STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265534	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	4401 North Hanley Road 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to follow their policies when staff failed to conduct a thorough investigation of a resident-to-resident altercation between two residents, when one resident (Resident #1) pulled a screwdriver on another resident (Resident #2) and attempted to stab him/her. The sample was eight. The census was 109.Review of the facility's Incidents and Accidents policy, revised 05/18/24, showed:-Purpose: It is the policy of this facility for staff to utilize Point Click Care Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident;-Definition:Incident: An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization;-Policy: Purpose of Incident Reporting:The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management or resident care;Conducting root cause analysis to ascertain causative/contributing factors as part of the quality assurance performance improvement (QAPI) to avoid further occurrences;Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements;-Process of Incident Reporting:Licensed staff will utilize [NAME] Click Care Risk Management to report incidents/accidents and assist with completion of any investigative information to identify root causes;Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy;-The following incidents/accidents require an incident/accident report but ae not limited to:Alleged abuse;Combative behavior;Resident-to-Resident altercations;-If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing (DON) and or Administrator. Review of the facility's Abuse and Neglect policy, revised 06/12/24, included:-Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property ae reported immediately to the Administration of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Definitions:Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff-to-resident abuse and certain resident-to-resident altercations;Physical abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking;-Policy: Guidelines:The facility will develop and operationalize policies and procedures for protection of residents and for the prevention, identification, investigation, and reporting of abuse and mistreatment. The purpose is to assure that the facility is doing all that is within its (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	control to prevent occurrences;Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below;Protection: The facility will protect residents from harm during an investigation;Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences;-When suspicion of abuse or reports of abuse occur, the following procedure will be initiated: The Licensed Nurse will:-Respond to the needs of the resident and protect him/her from further incident;-Document actions taken in the medical record;-Complete an incident report, if indicated;-Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse;-The Administrator or designee will complete an Administrative Investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse;-The Administrative Investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including facts that prove or disprove the alleged situation occurred, the plan of correction or action by the Administrative staff, all statements attached from residents and staff involved and any training or education that the Administration feels needs to be provided to staff or residents to ensure education has been provided to prevent future similar situations;-The Administrative Investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician's orders were followed, the resident was re-evaluated, and the plan of care was updated to reflect the change in medical or behavioral status;-The facility DON/Designee will ensure all clinical details and supportive plan of care interventions are completed for the Administrative Investigation;-Confidentiality: After a conclusion based on facts of the investigation is determined, internal reports, interviews and witness states shall be released to those who need to know. Even if the facility investigation is not complete, the Administrator will cooperate with any Department of Health and Senior Services investigation;-Environmental Assessment: Assess the environment for circumstances which may make abuse more likely to occur;-Resident Assessment: As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis;-Pattern Assessment: Facility will further investigate and/or determine whether a change in facility practices is warranted. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/01/26, showed:-Cognitively intact;-Mood interview showed feeling down, depressed, or hopeless seven to eleven days (half or more days) and no behaviors exhibited;-Diagnoses included psychotic disorder (a set of symptoms characterized by a loss of contact with reality, where a person has trouble distinguishing between what is real and what is not) and schizophrenia (a chronic, severe mental brain disorder that distorts how a person thinks, feels, acts, and perceives reality). Review of the Health Status Note dated 02/04/26 at 4:05 P.M. showed, Licensed Practical Nurse (LPN) E said the resident became increasingly violent and aggressive toward staff and another resident. Resident was observed yelling, threatening, and posturing aggressively. Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then obtained a screwdriver and attempted to stab another resident. No physical contact or injury occurred due to immediate staff intervention. A Code [NAME] (behavior emergency) was initiated immediately. Staff successfully de-escalated the situation and separated resident from others. Resident was directed to return to his/her room, which was completed with staff assistance. Psychiatric Nurse Practitioner (NP) was notified of the incident. New orders received to send resident to the hospital for a psychiatric evaluation. Arrangements initiated per protocol. Power of Attorney (POA) was notified of the resident's behavior and transfer plan. Resident refused vital signs at the time of the incident. No visible injuries noted to resident or others. Resident remained under staff supervision until transfer. On 02/04/26 at 4:08 P.M. the Health Status Note was stricken from the record by LPN E as a mistaken entry. LPN E rewrote the entry and changed screwdriver to an object.Record review of the Health Status Note dated 02/04/26 at 4:08 P.M., showed LPN E said the resident became increasingly violent and aggressive toward staff and another resident. Resident was observed yelling, threatening, and posturing aggressively. Resident then obtained an object and attempted to stab another resident. No physical contact or injury occurred due to immediate staff intervention. A Code [NAME] was initiated immediately. Staff successfully de-escalated the situation and separated resident from others. Resident was directed to return to his/her room, which was completed with staff assistance. Psychiatric Nurse Practitioner was notified of the incident. New orders received to send resident to the hospital for a psychiatric evaluation. Arrangements initiated per protocol. Power of Attorney was notified of the resident's behavior and transfer plan. Resident refused vital signs at the time of the incident. No visible injuries noted to resident or others. Resident remained under staff supervision until transfer. Review of the resident's care plan, in use at the time of the investigation, showed no documentation regarding the most recent (02/04/26) resident-to-resident altercation. There were no interventions added prior to the on-site investigation. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Mood interview showed feeling down, depressed, or hopeless two to six days (several days) and no behaviors exhibited;-Diagnoses included: Diabetes, psychotic disorder and schizophrenia. Review of the resident's nurses' notes showed no documentation related to the resident-to-resident altercation on 02/04/26. Review of the resident's care plan, in use at the time of the investigation, showed no documentation related to the altercation on 02/04/26. There were no interventions added prior to the on-site investigation. Review of the facility's investigation, dated 02/04/26, showed:-On 02/04/26 a Code [NAME] was called for the resident's hall due to erratic behaviors between Resident #1 and #2. Upon her (Administrator's) arrival, it was reported that there was almost a resident-to-resident altercation, but staff were able to intervene and there was no harm and/or physical contact. It was reported that Resident #1 was being sent out for behaviors and that he/she was not at baseline. Resident #2 was off the hall and didn't exhibit any signs or symptoms of distress. Resident #1 returned to the facility on [DATE] and on 02/10/26, she (Administrator) interviewed him/her to find out the source of the incident;-Root Cause: Resident #1 stated that he/she was yelling and talking to himself/herself out loud, and Resident #2 thought he/she was speaking to him/her, but he/she (Resident #1) wasn't. As a result, Resident #1 stated Resident #2 came towards him/her, and he/she (Resident #1) pulled a screwdriver out and waved it around. Resident #1 stated he/she didn't touch, hit, or make any contact with anyone. Resident #1 apologized and stated that he/she and Resident #2 were good friends and enjoy watching TV and movies with one another. Resident #1 was questioned about how he/she retrieved the screwdriver, and he/she stated from the maintenance closet outside of his/her hall;-Investigation did not include written statements from staff who were involved and/or witnessed the incident;-Investigation did not include written statements (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from Resident #1 or Resident #2;-Investigation did not include written statement from the maintenance employee whose cart the screwdriver was taken from;-No documentation that care plans were updated;-No in-service education prior to on-site investigation. During an interview on 02/10/26 at 10:50 A.M., Resident #2 said Resident #1 got irritated over some money. He/She wasn't hurt by Resident #1, but Resident #1 tried to hurt him/her. Resident #1 pulled a screwdriver out on him/her (Resident #2). He/She didn't know where Resident #1 got the screwdriver from. Resident #1 had the screwdriver in his/her pocket. Resident #1 tried to hit him/her, and Resident #2 moved back. Resident #2 was able to hit Resident #1. They were close up. Resident #1 kept trying to come after him/her. Resident #1 tried to shank (slash or stab) him/her with the screwdriver. Resident #1 tried to take Resident #2's life. Staff separated them and took Resident #2 outside to smoke. Staff just tried to keep Resident #2 calm. Resident #2 didn't know what they did for Resident #1. Resident #2 said his/her feelings were hurt because he/she looked out for Resident #1. It hurt Resident #2's feelings that Resident #1 did that to him/her. The police were called and asked if he/she wanted to press charges. Resident #2 said no because he/she was not a snitch. During an interview on 02/13/26 at 12:34 P.M., Resident #1 said he/she didn't want to talk about what happened. He/She was good. During an interview on 02/10/26 at 1:40 P.M., LPN E said he/she didn't mean to write screwdriver. The object Resident #1 had was a pencil. Staff intervened immediately when observation showed Code [NAME] was initiated. Resident #1 was agitated. LPN E looked and he/she saw Resident #1 grabbing an object. (pencil). LPN E said he/she grabbed the object from Resident #1. All residents were told to go to their rooms. They tried to calm Resident #1, but it wasn't working. Emergency Services were called. The Administrator was made aware. The Administrator was at the facility when the incident occurred and when the Administrator interviewed the resident, the resident told her it was a screwdriver. During an interview on 02/12/26 at 10:28 A.M., Certified Medication Technician (CMT) B said he/she was working on the day of the incident and saw what happened. He/She was passing medication. Resident #2 was outside of his/her room and blocking the room door. CMT B asked if Resident #1 was in his/her room. Resident #2 said he/she would get Resident #1 from the room so he/she could pass the medications. It took Resident #1 a long time to come out of the room. Resident #2 said Resident #1 was mad about not getting his/her money. Resident #1 and Resident #2 started arguing about money and Resident #1 being disturbed. Resident #1 and Resident #2 were in each other's face arguing. CMT B tried to pull Resident #2 away, but he/she broke loose. Resident #1 and Resident #2 started fighting. CMT B was waiting for someone from the back hall to help break them up. Resident #1 and Resident #2 kept arguing. Resident #1 pulled out a screwdriver from his/her back pocket. CMT B ran to the door, put the code in to get Resident #2 off the hall. Afterwards, CMT B went to the Assistant Director of Nursing (ADON) and Administrator to show them the screwdriver. It was left on the Administrator's desk. There was physical contact between Resident #1 and Resident #2. When LPN C came back, he/she said there was no physical contact. CMT B said he/she said there was physical contact, and that's what he/she told the police. CMT B didn't know where Resident #1 got the screwdriver from. During an interview on 02/10/26 at 10:56 A.M., Certified Nurse's Aide (CNA) F said he/she was told Resident #1 got a screwdriver. CNA F didn't know where the screwdriver came from but said Resident #1 went into employee rooms (areas only employees go into, break rooms, linen rooms) sometimes. That was the only way he/she could see Resident #1 got the screwdriver. During an interview on 02/10/26 at 1:20 P.M., the Administrator said Resident #1 was at the hospital. She didn't know what happened on the hall, but it was her understanding, there was a verbal altercation on the hall. Resident #2 was removed from the hall. There was no physical altercation between Resident #1 and #2. Resident #1 was sent out to the hospital for behaviors. This (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wasn't Resident #1's normal baseline behavior. No one was hurt. She wasn't aware about the object or the attempt to stab anyone. The information wasn't reported to her the way it was documented in Resident #1's progress note. There may have been some statements, but she would have to check. An investigation should had been done. She expected the incident to have been reported, a full investigation completed, and interventions implemented. She didn't know Residents #1 and #2 were roommates. During an interview on 02/11/26 at 10:06 A.M., the Administrator said Resident #1 was back, and he/she went back to his/her same room. Residents pull the light fixtures down on that hall and maintenance staff have to regularly replace the lights. Maintenance staff usually have the cart with them but can't watch the cart all of the time. The maintenance cart was the only thing she could think of how Resident #1 got the screwdriver. During an interview on 02/13/26 at 10:45 A.M., the Administrator said there wasn't an investigation, but she talked to Resident #1 and could get that statement together. During an interview at 12:30 P.M., the Administrator said she just interviewed Resident #1 who was involved in the incident. She didn't know why the DON didn't start the investigation. She didn't get statements from anyone else. Behaviors were usually clinical. Resident #1 was having a behavioral outburst. The Administrator only thought about the clinical part, sending the resident out, doing the risk management part, documentation and notifications.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #7), who had a history of elopement at prior facilities, was provided adequate supervision, when staff did not confirm the resident's whereabouts for at least 4.5 hours (from 2:30 P.M. to approximately 7:00 P.M.) on 01/12/26. Review of the resident's record showed the resident had a legal guardian and diagnoses which included schizoaffective disorder (a chronic mental health condition of schizophrenia symptoms (such as hallucinations, delusions, or disorganized thinking), bipolar type (involves alternating 'poles' of intense, elevated, or irritable mania/hypomania and profound, low energy depressive episodes that severely disrupt life), lack of coordination and muscle weakness. The resident's care plan showed he/she had a history of elopement at prior facilities and interventions included intensive monitoring. The sample was eight. The facility census was 109. The Administrator was notified on 2/13/26 at 5:12 P.M., of an Immediate Jeopardy (IJ) which began on 1/12/26. The IJ was removed on 2/13/26, as confirmed by surveyor onsite verification. Review of the facility's Elopements and Wandering Residents policy, revised 6/12/24, showed:-Purpose: This facility ensures that residents who exhibit wandering behavior and/are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk;-Definition: Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal oriented or aimless;-Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., and order for discharge or leave of absence) and/or any necessary supervision to do so;-Policy:-Preventing Elopements: The facility is equipped with door locks/alarms to help avoid elopements;-Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner;-The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary;-Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering:-Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the Interdisciplinary care plan team (IDT);-The Interdisciplinary Team (IDT) will evaluate the unique factors contributing to risk in order to develop a person-centered care plan;-Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff;-Adequate supervision will be provided to help prevent elopements;-Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly;-The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff;-Procedure for Locating Missing Resident: -Director of Nursing (DON) or designee shall notify the physician, and family member or legal representative;-Appropriate reporting requirements to the State Survey agency shall be conducted;-Procedure Post-Elopement: Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. Review of the facility's Incidents and Accidents policy, revised 5/18/24, showed:-Purpose: It is the policy of this facility for staff to utilize Point Click Care Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident;Definition:-Incident: An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization;-Policy: Purpose of Incident Reporting:-The purpose of incident reporting can include:-Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care;-Conducting root cause analysis to ascertain causative/contributing factors as part of the quality assurance performance improvement (QAPI) to avoid further occurrences;-Meeting regulatory requirements for analysis and reporting of incidents and accidents;-Process of Incident Reporting: The following incidents/accidents require an incident/accident report but are not limited to:-Elopement;-Documentation should include the date, time, nature of the incident, initial findings, immediate interventions, notifications and orders obtained or follow-up information. Review of the facility's Intensive Monitoring policy, revised 4/30/24, showed:-Purpose: To ensure a system is in place for residents who require increased monitoring for crisis, behavioral psychiatric issues;-Procedure: Residents who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by the facility staff;-Definitions: Intensive Monitoring is defined as periodic (e.g. hourly, every two hours, or every shift) check by a facility staff member;-Intensive Monitoring: Intensive monitoring is provided as periodic check by a facility staff member;-Residents may require more intensive monitoring based on their crisis, behavioral, psychiatric issues. The level of intensive monitoring shall be defined by the specific situation or resident assessment;-Residents who are showing poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring or one-to-one or two-to-one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor;-Based on the assessment of the resident at the discretion of the administrative staff of the facility supervisor, either intensive monitoring, one-to-one, or two-to-one;-The facility's Interdisciplinary Team will address the residents' behavioral concerns and ensure interventions are in place to address the residents' needs;-The facility staff will document the intensive monitoring in the resident's Electronic [NAME] Record (EMR). Review of the facility's Walking Rounds Shift Report policy, revised 5/7/24, showed:-Purpose: It is the policy of this facility to used walking round shift reporting to promote successful transfer of information between nursing staff at shift change in an effort to prevent adverse events, medication errors and medical mishaps;-Policy: Walking rounds shift report will be used for a 24-hour period to ensure continuity of care;-The walking rounds shift report may only be altered by the Director of Nursing (DON), or designee, if there are changes that need to be made;-All staff will be in-serviced on the use of walking rounds shift report prior to implementation as well as upon hire and as needed. Review of Resident #7's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 11/14/25, showed the following:-The resident was cognitively intact;-Diagnoses included schizoaffective disorder, bipolar disorder, lack of coordination and muscle weakness;-Sometimes felt lonely or isolated from those around him/her;-No documented mobility devices.Review of the resident's Elopement Assessments, dated 6/2/25 and 9/5/25, showed the resident scored a zero, not at risk for elopement. During an interview on 2/11/26 at 1:42 P.M., the resident's guardian said he/she requested on 1/6/26 the resident be moved to the secured unit of the facility to prevent elopement. He/She said the resident had eloped from previous facilities and had been caught smoking marijuana at this facility and she wanted him in a more secure area. During an interview on 2/12/26 at 9:56 A.M., the social service designee said the resident was not moved after the guardian's request because there were no open beds. The (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	social worker said their interventions were to put in referrals to other facilities but hadn't gotten any information back. They moved him to the secure unit after he was re-admitted to the facility from hospital stay. Observation on 2/11/26 at 2:30 P.M., showed the resident's room on 1/12/26 was located adjacent to an exit door at the end of a hall. Review of the resident's EMR, showed no additional elopement risk assessment completed after the guardian's request to move the resident to a secured unit. Review of the resident's care plan, in use at the time of the investigation, showed:-Problem: Resident at risk of elopement due to a history of elopement from prior secure facility, date initiated: 8/22/24, and revised 8/30/24;-Desired outcome: Resident will be monitored closely and remain safe through next review;-Interventions: Face Checks/Intensive monitoring will be completed per facility protocol, date initiated 8/22/24. Review of the resident's progress notes showed:-1/6/26 at 10:56 A.M., spoke with Guardian today, he/she wants this writer to send referral to a secure unit with all males. Social Worker will search male secure facilities and send referral;-1/12/26 at 9:19 P.M., LPN A said while doing rounds staff noticed resident was not in his/her room. After searching the common areas, code white was called. Staff searched the building extensively including but not limited to all resident rooms, bathrooms, shower rooms, common areas, and outside perimeter. Resident was not located. LPN A had not seen this resident since 1/9/26 at 7:00 A.M. Other residents stated they saw him/her today, 1/12/26 at or around 8:00 A.M. Guardian was called but no answer and a message was left. 911 was called. Police responded and took a statement from LPN A. Administration was notified. DON and Assistant Director of Nursing (ADON) were notified;-1/12/26 at 11:45 P.M., resident noted to be missing from their assigned room at approximately 8:00 P.M. Resident was last seen in room. Upon discovery of the resident's absence, an immediate search was initiated. The elopement protocol was initiated. The resident remains listed as eloped at this time;-1/13/26 at 9:25 A.M., call was placed to local hospitals and jails. Both stated they didn't have the resident in care;-1/13/26 at 10:03 A.M. late entry, resident's doctor was made aware that resident remains out of the facility. Resident left Monday (1/12/26) and did not return;-1/20/26 at 12:42 P.M., received call from physician at psychiatric care hospital, requesting information about the resident's medications, stated resident's mother told him/her to call because the resident was out on the streets for the last six days. The resident had been admitted to [NAME] Jewish Hospital Psychiatric Support Center. Medications and face sheet were faxed to the hospital.-1/26/26 at 2:31 P.M., resident admitted to the facility from hospital. No new orders or comment made. Physician and Guardian aware. Review of the resident's Medication Administration Record (MAR), dated January 2026, showed the following:-Paxil Oral Tablet 20 milligram (MG) (Paroxetine HCL) Give 1 tablet by mouth one time a day for Major Depressive Disorder at 7 A.M., start date 12/27/25, not administered 1/13/26 at 7:00 A.M.;-Potassium Oral Tablet (supplement) Give 20 milliequivalent (mEq) by mouth one time a day for heart at 7 A.M., start date 10/4/25, not administered 1/13/26 at 7:00 A.M.;-Seroquel Oral Tablet (Questiapine Fumarate) Give 200 mg by mouth at bedtime for schizoaffective, start date 10/10/25, not administered 1/12/26 at 8:00 P.M.;-Synthroid Oral Tablet 25 microgram (MCG) (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism, start date 12/27/25, not administered 1/13/26 at 7:00 A.M.;-Divalproex Sodium ER Oral Tablet Extended Release 24 hour 500 MG (Divalproex Sodium) Give 500 mg by mouth three times a day for seizures, start date 10/3/25, not administered 1/12/26 at 8:00 P.M.;-Buspirone HCL Oral Tablet 7.5 MG (buspirone HCL) Give 7.5 mg by mouth two times a day for agitation, start date 10/3/25, not administered 1/12/26 at 4:00 P.M.;-Gemfibrozil Oral Tablet 600 MG (Gemfibrozil) Give 600 mg by mouth two times a day for cholesterol, start date 10/3/25, not administered 1/12/26 at 4:00 P.M.;-Propranolol HCL Oral Tablet 20 MG (Propranolol HCL) Give 1 tablet by mouth two times a day for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265534	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	4401 North Hanley Road 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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	agitation, start date 10/3/25, not administered 1/12/26 at 4:00 P.M. During an interview on 2/11/26 at 2:06 P.M. LPN C said he/she didn't know what happened with the resident's elopement. Recently, the resident had started making contact with people on social media. The last time he/she saw the resident was the afternoon on 1/12/26. When the resident didn't come for dinner, he/she sent another resident (Resident #8) to get him/her for dinner. Resident #8 said Resident #7 didn't want to be bothered. After he/she gave report to LPN A, he/she left. LPN A called him/her at home and said Resident #7 wasn't at the facility. They started a search. The Administrator was notified. He/She (LPN C) didn't check on the resident before leaving. When staff think they know where the residents are, they just pass that information on to the next shift. LPN C said that he/she should have checked on Resident #7 and not taken the word of another resident regarding his/her whereabouts. LPN C was not aware Resident #7 was not in the building until LPN A called him/her at home.During an interview on 2/11/26 at 1:12 P.M., LPN A said when he/she came to work (shift began at 7:00 P.M.), the resident wasn't at the facility. LPN A was starting his/her rounds when a Certified Nurse's Aide (CNA) came and said they had not seen the resident. A search was started. A code white was called. LPN A didn't know if that CNA had told anyone else the resident hadn't been seen before telling him/her. LPN A didn't know of any elopement history for the resident and wasn't told the resident would leave. He/She didn't know how long the resident had been gone. The resident may have pushed the emergency doors open. After a delay, the doors will open. During the search, he/she noticed the alarm going off. Someone turned the alarm off. The alarm was loud but on the opposite side of the building, it was hard to distinguish from the call light system. During an interview on 2/13/26 at 2:02 P.M., CNA H said rounds are done every two hours. Nurses will do rounds if asked, but mainly CNA and Certified Medication Technicians (CMTs) do rounds. During an interview on 2/13/26 at 2:10 P.M., CNA I said rounds were every two hours and included checking to make sure residents are alive, clean, and where they are. Everyone was supposed to do rounds. Intensive monitoring meant to be able to see the resident constantly. During an interview on 2/13/26 at 2:20 P.M., the Regional Nurse Consultant said the cameras were broken. No video footage was available. Review of the facility's investigation, undated, showed:-At 11:45 A.M., resident did not come out to smoke;-At 1:15 AP.M. -1:30 P.M., door alarm to smoking area sounding - CNA G asked for the key to turn alarm off;-At 4:00 P.M., medications not given and documented as out of building;-At 7:00 P.M. shift change, LPN C did not report to oncoming nurse LPN A that the resident was not in building;-LPN C's written statement, dated 1/12/26, showed the resident left the facility, time unknown. Resident ate breakfast and lunch but did not come for dinner. He/She sent Resident #8 to tell Resident #7 to come to dinner. Resident #8 said Resident #7 refused and said he/she was asleep and did not want to eat or smoke. The last time LPN C laid eyes on the resident was between 2:00 P.M. to 2:30 P.M. During an interview on 2/13/26 at 9:07 A.M., the resident's physician's office said the notification was received on 1/16/26 at 10:11 A.M. from LPN C stating the resident had left on Tuesday (1/13/26) and had not returned. There were no notifications prior to this. Looking at their records, the physician's office said a resident note dated 10/9/25, showed the resident said he/she needed to get out of this place for a while. On 8/26/25, a note written by the physician showed the resident's judgement was impaired. The resident was followed by psychiatry. During an interview on 2/11/26 at 1:42 P.M., the Guardian said while the resident was out of the building, the resident was not dressed appropriately for the weather and did not bring his/her cell phone or wallet. The resident later told the Guardian that he/she didn't plan on being gone a long time. He/She just wanted to get out for a while. The resident was out of touch (did not think clearly). At some point while out of the facility, the resident asked someone to call his/her mom. The resident was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	taken to the hospital. The resident being without his/her medications was significant. Review of the local temperatures (AccuWeather St. Louis, MO) 1/12/26 - 1/14/26, showed low temperatures ranged from 20 to 32 degrees Fahrenheit (F) and high temperatures ranged from 47 to 66 degrees F. Review of the hospital after visit summary report, dated 1/14/26 to 1/26/26, showed diagnoses of disorganized schizophrenia. During an interview on 2/11/26 at 3:40 P.M., the Administrator said they had not determined how the resident left the building. During an interview on 2/13/26 at 3 P.M., the Administrator said staff told her the door alarm was faint. The door alarm is generally loud when the door is open, but when the door closes, the siren stops yelling and the alarm is faint. On 1/12/26, CNA G said he/she went to the nurse's station, got the key and turned the alarm off. CNA G wasn't working the resident's hall on 1/12/26. The Administrator said she didn't know if anyone checked to see if a resident had gotten out. The alarm wasn't reported. The alarm key was located at the nurse desk. The alarm had to have gone off between 1 P.M. - 3 P.M. on 1/12/26 because that is when the shift change was for CNA G.Unable to contact CNA G for an interview regarding turning off the alarm and if he/she tried to determine if any residents had eloped. During an interview on 2/13/26 at 11:23 A.M., the Administrator said she expected rounds to be completed, and it was not appropriate for LPN C to ask Resident #7 to check on Resident #8 or any other resident. She expected nursing to lay eyes on his/her residents and pass the information to the next shift. She wasn't aware of the physician's notes but said if she had, the resident wouldn't have stayed in the room adjacent to the exit door. She expected staff to follow the resident's care plan and conduct intensive monitoring. During an interview on 2/13/26 at 10:36 A.M., office staff said, per the Physician, the Nurse should have checked on the resident himself/herself, rather than asking another resident to check. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. 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). 2724566