STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265554	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meramec Nursing	940 Mattox Drive Sullivan, MO 63080

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 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, facility staff failed to notify one resident (Resident #4) of an altercation with another resident and two residents (Resident #4 and #8) after falls out of five sampled residents. The facility census was 45. 1. Review of the facility's Significant Condition Change and Notification policy, dated November 2019, showed staff are directed as follows:-The purpose is to ensure that the resident's family and/or representative are notified of resident changes such as an accident or incident, with or without injury, that has the potential for needed medical practitioner intervention;-A significant change in the resident's physical, mental or psychosocial status examples include: new bruises, allegation of abuse or neglect, or other abnormal assessment findings;-Calls will be made to the resident's representative until they are reached. A message may be left on an answering machine that does not give specific examples but leaves a request for the facility to be called;-All significant changes will be recorded in the resident record.2. Review of Resident #4's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/01/25, showed staff assessed the resident as follows:-Cognitively impaired;-Required partial to moderate assistance with wheelchair locomotion;-Dependent for all transfers;-Had two non-injury falls since prior assessment;-Diagnosis of dementia.Review of the resident's nurses notes, dated 06/01/25 through 09/08/25, showed staff documented;-On 06/07/25 at 7:41 A.M., Resident found on the floor near the bathroom in his/her room. The nurses note did not contain documentation staff notified the family and/or responsible party of the fall;-On 06/20/25 at 11:25 A.M., Resident spilled coffee on his/her lap. He/She was noted to have a four by four red area to his/her left groin. New treatment orders were obtained. The nurses note did not contain documentation staff notified the family and/or responsible party of the fall.-On 07/02/25 at 11:05 P.M. : LPN A documented he/she heard a wheelchair fall over in the hallway and upon further assessment the resident was on the floor lying next to a reclining wheelchair he/she knocked over. The nurses note did not contain documentation staff notified the family and/or responsible party of the fall.-07/12/25 at 12:41 A.M., Resident observed on the floor on his/her right hip/buttocks area after sliding out of bed. The nurses note did not contain documentation staff notified the family and/or responsible party of the fall.Review of facility's abuse and neglect investigation, dated 09/09/25, showed staff documented the resident in an altercation with another resident on 09/05/25. Review of the resident's nurses notes, dated 09/05/25, did not contain documentation staff notified the family and/or responsible party of the altercation.During an interview on 09/08/25 at 12:50 P.M., the legal guardian said he/she is not informed of a lot of things to include falls. He/She was not informed of the resident-to-resident incident that allegedly occurred on 09/05/25.During an interview on 09/08/25 at 2:30 P.M., LPN B said nurses are responsible to notify the physician of any changes in condition to the resident that include falls, resident to resident altercations and anything else that would be considered a change in condition. He/She said he/she should have notified the family and documented the change in condition with the resident that was reported to occur on 09/05/25 with the resident and a peer but was busy and didn't. 3. Review of Resident #8's admission MDS, dated [DATE], showed staff assessed the resident as follows:-Cognitively intact;-Had limited range of motion in one upper and one lower extremity;-Required partial to moderate assistance with transfers to a wheelchair;-Fell one to six months prior to admission;-Diagnosis of stroke and dementia.Review of the resident's Face Sheet showed it contained two emergency contacts and one power of attorney (legal document allowing a designated person to make decisions and act on the granters behalf).Review of facility's list of falls, dated 09/08/25, showed the resident had a fall on 08/18/25.Review of the resident's nurse notes, dated 06/01/25 through 09/08/25, showed staff documented:-On 08/18/25 did not contain documentation staff notified the family and/or representative of a fall; -On 08/19/25 at 12:26 P.M., resident on fall follow up charting. The nurses note did not contain documentation staff notified the family and/or representative of the fall;-On 08/26/25 at 11:00 P.M., resident on the floor next to his/her bed with legs crossed. The nurses note did not contain documentation staff notified the family and/or representative of the fall.4. During an interview on 09/08/25 at 2:30 P.M., Licensed Practical Nurse LPN B said nurses are responsible to notify the physician of any changes in condition to the resident that include falls, resident to resident altercations and anything else that would be considered a change in condition. He/She said the nurse should document the notification in the nurse notes. He/She said he/she was busy and did not get to it.During an interview on 09/08/25 at 3:00 P.M., the administrator said the nurses are responsible to notify the families any time there is a fall, incident involving the resident or changes