STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ackert Park Skilled Nursing & Rehabilitation Cente	894 Leland Avenue University City, MO 63130

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to provide a resident with an appropriate involuntary transfer discharge when they transferred one sampled resident (Resident #1) to the hospital and would not allow him/her to return, out of three sampled residents. The facility census was 51 residents. Review of the facility's Admission Criteria policy, revised 03/2019, showed: -Our facility admits only residents whose medical and nursing needs can be met; Policy Interpretation and Implementation: -The objectives of our admission criteria policy are to: -Admit residents who can be cared for adequately by the facility; -Assure the facility receives appropriate medical records prior to or upon the resident's admission; -Prior to or at the time of admission, the resident or representative is informed of any service limitations or special characteristics of the facility; -Prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident; -The acceptance of residents with certain conditions or needs may require authorization or approval by the Medical Director (MD), Director of Nursing Services (DON) and/or the Administrator; Review of the facility's Transfer or Discharge, Facility-Initiated policy, dated 10/2022, showed: Policy Statement: Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation specified in this policy; (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Facility-Initiated Transfer or Discharge means a transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences; -Documentation of Facility-Initiated Transfer or Discharge is when a resident is transferred or discharged from the facility, the following information is documented in the medical record: -The basis for the transfer or discharge; -If the resident is being transferred or discharged because his/her needs cannot be met at this facility, documentation will include: -The specific resident needs that cannot be met; -The facility's attempt to meet those needs; and -The receiving facility's service(s) that are available to meet those needs; -If the facility determines that the resident cannot return to the facility, the medical record will indicate that the facility made efforts to: -Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services; -Ascertain an accurate status of the resident's condition; -Find out from the hospital the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility; Appealing Transfer or Discharge: Residents have the right to appeal a facility-initiated transfer or discharge through the state agency that handles appeals. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/24, showed: -Cognitively intact; -Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) - behavior not exhibited; -Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) - behavior of this type occurred 1 to 3 days; -Mobility: Walker; (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included other specified anxiety disorders (Intense, excessive, and persistent worry and fear about everyday situations) with depression (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and mood disorder (Illnesses that affect the way you think and feel) due to known physiological conditions with depressive features. Review of the resident's physician order sheet, order dated 2/4/24, for Target Behavior: symptoms of mood disorders. At the end of each shift mark frequency-how often behavior occurred and Intensity-how resident responded to redirection. Intensity Code: 0=Did not occur, 1=Easily Altered, and 2=Difficult to redirect. Review of the resident's medical record, showed: -On 4/3/24 at 2:48 P.M., staff documented mood, verbal expressions of distress, persistent anger with self or others - 1 easily altered; -Action taken to alter persistent anger with self or others=redirect; -On 4/12/24 at 1:49 P.M., staff documented mood-apathetic, anxious, sad appearance, repetitive movements - difficult to redirect; -Action taken to alter mood-apathetic, anxious, sad appearance, repetitive physical movement one-on-one, given food/fluids, other; -On 4/12/24 at 1:49 P.M., staff documented mood-apathetic, anxious, sad appearance, showed, repetitive physical movements; -Actions taken to alter repetitive physical movement. Review of the resident's care plan, dated 8/11/23, showed: -Problem: Resident at risk for angry, hostile, defensive noncompliant behaviors and loss of control of behavior; -Goal: Prevention of behavior escalating into a dangerous one for self or others by attempting to defuse the situation; -Approaches: -Resident will go to a quiet place to calm himself/herself, dated 9/25/23; -Staff will point to their wrist as a gesture to go to a quiet place and calm himself/herself, dated 9/25/23; -Acknowledge concerns, frustration. Do not dismiss feelings. Use statements such as I understand that. or That must be hard/frustrating , dated 8/11/23; -Keep a neutral and open stance with hands visible in a non-threatening and non-aggressive manor. Keep two to three feet away, dated 8/29/23; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Maintain a calm demeanor, use a level, firm, tone of voice. Do not raise voice or speak with sarcasm or in a clipped irritated manor, dated 8/29/23. Review of the resident's progress notes dated 3/11/24 at 8:04 P.M., showed, resident had an outburst in the dining room, stating the TV was too loud. Nurse conversed with the resident the TV is low, and the residents wants to watch the news. Resident stated, Cut the damn TV down to another resident. The other resident state, the TV is not loud. Resident started getting aggressive and wanted to approach the other resident. Nurse extended his/her arms while resident tried to approach the other resident and touched the nurse. Nurse tried to calm resident down and separated both residents. Informed both to stop arguing in the dining room in front of other residents at mealtime. The resident was sent to the behavior unit at the hospital for evaluation. DON, psych, PCP, and daughter aware resident sent to the hospital. Review of the resident's After Visit Hospital summary, dated 3/11/24, showed: -Diagnosis: Aggressive behavior; -Understanding mood disorders (Illnesses that affect the way you think and feel) depression, (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and bipolar disorder (sometimes called manic-depressive illness, a disorder associated with episodes of mood swings ranging from depressive lows to manic highs what causes mood disorders, and how daily issues affect your health); -The resident was seen by Psychiatry as well and deemed stable for discharge. No indication for emergent psychiatric admission. Resources are below to help with outpatient psychiatry follow-up for management of mood disorder and aggressive behaviors; -Eight psychiatric services resources provided; -Nine therapy and counseling resources provided. Review of the resident's medical record and care plan, showed staff did not document implementation of any of the psychiatric or therapeutic services recommended in the After Visit Hospital summary. Review of the resident's medical record showed: -A progress note dated 4/8/24 at 11:08 A.M., showed, the resident started yelling and deflecting the conversation. While yelling he/she said that he/she would just go jump out a window. When asked if the resident was suicidal, he/she said No, I'm homicidal. The resident then said Just you try and send me to the hospital, I'm not going. He/She stormed out the room, the Administrator followed him/her. This reporter called the power of attorney (POA) and informed him/her of the situation. This reporter then called the psych Nurse Practitioner, who stated he/she would be in on Thursday, 4/11/24. No new orders. The resident received medication for anxiety. After further conversation, the resident stated he/she was upset because he/she had been out with family the prior weekend and it reminded him/her what it was like to live in the community, and he/she felt like she/she was missing out on life; -Record review showed no additional interventions; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A psychiatric progress note, dated 4/11/24, showed the staff report that he/she has been doing adequately from a behavioral standpoint. He/She has been socializing with peers and most of the time appears to be in good mood; -Depression with anxiety: Doing better; -Recommendations: -Continue the current psychotropics (drug(s) that affect a person's mental state) as he/she seem to have made significant improvement; -The possibility of a bipolar mood disorder cannot entirely be excluded; -A progress note on 4/21/24 at 7:09 P.M. showed, it was reported to this nurse that the resident attacked the receptionist. DON and Administrator immediately notified. Resident sent to the hospital for evaluation per psychiatrist recommendation; -A late entry progress note dated 4/23/24 at 5:52 P.M., showed on 4/21/24, this reporter returned to the facility regarding an alleged incident between this resident and the receptionist. This incident was witnessed by 10 residents and one staff member who all recounted witnessing the resident swinging at the receptionist over being upset about the wait time for getting cigarettes. The altercation resulted in the resident knocking the box of cigarettes out of the receptionist's hands and caused the receptionists to hold up his/her arms to prevent the resident from striking him/her in the face. As the resident was swinging, he/she was hitting the receptionist's arms with his/her closed fist. Since the receptionist was the only staff member in the immediate area, two other residents intervened by yelling at the resident to stop and attempting to get in between the resident and the receptionist; -A progress note dated 5/2/24 at 5:22 P.M., showed, on 4/21/24 at approximately 7:35 P.M. the DON made the primary care physician (PCP) aware resident was discharged to the hospital for aggressive behaviors and not to return per the PCP's recommendation which I (physician) agree with plan of action. Review of the Resident Transfer Form, dated 4/21/24 at 7:00 P.M., showed: -Sent to the hospital; -Contact person notified of transfer: Non applicable; -Clinician ordering transfer: Physician A and Physician B; -Reason for transfer: This nurse was informed resident allegedly attacked receptionist outside during smoke break (behavior); -Unplanned transfer; -At risk alerts: None; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Capabilities of the facility to care for this resident: Other- resident given emergent discharge from facility; -Facility would be able to accept resident back under the following conditions: Other-resident given emergent discharge from the facility; -Resident has had many behaviors since admission to facility on 8/11/23. Diagnosis-depression with anxiety and followed by psych; -No bed hold; -The form did not show what attempts the facility made to meet the resident's needs prior to discharging the resident. Review of the facility's Emergency Discharge letter, dated 4/21/24, showed; -Due to your verbal and aggressive behavior, the facility has found it necessary to issue this emergency discharge letter on 4/21/24. Today at the last smoke break you became upset because you stated that there was no seating available for you to sit. You became verbally abusive and then became physically aggressive toward a staff member that was trying to assist you. You have had several episodes in the past where you have been verbally aggressive. We have had conversations regarding these behaviors and put in place a positive behavioral agreement with which you voiced your satisfaction back in March. You have demonstrated that you are a risk to others. Therefore you will be discharged on [DATE] to the hospital. Review of the facility's Admission and Discharge Report, dated 4/1/24 -4/30/24, showed: -4/21/24 discharged Return Not Anticipated: resident discharged to home or self-care (routine discharge). During an interview on 4/25/24 at 2:26 P.M., a hospital representative said the resident received an immediate discharge from the facility on 4/21/24. The hospital representative spoke with the Administrator on 4/24/25 to see if the facility would reconsider taking the resident back. He/She also told the Administrator the resident was filing an appeal because he/she loved living at the facility and wanted to return. The hospital representative said the Administrator said they would not take the resident back, even with the appeal. The facility would take a regulatory citation instead. Therefore, the resident had to remain at the hospital for new placement. The resident was basically dumped at the hospital for a new disposition to be put in place. He/She said the facility sent the resident to the hospital with a complaint of aggressive behavior after he/she was verbally aggressive and then attacked the facility's receptionist. During a telephone interview on 5/2/24 at 10:46 A.M., Receptionist F said the resident came downstairs for the last smoke break around 6:03 P.M. on 4/21/24, and he/she began to pass out the cigarettes around 6:15 P.M. When the resident came downstairs, he/she wanted people to stop whatever they were doing to help the resident. The resident knocked the cigarettes out of his/her hand. Receptionist F said he/she went to tell the Administrator and DON what happened. He/She wasn't told about any other ways to calm the resident down. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 10:21 A.M., the Administrator said the resident's behaviors were explosive. He/She yelled, screamed, and was agitated. The Administrator said the resident wasn't getting what he/she needed. She created a positive reinforcement agreement for the resident, whereby if the resident didn't display behaviors for a certain amount of time, the facility would purchase him/her cigarettes. The Administrator said the resident didn't have any money. Not having money to purchase cigarettes contributed to the resident's behaviors. She knew the contract was frowned upon, but it worked for a while. The physician reviewed the resident's medical records and thought the diagnosis may be incorrect. She didn't know how to maintain or how to predict the resident's behavior. She was not sure how to handle the resident's behaviors or how she could keep the other residents safe. During an interview on 5/1/24 at 3:00 P.M., the Administrator said she wasn't officially told the resident was going to or had filed an appeal, so she wasn't involved. The appeal information was hearsay to her but was aware that the resident had the right to come back to the facility pending the outcome of his/her appeal. The Administrator said she was concerned that the resident had no repercussions and didn't want him/her to think there was no consequences related to his/her behavior. The Administrator, MDS Coordinator and DON all said they were concerned if the resident were allowed to come back to the facility he/she would go after the other residents who helped the receptionist. MO00235209 MO00235280

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to revise and/or update one resident's care plan after each event of verbal and/or physical aggression, failed to update/revise interventions, and failed to train facility staff how to properly implement the residents current care planned interventions (Resident #1). The sample was 3. The census was 51. Review of the facility's Comprehensive Care Plan policy, revised 09/2010, showed: -Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident; -Enhance the optimal functioning of the resident by focusing on a rehabilitative program; -Reflect currently recognized standard of practice for problem area and conditions; -Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident; -Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician or primary healthcare provider is integral to this process; -Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change; -The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; -At least quarterly; -Reflect the resident's expressed wishes regarding care and treatment goals. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/24, showed: (continued on next page)

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	265831	A. Building B. Wing	05/02/2024

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) - behavior not exhibited; -Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) - behavior of this type occurred 1 to 3 days; -Mobility: Walker; -Diagnoses included other specified anxiety disorders (Intense, excessive, and persistent worry and fear about everyday situations) with depression or mood disorder (Illness that affect the way you think and feel) due to known physiological condition with depressive features. Review of the resident's care plan, dated 8/11/23, showed: - Problem: Resident at risk for angry, hostile, defensive noncompliant behaviors and loss of control of behavior; -Goal: Prevention of behavior escalating into a dangerous one for self or others by attempting to defuse the situation; -Approaches: -Resident will go to a quiet place to calm himself/herself, dated 9/25/23. Staff will point to their wrist as a gesture to go to a quiet place and calm himself/herself, dated 9/25/23; -Acknowledge concerns, frustration. Do not dismiss feelings. Use statements such as I understand that. or That must be hard/frustrating , dated 8/11/23; -Keep a neutral and open stance with hands visible in a non-threatening and non-aggressive manor; -Keep 2-3 feet away, dated 8/29/23; -Maintain a calm demeanor, use a level, firm, tone of voice. Do not raise voice or speak with sarcasm or in a clipped irritated manor, dated 8/29/23; -The care plan did not show the resident was involved in creating the care plan; -The care plan did not show any identified triggers for the resident's care planned behavioral symptoms (e.g. Angry, hostile, defensive noncompliant behaviors, loss of control); -The care plan did not show staff reviewed and/or revised the implemented interventions when the desired outcomes were not met after each documented verbal or behavioral aggression. Review of the resident's progress notes, showed: (continued on next page)

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	265831	A. Building B. Wing	05/02/2024

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Ackert Park Skilled Nursing & Rehabilitation Cente	894 Leland Avenue University City, MO 63130

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/12/24 at 12:57 P.M., resident getting upset because he/she could not wait to be served in the dining room by staff. Called Certified Nurse Assistant (CNA) a bitch. Nurse informed resident to stop yelling and calm down. Staff have to make sure all residents are in the dining room and that the CNA was new. Resident escorted out of the dining room. Resident is difficult to direct at times; -No documentation related to event and/or intervention revision/update in the resident's care plan; -On 2/26/24 at 7:35 A.M., resident at front desk crying and yelling stating, I should be able to smoke whenever I want. They're my cigarettes. Receptionist states resident walked out of the front door, but came back in. Explained to resident that there are scheduled smoking times for safety purposed, however, resident continued crying and yelling. Eventually returned to floor to eat breakfast; -No documentation related to event and/or intervention revision/update in the resident's care plan; -On 3/11/24 at 8:04 P.M., resident had an outburst in the dining room, stating the TV was too loud. Nurse conversed with the resident the TV is low, and the residents want to watch the news. Resident stated, cut the damn TV down to another resident. The other resident stated, The TV is not loud. Resident started getting aggressive and wanted to approach the other resident. Nurse extended his/her arms while resident tried to approach the other resident and touched the nurse. Nurse tried to calm resident down and separated both residents. Informed both to stop arguing in the dining room in front of other residents at mealtime. The resident was sent to the behavior unit at the hospital for evaluation. DON, psych, PCP, and daughter aware resident sent to the hospital; -No documentation related to event and/or intervention revision/update in the resident's care plan. Review of the resident's after visit hospital summary, dated 3/11/24, showed: -Diagnosis: Aggressive behavior; -Understanding Mood Disorders (Depression and Bipolar Disorder), what causes mood disorders, and how daily issues affect your health; -The resident was seen by Psychiatry as well and deemed stable for discharge. No indication for emergent psychiatric admission. Resources are below to help with outpatient psychiatry follow-up for management of your mood disorder and aggressive behaviors; -Not documented on care plan; -Eight psychiatric services resources provided; -Nine therapy and counseling resources provided. Review of the resident's medical record, showed none of the resources provided by the hospital were reviewed, implemented by staff or added to the care plan. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, showed: -On 4/8/24 at 11:08 A.M., the resident started yelling and deflecting the conversation. While yelling he/she stated that he/she would just go jump out a window. When asked if the resident was suicidal, he/she stated no, I'm homicidal. The resident then stated just you try and send me to the hospital, I'm not going. He/She stormed out the room, the Administrator followed him/her. This reporter called the power of attorney (POA) and informed him/her of the situation. This reporter then called the psych Nurse Practitioner, who stated he/she would be in on Thursday, 4/11/24 to see the resident. No new orders. The resident received medication for anxiety. After further conversation, the resident stated he/she was upset because he/she had been out with family the prior weekend and it reminded him/her what it was like to live in the community, and he/she felt like she/she was missing out on life; -The care plan did not show any documentation related to this event and/or intervention revision/update: Psychiatric progress note, dated 4/11/24, showed: -The staff report that he/she has been doing adequately from a behavioral standpoint. He/She has been socializing with peers and most of the time appears to be in good mood; -The possibility of a bipolar mood disorder cannot entirely be excluded; -On 4/21/24 at 7:09 P.M., it was reported to this nurse that the resident attacked the receptionist. Director of Nursing (DON) and administrator immediately notified. Resident sent to the hospital for evaluation per psychiatrist recommendation; -The care plan did not show any documentation related to this event and/or intervention revision/update: -On 4/23/24 at 5:52 P.M., recorded as late entry, on 4/21/24, this reporter returned to the facility regarding an alleged incident between this resident and the receptionist. This incident was witnessed by 10 residents and one staff member who all recounted witnessing the resident swinging at the receptionist over being upset about the wait time for getting cigarettes. The altercation resulted in the resident knocking the box of cigarettes out of the receptionist's hands and caused the receptionists to hold up his/her arms to prevent the resident from striking him/her in the face. As the resident was swinging, he/she was hitting the receptionist arms with his/her closed fist. Since the receptionist was the only staff member in the immediate area, 2 other residents intervened by yelling at the resident to stop and attempting to get in between the resident and the receptionist. (continued on next page)

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	265831	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ackert Park Skilled Nursing & Rehabilitation Cente	894 Leland Avenue University City, MO 63130

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 10:21 A.M., the Administrator said the resident's behaviors were explosive. He/She yelled, screamed, and was agitated. The Administrator said the resident wasn't getting what he/she needed, so she created a positive reinforcement agreement for the resident, whereby if the resident didn't display behaviors for a certain amount of time, the facility would purchase him/her cigarettes. The Administrator said the resident didn't have any money and said no money to purchase cigarettes contributed to the resident's behaviors. She knew the contract was frowned upon, but it worked for a while. The physician reviewed the resident's medical records and thought the diagnosis may be incorrect. She doesn't know how to maintain, how to predict, or handle the resident's behavior. She had concerns about how to keep the other residents safe. The Administrator said the behaviors since admission should have been care planned, but they had interventions in place in the care plan to address the resident's behaviors. The DON said the resident participated in coming up with the interventions on the care plan, but the care plan did not show the resident's involvement. Review of the resident's care plan, showed staff did not include the positive reinforcement agreement as an intervention. During an interview on 5/1/24 at 1:57 P.M., Certified Medication Technician (CMT) D said the resident's care needs were in a care book but he/she didn't know if the resident had a behavior support plan. CMT D would get information about the resident during shift report. The resident was not patient and wanted things right away. CMT D said he/she could calm the resident down by talking to the resident, listening to the resident and letting the resident vent. He/She said the resident was frustrated but once the resident got it out of his/her system, he/she went back to normal. During an interview on 5/1/24 at 2:13 P.M., CNA C said he/she would go the charting system to look at the resident's care needs and for what to do when the resident had behaviors. He/She said it was not the first time the resident had an altercation, and the resident would go on [NAME]. He/She would try to talk to the resident to calm him/her down or re-direct him/her. CNA C would get information about the resident during shift report. During an interview on 5/1/24 at 3;00 P.M., the Administrator said the resident's outbursts were always the same and the resident could be mean with words. The physician reviewed the resident's medical record and thought the diagnosis may be incorrect. She expected staff to use the resident's care planned interventions and to document the resident's behaviors. The documentation should be accurate. He/She expected staff to follow the resident's care planned interventions and said staff had been in-serviced recently and thought they could have handled the situation better, but that was after the fact. They wanted to help the resident but he/she was unpredictable. The Administrator had not previously reviewed the suggested resources provided in the resident's 3/11/24 After Visit Hospital Summary. She expected any hospital summary information related to recommendations for physical and/or verbal aggression to have been documented and care planned, if applicable. However, the Administrator said none of the resources applied to the resident and did not say why.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to ensure resident behavior triggers, which may have predisposed the resident's aggression, were adequately monitored and addressed. Staff did not develop interventions to address the resident's behavior to deter him/her from responding aggressively towards other residents and staff (Resident #1). The sample was 3. The census was 51. Review of the facility's Comprehensive Care Plan policy, revised 09/2010, showed: -Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident; -Enhance the optimal functioning of the resident by focusing on a rehabilitative program; -Reflect currently recognized standard of practice for problem area and conditions; -Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident; -Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician or primary healthcare provider is integral to this process; -Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change; -The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; -At least quarterly; -Reflect the resident's expressed wishes regarding care and treatment goals. Review of Resident #1's care plan, dated 8/11/23, showed: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Resident at risk for angry, hostile, defensive noncompliant behaviors and loss of control of behavior; -Goal: Prevention of behavior escalating into a dangerous one for self or others by attempting to defuse the situation; -Approaches: -Resident will go to a quiet place to calm himself/herself, dated 9/25/23. Staff will point to their wrist as a gesture to go to a quiet place and calm himself/herself, dated 9/25/23; -Acknowledge concerns, frustration. Do not dismiss feelings. Use statements such as I understand that. or That must be hard/frustrating ., dated 8/11/23; -Keep a neutral and open stance with hands visible in a non-threatening and non-aggressive manor; -Keep 2-3 feet away, dated 8/29/23; -Maintain a calm demeanor, use a level, firm, tone of voice. Do not raise voice or speak with sarcasm or in a clipped irritated manor, dated 8/29/23; -The care plan did not show staff included the resident in creating the care plan; -The care plan did not show staff identified triggers for the resident's care planned behavioral symptoms (e.g. angry, hostile, defensive noncompliant behaviors, loss of control). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/24, showed: -Cognitively intact; -Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) - behavior not exhibited; -Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) - behavior of this type occurred 1 to 3 days; -Mobility: Walker; -Diagnoses- Other specified anxiety disorders with depression or; -Mood disorder due to known physiological condition with depressive features. Review of the resident's social service notes, showed: -On 8/11/23 at 2:23 P.M., the resident said he/she was nervous and had very high anxiety. He/she because tearful during the admission process. The resident said he/she got very depressed and had a hard time getting out of bed at times. Admission paperwork was reviewed and signed; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/28/23 at 12:41 P.M., the reporter (Social Worker H) received a phone call from the resident representative and asked about behavior's that the facility had seen with his/her family member. The resident's representative said he/she had wondered when the facility would start to see the resident's behaviors; -Staff did not document action steps and/or interventions in the medical record. Review of the resident's progress notes, showed: -On 2/12/24 at 12:57 P.M., resident getting upset because he/she could not wait to be served in the dining room by staff. Called Certified Nurse Assistant (CNA) a bitch. Nurse informed resident to stop yelling and calm down. Staff have to make sure all residents are in the dining room and that the CNA was new. Resident escorted out of the dining room. Resident is difficult to direct at times; -On 2/26/24 at 7:35 A.M., resident at front desk crying and yelling stating, I should be able to smoke whenever I want. They're my cigarettes. Receptionist states resident walked out of the front door, but came back in. Explained to resident that there are scheduled smoking times for safety purposed, however, resident continued crying and yelling. Eventually returned to floor to eat breakfast. Review of the resident's Positive Support Contract, dated 2/27/24, showed: -The resident voluntarily agreed to participate in an award agreement; -The facility has agreed to purchase one pack of cigarettes every four (4) days for the positive behavior and/or until the resident's financial benefits are approved; -Signatures included the resident's, Social Worker H's, and the Director of Nursing's (DON); -Staff did not document other interventions in the resident's medical record. Review of the resident's care plan, showed: -No documentation staff reviewed and/or revised the implemented interventions when the desired outcomes were not met after each documented verbal or behavioral aggression; -The Positive Support Contract was not documented as an intervention. During an interview on 5/1/24 at 10:21 A.M., the Administrator said the resident's behaviors were explosive. He/She yelled, screamed, and was agitated. The Administrator said the resident wasn't getting what he/she needed, so she created a positive reinforcement agreement for the resident, whereby if the resident didn't display behaviors for a certain amount of time, the facility would purchase him/her cigarettes. The Administrator said the resident didn't have any money and said no money to purchase cigarettes contributed to the resident's behaviors. She knew the contract was frowned upon, but it worked for a while. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, showed on 3/11/24 at 8:04 P.M., the resident had an outburst in the dining room, stating the TV was too loud. Nurse conversed with the resident the TV is low, and the residents wants to watch the news. Resident stated, cut the damn TV down to another resident. The other resident stated, The TV is not loud. Resident started getting aggressive and wanted to approach the other resident. Nurse extended his/her arms while resident tried to approach the other resident and touched the nurse. Nurse tried to calm resident down and separated both residents. Informed both to stop arguing in the dining room in front of other residents at mealtime. The resident was sent to the behavior unit at the hospital for evaluation. DON, psychiatry, primary care physician (PCP), and daughter aware resident sent to the hospital. Review of the resident's after visit hospital summary, dated 3/11/24, showed: -Diagnosis: Aggressive behavior; -Understanding Mood Disorders (Depression and Bipolar Disorder), what causes mood disorders, and how daily issues affect your health; -The resident was seen by Psychiatry as well and deemed stable for discharge. No indication for emergent psychiatric admission. Resources are below to help with outpatient psychiatry follow-up for management of your mood disorder and aggressive behaviors; -Not documented on care plan; -Eight psychiatric services resources provided; -Nine therapy and counseling resources provided. Review of the resident's medical record, showed no documentation staff reviewed or implemented any of the hospital recommended resources. Review of the resident's progress notes, showed: -On 4/8/24 at 11:08 A.M., the resident started yelling and deflecting the conversation. While yelling he/she stated that he/she would just go jump out a window. When asked if the resident was suicidal, he/she stated no, I'm homicidal. The resident then stated, just you try and send me to the hospital, I'm not going. He/She stormed out the room, the Administrator followed him/her. This reporter called the power of attorney (POA) and informed him/her of the situation. This reporter then called the psych Nurse Practitioner, who stated he/she would be in on Thursday, 4/11/24 to see the resident. No new orders. The resident received medication for anxiety. After further conversation, the resident stated he/she was upset because he/she had been out with family the prior weekend and it reminded him/her what it was like to live in the community, and he/she felt like she/she was missing out on life; -On 4/11/24, psychiatric progress note, showed: -Staff report that he/she has been doing adequately from a behavioral standpoint. He/She has been socializing with peers and most of the time appears to be in a good mood; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The possibility of a bipolar mood disorder cannot entirely be excluded. -On 4/21/24 at 7:09 P.M. a progress note showed, it was reported to this nurse that the resident attacked the receptionist. DON and Administrator immediately notified. Resident sent to the hospital for evaluation per psychiatrist recommendation; -On 4/22/24 at 6:10 P.M., a progress note showed, on 4/23/24 late entry documented, this reporter returned a call from the resident's family member who told this reporter the resident told him/her about the incident with the receptionist but stated it was the receptionist who had hit him/her. This reporter asked the family member if he/she knew if something else was going on with the resident since they had been noticing that while the resident's outburst have been less, they seem to be more explosive and threatening. The family member said the resident has had problems with behaviors forever and every time the resident gets somewhere, he/she leaves before help/treatment can be provided to him/her; -On 4/23/24 at 5:52 P.M., a progress note recorded as late entry, on 4/21/24, this reporter returned to the facility regarding an alleged incident between this resident and the receptionist. This incident was witnessed by 10 residents and one staff member who all recounted witnessing the resident swinging at the receptionist over being upset about the wait time for getting cigarettes. The altercation resulted in the resident knocking the box of cigarettes out of the receptionist's hands and caused the receptionists to hold up his/her arms to prevent the resident from striking him/her in the face. As the resident was swinging, he/she was hitting the receptionist's arms with his/her closed fist. Since the receptionist was the only staff member in the immediate area, 2 other residents intervened by yelling at the resident to stop and attempting to get in between the resident and the receptionist. During an interview on 5/1/24 at 10:21 A.M., the Administrator said the physician reviewed the resident's medical records and thought the diagnosis may be incorrect. She didn't know how to maintain, how to predict, or handle the resident's behavior and had concerns about how to keep the other residents safe. The resident had behavioral concerns when he/she was admitted to the facility and interventions had been care planned at that time, but the interventions should have been reviewed and updated since 9/25/23. During an interview on 5/1/24 at 1:57 P.M., Certified Medication Technician (CMT) D said the resident's care needs were in a care book, but he/she didn't know if the resident had a behavior support plan. CMT D would get information about the resident during shift report. The resident was not patient and wanted things right away. CMT D said he/she could calm the resident down by talking to the resident, listening to the resident, and letting the resident vent. He/She said the resident was frustrated but once the resident got it out of his/her system, he/she went back to normal. During an interview on 5/1/24 at 2:13 P.M., CNA C said he/she would go the charting system to look at the resident's care needs and for what to do when the resident had behaviors. He/She said it was not the first time the resident had an altercation, and the resident would go on [NAME]. He/She would try to talk to the resident to calm him/her down or re-direct him/her. CNA C would get information about the resident during shift report. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 3;00 P.M., the Administrator said the resident's outbursts were always the same and the resident could be mean with words. She expected staff to document the resident's behaviors. The documentation should be accurate. He/She expected staff to follow the resident's care planned interventions and said staff had been in-serviced recently. She thought staff could have handled the situation better, but that was after the fact. The staff wanted to help the resident, but he/she was unpredictable. The Administrator had not previously reviewed the suggested resources provided in the resident's 3/11/24 After Visit Hospital Summary. She expected any hospital summary information related to recommendations for physical and/or verbal aggression to have been documented and care planned, if applicable. However, the Administrator said none of the resources applied to the resident and did not say why.