STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary behavioral health care services for four residents' psychosocial well-being when staff did not address the resident's behaviors, which included repeatedly violating the Drug and Alcohol Abuse, Out on Pass, Visiting and Contraband policies and demonstrating physical and verbal aggression toward other residents and staff (Residents #4, #1, #7 and #5). The sample was 11. The census was 80. Review of the facility's behavior management policy, revised June 2020, showed:-Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. To ensure facility staff performs a timely and appropriate assessment of the resident's behavioral symptoms and implement appropriate interventions before and after the resident begins taking psychotherapeutic medications. The facility is responsible for providing behavioral health care and services which create an environment to promote emotional and psychosocial well-being, meet each resident's needs and include individualized approaches to care;-Upon observing the adverse behavioral symptom, staff will do the following as indicated: -Ensure the safety of the resident as well as all other residents; -Document the incident on the 24-hour report.-The Charge Nurse will assign a staff member(s) to monitor/shadow the resident as needed;-Such monitoring is for the protection of the resident as well as all others, and is not meant to restrict their movement or mobility;-Nursing Staff will continue to monitor the resident's behavior to determine what event(s), if any, precipitated the behavior and document the following information as indicated:-Date and time of behavior;-Location of resident when the behavior occurred;-Description of the behavior (e.g., what the resident said or did and if the behavior intensified);-Non-verbal cues;-What seemed to cause the behavior; and -Any interventions used and their effect.-In assessing the resident for potential causal factors, licensed nursing staff will consider the following factors and document their findings in the medical record:-Physical conditions (e.g., pain or discomfort, hunger or thirst, fatigue, toileting needs, incontinence);-Environmental conditions;-Psychosocial or emotional stressors (e.g., change in resident's customary routine, loneliness, frustration, fear of the unknown, possible abuse by staff or other residents, incompatibility with roommate, inability to communicate needs, lack of support system, loss of control due to changes in physical condition);-Medical conditions that require treatment; -Mental health conditions, which may contribute to resident's behavior;-It is also important for the facility to use an interdisciplinary team (IDT) approach which includes the resident, their family, or resident representative. Review of the facility's Out on Pass policy, revised August 2020, showed:-It is the policy of the facility to meet resident's physical and psychosocial needs to go out on pass. The facility will make reasonable efforts to ensure the resident's safety and uphold residents rights;-When a resident requests to go out on pass, the IDT will assess the resident's ability to participate in activities outside the facility, taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications without supervision;-The IDT assessment will be documented in the IDT notes;-When a resident requests to go out on pass without supervision, nursing staff will notify the attending physician and psychiatrist (if applicable) of the need to review the resident's status prior to allowing the resident to leave the facility;- If the resident's use of the out on pass order conflicts with the resident's plan of care or jeopardizes the resident's safety, the nursing staff will notify the attending physician and psychiatrist (if applicable) of the need to review the resident's status prior to allowing the resident to leave the facility;-The order for a pass out may be discontinued by the attending physician or psychiatrist (if applicable) at any time;-Prior to the resident leaving on pass, a Licensed Nurse will assess the resident's physical and mental status and ensure:-The resident has a supply of medications for the length of the pass per attending physician order;-The resident and responsible person (if applicable) were instructed of any special needs of the resident during the pass as applicable (e.g. special diet, medications); -A licensed nurse will document the medication provided to the resident for use while out on pass (if applicable), the time the resident left the facility, and the name of the accompanying responsible person;-When the resident returns to the facility, a licensed nurse will re-assess the resident to determine the resident's condition and any medication returned after going out on pass, if applicable;-The resident/responsible person will verbally notify a licensed nurse prior to going out on pass and will sign out and back in on the Resident Out On Pass Log;-The resident/responsible person will return to the facility at the agreed-upon time or notify the facility of any

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. Staff failed to accurately and thoroughly document the controlled substance shift change inventory tracker sheets, for one of the two facility floors. The census was 80.Review of the facility's Controlled Substance Prescriptions policy, revised August 2020, showed the following:-Policy: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations;-The Director of Nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications;-Documentation of a Controlled Substance Prescription: --Each controlled substance prescription is documented in the resident's medical record with the date and time of receipt and the signature of the person receiving the prescription. The prescription is recorded on the physician order sheet or telephone order sheet or posted elsewhere in the record and recorded on the Medication Administration Record (MAR); --Each prescription is recorded in the patient's health record in accordance with facility policy;-Security and Recordkeeping: --Controlled substances are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents. The pharmacy will include an individual resident-controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident unless directed otherwise by the facility; --Controlled substance medications are stored at the facility under double lock or as required by state regulations, separate from all other medications and counted at each change of custody or in accordance with facility policy. The access key to controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. Back up keys to all medication carts may be obtained from the provider pharmacy. Review of the facility's Shift Change Controlled Substance Inventory Count Sheet on 12/12/25, showed:-Nurse coming on to shift must verify count of all controlled substances with nurse coming off shift or any time the medication cart keys are exchanged;-Nurses must count total number of cards/containers and total number of count sheets, both for individual residents and applicable contingency supplies with controlled drugs;-Nurses must verify actual drug counts (#tabs, caps, patches, vials etc.) against each individual resident count sheet;-Any discrepancies must be reported immediately to director of nursing or nursing supervisor;-Every controlled substance medication and count sheet added or removed from the medication cart must be documented below;-There were areas to document the date, shift/time, nurse signatures, total number of cards/containers, total number of count sheets, medication and count sheets added (with space for the resident's name, medication and strength, and number of cards and count sheets) and medications and count sheets removed (with resident's name and medications). Review of the first floor Shift Change Controlled Substance Inventory sheets for 11/1 through 11/30, showed:-On 11/2/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/3/25, one nurse signature for the morning shift change;-On 11/4/25, one nurse signature for the evening shift change;-On 11/6/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/7/25, one nurse signature for the morning shift change and one nurse signatures for the evening shift change;-On 11/8/25, one nurse signature for the evening shift change;-On 11/9/25, one nurse signature for the morning shift change and nurse signature for the evening shift change;-On 11/11/25, one nurse signature for the morning shift change;-On 11/12/25, no documentation of any nurse signatures for the evening shift change;-On 11/17/25, one nurse signature for the morning shift change. No documentation of any nurse signatures for the evening shift change;-On 11/19/25, one nurse signature for the morning shift change;-On 11/20/25, no documentation of nurse signatures for the morning shift change and no nurse signature for the evening shift change;-On 11/21/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/23/25, one nurse signature for the evening shift change;-On 11/24/25, one nurse signature for the evening shift change;-On 11/25/25, one nurse signature for the evening shift change;-On 11/26/25, one nurse signature for the morning shift change. Staff documented the total number of cards at 24 for the morning shift and 25 for the evening shift, with no documentation of a resident's medication added;-On