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	01/16/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure residents right to personal privacy and confidentiality when Certified Nursing Assistant (CNA) A provided peri-care (incontinence care) to a resident (Resident #1) during a video call with CNA B and Scheduler H. CNA B was at home and two children were on camera with him/her. The resident's genitals and buttocks were exposed. Additionally, CNA B took pictures of a resident (Resident #2) while he/she slept and shared it to a group chat with staff and non-staff members. The sample was 18. The census was 109.Review of the facility's Resident Rights policy, dated September 2024, showed:-The resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;-The resident had a right to be treated with respect and dignity-The resident had a right to a safe, clean, comfortable and homelike; environment, including but not limited to receiving treatment and supports for daily living safely. Review of the facility's Personal Cell Phone policy, revised September 2025, showed:-It was the policy of the facility to provide quality care to residents without interruption;-The facility prohibited employees from using personal cell phones for any reason, on the nursing units or in working areas of the facility;-This included calls, texts, social media, or any other use of cell phones;-Under no circumstance should employees take pictures, videos, or any other personal representations of any resident for the purpose of personal use, social media or any other reason;-Employees who violated this policy were subject to disciplinary action up to and including termination. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/15/25, showed:-Severe cognitive impairment;-Difficulty focusing and disorganized thinking;-Rarely/never understood;-No behaviors;-Wheelchair for mobility;-Dependent on staff for all Activities of Daily Living (ADLs) and mobility;-Always incontinent of bowel and bladder;-Diagnoses included: Aphasia (a language disorder from brain damage (like stroke or injury) which impairs speaking) and hemiparesis (partial weakness on one side). Review of the resident's care plan in, use during survey, showed:-Focus: The resident had a behavior problem due to dementia (a severe decline in mental abilities);-Interventions: Staff provided an opportunity for positive interaction/attention, stopped and talked to him/her in passing. Staff explained all procedures to the resident before starting and allowed him/her to adjust to changes;-Focus: The resident had impaired cognitive function or impaired thought processes due to a stroke;-Intervention: Staff asked yes/no questions to determine the resident's needs. Review of a video call showed Scheduler H in the top frame of the video and CNA A in the middle frame. The sound was muted. CNA A was in Resident #1's room. The resident lay on his/her back in bed. The resident had on a black shirt, no pants, a brief and grey socks. CNA A said something to the resident, then removed his/her brief. The resident's genitals were exposed. CNA A and the resident exchanged words. CNA A rolled the resident onto his/her left side. The resident's buttocks were exposed. CNA B joined the video call after 36 seconds. Two young children were on camera with CNA B. One of the children waved at the (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	camera. Both children watched CNA A clean the resident's buttocks. The children left the video call after one minute and 21 seconds. CNA A, CNA B and Scheduler H remained on the call. CNA A and the resident exchanged words again. CNA A rolled the resident on his/her right side. The resident was on the edge of the bed. He/She held onto CNA A's buttock with both hands. CNA A moved his/her buttocks in a circle, looked back at the camera and smiled. CNA B laughed. The video ended. Observation on 01/14/26 at 9:14 A.M., showed the resident in the dining room, seated in his/her Broda chair (a specialized, high-quality medical wheelchair). The resident did not respond to questions. During an interview on 01/15/26 at 11:05 A.M., Scheduler H said he/she was in a group chat with co-workers and friends. He/She did not remember who initiated the call. He/She thinks the call was in September 2025. He/She did not think it was inappropriate to be on a video call while providing care. He/She did not know the call was recorded. He/She did not share any videos or photos. He/She was not oriented on resident rights and personal cell phone policies. The facility in-serviced staff after something happened. He/She was suspended on 01/09/26 and terminated on 01/15/26. During an interview on 01/15/2026 at 11:31 A.M., CNA A said he/she did not remember when the call occurred. He/She was a part of a cousins group chat. The group chat included staff and non-staff. He/She knew it was wrong to answer the call while providing care. He/She did not know why he/she did it. He/She was not oriented on resident rights and personal cell phone policies. He/She was suspended on 01/09/26 and terminated 01/15/2026. Review of CNA A, CNA B and Scheduler H employee files, showed they acknowledged receipt of the resident's rights policy. 2. Review of Resident #2's quarterly MDS, showed:-Severe cognitive impairment;-Difficulty focusing and disorganized thinking;-Rarely/never understood;-No behaviors;-Wheelchair for mobility;-Diagnoses included: Dementia, high blood pressure, seizure disorder, anxiety disorder (a mental health condition marked by persistent, excessive fear and worry about everyday situations) and depression. Review of a photo received by Department of Health & Senior Services (DHSS), showed Resident #2 sleeping in a recliner. The photo was sent to a group chat by CNA B. The group chat included other staff and non-staff members. During an interview on 01/16/26 at 12:01 P.M., the Director of Nursing identified the resident in the photo as Resident #2. During an interview on 01/15/26 at 11:05 A.M., Scheduler H said he/she muted the group chat. He/She did not see the photo of the resident. During an interview on 01/15/26 at 11:31 A.M., CNA A said he/she muted the group chat. He/She did not see the photo of the resident. He/She would have reported it. During an interview on 01/15/26 at 02:39 P.M., the Regional Director of Clinical Services said she was notified via email, of the video and photos on the evening of 01/08/26. Staff were suspended after review of the video. She would have expected staff in the group chat to report the videos when they occurred. 27123342712840

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met acceptable professional standards of care when staff failed to administer and document morning and afternoon medications as order by the physician for seven residents (Resident #8, Resident #7, Resident #11, Resident #9, Resident #12, Resident #2 and Resident #6 and Resident #10). Additionally, the facility failed to refill Hydrocodone (prescription opioid used for moderate to severe pain) 5-325 milligrams (mg) for one resident (Resident #4) who had severe pain in a timely manner. The resident did not receive his/her hydrocodone for two days. The sample was 18. The census was 109.Review of the facility's Medication Administration policy, dated October 2024, showed:-Medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection;-Ensure the six rights of medication administration were followed:a. Right resident;b. Right drug;c. Right dosage;d. Right route;e. Right time;f. Right documentation;-Administered within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Review of the facility's Medication and Treatment Orders policy, undated, showed:-Orders for medications and treatments would be consistent with principles of safe and effective order writing;-Only authorized personnel may call in orders for prescribed medications to the pharmacy;-Drugs and biologicals (treat diseases by targeting specific parts of the immune system) required to be refilled will be reordered from the issuing pharmacy in a timely manner prior to the last dosage being administered to ensure refills are readily available. 1. Review of Resident #8's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 10/14/25, showed:-Cognitively intact;-Wheelchair for mobility;-Partial/moderate assistance with activities of daily living (ADLs) and mobility;-Received scheduled pain medication;-Diagnoses included: Stroke, dysphagia (difficulty swallowing), insomnia, anemia, high blood pressure, chronic kidney disease, diabetes, high cholesterol, acid reflux, major depressive disorder and psychotic disorder. Review of the resident's care plan, in use during survey, showed:-Focus: The resident had diabetes;-Intervention: Staff administered medications as ordered by physician;-Focus: The resident had acid reflux;-Intervention: Staff administered medications as ordered by physician;-Focus: The resident was on diuretic therapy due to edema (swelling);-Intervention: Staff administered diuretic (removal of excess water and sodium) medications as ordered by physician;-Focus: The resident was on antiplatelet therapy (medications used to prevent blood from clumping) due to history of stroke;-Intervention: Staff administered antiplatelet medications as ordered by physician;-Focus: The resident used psychotropic medications due to depression;-Intervention: Staff administered psychotropic medications as ordered by physician;-Focus: The resident had weakness due to stroke;-Intervention: Staff administered medications as ordered by physician;-Focus: The resident had potential for pressure injury development due to history of ulcers, incontinence and immobility;-Intervention: Staff administered medications as ordered by physician. Review of the resident's Order Summary Report, dated January 2026, showed:-Airborne oral tablet, chewable (multi-vitamins with minerals). Give one tablet by mouth once a day to support immune system for six months;-Allopurinol tablet (used to lower uric acid levels) 100 mg. Give half tablet by mouth once a day for gout (painful form of inflammatory arthritis caused by high levels of uric acid in the blood);-Clopidogrel bisulfate tablet (used to prevent blood clots) 75 mg. Give one tablet by mouth once a day for blood clot prevention;-Ferrous sulfate oral tablet (iron) 325 mg. Give one tablet by mouth once a day for supplement;-Folic acid oral tablet (vitamin B-9) 1 mg. Give one tablet by mouth once a day for (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplement;-Furosemide tablet (diuretic) 20 mg. Give one tablet by mouth once a day;-Pepcid oral tablet. Give 10 mg by mouth in the morning for indigestion;-Carvedilol oral tablet (used to manage high blood pressure) 6.25 mg. Give one tablet by mouth twice a day for high blood pressure;-Gabapentin capsule (used to treat neuropathic pain (nerve pain)) 100 mg. Give one capsule by mouth twice a day for neuropathy pain;-Venlafaxine oral tablet (anti-depressant used to treat major depressive disorder) 37.5 mg. Give one tablet by mouth twice a day for major depressive disorder. Review of the resident's Medication Administration Record (MAR), dated January 2026, showed:-Airborne not administered on 01/03/26. No documentation as to why;-Allopurinol not administered on 01/03/26. No documentation as to why;-Clopidogrel bisulfate not administered on 01/03/26. No documentation as to why;-Ferrous sulfate not administered on 01/03/26. No documentation as to why;-Folic acid not administered on 01/03/26. No documentation as to why;-Furosemide not administered on 01/03/26. No documentation as to why;-Pepcid not administered on 01/03/26. No documentation as to why;-Carvedilol not administered on 01/03/26 midday. No documentation as to why;-Gabapentin not administered on 01/03/26 at 8:00 A.M. No documentation as to why;-Venlafaxine not administered on 01/03/26 at 7:00 A.M. No documentation as to why. 2. Review of Resident #7's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-Wheelchair for mobility;-Substantial assistance with ADLs;-Partial to moderate assistance with transfers;-Diagnoses included: Congestive heart failure (CHF), diabetes, acid reflux, high blood pressure, high cholesterol, arthritis, depression and stroke. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident had diabetes;-Intervention: Staff administered diabetes medication as ordered by physician;-Focus: The resident was on anticoagulant therapy (used medications, often called blood thinners, to prevent blood from clotting easily) due to atrial fibrillation (AFib) (irregular heart beat) and history of stroke;-Intervention: Staff administered anticoagulant medications as ordered by physician;-Focus: The resident used psychotropic medications due to insomnia and depression;-Intervention: Staff administered psychotropic medications as ordered by physician;-Focus: The resident was on diuretic therapy due to CHF;-Intervention: Staff administered diuretic medications as ordered by physician;-Focus: The resident had a stroke which resulted in dysphagia, severe weakness of lower limb and cognitive deficit;-Intervention: Staff administered medications as ordered by physician;-Focus: The resident had potential for pressure injury development due to history of ulcers, incontinence and immobility;-Intervention: Staff administered medications as ordered by physician. Review of the resident's Order Summary Report, dated January 2026, showed:-Cyanocobalamin (prevents vitamin B12 deficiency) tablet 1000 micrograms (mcg). Give one tablet by mouth once a day for supplement;-Fenofibrate micronized oral capsule (used to lower high triglycerides and bad cholesterol) 200 mg. Give 200 mg by mouth once a day for cholesterol;-Glycolax powder (used to treat constipation). Give 17 grams by mouth once a day for constipation;-Lisinopril tablet (treats high blood pressure) 10 mg. Give one tablet by mouth once a day for high blood pressure;-Metoprolol succinate ER tablet (treats high blood pressure) 50 mg. Give one tablet by mouth once a day for high blood pressure;-Spironolactone oral tablet (used to treat high blood pressure and fluid retention) 25 mg. Give half tablet by mouth once a day for high blood pressure;-Venlafaxine oral tablet 37.5 mg. Give one tablet by mouth once a day for depression;-Apixaban oral tablet (blood thinner) 5 mg. Give 5 mg by mouth twice a day for AFib. Review of the resident's MAR, dated January 2026, showed:-Cyanocobalamin not administered on 01/03/26. No documentation as to why;-Fenofibrate not administered on 01/03/26. No documentation as to why;-Glycolax not administered on 01/03/26. No documentation as to why;-Lisinopril not administered on 01/03/26. No documentation as to why;-Metoprolol succinate not administered on 01/03/26. No documentation as to why;-Spironolactone not administered on 01/03/26. No (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation as to why;-Venlafaxine not administered on 01/03/26. No documentation as to why;-Apixaban not administered on 01/03/26 at 7:00 A.M. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. During an interview on 01/15/26 at 12:00 P.M., the resident said sometimes his/her medication was administered late. He/She could not remember if he/she missed any doses on 01/03/26. 3. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Wheelchair for mobility;-Substantial assistance with ADLs and mobility;-Diagnoses included: Dementia, fractured left femur, Chronic Obstructive Pulmonary Disease (COPD), anemia, hypothyroidism (underactive thyroid), heart disease, Obsessive Compulsive Disorder (OCD) (uncontrollable, reoccurring thoughts and repetitive behaviors) and brittle bones. Review of the resident's care plan in use during survey, showed:-Focus: The resident used antidepressant medications due to depression;-Intervention: Staff administered antidepressant medications as ordered by physician;-Focus: The resident was on pain medication therapy due to brittle bones and left femur fracture;-Intervention: Staff administered pain medications as ordered by physician;-Focus: The resident was on antiplatelet therapy due to rheumatic mitral stenosis (narrowing of the mitral valve);-Intervention: Staff administered antiplatelet medications as ordered by physician;-Focus: The resident was at risk for malnutrition due to chronic/progressive diseases;-Intervention: Registered Dietician evaluated and made diet changes as needed. Review of the resident's Order Summary Report, dated January 2026, showed:-Aspirin Tablet 81 mg. Give one tablet by mouth once a day for deep vein thrombosis (a serious condition where a blood clot forms in a deep vein) prevention;-Cetirizine oral tablet (over-the-counter antihistamine) 10 mg. Give one tablet by mouth once a day for allergies;-Cholecalciferol oral capsule (used to treat and prevent vitamin D deficiency) 50 mg. Give one capsule by mouth once a day for vitamin D deficiency;-Folic acid tablet 1 mg. Give one tablet by mouth once a day for supplement;-Losartan potassium oral tablet to (used treat high blood pressure) 50 mg. Give 50 mg by mouth one time a day for high blood pressure;-Sertraline oral tablet (treats OCD) 25 mg. Give one tablet by mouth once a day for depression;-Super B-Complex Oral Tablet (dietary supplement). Give one tablet by mouth once a day for supplement;-Trelegy ellipta inhalation aerosol powder breath activated (used for the long-term, maintenance treatment of COPD) 100-62.5-25 mcg. One puff inhaled orally once a day for COPD;-Eliquis oral tablet (blood thinner) 5 mg. Give one tablet by mouth twice a day for AFib;-Polysaccharide iron complex oral capsule (used to treat anemia). Give 150 mg by mouth twice a day for vitamin;-House shake (a high-protein, nutrient-dense meal replacement supplement) three times a day for supplement;-Oyster calcium (treats calcium deficiencies) oral tablet 500 mg. Give 500 mg by mouth three times a day for left hip fracture. Review of the resident's MAR, dated January 2026, showed:-Aspirin not administered on 01/03/26. No documentation as to why;-Cetirizine not administered on 01/03/26. No documentation as to why;-Cholecalciferol not administered on 01/03/26. No documentation as to why;-Folic acid not administered on 01/03/26. No documentation as to why;-Losartan not administered on 01/03/26. No documentation as to why;-Sertraline not administered on 01/03/26. No documentation as to why;-Super B-Complex not administered on 01/03/26. No documentation as to why;-Trelegy Ellipta inhalation aerosol powder breath activated not administered on 01/03/26. No documentation as to why;-Eliquis not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Polysaccharide iron complex not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-House shake not administered on 01/03/26 at 7:00 A.M and midday. No documentation as to why;-Oyster calcium not administered on 01/03/26 at 8:00 A.M and 12:00 P.M. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. 4. Review of Resident #9's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Wheelchair (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and walker for mobility;-Set up or clean up assistance with ADLs and mobility;-Received scheduled pain medication;-Diagnoses included: Dementia, anxiety disorder, major depressive disorder, hypothyroidism, heart failure and overactive bladder. Review of the resident's care plan, in use during survey, showed:-Focus: The resident had hypothyroidism;-Intervention: Staff administered thyroid replacement therapy as ordered;-Focus: The resident used psychotropic medications due to depression and anxiety;-Intervention: Staff administered psychotropic medications as ordered by physician;-Focus: The resident was on anticoagulant therapy due to AFib;-Intervention: Staff administered anticoagulant medications as ordered by physician;-Focus: The resident was on diuretic therapy due to CHF;-Intervention: Staff administered diuretic medications as ordered by physician. Review of the resident's order summary report, dated January 2026, showed:-Buspirone oral tablet (used to treat anxiety) 5 mg. Give half tablet by mouth once a day for anxiety related to dementia;-Cyanocobalamin tablet 1000 mcg. Give one tablet by mouth once a day for supplement;-Famotidine oral tablet (used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers) 10 mg. Give 10 mg by mouth once a day for indigestion;-Furosemide tablet 40 mg. Give one tablet by mouth once a day for edema;-Pataday ophthalmic solution (used to relieve itchy, red eyes) 0.2 %. Instill one drop in both eyes once a day for allergies;-Polyethylene glycol 3350 powder (laxative used to relieve occasional constipation). Give 17 grams by mouth once a day for constipation;-Potassium chloride Extended Release (ER) oral capsule (used to treat potassium deficiency) 10 milliequivalent. Give two capsules by mouth once a day for low potassium;-Duloxetine oral capsule delayed release sprinkle (used to treat major depressive disorder) 20 mg. Give 20 mg by mouth twice a day for depression;-Eliquis oral tablet 2.5 mg. Give one tablet by mouth twice a day for AFib;-Memantine tablet (used to treat Alzheimer's disease) 5 mg. Give one tablet by mouth twice a day for memory loss;-Metoprolol tartrate tablet 25 mg. Give one tablet by mouth every 12 hours for high blood pressure;-Oyster shell calcium tablet 500 mg. Give one tablet by mouth twice a day for supplement;-Pyridium oral tablet (used to temporarily relieve pain) 100 mg. Give one tablet by mouth twice a day for pain. Review of the resident's MAR, dated January 2026, showed:-Buspirone not administered on 01/03/26. No documentation as to why;-Cyanocobalamin not administered on 01/03/26. No documentation as to why;-Famotidine not administered on 01/03/26. No documentation as to why;-Furosemide not administered on 01/03/26. No documentation as to why;-Pataday ophthalmic solution not administered on 01/03/26. No documentation as to why;-Potassium chloride not administered on 01/03/26. No documentation as to why;-Duloxetine not administered on 01/03/26. No documentation as to why;-Eliquis not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Memantine not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Metoprolol tartrate not administered on 01/03/26 at 8:00 A.M. No documentation as to why;-Oyster shell calcium not administered on 01/03/26 at 7:00 A.M. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. During an interview on 01/16/26 at 1:49 P.M., the resident said he/she did not get his/her medication on time. Sometimes he/she did not get his/her thyroid and anxiety medication in the morning. He/She had trouble with anxiety and depression. He/She needed his/her medication in the morning. He/She was anxious when he/she did not get his/her medication. 5. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Wheelchair for mobility;-Substantial assistance with ADLs and mobility;-Diagnoses included: Parkinson's disease (a progressive, neurological disorder affecting the central nervous system), stroke, high blood pressure and respiratory failure. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident was on anticoagulant therapy due to AFib;-Intervention: Staff administered anticoagulant medications as ordered by physician;-Focus: The resident used anti-anxiety (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications due to depression;-Intervention: Staff administered anti-anxiety medications as ordered by physician;-Focus: The resident had Parkinson's Disease;-Intervention: Staff administered medications as ordered by the physician;-Focus: The resident had acute/chronic pain due to comorbities (two or more distinct medical conditions present in the same person at the same time);-Intervention: Staff administered pain medication as ordered by physician Review of the resident's Order Summary Report, dated January 2026, showed:-Acetaminophen oral tablet 325 mg. Give two tablets by mouth twice [NAME] for pain;-Aspirin oral capsule 81 mg. Give one capsule by mouth once a day for stroke;-Amantadine oral capsule (used to treat Parkinson's disease) 100 mg. Give one capsule by mouth twice a day for Parkinson's;-Diltiazem ER 12-hour oral capsule (used to treat high blood pressure) 60 mg. Give one capsule by mouth every 12 hours for high blood pressure;-Eliquis oral tablet 5 mg. Give one tablet by mouth twice a day for AFib;-House supplement 120 milliliters (ml) once a day for nutrition;-Lidocaine (numbs tissue) external patch 4 %. Apply to left shoulder topically inthe morning for arthritis pain;-Losartan potassium tablet 50 mg. Give one tablet by mouth once a day for high blood pressure;-Polyethylene glycol 3350 powder. Give 17 grams by mouth once a day for constipation. Review of the resident's MAR, dated January 2026, showed:-Aspirin not administered on 01/03/26. No documentation as to why;-Acetaminophen not administered on 01/03/26 at 7:00 A.M. No documentation as to why; -Amantadine not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Diltiazem not administered on 01/03/26 at 8:00 A.M. No documentation as to why;-Eliquis not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-House supplement not administered on 01/03/26. No documentation as to why;-Lidocaine external patch not administered on 01/03/26. No documentation as to why;-Losartan potassium not administered on 01/03/26. No documentation as to why;-Polyethylene glycol 3350 powder not administered on 01/03/26. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. 6. Review of Resident #2's quarterly MDS, showed:-Severe cognitive impairment;-Totally dependent on staff for ADLs;-Diagnoses included: Dementia, high blood pressure, seizure disorder, anxiety disorder and depression. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident had a mood problem due to major depressive disorder;-Intervention: Staff administered medications as ordered;-Focus: The resident had a seizure disorder;-Intervention: Staff gave medications as ordered. Monitored/documented for effectiveness and side effects; Review of the resident's order summary report, dated January 2026, showed:-Ascorbic acid oral tablet (a dietary supplement to prevent deficiency and support overall health) 500 mg. Give one tablet by mouth once a day;-Calcium carbonate tablet chewable (used to treat heartburn) 500 mg. Give two tablets by mouth once a day; -Cholecalciferol oral tablet 25 mcg. Give two tablets by mouth once a day for supplement;-Cyanocobalamin oral tablet 1000 mcg. Give one tablet by mouth once a day;-Escitalopram oxalate tablet (used to treat major depressive disorder) 10 mg. Give one tablet by mouth once a day for depression;-Lacosamide oral tablet (used to control epilepsy) 50 mg. Give one tablet by mouth twice a day for seizures;-Lasix oral tablet (diuretic) 20 mg. Give one tablet by mouth in the morning for edema;-Levetiracetam tablet (anticonvulsant) 250 mg. Give one tablet by mouth twice a day for seizures;-Metoprolol succinate ER tablet 25 mg. Give one tablet by mouth once a day for high blood pressure;-Oxybutynin chloride oral tablet (relaxes the bladder) 2.5 mg. Give one tablet by mouth twice a day for overactive bladder;-Pantoprazole sodium tablet delayed release (used to decrease stomach acid) 40 mg. Give one tablet by mouth twice a day for acid reflux. Review of the resident's MAR, dated January 2026, showed:-Calcium carbonate not administered on 01/03/26. No documentation as to why;-Cholecalciferol not administered on 01/03/26. No documentation as to why;-Cyanocobalamin not administered on 01/03/26. No documentation as to why;-Escitalopram (continued on next page)

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	01/16/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxalate not administered on 01/03/26. No documentation as to why;-Lasix not administered on 01/03/26. No documentation as to why;-Lacosamide not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Levetiracetam not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Metoprolol succinate ER not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Oxybutynin chloride not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Pantoprazole sodium not administered on 01/03/26 at 7:00 A.M. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. 7. Review of Resident #6's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on staff for ADLs and mobility;-Received scheduled pain medication;-Diagnoses included: Dementia, high blood pressure, high cholesterol, diabetes, vitamin deficiency, constipation, osteoarthritis (degenerative joint disease where protective cartilage breaks down over time, causing bones to rub together, leading to pain, stiffness, swelling, and reduced movement), and edema. Review of the resident's care plan in use during the survey, showed:-Focus: The resident had diabetes;-Intervention: Staff gave diabetes medication as ordered by doctor. Staff monitored/documented side effects and effectiveness;-Focus: The resident had an alteration in musculoskeletal status due to plantar flexion contracture (the ankle and foot become stuck pointing downwards);-Intervention: Staff gave pain medication as ordered by the physician. Staff monitored/documented side effects and effectiveness. Review of the resident's order summary report, dated January 2026, showed:-Amlodipine besylate tablet (a prescription calcium channel blocker) 10 mg. Give one tablet by mouth once a day for high blood pressure;-Glipizide tablet (used to lower blood sugar) 10 mg. Give one tablet by mouth in the morning for diabetes;-Multiple vitamin tablet. Give one tablet by mouth once a day for supplement;-Vitamin B-12 oral tablet 1000 mcg. Give one tablet by mouth once a day for vitamin supplement;-Lisinopril tablet 20 mg. Give one tablet by mouth twice a day for hypertension;-Metformin tablet (lowers blood sugar) 1000 mg. Give one tablet by mouth twice a day for diabetes;-Metoprolol tartrate oral tablet 50 mg. Give 50 mg by mouth twice a day for high blood pressure;-Acetaminophen extra strength tablet 500 mg. Give one tablet by mouth three times a day for pain;-Ibuprofen oral tablet 200 mg. Give 400 mg by mouth before meals and at bedtime for back pain. Review of the resident's MAR, dated January 2026, showed:-Amlodipine besylate not administered on 01/03/26. No documentation as to why;-Glipizide not administered on 01/03/26. No documentation as to why;-Multiple vitamin not administered on 01/03/26. No documentation as to why;-Vitamin B-12 not administered on 01/03/26. No documentation as to why;-Lisinopril not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Metformin not administered on 01/03/26 at 7:00 A.M. No documentation as to why;-Acetaminophen not administered on 01/03/26 at 7:00 A.M. and midday. No documentation as to why;-Ibuprofen not administered on 01/03/26 at 7:30 A.M. and 11:30 A.M. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. 8. Review of Resident #10's comprehensive MDS, dated [DATE], showed: -Cognitively intact;-Wheelchair for mobility;-Supervision or touch assistance with ADLs;-Totally dependent with mobility;-Diagnoses included: Seizures, OCD, vitamin deficiency and cognitive communication deficit. Review of the resident's care plan, in use during survey, showed:-Focus: The resident used psychotropic medications due to OCD and appetite stimulant;-Intervention: Staff administered psychotropic medications as ordered by physician. Review of the resident's order summary report, dated January 2026, showed:-Cholecalciferol oral tablet 25 mcg. Give three tablets by mouth once a day for supplement;-Cyanocobalamin tablet 1000 mcg. Give one tablet by mouth once a day for supplement;-Magnesium oxide tablet (treats low magnesium levels) 400 mg. Give one tablet by mouth once a day for supplement;-Sertraline tablet 100 mg. Give one and a half tablets by mouth once a day for OCD;-Doxycycline (continued on next page)

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	265766	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, MO 63021

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hyclate oral tablet (used to treat bacterial infections) 100 mg. Give 100 mg by mouth twice a day for prophylaxis (a preventative healthcare measure, to guard against, stop, or reduce the risk of diseases and infections before they start). Review of the resident's MAR, dated January 2026, showed:-Cholecalciferol not administered on 01/03/26. No documentation as to why;-Cyanocobalamin not administered on 01/03/26. No documentation as to why;-Magnesium oxide not administered on 01/03/26. No documentation as to why;-Sertraline not administered on 01/03/26. No documentation as to why;-Doxycycline hyclate not administered on 01/03/26. No documentation as to why. Review of the resident's progress notes showed no documentation of why medications were not administered. During an interview on 01/15/26 at 10:23 A.M., the resident said he/she often did not get his/her medicine on time. Sometimes his/her medicine was not given in the morning. Staff did not come in his/her room to give it to him/her. 9. Review of the facility staffing sheet, dated 01/03/26, showed Licensed Practical Nurse (LPN) E, LPN G, and Certified Medication Technician (CMT) F assigned to the 300 hall. During an interview on 01/15/26 at 11:05 A.M., Scheduler H said there was a CMT scheduled for 300 east and 300 west. The CMT scheduled on 300 west called off. The CMT on 300 east refused to pass medication on 300 west. Scheduler H could not remember the CMT's name. If a CMT calls off, the nurse assigned to the hall passed the medication. Scheduler H is a CMT. Scheduler H arrived at the facility at 12:41 P.M. The nurse assigned to 300 west passed the medication and Scheduler H helped. He/She was not sure why the MAR was blank. During an interview on 01/15/26 at 12:46 P.M., CMT C said the medication pass started at 7:00 A.M. Medication could be passed one hour before or one hour after it was scheduled. There was a CMT for each floor. If the CMT called off, the scheduled nurse passed the medications. Sometimes a CMT was pulled from another floor. If a medication was not given, it was documented in the MAR and progress notes. If the MAR was blank, the medication was not given. During an interview on 01/16/26 at 10:38 A.M., Nurse Manager D said there was a CMT scheduled on each floor. If the CMT did not show up, the nurse or nurse manager passed medications. If a medication was not passed, it should be documented in the MAR and progress notes. If the MAR is blank, the medication was not given. During an interview on 01/27/26 at 8:21 A.M., LPN E said he/she could not recall 01/03/26. The facility was always short staffed. He/She does not know the policy for medication pass when the CMT called off. They usually called in another CMT. Scheduler H was a CMT and worked on the weekend. Sometimes he/she passed the medication. There were two nurses scheduled on 300 hall. The nurse assignments on the 300 hall were heavy. He/She did not pass medications on the cart. During an interview on 01/27/26 at 9:36 A.M., CMT F said he/she was not scheduled on 01/03/26. He/She was called in to work. He/She worked from 6:55 A.M. to 9:00 P.M. He/She was assigned to hall 300 east. The CMT scheduled on 300 west called off. The facility tried to pull a CMT from the second floor. The CMT refused to help pass medication on the third floor. The nurse scheduled on 300 west said he/she would pass medication. The nurse had the keys for the medication cart. He/She could not remember the nurse's name. Scheduler H came in. CMT F did not see Scheduler H pass medication. If a medication is not given, it was documented in the MAR and progress notes. If the MAR was blank, the medication was not given. During an interview on 01/28/26 at 11:39 A.M., LPN G said he/she was assigned to 300 east and LPN E was assigned to 300 west. Sometimes there were two nurses and two CMTs scheduled on 300 hall. There was not a CMT on 300 west. Scheduler H asked CMT F to pass meds on 300 hall. CMT F refused to pass meds on 300 west. CMT F said they should have asked him/her in advance. LPN E passed medication to some of the residents. Several residents did not receive their medications. When CMT F refused to pass medications, LPN E should have passed them. During an interview on 01/16/26 at 12:01 P.M., the Director of Nursing (DON) said Scheduler H was responsible for scheduling staff. There was a CMT assigned to each (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor. Sometimes there were two CMTs assigned to the 300 hall. If a CMT did not show up for his/her shift, they would replace him/her. If a replacement was not found, the nurse passed medications for their assignment. The CMT assigned to 300 west was late on 01/03/26. She was told the nurse passed medication. Scheduler H came in and helped the nurse pass medications. If a medication was not given, it was documented in the MAR and progress notes. She was not aware the MAR was blank. If the MAR was blank, the medication was not given. She would have expected staff to notify her if the medications were not given. She should have checked the MAR. 10. Review of Resident #4's pain assessment, dated 08/07/25, showed:-Pain presence: Yes;-Pain frequency: Almost constantly;-Pain intensity: Severe;-Indicators: Verbal complaints daily. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Set up/supervision with ADLs;-Independent with mobility;-Received scheduled pain medication;-Diagnoses included: Legal blindness, CHF, depression, anxiety and osteoarthritis (the degeneration of cartilage in joints, leading to pain). Review of the resident's care plan, in use during the survey, showed:-Focus: The resident had pain due to chest pain, muscle spasms and chronic pancreatitis (inflammation of the pancreas);-Intervention: Staff administered pain medication as ordered. Review of the resident's Order Summary Report, dated January 2026, showed hydrocodone-acetaminophen tablet 5-325 mg. Give one tablet by mouth every six hours for pain. Review of the resident's MAR, dated January 2026, showed:-Hydrocodone-acetaminophen tablet:-01/02/26 administered at 12:00 A.M. Not administered at 6:00 A.M. No documentation as to why. Staff documented 13 (means not available) at 12:00 P.M. and 6:00 P.M.;-01/03/26 not available at 12:00 A.M., 6:00 A.M. and 12:00 P.M. Given at 6:00 P.M.;-01/04/26 staff documented nine (means see progress notes) at 12:00 A.M. Not available at 6:00 A.M. and 12:00 P.M. Given at 6:00 P.M. Review of the resident's outbound (sent by facility) electronic order transmissi