STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident's right (Resident #2) to be free from physical abuse when his/her roommate (Resident #3), who had a history of aggressive behaviors, punched him/her in the face, then displayed a sharp knife and threatened to kill him/her. The sample was 7. The census was 140. The facility was notified of past non-compliance on 6/6/25. Facility staff immediately intervened, notified administration, separated the residents, and provided assessment and services to the involved residents. Staff were in-serviced on abuse and neglect prevention. The deficiency was corrected on 5/23/25. Review of the facility's abuse prevention and prohibition program revised 10/24/22, showed: -Each resident has the right to be free from mistreatment, neglect and abuse. The facility has zero-tolerance for abuse and neglect. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property; -The facility screens for potentially abusive residents during the pre-admission process; -The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts; -The facility ensures protection of residents during abuse investigations; -The presence of a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental behavior. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/15/25, showed: -Cognitively intact; -Diagnoses included bipolar disorder (a mood disorder characterized by extreme mood swings, ranging from periods of intense elation or irritability (mania) to periods of deep sadness or hopelessness (depression)), anxiety disorder and schizoaffective disorder (a mental illness characterized by a combination of symptoms from both schizophrenia and a mood disorder such as depression or mania). (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
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	Review of the resident's progress notes, dated 5/22/25 at 11:45 P.M., showed the resident was verbally and physically aggressive. Staff separated residents immediately. A head-to-toe skin assessment was completed. A pain assessment was completed. The resident was given one to one time with staff to deescalate/vent and verbalize feelings. A room search was completed. The police were called. The resident was placed on one to one to ensure protective oversight. Physician and family notified of altercation. Review of the resident's skin observation, dated 5/22/25 at 10:40 P.M., showed moderate swelling to his/her right eye. He/She refused an x-ray. Review of the resident's progress notes, showed: -On 5/23/25 at 9:55 A.M., a psychosocial assessment was completed on the resident. No signs or symptoms of distress; -On 5/24/25 at 10:08 A.M., the interdisciplinary team met on 5/23/25 to discuss altercation between residents. New interventions put in place. During an interview on 6/3/25 at 10:00 A.M., Resident #2 said he/she was on a one to one observation. The staff member was sitting in the hallway with the door closed. Resident #3 pulled his/her bed next to Resident #2's bed. Resident #3 accused Resident #2 of moving his/her pillow. Resident #2 said he/she did not move the pillow. Resident #3 said Fuck you! I'm a gangster. Don't disrespect me. I'll kill you. Resident #3 punched Resident #2 in the face. Resident #3 pulled out a pocket knife with a black handle and sharp, silver blade. The aide entered the room and yelled He/She has a knife. He/She left the room to get help, then came back. Staff separated the residents. The facility called the police. Review of Resident #3's quarterly MDS dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included adjustment disorder (a person experiences emotional or behavioral symptoms after a stressful life event, change, or loss, and the symptoms are more intense than what would be expected for the event), cocaine dependency, other stimulant abuse, schizoaffective disorder, and major depressive disorder. Review of the resident's progress notes, dated 5/22/25 at 11:45 P.M., showed the resident was verbally and physically aggressive. Staff separated residents immediately. A head-to-toe skin assessment was completed. A pain assessment was completed. The resident was given one to one time with staff to deescalate/vent and verbalize feelings. A room search was completed. The police were called. The resident was placed on one to one to ensure protective oversight. Physician and family notified of altercation. Review of the facility's investigation, dated 5/22/25, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	-Summary: Staff responded to an altercation at 10:30 P.M. Resident #3 said he/she moved his/her bed next to Resident #2's bed. Resident #3 was upset about Resident # 2's pillow overlapping on his/her bed. Resident #3 got out of bed, walked around to Resident # 2's bed and was verbally and physically aggressive towards him/her. An altercation occurred. Staff separated the residents. A room search was completed, and contraband was removed from room. Police were called and both residents remained on one to one to ensure protective oversight. Head to toe skin assessments and pain assessments completed on both residents; -Interventions: Immediate separation of residents, de-escalation of situation, psych visit from facility physician requested, police contacted, continuation of enhanced observation, psychosocial follow-up completed, staff in-servicing: abuse/neglect, residents' rights, de-escalation, one to one monitoring and nurse practitioner assessment. Review of the resident's hospital discharge paperwork dated 5/23/25, time unknown, showed the resident was transported to the hospital by the police. The resident said he/she resided in a transitional home and had an altercation with his/her roommate. The resident fell on his/her back during the altercation. The police told him/her, he/she should go somewhere else until the boss arrived at the facility. X-rays completed with no notable findings. The resident was discharged back to the facility. Review of the resident's progress notes, showed: -On 5/23/25 at 9:58 A.M., a psychosocial assessment was completed on the resident. No signs or symptoms of distress; -On 5/24/25 at 10:17 A.M., the interdisciplinary team met on 5/23/25 to discuss altercation between residents. New interventions put in place. Review of the resident's care plan, in use during the survey and revised on 5/25/25, showed: -Focus: The resident had potential to be verbally aggressive toward staff and residents (initiated 4/11/15). On 5/20/25 the resident was verbally aggressive with facility administrator. On 5/22/25 altercation with another resident; -Goal: The resident will verbalize understanding of need to control verbally abusive behavior; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Give the resident as many choices as possible about care and activities. Psychiatric/Psychogeriatric consult as indicated. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Review of Certified Nursing Assistant (CNA) C's written statement, dated 5/22/25 (time unknown), showed he/she sat outside the residents' room on the 200 hall. He/She heard Resident #2 and Resident #3 fussing at each other. He/She went in the room, and they were fighting. He/She ran down the hall to get help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	During an interview on 6/4/25 at 7:54 A.M., CNA B said he/she has worked as needed (PRN) at the facility for two years. On 5/21/25, he/she was assigned to one to one with Resident #3. Another CNA was on one to one with Resident #2. Both CNAs were sitting in the hallway with the door closed. Resident #2 was in bed. Resident #3 went out to smoke and returned to his/her room. Around 10:00 P.M., he/she heard the residents arguing. The CNA on one to one with Resident #2 opened the door and Resident #3 was standing over Resident #2 with a hunting knife in his/her hand. He/She opened the door and yelled down the hall for assistance. Resident #2 fell on top of Resident #3 when staff tried to separate them. The Certified Medical Technician (CMT) took Resident #3 to the dining room. Staff did not find the knife. The police were called and took Resident #3 to the hospital. He/She was only in-serviced on abuse/neglect. During an interview on 6/4/25 at 11:44 A.M., the Administrator said Resident #3 was verbally and physically aggressive prior to the altercation. After the incident, Resident #3 went to the hospital. When staff cleaned out the resident's room they found the knife. It was a pocket knife. The tip was broken, and it did not appear to be new. Resident #3 came back to the facility the next day. He/She was placed on a one to one observation. He/She started yelling and beating on the glass. The police were called, and he/she was arrested for assault. MO00254863

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow up with the facility's primary care physician and/or the resident's Veteran's Affairs (VA) physician to get medication orders after finding filled prescription bottles in the resident's room after he/she returned from an appointment for one out of three sampled residents (Resident #6). Additionally, the facility failed to provide care consistent with professional standards of practice when staff sat in the hallway, outside the residents' room, with the door closed during one-to-one observation. The residents (Resident #2 and Resident #3) had a physical altercation inside their room and Resident #3 displayed a knife and threatened to kill Resident #2. The sample was 7. The census was 140. Review of the facility's Physician Order policy, dated 10/24/22, showed: -Purpose: To ensure that all physician orders are complete and accurate; -The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary; -Whenever possible the Licensed Nurse receiving the order will be responsible for documenting and implementing the order; -Documentation pertaining to physician orders will be maintained in the resident's medical record. Review of the facility's Enhanced Supervision policy, undated, showed: -To initiate enhanced supervision when there is a reasonable assumption that the resident has tried to harm themselves, harm others, expresses suicidal thoughts or intent, or resident has had increased behaviors; -The facility considers enhanced supervision as a means to enhance the oversight of the resident; -Facility staff are educated on the types of enhanced supervision which may include but not limited to the following: -One to one Observation: Staff member will be scheduled to keep resident within line of sight. 1. Review of Resident #6's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/5/25, showed: -Cognitively intact; -Preadmission Screening and Resident Review (PASRR, used to identify individuals who may have serious mental illness (SMI), intellectual disability (ID), developmental disability (DD) or related condition (RC)) showed mental retardation; -No behaviors noted; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	-Diagnoses included stroke, hemiplegia (complete or sever loss of strength on one side of the body) or hemiparesis (mild weakness on one side of the body) affecting right side of body, traumatic brain injury (TBI, brain injury affecting cognitive physical or psychosocial functions) and needed assistance for personal care. Review of the resident's care plan, undated, showed: -Problem: At risk for impaired cognitive function related to history of cerebral infarction and history of TBI; -Interventions included: Administer medications as ordered; Ask simple yes/no question in order to determine the resident's needs; Use task segmentation to support short term memory deficits. Break tasks into one step at a time. Review of the resident's progress notes, dated 3/2/25 through 6/3/25, showed: -On 5/27/25, at 5:11 P.M., the resident had a physician appointment scheduled for 5/28/25 at 10:40 A.M.; -There was no documentation found showing the resident went to the appointment, when he/she returned from the appointment and if there were any new orders. During an interview on 6/3/25 at 9:25 A.M., the resident said: -He/She had medication from his/her last appointment at the VA and a facility staff person took the filled medication bottles from his/her room; -He/She had not received the medications from the nurses and could not understand why; -He/She kept asking the nursing staff for the medications that his/her VA physician prescribed but they would not administer the medications to the resident; -He/She did not know why; -He/She was constantly itchy, uncomfortable and believed it was due to missing medications; -He/She showed the prescription documents which corresponded to the medications the facility staff removed from his/her room. Review of the prescription documents, showed: -An order dated 5/28/25, for Diphenhydramine (Benadryl, antihistamine) 25 milligram (mg) capsule (cap), take one at night as needed; -An order dated 5/28/25, for Prednisone (decreases inflammation) 10 mg tablets. Take four tablets for seven days; Take two tablets for two days; Take one tablet one day. Start on 5/28/25. Review of the resident's physician order sheet, dated 6/3/25, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	-An order dated 5/14/25, for acetaminophen extra strength (Tylenol, pain and fever reducer) 500 mg, give two tablets every six hours as needed for pain/discomfort/elevated temperature; -No orders for Diphenhydramine 25 mg or Prednisone 10 mg. Review of the resident's progress notes, dated 3/2/25 through 6/3/25, showed: -No documentation the facility staff found filled prescription bottles in the resident's room and removed them; -No documentation the facility tried to notify the primary care physician (PCP) or VA physician to obtain new orders for the Prednisone 10 mg or Diphenhydramine 25 mg capsules. Observation on 6/4/25 at 8:19 A.M., showed: -The resident was getting help with dressing from Certified Nursing Assistant (CNA) D; -The resident had several small areas of reddened skin on his/her back and shoulders. During an interview on 6/4/25 at 8:36 A.M., Licensed Practical Nurse (LPN) G said: -If residents come in to the facility with medications from home, the hospital or the VA, nursing staff were instructed to remove the medications from the resident's room because the facility can not verify what is actually in the medication bottles, medications are only administered by the facility so they could verify what the resident actually took which reduced the risk of overdose; -The medications were then stored in the medication room and were destroyed by the Assistant Director of Nursing (ADON). Observation on 6/4/25 at 8:40 A.M., of the medication room for the hall in which the resident resided, showed: -There were no medications bottles from other pharmacies found for the resident; -LPN G was not aware of any stored medications from other pharmacies for the resident. During an interview on 6/4/25 at 8:48 A.M., Certified Medication Technician (CMT) E said: -He/She was responsible for passing medications to the resident today and had not passed any medications to the resident yet; -The resident complained of feeling uncomfortable and asks for acetaminophen extra strength every morning and the CMT administers the medication as ordered; -CMT E pulled up the medications scheduled for administration to the resident during the A.M. medication pass and showed there were no orders for Prednisone; -He/She was not aware the resident had an order for Prednisone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	During an interview on 6/4/25 at 9:05 A.M. and at 9:15 A.M., ADON F said: -When residents admit with filled prescriptions from the hospital, home, or VA, nursing staff are instructed to remove the medications from the residents room for their safety; -All outside medications are taken to the medication room to get destroyed if they are not able to send the medications home with the residents' family or return unopened bubble packs to the pharmacy for credit to the residents' account. The medications are then reordered from the facility pharmacy and administered to residents by staff; -She tells residents their outside medications will get destroyed by the facility and hopes her nursing staff explains the same to the residents; -She was aware the resident came back with two bottles of medications from the VA and they were removed from the resident's room; -She explained to the resident they had to remove them from his/her possession for his/her safety but would use the medications and administer them to the resident as prescribed; -She gave the two medication bottles to LPN G and asked the LPN to put in the appropriate orders for the Diphenhydramine and Prednisone; -She expected LPN G to get the orders and put them in the resident's electronic medical health record (EMHR); -She tried to call the resident's physician at the VA twice on the day she received the two medication bottles and could not get through; -She asked the resident for the corresponding paperwork from the VA physician and the resident never got back to her. During an interview on 6/4/25 at 9:15 A.M. and at 9:27 A.M., LPN G said: -A CNA gave him/her two medication bottles (Diphenhydramine and Prednisone) after the CNA had found them in the resident's room; -LPN G did not put an order for the medications because he/she did not have the corresponding paperwork from the resident's VA appointment; -He/She asked the resident for the corresponding paperwork to the medications and the resident said he/she would get them from the VA to clarify the orders; -LPN G did not call the resident's physician from the VA; -The resident never got back to LPN G with the appropriate paperwork; -LPN G could not tell when the prescription bottles were filled by the pharmacy, saying they could be a year old; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	-LPN G pulled the two medication bottles filled by the VA for the resident, one for Diphenhydramine 25 mg and the other for Prednisone 10 mg, and could not located the fill date on the prescription bottles; -The Surveyor showed LPN G the fill date on both medication bottles and the LPN confirmed they were both filled by the VA pharmacy on 5/28/25; -He/She should have documented in the resident's progress notes when the medication bottles were found in the resident's room, what the prescription was on the bottles, contacted either the facility PCP or VA physician to get the appropriate orders, and if there was no response from either physician, he/she should have included that in the progress note and reported it to on-coming nursing staff so they could follow up; -The resident was at risk of suffering complications related to delayed treatment of Prednisone, including but not limited to increased inflammatory response and respiratory depression and was at risk of feeling uncomfortable and itchy with delayed administration of the Diphenhydramine. During an interview on 6/4/25 at 9:22 A.M., ADON F said: -She asked the resident if she could look at the corresponding paperwork to the two medications (Diphenhydramine and Prednisone); -The resident showed ADON F the corresponding paperwork that was in the resident's room which had the orders for both medications; -The resident shrugged his/her shoulders when ADON F asked if the resident remembered her asking for the paperwork sometime last week; -ADON F did not think to call the facility PCP to verify the orders once she had possession of the two medication bottles; -She should have documented in the resident's progress notes when the medication bottles were found in the resident's room, what the prescription was on the bottles, noted the time and results of her calling the resident's VA physician, contacted the facility PCP and if there was no response from either physician, he/she should have included that in the progress note and reported it to on-coming nursing staff so they could follow up. During an interview on 6/4/25 at 1:31 P.M., the Director of Nursing (DON) said: -She expected nursing staff to have knowledge of and to follow facility policies; -If residents came to the facility with filled prescriptions from the VA, she expected nursing to remove the medications from the residents' possession for safety; -She expected nursing staff to follow up with the residents' VA physician to clarify orders and if they were not available, to notify the facility PCP of the situation, noting the prescription and the order on the prescription bottle, get new orders, including to use the medication from the VA until it was empty and then order more from the facility pharmacy if needed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	-She expected nursing staff to continue to try to follow up with the VA physician for continuity of care and to ensure the plan of care was followed; -She expected nursing staff to document everything in a progress note in the resident's EMHR, including what medications were found and removed from the resident's room, who they tried to contact and the results of the conversation, including any new orders; -She expected nursing staff to document in progress notes if they were not able to clarify order with the VA physician or facility PCP, including that they reported the same to the oncoming nurse so they could follow up on the situation; -She also expected nursing staff to inform management of the situation immediately so they could ensure it was followed up on and the resident received their medications as per plan of care; -It was not appropriate to depend on or ask a resident to get the corresponding paperwork to medications as residents were not always cognitively able to perform the task and it was the nurses responsibility to do so, not the residents; -It was not appropriate to wait several days to clarify an order from a physician. It was actual non-compliance as nursing staff were not following plan of care or attempting to follow physician orders; -Delaying treatment could put the resident at risk for several different health complications depending on what why the medication was prescribed; -It was not appropriate to destroy any outside medications residents brought in from home, the hospital, or other facility's as medications were very expensive and pharmacies may not fill the prescription again as it was too soon since it was last filled. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included bipolar disorder, anxiety disorder and schizoaffective disorder (a mental illness characterized by a combination of symptoms from both schizophrenia and a mood disorder such as depression or mania). Review of Resident #3's quarterly MDS dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included adjustment disorder (a person experiences emotional or behavioral symptoms after a stressful life event, change, or loss, and the symptoms are more intense than what would be expected for the event), cocaine dependency, other stimulant abuse, schizoaffective disorder, and major depressive disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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	During an interview on 6/4/25 at 11:44 A.M., the Administrator said on 5/21/25, Resident #2 was on one to one for smoking in his/her room. Resident #3 was on one to one for aggressive/erratic behaviors. Review of the facility's investigation dated 5/22/25, showed: -Staff responded to an altercation at 10:30 P.M. Resident #3 said he/she moved his/her bed next to Resident #2's bed. Resident #3 was upset about Resident # 2's pillow overlapping on his/her bed. Resident # 3 got out of bed, walked around to Resident # 2's bed and was verbally and physically aggressive towards him/her. An altercation occurred. Staff separated the residents; -Staff in-serviced on one-to-one observations. During an interview on 6/3/25 at 10:00 A.M., Resident #2 said he/she was on a one to one. The staff member was sitting in the hallway with the door closed. Resident #3 pulled his/her bed next to Resident #2's bed. Resident #3 accused Resident #2 of moving his/her pillow. Resident #2 said he/she did not move the pillow. Resident #3 said Fuck you! I'm a gangster. Don't disrespect me. I'll kill you. Resident #3 punched Resident #2 in the eye. Resident #3 pulled out a pocket knife. The knife had a black handle and sharp, silver blade. Resident #3 said he would stab Resident #2. The aide entered the room and yelled (He/She) has a knife. He/She left the room to get help, then came back. Staff separated the residents. Review of CNA C's written statement dated, 5/22/25 (time unknown), showed he/she sat outside the residents' room on the 200 hall. He/She heard Resident #2 and Resident #3 fussing at each other. He/She went in the room, and they were fighting. During an interview on 6/4/25 at 7:54 A.M., CNA B said on 5/21/25, he/she was assigned to one to one with Resident #3. Another CNA was on one to one with Resident #2. Both CNAs were sitting in the hallway with the door closed. The residents were on one to one for smoking, therefore, staff did not have to be inside the resident's room. The residents have the right to close their doors. He/She does not like to sit in the resident's room because they have mice. He/She was only in-serviced on abuse/neglect. During an interview on 6/6/24 at 10:10 A.M., ADON A said staff should be within arm's length of the resident during a one to one. It is not appropriate for staff to sit in the hallway, with the resident's door closed. During an interview on 6/4/25 at 1:59 P.M., the DON said staff should always be with the resident during a one to one. They should document what the resident is doing. It is never appropriate for staff to sit in the hallway, with the door closed during a one to one. Staff are supposed to be within arm's length of the resident. During an interview on 6/4/25 at 11:44 A.M., the Administrator said during the one to one, staff are supposed to be within eye sight or arm's length of the resident. It is not appropriate to sit in the hallway with the door closed. MO00254863

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a behavioral management program for one resident (Resident #3) who frequently yelled, cursed and threatened residents and staff members, and used illicit substances. The resident's behaviors escalated, and he/she punched his/her roommate in the face, displayed a knife and threatened to kill him/her. Additionally, staff did not complete a Pre-admission admission Screening and Resident Review (PASRR) (a federally mandated screening process for individuals with serious mental illness (SMI), intellectual disability/developmental disability (IDD/DD), and/or related condition who apply for or reside in a Medicaid Certified bed in a nursing facility regardless of payment source) when it was determined the resident would be admitted to the facility for long-term care. The sample was 7. The census was 140. Review of the facility's Behavior Management policy, undated, showed: -Purpose: 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 that create an environment that promotes emotional and psychosocial well being meet each resident's needs and include individualized approaches to care; - The concept of behavior management is an interdisciplinary process. The key components of this process are: -Identifying residents whose behaviors may pose a risk to self or others; -Developing individual and practical care strategies based on assessed needs; -Implementing the behavior management program; -Ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs. -When a resident exhibits adverse behavioral symptoms (crying, yelling, hitting, biting, etc.), licensed nursing staff will document the behaviors in the medical record, noting the time the behavior(s) occur, prior events, possible causal factors and interventions attempted; -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 notification of the Attending Physician; -Document notification of the resident's family and/or responsible party about the change in behaviors and the Attending Physician's response; -Document the incident on the 24 hour report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	-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 (what the resident said or did and if the behavior intensified); -Non-verbal cues (darting eyes may indicate anxiety or fear, crossed arms may signal withdrawal or fear, and tears may indicate sadness, frustration or fear); -What seemed to cause the behavior; -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 (pain or discomfort, hunger or thirst, fatigue, toileting needs, incontinence); -Environmental conditions (inappropriate room temperature, noise, overcrowding); -Psychosocial or emotional stressors (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, financial concerns); -Medical conditions that require treatment (diabetes mellitus, heart disease, chronic obstructive pulmonary disease (COPD), infection, constipation, recent stroke, arthritis); -Mental health conditions, which may contribute to resident's behavior (consider if the resident could be cheeking medications. If a dose adjustment is necessary due to a change in a medical condition, or there has been an increase in the resident's hallucinations and/or delusions). Review of Resident #3's history and physical assessment, dated 1/23/25, showed: -admitted to the hospital on [DATE] for shortness of breath; -He/She smoked 8-9 cigarettes per day; -admitted to using cocaine prior to arrival at hospital; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	-Urinalysis was positive for cocaine. Review of the resident's social history and initial assessment, dated 2/5/25 at 9:06 A.M., showed: -Reason for admission: Long term care/rehab; -History of drug abuse, blank; -History of smoking, blank; -Anticipated length of stay: Long-term. Review of the resident's care plan, in use during the survey, showed: -Focus: The resident was a smoker; -Goal: The resident will not suffer injury from unsafe smoking practices; -Intervention: Instruct resident about smoking risks and hazards and about available smoking cessation aids. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify the charge nurse immediately if it is suspected resident has violated facility smoking policy. The resident can smoke unsupervised. The resident's smoking supplies are stored by staff; -Focus: The resident used oxygen therapy as needed due to congestive heart failure (CHF) and COPD; -Goal: The resident will have no signs and symptoms of poor oxygen absorption; -Intervention: Change resident's position every two hours to facilitate lung secretion movement and drainage; -No documented discharge planning. Review of the resident's progress notes, showed: -On 2/16/25 at 12:08 P.M., the nurse practitioner noted the resident was seen for an initial evaluation following an acute admission [DATE] - 02/03/2025) for acute CHF/COPD exacerbation. He/She presented to the emergency room with shortness of breath, non-productive cough, and substernal chest pain. He/She reported cocaine use the day before. He/She had multiple admissions 7/24/24, 8/24/24, 9/24/24, 12/24/24 for similar concerns; -On 2/19/25 at 2:42 P.M., the Administrator counseled the resident on smoking in his/her room. The resident was informed he/she would be terminated immediately if it happened again. The resident verbalized an understanding. At 2:50 P.M., the social worker talked to resident about smoking in the facility and in his/her room. Social Services informed the resident he/she would be immediately discharged from the facility if he/she did it again. The resident verbalized understanding. Review of the resident's psychiatric notes, dated 2/19/25, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	-Chief complaint: They don't want to help. I asked them to get me in rehab; -Review of symptoms: Depressed, anxious and irritable; -Feelings: Expressed feelings of helplessness/hopelessness; -Judgement: Poor insight/judgement; -Dangerousness assessment: Danger to self; -Recommendation: Not a good fit for the facility; -Resident made aware if he/she continued to smoke in his/her room, he/she would be discharged ; -The social worker said the resident refused to complete the rehab program. Review of the medical record, showed no documented psychiatric visits for March or April, 2025. Review of the Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/28/25, showed: -admitted [DATE]; -Moderate cognitive impairment; -Little to no interest in doing things; -Felt down, depressed, or hopeless; -Trouble falling asleep; -Tired and little energy; -Poor appetite; -Trouble concentrating on things; -No behaviors exhibited; -Diagnoses included CHF, COPD, adjustment disorder (a person experiences emotional or behavioral symptoms after a stressful life event, change, or loss, and the symptoms are more intense than what would be expected for the event), cocaine dependency, other stimulant abuse, schizoaffective disorder (a mental illness characterized by a combination of symptoms from both schizophrenia and a mood disorder such as depression or mania), and major depressive disorder; -No antipsychotic medications. Review of the resident's progress notes, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	-On 3/20/25 at 2:30 P.M., social services reviewed the smoking policy with the resident and explained the importance of smoking in designated areas; -On 3/24/25 (late entry) 8:30 A.M., social services reviewed the smoking policy with the resident and explained the importance of smoking in designated areas; -On 4/10/25 at 12:40 P.M., the resident used foul language towards dietary staff, in the dining room. Social services informed the resident if the behavior continued, he/she could not eat in the dining room. Review of the resident's care plan, in use during the survey, showed: -Focus: The resident had potential to be verbally aggressive toward staff and residents (initiated 4/11/15); -Goal: The resident will verbalize understanding of need to control verbally abusive behavior; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Give the resident as many choices as possible about care and activities. Psychiatric/Psychogeriatric consult as indicated. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Review of the resident's progress notes, showed: -On 4/16/25 at 4:06 P.M., social services reviewed the smoking policy with the resident and explained the importance of smoking in designated areas; -On 5/20/25 at 3:16 P.M., the Administrator noted, the resident voiced disapproval regarding an incident with another resident. The resident was caught taking inappropriate pictures of a female staff member and resident. The resident was aggressive. He/She walked around the Administrator's desk, pointed his/her finger in the Administrator's face and said, I will kick your ass. The Administrator tried to redirect the resident. The resident became irate and approached the Administrator briskly with clenched fists. Review of the resident's psychiatric note, dated 5/21/25 (time unknown), showed: -Chief complaint: They moved me down the hall and I don't like that. I want to get out of here; -Review of symptoms: The resident was anxious and notably pissed off; -Interview behaviors: Uncooperative, irritable, negative, hostile and aggressive; -Mood: He/She was angry and tried to control it; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	-Feelings: Negative feelings evident with hopelessness/helpless; -Insight/judgement: The psychiatrist was notified this date of the resident threatening violence and sexual actions towards residents and staff; -Dangerousness assessment: The resident was a danger to others; -Recommendation: Discharge the resident and request police intervention for threats of dangerousness. Review of the resident's record, showed no laboratory work was completed. Review of the resident's progress notes, dated 5/22/25 at 11:45 P.M., showed the resident was verbally and physically aggressive. Staff separated residents immediately. A head-to-toe skin assessment was completed. A pain assessment was completed. The resident was given one to one time with staff to deescalate/vent and verbalize feelings. A room search was completed. The police were called. The resident was placed on one to one to ensure protective oversight. Physician and family notified of altercation. During an interview on 5/23/25 at 2:35 P.M., the Administrator reported the resident had a history of homelessness and incarceration. He/She had been displaying pen behaviors (slang for behaviors often displayed by people who have served time in prison). The resident had an altercation with his/her roommate. He/She was discharged from the hospital back to the facility at 9:00 A.M. The resident was throwing stuff and cornered the Administrator. The police returned to the facility. The police found a crack pipe (used to smoke crack cocaine) with residue, alcohol bottles and cans with holes in them (used to smoke illegal substances). The resident was arrested. Review of the facility's discharge letter, dated 5/23/25, showed: -The facility could not meet the resident's needs; -The resident's presence was a danger to the health and safety of others in the facility; -The resident became irate with a staff member and threw a full urinal- filled with urine into the charge nurse's face. The resident was alert and oriented and showed no regard for what transpired. During an interview on 6/6/24 at 10:10 A.M., the Assistant Director of Nursing (ADON) A said he/she has worked at the facility for three years. He/She assisted with the 200 hall. He/She did not approve referrals. He/She greeted the residents upon arrival to the facility. The resident was admitted for rehab/long-term care. The ADONs read the history and physical prior to admission. He/She was not aware of the resident's substance use. The resident's behaviors were in and out. At baseline the resident was pleasant. His/Her behaviors started two to three weeks after admission. The resident had to be redirected about smoking in his/her room. Staff would give the resident space to calm down. Sometimes he/she would apologize for the behavior. The psychiatrist was in the building often. He/She is not sure if the resident had regularly scheduled visits with the psychiatrist. The resident was placed on one to one observation after the incident with the Administrator. ADON A thinks the interventions the facility put in place worked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beauvais Rehab and Healthcare Center	3625 Magnolia Avenue Saint Louis, MO 63110

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 - Few	During an interview on 6/4/25 at 11:37 A.M., the social worker said the resident was alert and oriented. He/She signed in and out of the building. He/She was admitted due to homelessness. He/She had a substance abuse issue. The nursing department was responsible for addressing his/her substance use issues. The social worker thinks the resident was placed on a one to one after he/she tried to attack the Administrator. The resident was verbally aggressive towards staff prior to the incident. He/She was not present for the resident-to-resident altercation. The police were called, and the resident was escorted to the hospital. The resident returned to the facility and the police were called again. The resident was arrested. He/She thinks the resident was seeing a psychiatrist. She did not know if a PASRR was completed for the resident. Someone from corporate does the referrals. During an interview on 6/4/25 at 1:59 P.M., the Director of Nursing said she has been at the facility for five days. When Resident #3 displayed verbal and physical aggression, the resident's physician and family should have been notified. They should have looked at the resident's meds and adjusted if needed. She would have put the resident on one to one observation and obtained labs. If a resident is using illicit drugs something should have been put in place. The social worker and the nursing department should have worked together to find resources. The substance use issue should have been addressed during the admission assessment. It should have been on the resident's care plan. During an interview on 6/4/25 at 11:44 A.M., the Administrator said he did not know why the resident was admitted to the facility. He did not see the referral. He was not aware the resident was actively using cocaine. The police found drug paraphernalia. He assumed a PASRR was completed for the resident. The facility was trying to find placement for the resident and then everything kicked off. After the resident tried to attack him, he just avoided the resident. It was hard to put interventions in place for the resident, because he/she was non-compliant. The resident was placed on a one to one. He tried to get a psych evaluation, but the resident was very aggressive towards the psychiatrist. The psychiatrist wanted the resident discharged from the facility. The Administrator did not want to discharge the resident to a homeless shelter. MO00254863