STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265680	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Skilled Nursing & Rehabilitation Center	37 North Clark Avenue Ferguson, MO 63135

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to ensure one of four sampled residents was free from abuse. Certified Nurse Aide (CNA) A pulled on Resident #1's hair while taking the resident back to his/her room for hygiene care. The census was 62. The Administrator was notified on 4/3/25, of the past non-compliance. On 3/26/25, the management was notified of an abuse allegation that occurred the evening of 3/25/25. Upon notification of an abuse allegation on 3/26/25, the facility immediately suspended staff, investigated and implemented abuse/neglect in-servicing to all facility staff. During the onsite investigation, interviewed staff verified recent in-servicing and verbalized education. The deficiency was corrected on 3/26/25. Review of the abuse/neglect policy, revised 5/24/23, showed: -Purpose: the facility has a zero tolerance policy on any form of abuse or neglect against residents. Each resident has the right to be free from verbal, sexual, physical, mental abuse and neglect. Residents will not be subjected to abuse by anyone, including staff, other residents or any individual in the facility. The prime directive is to develop and operationalize policies and procedures for screening and training for all staff for protection of residents and the prevention, identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of property in an effort to prevent any occurrence of the abuse; -Definitions: -Abuse: a willful infliction of injury, unreasonable confinement, intimidation, pain, mental anguish or punishment with resulting physical/mental harm; -Physical abuse: includes hitting, slapping, pinching and kicking. It also includes controlling behaviors through corporal punishment; -Training: All staff will be trained upon orientation and continued facility in-service training that focus on facility policies and procedures related to abuse prohibition practices which include but not limited to: -What constitutes abuse, neglect and misappropriation of resident property; -Appropriate interventions to implement with aggressive behavior of staff, residents and visitors; (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: 265680	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Oak Knoll Skilled Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 37 North Clark Avenue Ferguson, MO 63135	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-How staff, residents, and visitors should report their knowledge relating to any allegations without fear of retaliation; -How to recognize signs of burnout, frustrations and stress that may lead to abuse; -Prevention: Resident, families. Volunteers and staff are provided with information on how and to whom to report concerns, incidents, accidents, complaint, grievances and provide feedback without the fear of retribution. Concerns can be made directly or anonymously by filling out a complaint/grievance form and placing it under the administrator's and/or social worker designee's office door. Administration will identify, correct and intervene on all risk situations in which abuse, neglect and/or misappropriation of the resident property are likely to occur. The following is an analysis of intervention approach: -Sufficient deployment of staff on each shift to meet the needs of residents and assure that staff assigned have knowledge of the resident care needs; -Features of the physical environment where abuse and/or neglect incident/accidents are more likely to occur, such as secluded areas of the facility; -The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, and/or ignoring residents while giving care; -The assessment, care planning, and monitoring of all residents with needs and behaviors with may lead to conflict, abuse or neglect including residents with a history of aggressive behaviors, residents who have behaviors such as residents with communication disorders and those dependent on staff for assistance; -Identification and investigation: an investigation will ensue following a report of abuse or suspicion of abuse: -Staff, residents, family members and visitors are to report any suspected abuse to any of the following persons: Administrator, Director of Nursing (DON), nurse, social worker and administration department heads; -Reporting: the facility must begin the investigation immediately to collect accurate data related to the incident/accident. Investigation will include statements from staff and residents, security camera review and nurses' assessments. Review of Resident #1's medical record, showed: -admitted : 7/16/17; -Diagnoses included dementia without behavior disturbances, mood disturbance, anxiety, stroke, diabetes, aphasia (difficulty speaking), and contracture of the right hand. Review of the care plan, in use during the abbreviated survey, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Oak Knoll Skilled Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 37 North Clark Avenue, Ferguson, MO 63135	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: the resident is limited in ability to perform daily self care tasks due to right sided weakness; -Goal: the resident will have care needs met; -Approach: staff provide assistance with transfers, toileting, bathing and other care needs; -Problem: Cognitive loss/Dementia; -Goal: the resident will have positive experiences in daily routine; -Approach: calm the resident if signs of distress develop during the decision making process. Respect the resident's right to make decisions. Staff provide cues and supervision for daily care. Observation of the facility's video footage, dated 3/25/25, showed Resident #1 in his/her wheelchair in the dining room. Three staff were noted in the nursing station counter area. Certified Medication Technician (CMT) B, CNA A and CNA C. CNA A stood at the edge of the counter, speaking to the resident. The resident propelled away from the desk and CNA A approached the resident and spoke into the resident's ear. The resident used his/her left arm, swung behind himself/herself and stuck CNA A in the face as he/she propelled away. CNA A followed the resident and grabbed the resident's hair. The resident used his/her left hand and grabbed CNA A's left wrist. CNA A released the resident's hair and looked at his/her wrist and pushed the resident toward the hallway. CNA A grabbed the resident's hair again, released the hair and grabbed and held onto the hair a third time, as he/she pushed the resident down the hallway. CNA C and CMT B did not intervene during the incident. Review of CNA A's time sheet, dated 3/25/25, showed: -In: 3:36 P.M.; -Out: 10:55 P.M.; -No additional days worked after 3/25/25. During an interview on 4/3/25 at 8:22 A.M., the DON said on the morning on 3/26/25, she was notified by Resident #4 that Resident #3 had observed the interaction between CNA A and Resident #1 the evening of 3/25/24. Resident #4 recommended the DON view the camera. The DON said she and the Administrator viewed the footage and verified the allegation. Resident #1 received a skin assessment with no abnormal findings and due to his/her cognitive status, was not able to recall the incident. CNA A worked the evening shift and was not scheduled to return for duty for several days. The management team started an investigation, obtained statements, and suspended all of the staff in the footage pending investigation. CNA A was terminated. In-servicing on all facility staff was conducted for abuse/neglect policy and reporting. During an interview on 4/3/25 at 11:13 A.M., CNA C said he/she worked the evening shift of 3/25/25 with CNA A and CMT B. The shift was short staffed, and staff were very busy. He/She did not witness any abuse or an incident between CNA A and Resident #1. He/She received abuse/neglect in-servicing yearly and on 3/26/25. If he/she witnessed or if any allegation of abuse were reported, he/she would protect the resident, tell the charge nurse and notify the DON. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/35 at 11:30 A.M., CMT B said he/she worked the evening shift on 3/25/25 with CNAs A and C. The shift had been busy. He/She did not observe an altercation between Resident #1 and CNA A. Later in the shift, CNA approached him/her for topical ointment for scratches to his/her left wrist. CNA A said Resident #1 scratched him/her earlier in the shift while taking the resident to his/her room for care. Any witnessed or reported abuse/neglect is immediately reported to the DON and Administrator. The resident is protected, and the charge nurse notified. CMT B was in-serviced on the abuse/neglect policy prior to his/her shift on 3/26/25. During an interview on 4/3/25 at 11:46 A.M., CNA A said he/she worked the evening shift on 3/25/25 and worked with Resident #1. Resident #1 had soiled himself/herself and CNA A whispered in the resident's ear he/she needed to be changed. Resident #1 reached back and scratched his/her face. In a reaction, CNA A grabbed the resident's hair, the resident then grabbed and dug his/her fingers into CNA A's left wrist. CNA A released the resident's hair and grabbed it again to prevent the resident from scratching him/her. He/She had been terminated on 3/26/25. He/She felt very badly about what happened and cried during the interview. He/She said it was wrong to grab the resident's hair and he/she did not mean to hurt or frighten the resident. His/Her left wrist bled from the resident's nails and he/she reacted without thinking. He/She was in-serviced on abuse/neglect prevention around seven months ago. During an interview on 4/3/25 at 11:58 A.M., CNA E said the facility provided frequent in-services. He/She was in-serviced on abuse/neglect on 3/26/25. Staff report all abuse/neglect issues to the nurse and the DON immediately. Staff should intervene and protect the resident and get help if needed. During an interview on 4/3/25 at 12:05 P.M., Licensed Practical Nurse (LPN) D said he/she was in-serviced on 3/26/25 regarding abuse/neglect. Staff should protect the resident first and intervene. The nurse provides a skin assessment, reports to the DON and Administrator and suspends the staff. Staff are responsible for resident safety. During an interview on 4/3/35 at 1:16 P.M., the Administrator said all departments had been in-serviced on the abuse/neglect policy on 3/26/25. MO00251777