STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, 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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary physical restraints when staff held one resident's wrist down while providing personal care (Resident #503). The staff did not follow facility policy or the resident's care plan when the resident was resistive to care. After the resident refused care, the staff continued to provide care while holding the resident down, instead of allowing the resident to calm down and self-soothe, as the care plan instructed. During the forced care, the resident's behaviors remained escalated when he/she swung, kicked, and bit the staff. A skin assessment on the day of the incident showed a skin tear to the resident's chin and bruising on both hands. The sample was 23. The census was 111. The Administrator was notified on 5/16/25 at 3:30 P.M., of the past non-compliance, which began on 5/12/25. The facility immediately removed the Registered Nurse (RN) from the floor. The Assistant Director of Nursing (ADON) assumed responsibility of the nurse's assignment. The Certified Nurse Aide (CNA) remained in the lower conference room with the Director of Nursing (DON). The police were called, and two officers responded. Nursing Administration was sent to the floor to conduct interviews on all able residents, collect statements from all staff on the floor, and perform head to toe skin assessments on all residents who were unable to be interviewed. The Administrator and police interviewed the resident and his/her roommate. A skin assessment was completed on Resident #503. The nurse was terminated. The CNA was re-educated on expectations when dealing with alleged violations and specifically, reporting parameters. The CNA was suspended pending the investigation. An all-staff education was immediately started on abuse, neglect, and exploitation with emphasis on identifying and reporting, along with care approaches when caring for combative residents, resident safety, and restraints. The noncompliance was corrected on 5/14/25. Review of the facility's Restraint Free Environment policy, date implemented 4/22/25, showed: -Policy: It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of such restraints; -Definitions: Physical restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to holding down a resident in response to a behavioral symptom, or during the provision of care if the resident is resistive or refusing the care; (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 0604 Level of Harm - Actual harm Residents Affected - Few	-Compliance guidelines: The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms. Review of the facility's Managing Resident Behaviors -Assessment, Intervention and Monitoring policy, undated, showed: -Definitions: Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. Behavior is regulated by the brain and is influenced by past experiences, personality traits, environment, and interactions with other people. Behavior can be a way for an individual to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated; -Behavioral or Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors and those that cannot; -Policy: The facility will provide appropriate and compassionate care specific to individuals who demonstrate behaviors in an effort to minimize resident distress and promote a sense of safety and well-being; -General guidelines: -Behavioral symptoms will be identified using comprehensive assessments; -Assessment: As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: the resident's usual patterns of cognition, mood, and behavior; the resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration, and other triggers; and the resident's previous patterns of coping with stress, anxiety, and depression; -Management: The care plan will incorporate findings from the comprehensive assessment; -Monitoring: If any devices (restraints) are prescribed, the Interdisciplinary Team (IDT) will monitor the situation to ensure that they are beneficial to the individual (for example, enhancing function and improving symptoms) and are not causing complications or disabling the individual. Review of Resident #503's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/6/25, showed: -Severe cognitive impairment; -Physical symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing, and abusing other sexually): behavior of this type occurred one to three days; (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	-Verbal behavioral symptoms directed towards others (e.g. threatening others, screaming at others, cursing at others) behavior of this type occurred one to three days; -Other behavioral symptoms not directed towards others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste or verbal/vocal symptoms like screaming, disruptive sounds) behavior of this type occurred one to three days; -Did any of the identified symptoms put the residents at significant risk for: -Physical illness or injury? Yes; -Significantly interfere with resident care? Yes; -Significantly interfere with resident participation in activities or social interaction? Yes; -Significantly disrupt care of living environment? Yes -Did the resident reject evaluations or care (e.g. bloodwork, taking medications, Activities of Daily Living (ADLs, grooming, dressing, personal hygiene) assistance) that is necessary to achieve the resident goals for health and well-being? Behavior of this type occurred one to three days; -How does resident current behavior status, care rejection or wandering compare to last assessment? Worse; -Required partial/moderate assistance. (Helper does less than half the effort) for toilet hygiene, lower body dressing and rolling left to right; -Required substantial/maximal assistance (helper does more than half the effort) for personal hygiene; -Diagnoses included: High blood pressure, diabetes, arthritis, dementia, anxiety and depression and multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue). Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Resident is/has potential to be physically and verbally aggressive related to anger. History of harm to others, poor impulse control. On 7/2(no year), aggression noted, on 3/15(no year), aggression and on 4/25(no year), altercation; -Goal: Resident will demonstrate effective coping skills through review date. Resident will not harm self or others through review date; -Interventions included: (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	-Assess and anticipate resident needs: Food, thirst, toileting needs, comfort level, body positioning, pain, etc. -Behavior monitoring every shift; -Give the resident as many choices as possible about care and activities; If resident noted to be agitated, ensure he/she is safe and allow him/her to calm down and self-soothe; -Resident's potential triggers for physical aggression are overstimulation, boredom and pain. Resident's behaviors are de-escalated by giving space and reducing stimulation, monitoring for pain, and provide meaningful activities; -Medication review; -Monitor/document/report as needed any signs and symptoms of resident posing danger to self and others; -Upon reapproach after self-soothe, approach at eye level, palms open and explain what you are going to do; -When the resident becomes agitated: Intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation; if response is aggressive, staff to walk calmly away and approach later; -Focus: Resident required assistance with selfcare, and mobility related to multiple sclerosis, senile degeneration of the brain, dementia with agitation, resident will refuse care at times, hospice services; -Goal: Resident will maintain current selfcare/mobility status throughout the review date; -Interventions included: Personal hygiene: Substantial/maximal assistance; toileting hygiene: partial/moderate assistance. Review of the facility's five-day summary of investigation, undated, showed: -Summary of Event: On 5/12/25 at approximately 2:30 P.M., Resident #503's assigned CNA reported to the Administrator that when providing peri care (the process of cleaning a patient's genital and anal area) to the resident, the CNA felt the nurse was too aggressive and restrained the resident by his/her wrist when he/she became combative. The CNA reported the resident bit the nurse's arm, and the nurse grabbed the resident's lower jaw to try to get the resident to release his/her arm. During this event that allegedly occurred somewhere around 9:00 A.M., the CNA felt he/she had to remain in the room to deescalate the situation and ensure the residents' safety. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's statement of an interview completed on 5/12/25, showed the Administrator and the police officer interviewed the resident immediately following the incident. While the resident is not a good historian and has a Brief Interview for Mental Status (BIMS) score of 00, (a score of 0-7, showed the resident had severe cognitive impairment) he/she was able to communicate bad nurse while making a motion with his/her wrist that appeared like someone holding them together in front of his/her face. When asked additional probing questions, the resident was unable to provide any response. Review of the progress notes dated 5/11/25 through 5/12/25, showed no progress note written for 5/12/25. Review of the resident's skin observation tool, showed: -On 5/9/25: Is skin intact? Yes; -Notes: Blank; -On 5/12/25: Is the skin intact? No; -Observation: -Site: Number 4, face, type: Skin tear; -Site: Number 27 back of left hand, type: Bruising; -Site: Number 30 back of right hand, type: Bruising; -Site Number 16 left antecubital (bend of elbow), type: Scratch; -Site: Number 15 right antecubital, type: Scratch; -Notes: 4. [NAME] pin dot opening; 4. Right side of face chin fingernail opening; 27. Back of hand has three dime size bruises; 30. Back of hand four dime size bruises near thumb; -On 5/13/25: is the skin intact? Blank; -Observation: Blank; -Notes: Bruises to both arms and small scab on right cheek. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/25 at 8:22 A.M., CNA A said the incident happened on 5/12/25, he/she must have written the wrong date in his/her statement. The resident can be combative if he/she feels like you're not listening to him/her, or if your nagging at him/her, or if you are trying to wake him/her up. CNA A was assigned to care for the resident on 5/12/25. After breakfast he/she went to change the resident's brief, and the resident said no and refused. The next time the CNA went into the room the resident said No, let me sleep. The CNA said the same thing has happened in the past, and when he/she reported it to the nurse the nurse said okay. The CNA reported the resident refused to the nurse, RN B. The nurse said come on, and he/she would help him/her. While walking to the room, the nurse stated in a whisper tone, these people know who to play with and who not to play with. CNA A said he/she thought the resident and nurse were familiar with each other. The nurse stood by the wall as the CNA adjusted the height of the bed. The resident was awake and calm. The CNA explained the procedure and pulled down the resident's pants. The resident began kicking and yelling stop, I don't want my brief changed, and at that point the nurse approached the resident and grabbed his/her wrists and held them down while the CNA unfastened the brief and started to clean the resident. The CNA tucked the fasteners under the resident, to get ready to turn the resident on to his/her side. The CNA told the nurse he/she was ready to turn the resident, while the nurse was holding the resident's wrist, the nurse scooped up the resident's legs and flipped him/her onto their left side. The nurse and the CNA changed places; now the nurse was cleaning the resident, and the CNA was holding the resident's wrist loosely. The resident got his/her hands loose twice and pulled the CNA's hair. They changed places again. The CNA finished cleaning the resident, and the nurse held the resident's wrist. After they finished cleaning the resident, the resident was turned onto his/her back, then the resident was turned slightly to get the brief adjusted under the resident. The resident was kicking. The CNA said he/she was trying not to hurt the resident. The resident bit the nurse's arm. The nurse had his/her hands on the resident's face, trying to unclench the resident's teeth. The nurse said in a whisper voice, This [expletive] won't unclench his/her teeth in my arm. The CNA told the nurse to chill, and he/she put his/her hand between the nurse's arm and the resident's teeth. They fastened the resident's brief, and the CNA pulled the resident's pants up and lowered the bed down. The resident had some bleeding on the right side of his/her chin, but he/she did not see any bruising on the resident. The CNA asked the nurse if he/she was going to fill out an incident report because he/she knew he/she would need to write a statement. The nurse said What incident report? he/she has gotten bitten plenty of times. The CNA said typically when a resident says stop, he/she would stop. After the incident the CNA kept it to him/herself because he/she was conflicted because he/she looked at the nurse as a leader and thought the nurse might retaliate against him/her. At lunch time the CNA went to the Administrator's office to report the incident. The Administrator called the police. The CNA talked with the police and the higher ups (nurse managers), wrote a statement, and was educated on reporting allegations of abuse and neglect immediately and about not restraining residents. The CNA was suspended. Review of RN B handwritten statement, dated 5/12/25, showed he/she was called into a resident's room to assist CNA (no name provided) to change the resident because he/she was resisting care. We went to assist with care, informed resident of what we were about to do. Resident became verbally aggressive. We continued to reposition and change resident due to being soiled to the sheet. We lowered the bed and left the resident clean and call light in place. Resident stated he/she would tell his/her sister. We informed him/her we want him/her to be clean and comfortable while he/she's here. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/25 at 9:21 A.M., Police Officer D said he/she responded to a call to the facility on 5/12/25. The nurse was attempting to change the resident's brief, and they had a problem; one nurse held the resident, and one nurse was changing the resident. The resident bit one nurse. The resident had some bruises, but Police Officer D did not know if the bruises were new or old. Police Officer D did not feel there was an intent to harm the resident. The nurse who got bit said he/she was just trying to do his/her job. Observation and interview on 5/16/25 at 11:05 A.M., showed the Nurse Practitioner (NP) entered the resident's room. The resident was asleep in bed. The NP called the resident's name and pulled the resident's blanket part way down. The resident began yelling Go away, drop dead and began swinging. The NP covered the resident up and left the resident's room. The NP said, the resident was at his/her baseline, what she could see, the skin on the resident's arms looked the same as it did last month. The resident has very fragile skin. Review of CNA A's written statement dated 5/12/25, showed, on May 5 at 10:30 A.M., he/she asked the resident if it was okay to change his/her brief and the resident did not answer. The CNA attempted to change the resident, and the resident yelled and kicked and said no. So, the CNA went to RN B (nurse) and told the nurse the resident refused. The nurse followed the CNA to the resident's room. While walking to the room, the nurse was gloving up and saying, These people know who to play this shit on, They know who to pull this shit on. So, CNA A thought the nurse and the resident were familiar with each other. When entering the room, the nurse stood against the wall, and the CNA started to raise the bed up to the desired height. The nurse told the CNA that he/she could start pulling the resident's pants down, while the CNA was raising the bed up. The CNA told the nurse Yea, I'm aware, I'm just raising the bed up. So, CNA A pulled the resident's pants down, and the nurse immediately grabbed the resident's wrist and started holding the resident down. The CNA proceeded to clean the resident and the whole time he/she was cleaning and wiping the resident, the resident was still being held down, while sometimes finding his/her way free from the nurse. When the resident could free his/her hands, the resident pulled the CNA's hair and swung on him/her. The nurse then grabbed the resident's hands again, flipped the resident onto his/her left side so the nurse could put the brief under the resident. While the nurse put the brief under the resident, the CNA had to hold the resident. While the CNA was holding the resident, the resident got free and managed to pull the CNA's hair again. So, the CNA grabbed the resident's wrist, and as soon as the CNA grabbed it, the nurse stopped with the brief and grabbed the resident's wrist. After the CNA got the brief fully under the resident, they put the resident on his/her back. The brief needed to be pulled up between his/her legs and as the CNA was doing that the nurse was still trying to hold the resident down and in the midst of that, the resident bit the nurse's arm. The CNA didn't notice it until the nurse started gripping the resident's face/cheeks so the resident would unclench his/her teeth from the nurse's arm. The resident wasn't unclenching, so the nurse proceeded to smush the resident's face, as the nurse was still holding both arms with one hand. When the CNA saw what was happening, the CNA stopped fooling with the brief and told the nurse to chill out. The CNA went back to fastening the brief and the resident was kicking. So, the nurse picked up the resident's legs up and tossed them back on the bed and proceeded to hold the resident's legs down too. The CNA finally got to pull up the resident's pants and the nurse was still holding the resident. They covered the resident up, lowered the bed down, and left the room. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/25 at 2:51 P.M., the NP said if staff were trying to provide care, and the resident was resistive and became combative, staff should make the resident safe and give them some time. They could try to find a staff member who was familiar with the resident and take them with them when they check back in 10-15 minutes. Staff should explain what needs to be done and provide reassurance. If a resident was swinging at staff, staff should deflect, and they could try to give the resident a hand to hold on to. Staff should not hold residents down to provide care. Review of the facility's five-day summary of investigation showed: -Disposition: The Facility cannot substantiate abuse, neglect, or the restraint of Resident #503 due to the lack of corroborating witnesses, a lack of prior reported concerns, and the resident being unable to provide a meaningful account of the event. The facility substantiated a professional conduct violation and failure to follow facility protocols when caring for combative residents and the RN was terminated at the time of discovery and had no further access to any resident. All staff were reeducated on abuse, neglect, and exploitation with an emphasis on identifying and reporting. Staff were also educated on care approaches when caring for combative residents, resident safety, and restraints. Education is being completed on an ongoing basis for agency staff and prior to the next shift worked for any facility staff. The reporting CNA was allowed to return to work. Monitoring of Resident #503 showed no deviation to baseline mood or behavior, and no latent bruising or other injury from the alleged violation. During an interview on 5/16/25 at 2:30 P.M. and on 5/17/25 at 3:30 P.M., the Administrator said sometimes the resident refused care or can become combative with care. The facility has been working on trying to figure out if anything triggers the resident. Sometimes there are no triggers, the resident will start out okay then become combative, then stop, all within a few minutes. The staff felt the resident may become overstimulated on a regular floor, so they decided to trial him/her on the memory care hall. The memory care hall is smaller, and the staff are more consistent. Currently the facility has assigned one staff member to the resident so they can keep the resident in their direct sight. If a resident was resisting care or was combative, the Administrator would expect staff to make sure the resident was in a safe position and step away, to allow the resident to self soothe. Staff should attempt three times to provide care. If the resident continues to resist care, the CNA should report this to the nurse, which the CNA did. The Administrator would expect for the nurse to assess the resident and try to provide care. If the resident continued to resist care, the nurse should stop and report it to the DON and Administrator. They may need to call the family to see if they could encourage the resident or they may need to call the physician. It is never appropriate for the staff to restrain a resident to provide care. If the resident said no, staff should have stopped, even if the resident was incontinent. Staff should not force care. The Administrator expects staff to follow the facility's policy and procedures. MO00254142