

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when another resident hit the resident in the face, resulting in the resident's face being scratched (Residents #4 and #5). The sample was five. The census was 113.</p> <p>Review of the facility's Abuse, Neglect and Exploitation Policy, dated 4/28/25, showed the following:</p> <p>-Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property;</p> <p>-Definition: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/3/25, showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Verbal behaviors;</p> <p>-No impairment to extremities;</p> <p>-Partial to Moderate assistance with activities of daily living (ADLs, self care);</p> <p>-Diagnoses of stroke, high blood pressure, diabetes and depression.</p> <p>Review of the resident's care plan, dated 6/9/25, showed the following:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Focus: The resident has a behavior problem of physical aggression, and verbal aggression in regards to cognitive communication deficit and depression;</p> <p>-Intervention: Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and potential causes.</p> <p>Review of the resident's nurse's notes, dated 6/25/25 at 5:02 P.M., showed, the nurse heard yelling coming from 400 west hallway. The nurse went down the hall to see why resident was yelling. Another resident stated he/she was hit by Resident #4 in the face. Certified Nurse Aides (CNAs) had already separated residents from each other and confirm this resident was aggressive and hit the other resident in the face, causing an injury. Another nurse removed Resident #4 from the west hallway and down to his/her room to provide a quiet space. The resident was placed in line of sight monitoring. skin assessment was attempted and resident refused. The resident's family was notified. The nurse practitioner (NP) and nurse manager was notified and 911 called. The resident was interviewed by police and resident sent to hospital for further evaluation.</p> <p>Review of Resident #5's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognitive status not documented;</p> <p>-No behaviors;</p> <p>-No impairment of extremities;</p> <p>-Wheelchair mobility;</p> <p>-Partial to Moderate assistance with ADLs;</p> <p>-Diagnoses of stroke, high blood pressure and seizure disorder.</p> <p>Review of the resident's nurse's note dated 6/25/25 at 4:43 P.M., showed the nurse heard yelling coming from 400 west hallway. The nurse went down the hall to see why the resident was yelling. The resident said he/she was hit by another resident in the face. CNAs had already separated the residents from each other. The nurse assessed the resident and he/she has two scratches to his/her face. One above his/her top lip and one on the side of his/her left eye. The nurse cleaned blood off the resident with wound cleaner, no bandages were needed. The resident's glasses were bent during altercation, which were able to be bent back into shape. The resident did complain of pain and as needed pain medication was given. The resident's power of attorney was notified. The NP and nurse manager were notified.</p> <p>During an interview on 6/26/25 at 9:15 A.M. the resident said he/she did not want to be hit in the face by Resident #4. The resident said he/she has had a problem with Resident #4 but had not been hit before. The resident said he/she felt safe at the facility. Observation at that time, showed the resident had no visual bruising to his/her face.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/25 at 9:27 A.M., Certified Medicine Technician (CMT) B said Resident #4 came rolling in his/her wheelchair down the west wing hall. Resident #5 was sitting outside his/her room. When Resident #4 wheeled almost past Resident #5, Resident #4 swung a with an open fist and hit Resident #5 in the face. CMT B yelled for Resident #4 to stop. Resident #4 looked at Resident #5 and hit him/her fast three or four more times in the face. CMT B said he/she grabbed Resident #4's hands, and he/she shook loose. Resident #4 reached again and tried to grab for Resident #5's face. CMT B turned Resident #4's wheelchair around to get him/her away. CMT B said he/she had heard the two residents did not get along but he/she had never seen anything. CMT B said Resident #4 could be aggressive with care and when getting medications. CMT B said he/she was recently inserviced on the facility abuse and neglect policy.</p> <p>During an interview on 6/26/25 at 9:23 A.M., Licensed Practical Nurse (LPN) A said the two residents had sat together and talked and socialized and also argued. LPN A said Resident #4 had never gotten physical until now. Resident #4 was sent to the hospital for evaluation. LPN A said he/she was recently inserviced on the facility abuse and neglect policy.</p> <p>During an interview on 6/26/25 at 12:13 P.M., the Administrator and Director of Nursing said they would expect the facility's abuse and neglect policy to be followed as written. The Administrator said Resident #4 had a history of being verbally aggressive with residents and staff. The staff would just try to redirect the resident. This was the first time Resident #4 had gotten physical with anyone. The resident was given an immediate discharge and not be allowed back due to safety issues.</p> <p>MO00256468</p>		