

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  St Joseph Chateau		STREET ADDRESS, CITY, STATE, ZIP CODE  811 North 9th Street Saint Joseph, MO 64501	

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 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to allow one resident to return to the facility without a documented reason that the resident's needs could not be met (Resident #1). This affected one resident of five residents sampled. The facility's census was 68. Request for the facility policy on Transfers and Discharges was not provided by the facility. 1. Review of Resident's admission Record, dated 9/11/25, showed:- Resident had a court appointed guardian as the responsible party;- Diagnosis included: major depressive disorder, diabetes, pulmonary disease (respiratory system), traumatic brain injury, Parkinson's disease, anxiety disorder, and paranoid schizophrenia; Review of Resident's Care Plan, revised on 8/21/25, showed:- Resident was adjusting to new surroundings and would like help getting comfortable in his/her new home. Staff should help resident maintain preferences in his/her daily living;- Resident and Guardian wish for resident to stay at the facility long term; Staff to evaluate discharge and long-term care goals annual and as needed;- Resident had the right to refuse cares;- Behaviors: Resident had a history of attention seeking behaviors;- Resident had made statements of self harm. Staff interventions to monitor closely, search room for dangerous items, send resident out for mental evaluation, utilize talk therapy, and provide medications as prescribed;- If Resident makes statements of self-harm, inform charge nurse and doctor immediately. Staff to take all reports of self-harm seriously and follow up on them;- Resident had history of depression and anxiety, administer medications as ordered and psychiatric services as needed;- Resident was at risk for elopement related to wandering;- Resident had the right to remain in the nursing facility unless a transfer or discharge was ordered by the physician;- Resident had schizophrenia and takes antipsychotic medications and is at risk for behaviors and adverse effects of medications. Staff monitor for increased behaviors and report to physician or psychiatric services. Review of Resident's Physician Order Summary Report, dated 9/11/25, showed:- On 6/5/25 order to monitor for adverse reactions for use of antidepressant medications;- On 8/19/25 order to monitor for adverse reactions for use of antipsychotics;- On 6/5/25 order to record type of behaviors and number of episodes;- On 3/5/25 order refer to Hospital Psychiatric Outpatient Services;- On 5/5/25 or for restorative program three times weekly for walking as a therapeutic activity. Review of the Resident's Progress notes, showed:- On 6/19/25 documentation by Psychiatric-Mental Health Nurse Practitioner showed resident had previously been sent to ER for making suicidal statements. He/she displays significant drug seeking behaviors, and had moderately severe depression. Resident denied Suicidal Ideation (SI): Chronic baseline SI, no plan or intent expressed;- On 7/30/25 documentation by Psychiatric-Mental Health Nurse Practitioner showed chronic baseline SI, no plan or intent expressed;- On 8/2/25 documentation by Psychiatric-Mental Health Nurse Practitioner ordered to increase trazadone and nortriptyline to help resident with his/her anxiety;- On 8/4/25 at 10:10 P.M. The Director of Nursing (DON) reports resident reported SI;- On 8/4/25 at 10:22 P.M. The resident was transported to emergency facility for evaluation;- On 8/5/25 at 7:02 A.M. The resident returned to the facility accompanied by emergency medical services, no new orders;- On 8/5/25 at 8:37 A.M. Lab report from medical facility showed resident tested positive for UTI, cipro 500 MG ordered;- On 8/5/25 at 11:22 A.M. The Social Services Director (SSD) documented the resident had requested to move to another facility and SSD said they would try to accommodate the request with their guardian;- On 8/13/25 documentation by Medical review by Psychiatric-Mental Health Nurse Practitioner showed resident's mood appeared to be good and he/she was not tearful and smiled throughout the conversation. He/she did not appear to be overly anxious and did not display clinical symptoms of anxiety. -On 8/19/25 at 11:03 A.M. The Guardian was contacted and consented to current psychotropics that resident was taking;- On 8/20/25 at 12:25 P.M. The SSD documented that resident stated he/she did not have any urges to hurt himself/herself;- On 8/21/25 Psychotherapy visit documentation showed: The resident continues to be challenged by symptoms of anxiety and depression and demonstrates some disruptive behaviors. Resident was motivated to participate in psychotherapy and was cognitively able to benefit from treatment. Resident symptoms have had variable improvement and treatment goals have not been completed yet. Continue current treatment plan since progress towards treatment goals is evident, ongoing support will be necessary to maintain therapeutic gains;- On 8/29/25 at 6:45 P.M. the police arrived with a social worker stating the resident had called into the suicide hotline. Upon evaluation it was decided the resident needed to be seen at a facility emergency room for a full evaluation;- On 9/2/25 The Resident transferred to emergency room for SI.- On 9/2/25 at 10:17 A.M. Search of resident's</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide a written 30-day notice of discharge, the bed hold policy, a discharge summary, and the reason for discharge to one resident's (Resident #1) representative in writing out of the 5 residents sampled, and additionally failed to provide the statement of appeal rights, or the name, address, or telephone number of the Office of the State Long Term Care Ombudsman (advocates for the residents in nursing facilities) and failed to notify the Ombudsman that the resident was discharged. The facility's census was 68. A request was made for the facility's Discharge Policy but was not provided. 1. Review of Resident's admission Record, dated 9/11/25, showed:- Resident had a court appointed guardian as the responsible party;- Diagnosis included: major depressive disorder, diabetes, pulmonary disease (respiratory system), traumatic brain injury, Parkinson's disease, anxiety disorder, and paranoid schizophrenia; Review of the Resident's Care Plan, revised 8/21/25, showed:- Resident had been adjusting to his/her new surroundings and would like help getting comfortable in his/her new home. Staff should help Resident maintain his/her preferences in his/her daily living;- Resident and Guardian wished for resident to stay at the facility long term; Staff to evaluate discharge and long-term care goals annually and as needed;- Resident had history of recent hospitalizations at a psychiatric unit facility and the psychiatrist deemed the resident as not a threat to self or others. - If Resident makes statements of self-harm, inform charge nurse and doctor immediately. Staff to take all reports of self-harm seriously and follow up on them;- Resident had the right to receive a 30 day notice of discharge/transfer which includes reason, effective date, location to which the Resident will be transferred/discharged with the telephone number of the Ombudsman;- Resident had the right to appeal the 30 day notice;- Resident had the right to remain in the nursing facility unless a transfer or discharge was ordered. Review of the progress notes, showed on 8/29/25 at approximately 6:45 P. M. the police arrived with a social worker stating the Resident had called into the suicide hotline. Upon evaluation it was decided Resident needed to be seen at a facility emergency room for a full evaluation; Review of the Resident's Medical Record showed:- No bed hold notice provided, no notification of right to appeal discharge, and No Ombudsman contact information for the transfer of Resident on 8/29/25 in the record;- No discharge instructions, recapitulation of resident's stay, final summary status, or reconciliation of medications provided to the Guardian;- A discharge notification signed by attending physician and did not contain reason for discharge. Review of request for Bed Hold Notice for 8/29/25, showed:- Social Services Director (SSD) was only able to provide an old Bed Hold Notice from 8/4/25 which was not in electronic Medical Record;- No Bed Hold Notice for 8/29/25 was provided; Record review of communication to the Guardian on 9/4/25 at 2:18 P.M., the Assistant Director of Nursing (ADON) documented:- Resident was currently inpatient at a Mental Health Hospital and due to resident making statements of SI if they are returned to the facility, the team believes it in his/her best interest for the resident not to return. The facility believes the Resident needs a higher level of care that they are unable to provide due to ongoing SI. The facility admissions team would reach out to the Mental Health Hospital to communicate that as Power of Attorney you are in agreement with him/her not returning. Review of the progress notes, showed: -Resident transferred to emergency room facility on 9/2/25 for suicidal ideations. -On 9/2/25 at 10:17 A.M. Search of the Resident's room showed no dangerous items or medications;- On 9/2/25 at 10:41 A.M. Social Services and nursing staff requested guardian's permission to send referrals to alternative placements for the Resident. Guardian agreed to facility attempting to find alternate placement;- On 9/5/25 at 1:39 P.M. One facility out of eight referrals agreed to accept the resident. Discharge orders and pharmaceutical orders completed and signed. emergency room facility agreed to keep resident until resident's discharge on [DATE]. The Guardian updated and agreed to transfer;- On 9/8/25 at 3:17 P.M. Resident was then transferred to another skilled nursing facility (SNF). Record review of communication between the ADON, Administrator, and SSD on 9/4/25 at 2:56 P.M., the Guardian said:- As Guardian it was agreed to allow the facility to look for an intake program for mental health evaluation while also looking for other permanent placement locations. I did not agree that the Resident would not be returning to the facility while this search was ongoing. It is my expectation that if there is no alternative setting to place the resident temporarily or otherwise that the Resident be returned to the facility. The SSD had already discussed previously about the Resident not returning to the facility when offering to send out referrals for new permanent placement and reassured me that the resident would indeed be accepted back until efforts to relocating him/her were</p>		