STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265539	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aegis Health and Rehabilitation	1441 Charic Drive Wildwood, MO 63021

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the facility's policy and acceptable standards of practice when staff failed to accurately complete a post (after) fall observation report for 72 hours by not obtaining current vital signs for two residents sampled (Resident #1 and #3) and failed to complete post fall observations for 72 hours for one resident (Resident #2). The facility failed to notify the physician and emergency contact when one resident (Resident #1) had a fall. The facility failed to update the residents' care plans timely after falls for two residents (Resident #1 and #3) and failed to update the care plan for one resident (Resident #2). The facility failed to document Resident #2 had a fall in the nurse progress notes. The sample was 3. The census was 62.Review of the facility's Incident and Accident policy, revised 9/1/22, showed:-Policy: It is the policy of this facility for staff 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;-Definitions: -Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident; -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. This can involve a visitor, vendor, or staff member;-Policy Explanation: 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; -Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements; -Meeting regulatory requirements for analysis and reporting of incidents and accidents;-Compliance Guidelines: -1. Incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information; -2. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root causes; -5. The following incidents/accidents require an incident/accident report but are not limited to: -Falls; -Observed accidents/incidents; -6. In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm; -7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions; -8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events; -9. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury; -10. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner; -11. The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital; -12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information; -13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions; -15. 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. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/28/25, showed:-Cognitively intact;-Always continent of bowel and bladder;-Falls since admission/entry or reentry or the prior assessment, No;-Diagnoses included inflammatory bowel disease, diabetes, malnutrition, syncope (temporary loss of consciousness) and collapse. Review of the resident's care plan, in use during the survey, showed:-Focus: Resident had an actual fall, date initiated 8/14/25;-Goal: The resident will resume usual activities without further incident, date initiated 8/14/25;-Interventions: -If fall is unwitnessed or Resident hits head during fall: begin Neuro-checks x per facility protocol, date initiated 8/14/25; -On 8/5/25 resident had an unwitnessed fall in room. Encourage resident to use call light and call for assistance for transfer assist; date initiated 8/14/25; -For no apparent acute injury, determine and address causative factors of the fall, date initiated 8/14/25. Review of the risk management incident report (not part of the medical