| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265831 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monarch Springs Wellness & Rehabilitation | 894 Leland Avenue<br>University City, MO 63130 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, the facility failed to notify one resident's legal guardian of a change of condition and transfer to a hospital (Resident #3). The sample size was 4. The census was 45.Review of the facility's Change of Condition Policy, dated 1/2025, showed the following:-Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner;-Policy:- Definition: An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death;-I. Members of the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent an ACOC;-II. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to:--A. An injury/accident;--B. A significant change in the resident's physical, cognitive, behavioral or functional status;--C. A significant change in treatment; and/or a decision to transfer or discharge the resident from the facility;-Procedure:-Family Notification: The Licensed Nurse will notify the resident, the resident's responsible party, or the family/surrogate decision-makers of any changes in the resident's condition as soon as possible. Review of Resident #3's medical record, showed diagnoses included schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and major depression. Review of the resident's care plan, dated 11/2/25, showed the resident has a Public Administrator appointed as his/her legal guardian, who manages the resident's medical and financial needs. Review of the resident's medical record, showed documentation of the Public Administrator Guardianship, dated 8/20/25. Review of the resident's nurse's note, dated 12/24/25 at 6:34 A.M., showed the resident remains in the hospital. Review of the Complaint/Investigation Report, dated 12/26/25 showed, the reporter was contacted on 12/25/25 by the hospital psychiatrist asking mental health questions about the resident. The resident had been at the hospital since 12/23/25 and no one from the hospital or facility called to notify the resident's guardian that the resident had been sent out to the emergency room and admitted until two days later. Review of the resident's nurse's note, dated 12/27/25 at 6:16 P.M., showed the resident returned from hospital via ambulance. Further review of the resident's medical record, showed no documentation of the resident's change of condition or the resident's guardian being notified of the resident's change in condition. During an interview on 12/29/25 at 12:25 P.M. Licensed Practical Nurse (LPN) A said the Administrator, the Social Service Director and other management were present while the resident was having behaviors. LPN A was instructed to send the resident to the hospital. LPN A was working with an orientee at the time and assumed the orientee called the resident's physician and guardian and documented the incident. During an interview on 12/29/25 at 12:35 P.M., the resident said he/she went the hospital but was not sure when. He/She has a guardian but was not sure of his/her name. He/She did not know if the facility should contact his/her guardian regarding his/her care. During an interview on 12/30/25 at 9:50 A.M., LPN B said LPN A should have called the resident's physician and guardian about the resident going to the hospital. He/She was not sure if the guardian was notified. There was a lot going on at that time. On the day the resident went out to the hospital, LPN B was an orientee and it was his/her first day. Standard protocol for any facility is to call the resident's physician and get an order to send the resident to the hospital and to contact the guardian to make them aware. During an interview on 12/29/25 at 2:25 P.M. with the Director of Nursing (DON) and Administrator, the DON said LPN A should have called the resident's guardian and documented the call and the change of condition in the resident's medical record. LPN A did not do a proper follow-up. The DON did not know why this was not completed. The Administrator agreed with the DON. 2701154 |