN C tried to explain to the resident that he/she had to stay at the nurse's station. The resident tried to leave so LPN C followed him/her. LPN C got in front of the resident. The resident swung at him/her. LPN C moved behind the resident, but the resident still tried to swing and elbow him/her from behind. LPN C didn't remember if the night staff came before the resident had been sent to the hospital or not. There was no other female staff to take the resident to bed. It was change of shift and people were leaving. If there had been someone else, he/she would have gotten that person to take the resident to bed. LPN C didn't want a confrontation. The resident was in kind of a mood and told LPN C that he/she was tired and wanted to go to bed. LPN C had only been working a few weeks when the incident happened. During orientation it was explained how to handle a 1:1 resident. Residents on 1:1 had to be in reach and room checks needed to be done.<br><br>During an interview on 6/25/25 at 10:43 A.M. CNA A said he/she had worked C-Hall. The resident was upset because he/she wanted to go to his/her room. He/She didn't remember who was the 1:1 staff for that night but said the 1:1 staff who was previously assigned to the resident left sometime after 11:00 P.M. The night shift 1:1 had not come in yet so the resident was told he/she had to sit at the nurse station. The resident was sent out to the hospital before the night 1:1 staff came.<br><br>During an interview on 6/25/26 at 1:16 P.M., the Social Worker said she didn't know the resident had been sent out. If staff were assigned to be 1:1, that person had to stay or take the resident to the nurse. The nurse could assign other staff to be 1:1 or that nurse could be the resident's 1:1 staff. Someone should have taken the resident to his/her room to sleep.<br><br>During an interview on 6/25/25 at 1:40 P.M., the Staffing Coordinator said staff who were running late should be there within 30 minutes. CNA D stayed over a little late with the resident. The nurse could have taken the resident to his/her room since the assigned staff was running late. The Staffing Coordinator said LPN C could have reassigned another staff person to sit with the resident or LPN C could have sat with the resident in his/her room until the replacement 1:1 staff arrived.<br><br>During an interview on 6/25/25 at 1:10 P.M., the Interim DON said the resident's 1:1 was running late. LPN C brought the resident to the nurse's station. He didn't know what time the assigned 1:1 finally came. The resident tried to go to his/her room. Someone else should have taken the resident to his/her room, preferably a female staff. LPN C's failure was that he/she didn't get a female staff to get the resident to bed. LPN C shouldn't have told the resident he/she would have to sit at the nurse's desk all night. LPN C was asked why he/she didn't get someone else to get the resident to bed. LPN C said he/she wasn't thinking. The Interim DON didn't think how LPN C responded helped the resident's behavior. They played on each other. It was a bad situation. LPN C didn't work on the resident's hall anymore. It was an education and training issue. LPN C was a good nurse but was still fairly new. It was a training opportunity. He expected LPN C to have changed the assignment to get someone to take the resident to his/her room.<br><br>During an interview on 6/25/25 at 2:55 P.M., the Administrator said someone should have put the resident to bed. She could understand the resident was tired and expected someone to put him/her to bed. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain effective pest control by ensuring resident rooms were free from mice and/or mice excrement in Residents #9, #10, and #11's rooms. In addition the facility failed to ensure the common/activity area on C-Hall was free from roaches. The sample was eleven. The census was 106.<br><br>Review of the facility's Pest Control policy, last reviewed 5/14/24, showed:<br><br>-Purpose: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents;<br><br>-Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitoes, flies, mice, and rats);<br><br>-Policy: Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis.<br><br>Review of the facility's pest control vendor invoices, showed:<br><br>-Dated 1/31/25, rodent and roach control, all units, exterior, offices, and common area;<br><br>-Dated 2/28/25 at 10:43 A.M., office will reach out for the raccoon. Sprayed exterior, interior, and checked rodent boxes;<br><br>-No other pest control documentation provided.<br><br>1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/19/24, showed:<br><br>-Cognitively intact;<br><br>-No functional limitations in range of motion in upper/lower extremities (ambulatory);<br><br>-Diagnoses included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and hypertension.<br><br>Observation of the resident's room on 3/11/25 at 12:15 P.M., showed mice feces/droppings in the corner of the room, along the wall and underneath the resident's shoes. There was a hole in the wall where the corners line up, approximately the size of a golf ball where the cove base had separated from the wall.<br><br>During an interview on 3/11/25 at 12:15 P.M., the resident said he/she had seen mice in his/her room. The Maintenance Supervisor was going to put down traps but he can't get rid of all the mice. Staff only mop the main part of his/her room, not where the mice feces/droppings were around his/her shoes and along the wall. He/She couldn't remember the last time he/she saw a pest company at the facility.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Review of Resident #10's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-No functional limitations in range of motion in upper/lower extremities;<br><br>-Diagnoses included diabetes and depression.<br><br>Observation of the resident's room on 3/10/25 at 1:40 P.M., showed mice feces/droppings in the closet of his/her room.<br><br>During an interview on 3/10/25 at 1:40 P.M., the resident said he/she had seen mice in his/her room.<br><br>3. Review of Resident #11's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-No functional limitations in range of motion in upper/lower extremities;<br><br>-Diagnoses included schizophrenia, depression, and dementia.<br><br>Observation of the resident's room on 3/10/25 at 1:50 P.M., showed holes inside the wall where his/her bed was pushed up against. The base cove was separated from the wall. One chocolate chip cookie was visible on the floor nearest the head of the resident's bed on the floor against the wall. Mice droppings were visible on the floor along the wall.<br><br>During an interview on 3/10/25 at 1:50 P.M., the resident said there were holes in the wall along the side of his/her bed where the mice came in and out of his/her room.<br><br>4. During an interview on 3/10/25 at 4:20 P.M., Certified Nurse Assistant (CNA) I and Laundry Attendant H both said they saw mice on A-Hall.<br><br>During an interview on 3/10/25 at 3:10 P.M., Licensed Practical Nurse (LPN) G said he/she had seen mice, but not in his/her office. He/She had only seen them in the trash cans in resident rooms.<br><br>During an interview on 3/10/25 at 1:45 P.M., the Physical Therapist said he/she had not seen any mice, roaches, bedbugs for a few weeks. He/She said there had been mice in the gym. He/She didn't know if there was a logbook for reporting pest or online system.<br><br>5. Observation of the common area/activity room on C-Hall on 3/10/25 at 2:10 P.M., showed two residents in the area at the time of the observation. One was seated at a table and the other sat on a bean bag that was on the floor. Both were watching TV. There was a brown cabinet with a sink and a microwave on top of the cabinet. There were three doors to the brown cabinet. Inside the cabinet doors were several dead roaches with egg sacs and at least four live roaches crawling on the inside of the opened cabinet door.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. During an interview on 3/11/25 at 10:16 A.M., the Medical Records Representative said the old pest company stopped coming sometime at the end of last year, so they had to get a new company. He/She said the new company had come to the building a couple weeks ago. He/She said the Administrator told him/her to provide the invoices from the new company for review. He/She didn't have any other invoices besides those two. The facility had to reach out to the old company to get previous invoices.<br><br>7. During an interview on 3/12/25 at 12:19 P.M., the Administrator said she expected the facility to have and maintain a pest control program and she expected the facility to be free from mice, roaches and other pests.<br><br>MO00250594<br><br>MO00250812 |