Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview and record review, the facility failed to ensure residents were cared for in a dignified way that a reasonable person would expect, when they failed to cover two resident's skin while in common areas of the building. This affected two of 16 sampled residents (Resident #47 and Resident #32). The facility additionally failed to provide a dignified dining experience when the noise levels were so great in the dining room, that one resident (Resident #14) no longer ate in the dining room due to the noise. The facility census was 62. Review of the facility provided policy, Promoting and Maintaining Resident Dignity, date reviewed 9/1/22 showed in part: -It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. -All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. -The resident's former lifestyle and personal choices will be considered with providing care and services. -Groom and dress residents according to resident preference. 1. Review of Resident # 14's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 1/29/24 showed: -Brief Interview of Mental Status (BIMS) of 13, indicated very minimal cognitive loss. -No mood or behavior issues -Supervision to touch assist for Activities of Daily Living (ADLs:an individual's daily self-care activities such as eating, bathing, walking and transfers) (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

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 04/05/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses of Congestive Heart Failure (the heart's inability to pump blood throughout the body), Atrail Fibrillation (A-Fib: an irregular, fast heart beat), Hypertension (high blood pressure) and Viral Hepatitis C (a viral infection that causes liver swelling and damage). During an interview on 3/25/24 at 11:19 A.M., Resident #14 said: -He/She did not eat in the dining room anymore because other residents [NAME] their music and cell phones and the noise disturbs him/her. -He/She does not like when others play music on their phones. -Staff do nothing when cell phones are used in the dining room -The facility smells bad at times he/she cannot eat because of the smell. During an interview on 3/28/24 06:37 A.M. the Housekeeping Supervisor said: - There's always an odor on the 200 hallway, between 208 and 202. due to the floor tiles being irreparably soiled. During an interview on 3/28/24 at 12:53 P.M., Certified Nurse Aide (CNA) A said: -Music should not be that loud in the dining room. -He/She would ask the resident to turn it down or get the Charge Nurse. -The facility odor is really bad. During an interview on 3/28/24 at 10:04 A.M. the Director of Nursing (DON) said: -She thinks the odor is from the floor. -She thinks the tiles need to be replaced -Music should not be played that loud in the dining room. -She was not aware there was a resident who was not eating in the dining room due to noise. -She was not aware a resident was not eating at times due to the smell. 46706 2. Review of Resident #47's care plan, revised 1/15/24 showed: -The resident has an ADL self care performance deficit; -The resident has impaired cognitive function; (continued on next page)

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 04/05/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident is dependent on staff for meeting motional, intellectual, physical and social needs; -The resident requires extensive assistance with dressing. Review of the resident's significant change MDS, dated [DATE] showed: - Severe cognitive impairment; - Required partial assistance with dressing upper body: - Required substantial assistance with dressing lower body; - Lower extremity impaired on one side; - Occasionally incontinent of urine; - Diagnoses included stroke, dementia and high blood pressure. Observation on 3/25/24 at 12:25 P.M., showed: -The resident was walking down the hall past the dining room assisted by hospice staff; - The resident 's skin was exposed on his/her left chest; - The dietary staff was serving lunch in the dining room; - 12 residents were the dining room eating lunch when the resident walked by with his/her skin exposed; - The resident walked by CNA A and CNA D; - Neither CNA A or CNA D assisted the resident in covering his/her exposed skin. During an interview on 3/25/24 at 1:28 P.M., CNA A said: -The resident should have no skin exposed; -The hospice aide got him/her up but the facilty staff is still responsible if they see exposed skin to assist the resident in covering up; -He/she did not notice the resident's skin was exposed. During an interview on 3/25/24 at 1:46 P.M., CNA D said: -The resident should have no skin exposed; -The staff should make sure the resident is dressed before coming out of their room; (continued on next page)

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 04/05/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she could not remember if the resident's skin was exposed because he/she was busy passing lunch trays. During an interview on 3/28/24 at 11:02 A.M., RN A said: - No one should be able to see the resident's skin showing when they are out of their room; - Staff should adjust the resident's clothes to fit if they notice exposed skin in the hall or public areas; - The resident is cognitively impaired and staff assists him/her with dressing. 31102 3. Review of Resident #32's care plan, revised 1/4/24 showed: - The resident has a legal guardian. The resident has a history of making poor choices and mental health diagnoses of mild intellectual disorder (deficits in intellectual functions pertaining to abstract/theoretical thinking), Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), bipolar (a mental health condition that causes extreme mood swings that include emotional highs and lows), anxiety, mood disorder (marked disruptions in emotions) and oppositional defiant disorder (a type of behavior disorder). - Keep the guardian informed of the resident's status. Review of the resident's Quarterly MDS, dated [DATE] showed: - Cognitive skills intact; - Rejected care one to three days; - Lower extremity impaired on one side; - Required supervision touching assistance with toilet use dressing, personal hygiene and transfers; - Occasionally incontinent of urine; - Diagnoses included anxiety, bipolar, and Schizophrenia. Observation on 3/25/24 at 12:54 P.M., showed: - The resident sat in his/her wheelchair and propelled him/herself up and down the halls, out to smoke and in the activity room and dining room with his/her shirt pulled up from the left to the right side with approximately two to ten inches of his/her abdomen showing. The resident passed multiple staff and no one offered to pull his/her shirt down or provide assistance to pull the shirt down. (continued on next page)

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 04/05/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/26/24 at 8:30 A.M., showed: - The resident was in his/her wheelchair in the dining room and approximately four inches of the resident's abdomen was showing on the right side. The staff did not assist him/her to pull the shirt down or offer assistance to pull the shirt down. Observation on 3/28/24 at 8:13 A.M., showed: - The resident laid in bed on his/her back; - From the hallway you could see approximately four inches of the resident's abdomen showing; - The privacy curtain was not pulled. During an interview on 3/27/24 at 10:56 A.M., LPN A said: - The resident's skin should not be showing; - Some of the residents have clothes that don't fit and at times it's impossible to get the residents to change into clothes that do fit. During an interview on 3/28/24 at 6:27 A.M., CNA C said: - The resident's skin should not be showing if they are out in the hallways or dining room; - When staff notice it, they should offer to pull the shirt down. During an interview on 3/28/24 at 12:53 P.M., CNA A said: - No one should be able to see the resident's skin showing either in the hallways, dining room/activity room, their room or from the hallway; - Should pull the resident's shirt down and pull privacy curtain. -Music should not be that loud in the dining room. -She would ask the resident to turn it down or get the Charge Nurse. During an interview on 3/28/24 at 6:55 P.M., the DON said: - The resident's skin should not be showing, the residents should be covered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 46706 Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not reconciling each month. The facility managed funds for 56 residents. The facility census was 62. 1. Record review of the facility maintained bank statements for account ending in #8793 for months 03/2023 through 02/2024 showed no documentation of reconciliations. Record review of the facility maintained reconciliation forms for account ending in #8793, dated 03/2023 through 02/2024, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of reconciliation. Email correspondence dated 04/02/24 at 4:23 P.M., showed the Business Office Manager said the reconciliations were not reconciled properly. During an interview on 04/08/24 at 2:28 P.M., the Business Office Manager said the resident trust accounts did not reconcile. U4413

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, record review and interviews, the facility failed to ensure they maintained a safe, clean, comfortable environment for the residents when staff did not keep all areas of the facility clean and safe. The facility census was 62. Review of the facility provided policy, Safe and Homelike environment, dated 9/1/21 showed: -In accordance with resident's rights the facility will provide a safe, clean homelike environment; -Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment; -The facility will maintain adequate and comfortable lighting levels in all areas; -Minimize odors by disposing of soiled linens promptly and reporting lingering odors to the Housekeeping department; -Report any unresolved environmental concerns to the Administrator. Review of the facility provided policy Routine Cleaning, dated 9/1/21 showed: -Cleaning refers to the removal of visible soil from objects and surfaces Review of the facility provided policy Cycle Cleaning dated 9/1/21 showed in: -Routine cleaning of environmental surfaces and non-critical resident care items shall be performed and sufficient enough to keep surfaces clean and dust free; -Specific areas include: hallways, dayrooms, dining rooms, showers, utility, bathrooms and Resident rooms. 1. Observation on 3/25/24 at 10:41 A.M. showed: -room [ROOM NUMBER] floor was sticky, the bathroom door frame was chipped, room door frame was chipped and peeling with loose kickboard on lower 1/3 of the door sticking out away from door. The floor had dirt, debris and dust on it. 2. Observations beginning on 3/25/24 at 12:02 P.M. showed: -The front dining room trash can was dirty with white and coffee ground colored dried food debris. The wall behind the trashcan had brown dried substance that ran down the wall. The floor had dark, black sticky substance beside the trashcan and on the soda machine. (continued on next page)

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 04/05/2024
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The back dining room wall trim was loose, thresholds had dark brown black debris stuck on and in the grooves and at the floor connection. -The back hall had multiple gouged, chipped paint areas on the lower 1/3, and the hand rail at rooms [ROOM NUMBERS] were loose. The paper towel holder on the wall had corrugated finish that was caked with dust and debris. -The back exit double doors had approximately a 1/4 inch gap where doors meet, daylight was visible. -room [ROOM NUMBER] carpet was stained and dirty. -The fire doors to the back hall had white crusty debris behind the doors in the corner of the wall with dark dusty debris. -The threshold at the back hall fire doors was loose. -The back hall fire door laminate was chipped and broken. 3. Observations beginning on 3/26/24 at 9:55 A.M. showed: -room [ROOM NUMBER] toilet seat was broken and slid to the right side. The toilet had dark brown colored liquid debris on inside ceramic, and dripped down the wall to the right of the toilet. -The 120's hall ceiling light, by the attic entrance, was not working. -A large cobweb was in the corner at the emergency exit doors of 100 hall. -room [ROOM NUMBER] had tape holding the call light cover in place. Shower room [ROOM NUMBER] had a blue sock tied around the handle and door latch, preventing it from closing. -The front shower room had dark black, mold like substance in the corners of the shower, the toilet was broken and missing pieces of pipe that extend into the wall, a black/brown substance was dried in the toilet, dark black/brown debris was on the floor at the edge of the toilet, pink rust colored debris was on the toilet, multiple 1 inch tiles were cracked/broken with missing pieces. The hand rail in the shower was rusted. The light fixture had multiple dead bugs. -The wall by room [ROOM NUMBER] had approximately a 24 inch (in) by 18 in piece of cardboard over a hole in the wall, with 2 exposed pipes. -The nurse's station area had a blue rectangular cushion in the corner with dark black, mold like substance on it. -200 hall handrails were not firmly/securely affixed to the wall. 4. During observation and interview on 3/27/24 at 10:18 A.M. showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Certified Medication Technician (CMT) B was attempting to open shower room [ROOM NUMBER] for a resident. -He/She used the code pad three times without success. -The resident said the door has been like that for a very long time. -CMT B said the blue sock was there to prevent the door from shutting and locking, as it did not work. He/She was told to remove the sock on Monday. The door will not open from the inside if it shuts and latches. -CMT B was unsuccessful in opening the door and walked away. 5. During an interview on 3/28/24 at 5:17 P.M. the Housekeeping Director said : -Daily cleaning of the resident rooms included dusting, mopping and disinfecting of the bathroom. -Focus areas/deep cleaning are scheduled every month, with a different focus every day. -The deep clean/focus area schedule is made depending on what he/she determined to be areas of concern. -He/She does not track if the focus areas/deep cleaning list is completed. -He/She expected staff to work on the focus areas but does not inspect or follow up to ensure compliance. -He/She used a duster for the hallways and corners. -He/She thought the shower rooms were being cleaned daily, but did not check to ensure it was done. -He/She added the the shower rooms to the weekly cleaning list today. -Mattress should be cleaned by nursing, then disinfected by housekeeping staff. 31102 6. Observation on 3/25/24 at 9:19 A.M., showed: - The facility had removed the old nurse's station and now used it to store lifts; - A strong odor of urine was noted. 7. Observation on 3/25/24 at 10:30 A.M. showed: - room [ROOM NUMBER] A - the threshold to the resident's room has a lot of old duct tape on it. The wall by the resident's bed has the paint missing and the white sheet rock is showing; (continued on next page)

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 04/05/2024
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER]- there's a strong odor of urine outside of the resident's room; bed 1 - the mattress has a strong odor of urine; - room [ROOM NUMBER]- there are seven tiles by the bathroom door that are stained. The bathroom light is so dim you can hardly see. All the tiles in the bathroom are stained and there's a strong odor of urine. 8. Observation on 3/25/24 at 11:47 A.M., showed on the 200 hallway there were multiple gnats in various resident's rooms. 9. Observation on 3/27/24 at 10:27 A.M., showed the 200 hall continued to have a strong odor of urine, especially in rooms 202, 208, 210 and the bathroom shared by rooms [ROOM NUMBERS]. During an interview on 03/26/24 at 10:31 A.M., - Resident #29 said the light in the bathroom of room [ROOM NUMBER] is real dim and he/she was hoping they would put a brighter light bulb in. The bathroom floor has always looked stained but he/she thinks it could be cleaner; - Resident #10 said he/she can't hardly see in the bathroom (shared between room [ROOM NUMBER] and 210) because the light is so dim and the floor does not look clean. During an interview on 3/26/24 at 10:43 A.M., Certified Medication Technician (CMT) B said: - The urine odors on the 200 hall are terrible; - Resident #29's room is terrible. The tiles would probably need to be pulled up and replaced because of the urine; - Several of the mattresses on the 200 hall have a urine odor. -The shower room toilet has not been working since December. During an interview on 3/27/24 at 10:56 A.M., Licensed Practical Nurse (LPN) A said: - The toilet in the shower room has been broken for several months, like before Christmas; - There is an odor on the 200 hall and he/she would compare it to an [NAME] odor. It, at times can take your breath away and burns your eyes; - There are several residents on the 200 hall who urinate in bed, throw their wet incontinent pads under the bed or on the floor and will urinate on the bathroom floor; - He/she thought the urine odors were coming from the residents' mattresses, wheelchairs and the floor; - The gnats are especially bad in room [ROOM NUMBER] but they are also in other residents' rooms. (continued on next page)

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 04/05/2024
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 6:27 A.M., CNA C said: - There's a resident in room [ROOM NUMBER] who urinates on the floor; - There's always an odor of urine on the hallway. During an interview on 3/28/24 at 6:37 A.M., the Housekeeping/Laundry Supervisor said:- There's always an odor on the 200 hall; - The odor is usually between rooms 202 to 210; - The bathroom floor between rooms [ROOM NUMBERS] had been reported to the previous maintenance director. He/she did not know if the current maintenance director was aware of the odor or not. During an interview on 3/28/24 at 10:04 A.M., the DON said;- She was aware of the urine odors on the 200 hall and thought the urine odors were coming from the floors. She thinks the tiles need to be replaced; - She has replaced one mattress on the 200 hall; - The gnats are bad on the 200 hall but they are better because pest control has been in twice for the gnats. During an interview on 3/28/24 at 10:10 A.M., the Maintenance Director said;- He/She had only been in the facility for three weeks; - Sometimes he/she noticed an odor and thought there might be a little bit of an odor in the bathroom between rooms [ROOM NUMBERS]. -He/she is responsible for cleaning vents only. Housekeeping is responsible for cleaning rooms, hallways, and baseboards. -He/she was not aware some of the handrails were loose. -He/she thinks there was a list of things that must be checked every month, he was not sure if handrails were on that list. During an interview on 3/28/24 at 10:34 A.M., CMT A said:- There are strong urine odors on the 200 hall; - The urine odors have been there since he/she started last August; - Staff don't like to work on the 200 hall because of the urine odors; - Some of the staff wear masks because of the odors; - The gnats are worse on the 200 hall. (continued on next page)

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 04/05/2024
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 7:03 P.M., the Administrator said;- The urine odors are mainly coming from room [ROOM NUMBER] hall; - They have talked about a variety of things to resolve that. They have cleaned the room, changed the mattress but the resident urinates all over the place; - They do not believe the floor is salvageable; - It took three trips from pest control to address the gnat problem. They are bringing more blue lights with sticky pads for the gnats.

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31102

Based on interviews and record reviews, the facility failed to ensure staff provided a written notice of transfer or discharge to residents or their responsible parties and the reasons for the transfer, in writing and in a language they understood. The notice should include the effective date of discharge or transfer; the location to which the resident is transferred or discharged ; a statement of the resident's appeal rights, including the name, address (mailing and electronic mail), telephone number of the entity which receives requests and information on how to obtain the appeal form and assistance in completing and submitting it; the name, address (mailing and electronic mail)and telephone number of the Office of the State Long-Term Care Ombudsman; and for residents with a mental disorder or related disabilities, the mailing, electric mail (e-mail) address and telephone number of the agency for protection and advocacy for individuals with mental disorders established under the Protection and Advocacy for Mentally Ill Individuals Act. This affected one of 16 sampled residents, Resident #5. The facility additionally failed to send a copy of the notice to a Representative of the Office of the State Long - Term Care Ombudsman, which affected three residents, (Resident #5, #13 and #32). The facility census was 62.

Review of the facility's policy for transfer and discharge, dated 9/1/21 showed, in part:

- It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered;

- Emergency transfers/discharges: initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified);

- Contents of the notice must include: the reason for the transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged ; a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request: and the name, address (mailing and email) and telephone number of the Office of the State Long -Term Care Ombudsman; for nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities must be included in the notice; for nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder must be included in the notice;

- A copy of the notice shall be provided to a representative of the Office of the State Long - Term Care Ombudsman

- Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand;

(continued on next page)

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Provide a notice of of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer; - Social Services Director, or designee, shall provide notice of transfers to a representative of the State Long - Term Care Ombudsman via monthly list. 1. Review of Resident #32's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/4/24 showed;- Cognitive skills intact; - Rejected care one to three days during the assessment period; - Lower extremity impaired on one side; - Required supervision or touching assistance with toilet use, dressing, personal hygiene and transfers; - Occasionally incontinent of urine; - Diagnoses included: Anxiety, Bipolar (a mental health condition that causes extreme mood swings that include emotional highs and lows), and Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Review of the resident's progress notes, dated 3/19/24 showed: - At 12:16 P.M., the resident became angry at lunch time because he/she received a hamburger for lunch instead of a cheeseburger. The resident threw her food and began calling staff bitches. Redirection was attempted but the resident became argumentative; - At 12:21 P.M., call placed to the resident's guardian and explained the resident's behaviors and the guardian requested for the resident to be sent to the hospital for a psych evaluation. Received an order from the physician to send the resident to the emergency room (ER) for treatment and evaluation; - At 12:34 P.M., notified the emergency medical services of the transfer; - At 12:49 P.M., the resident was transferred to the ER for evaluation and treatment; - Did not have a copy of any discharge letter that would have been issued to the resident and did not have any documentation of the bed - hold letter sent with the resident when he/she was transferred to the hospital. 46706 2. Review of Resident #5's Quarterly MDS, dated [DATE] showed; - Severe cognitive impairment; - The resident had hallucinations (a false perception of objects or events involving the senses); (continued on next page)

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 04/05/2024
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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident had delusions (a false belief or judgment about external reality); - Required supervision or touching assistance with eating; -Incontinent of bowel and bladder; - Diagnoses included Schizophrenia, hemiplegia (paralysis of one side of the body, stroke, high blood pressure. Review of the resident's progress notes, dated 11/16/23 showed: -3:00 P.M -SSD informed nurse that he/she thought resident was having a stroke. Nurse immediately assessed resident. Resident found in bed leaning to right side. Right facial droop notes. Resident did not open eyes to voice or sternal rub. Oxygen saturation found to be 88% and 2 liters of oxygen was applied per nasal cannula. Heart rate 58. Blood pressure taken manually in left arm was 96/54. Respirations were 10 per minutes. Temp 98.1. Skin pale, cool and moist. Bilateral upper and lower lobes had inspiratory and expiratory wheezing with diminished air movement. Physician was called and orders to send to emergency room for eval was obtained. EMS arrived 3:05 P.M. Report was given. Resident left building at 3:15 P.M. - The record did not contain copy of any discharge letter that would have been issued to the resident and did not have any documentation of the bed - hold letter. 3. Review of Resident #13's Quarterly MDS, dated [DATE], showed; - No cognitive impairment; - The resident is independent with ADLs; - The resident is occasionally Incontinent of urine; - Diagnoses included psychotic disorder, anxiety, and depression. Review of the resident's progress notes, dated 10/8/23 showed: -12:43 P.M. - The resident has been wandering the halls obsessing over hand sanitizer, he/she will go to each sanitizing station and completely fill her hands with hand sanitizer and rub it all over her body. Another resident was strolling by and asked resident if she was hungry, resident then made a mouthful of spit and tried to spit on another resident. Approx five minutes after this situation, resident began arguing with another female resident which almost became physical. Resident does not take redirection and says, You are no authority to me; -1:18 P.M. - Call placed to the resident's physician related to the resident's behaviors, received order to send to ER for evaluation. EMS arrived and resident was in the hallway yelling at paramedics, refusing to go with EMTS, using word salad, non-sensical statements. Resident hit the female paramedic resulting in arm restraints, resident left nursing home at 1:20 P.M (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A copy of the notice provided to a representative of the Office of the State Long - Term Care Ombudsman was not found. During an interview on 3/27/24 at 11:13 A.M., the Social Services Designee (SSD) said: - When the Ombudsman was onsite at the facility, they discussed the transfers and discharges but he/she did not have a formal way to notify the Ombudsman of the transfers and discharges. During an interview on 3/28/24 at 6:55 P.M., the Director of Nursing said: - The transfers and discharges should be faxed to the Ombudsman; - She thought Social Services was sending them to the Ombudsman as a group.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 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. 31102 Based on observations, interviews, and record reviews, the facility failed to ensure staff followed professional standards of quality when staff failed to ensure blood sugars were checked prior to meal which affected two of 16 sampled residents, (Resident #32 and #53), failed to obtain blood sugar on the day the physician ordered for Resident #53, failed to obtain an order to check blood sugars for Resident #32, and failed to clarify a Vitamin D3 supplement order for Resident #41. The facility census was 62. Review of the facility's policy for medication administration, revised 9/1/22, showed, in part: - Medications are administered by licensed nurses, or other staff who are 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. 1. Review of Resident #53's physician order sheet (POS), dated March 2024, showed: - Order date: 8/23/22 - Check blood sugars weekly, one time a day every Saturday related to diabetes mellitus. Notify physician if blood sugar is less than 60 or greater than 250; - Start date: 2/16/24 - Lantus (long acting) insulin pen, 10 units in the morning for diabetes mellitus. The facility did not provide the resident's complete medication administration record (MAR). Observation on 3/28/24 at 7:39 A.M., showed: - The resident had finished breakfast and was in his/her room; - At 7:42 A.M., Licensed Practical Nurse (LPN) A obtained the resident's blood sugar of 188; and the resident was only supposed to have it checked on Saturdays. - At 7:45 A.M., LPN A administered Lantus insulin in the back of the resident's right arm. 2. Review of Resident #32's POS dated, March 2024 showed: - Start date: 9/26/23 - Insulin Glargine (Lantus) 75 units in the mornings for diabetes mellitus; - Start date: 9/26/23 - Insulin Lispro (Humalog), fast acting insulin, per sliding scale before meals and at bedtime for diabetes mellitus. If blood sugar is greater than 450, notify physician; - Did not have a physician's order to obtain blood sugars. The facility did not provide the resident's complete MAR. Observation on 3/28/24 at 7:48 A.M., showed: (continued on next page)

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 04/05/2024
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident had finished breakfast and was in his/her room; - At 7:50 A.M., LPN A obtained the resident's blood sugar of 373; - At 7:57 A.M., LPN A administered Lantus insulin 75 units in the resident's left side of abdomen; - The resident refused the Humalog insulin. - LPN A obtained the resident's blood sugar after they ate and did not have a physician's order to obtain the blood sugar. During an interview on 3/28/24 at 10:17 A.M., LPN A said: - He/she tried to get the residents' blood sugars before breakfast but it depended on when the charge nurses finished report and when the dietary sent the meal trays out. This morning, dietary sent the trays out early; - Should follow physician's orders for obtaining the blood sugars; - There should be an order for blood sugars. During an interview on 3/28/24 at 6:55 P.M., the Director of Nursing (DON) said: - Staff must have an order for blood sugars; - The blood sugars should be obtained before the meal; - Staff should not obtain a blood sugar daily if the order said for weekly on Saturday. 44395 3. Review of Resident #41 POS dated March 2024 showed start date 9/16/22: Vitamin D3 tablet, 1 tablet by mouth one time a day for supplement. Observation on 3/28/24 at 9:12 A.M. showed: -The resident was sitting in his/her room. -Certified Medication Technician (CMT) C removed a bottle of Vitamin D3 25 micrograms (mcg) from the top drawer of the medication cart. -He/she read the label of the bottle and the electronic MAR. -CMT C said the order in the electronic record did not say the dosage of the tablet to be given. He/she would have to notify the Charge Nurse to clarify that order. -He/she opened the bottle of Vitamin D, tapped the bottle on the side of the medication cup, and expelled a single pill. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she continued setting up the resident's other medications. -He/she administered the medications including the Vitamin D to the resident. -He/she returned to the cart and began preparring medication for another resident. During an interview on 3/28/24 at 9:15 A.M. CMT C said: -He/She would have to nofity the Charge Nurse that the medication did not have a dosage in the order. -There are different doses of Vitamin D. -He/she probably should have held the medication until the order was clarified.

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 04/05/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observations, interviews, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal and urinary catheter care to two of 16 sampled residents, (Resident #20 and #33). The facility census was 62. The facility did not provide a policy for perineal care or catheter care. 1. Review of Resident #20's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/15/24 showed: - Long and short term memory problems; - Upper and lower extremities impaired on one side; - Dependent on staff for toilet use, dressing and transfers; - Always incontinent of bowel and bladder (the inability to control urine or bowel movements) - Diagnoses included aphasia (a language disorder that affects a person's ability to communicate), stroke, dementia, seizure disorder, anxiety, depression, hemiplegia (paralysis affecting one side of the body) and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Review of the resident's care plan, revised 1/29/24 showed: - The resident had an activities of daily living (ADL) self - care performance deficit related to dementia, hemiplegia and old stroke with right side impairment; - The resident does not use the toilet. The resident is incontinent of bowel and bladder and wears incontinent briefs. Required extensive assistance for toileting with staff assistance. Observation on 3/28/24 at 8:51 A.M., showed: - Certified Nurse Aide (CNA) A used a new wipe and wiped up one side of the resident's groin and with the same area of the wipe, and wiped down the groin; - CNA A used a new wipe and wiped down the other side of the groin and used the same area of the wipe, and wiped down the middle perineal folds; - The resident urinated onto the incontinent cloth pad; - CNA A used a new wipe and wiped down the middle perineal folds; - CNA A did not separate clean all the perineal folds; (continued on next page)

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 04/05/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A and CNA B turned the resident onto his/her side; - CNA A wiped up the outer buttocks, used a new wipe and wiped from front to back used a new wipe and wiped up the inner buttocks; - CNA A did not separate and clean all areas of the skin where urine had touched; - CNA A and CNA B removed the wet fitted sheet, did not clean the mattress and placed a clean fitted sheet on the mattress. 2. Review of Resident #33's quarterly MDS, dated [DATE] showed: - Cognitive skills intact; - Lower extremities impaired on both sides; - Dependent on staff for toilet use and transfers; - Had a urinary catheter (sterile tube inserted into the bladder to drain urine); - Always incontinent of bowel; - Diagnoses included congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), neurogenic bladder (dysfunction that results from interference with the normal nerve pathways associated with urination), chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and peripheral vascular disease (PVD, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the resident's care plan, revised 2/29/24 showed: - The resident had an ADL self - care performance deficit; - The resident required extensive to total staff assistance with ADLs related to weakness, limited range of motion (ROM), morbid obesity, wounds, and COPD; - The resident required total assistance by one staff for toileting. Observation on 3/28/24 at 6:50 A.M., showed: - CNA A wiped down each side of the groin with a new wipe each time; - CNA A wiped across the abdominal fold with a new wipe; - CNA A did not anchor the catheter tubing and wiped down the tubing; - CNA A used a new wipe and wiped down the middle, folded the wipe and wiped down the inner right leg; (continued on next page)

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 04/05/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A did not separate and clean all the perineal folds; - CNA A and CNA B turned the resident onto his/her side; - CNA A used the same area of a new wipe and wiped up and down the outer left hip; - CNA A used a new wipe and cleaned the rectal area four times with a smear of fecal material on each wipe; - CNA A wiped each side of the inner buttocks; - CNA A did not separate and clean all the perineal folds. During an interview on 3/28/24 at 12:53 P.M., CNA A said: - He/she should have separated and cleaned all areas of the skin where urine had touched; - Should not use the same area of the wipe to clean different areas of the skin; - Should not fold the wipe during peri care; - Should have anchored the catheter tubing then wiped down it; - The mattress should have been cleaned after the resident urinated on it. During an interview on 3/28/24 at 6:55 P.M., the Director of Nursing (DON) said: - She expected the staff to separate and clean all areas of the skin folds; - Staff should not use the same area of the wipe; - Staff should have started over with peri care after the resident had urinated; - Staff should have anchored the catheter tubing at the insertion site.

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 04/05/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46706 Based on observation, interview and record review, the facility failed to provide supervision while eating for one resident out of 16 sampled residents (Resident #5) who is a choking risk while dining in his/her room per the resident's care plan. The facility census was 62. The facilty did not provide the requested policy on accidents. 1. Review of the Resident #5's care plan dated 10/23/23, showed: - ADL self-care performance deficit due to right sided hemiplegia; -The resident is dependent on staff for meeting emotional and physical needs related to cognitive deficits; - The resident has had choking episode while eating related to dysphagia (difficulty swallowing); - The resident is to be monitored by staff while eating. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/24 showed; - Severe cognitive impairment; - Substantial assistance with Activities of daily living (ADLs); - The resident had hallucinations (a false perception of objects or events involving the senses); - The resident had delusions (a false belief or judgment about external reality); - Required supervision or touching assistance with eating; - Coughing or choking with food; - Mechanically altered diet; -Incontinent of bowel and bladder; - Diagnoses included Schizophrenia, hemiplegia (paralysis of one side of the body, stroke, high blood pressure. Review of the residents MDS progress notes showed: (continued on next page)

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/9/24: Quarterly MDS review: Assessment/interview with resident. He/she does report a cough sometimes. Noted restorative aide documentation showes he/she coughs while eat/drinking and does have dysphagia and history of choking episodes while eating, history of aspiration pneumonia. Review of the resident's progress notes showed: -3/26/24: Therapist discussed with speech-language pathologist (SLP - works in health care and diagnoses swallowing disorders) information for best practices and care. The resident requires supervision with all meals due to impaired labial and lingual function (primary function is to provide stability of the upper and lower lip and the tongue) resulting in difficulty with management of bolus in mouth and difficulty swallowing. Information was discussed with the Interdisciplinary Care Team (IDT). Observation on 03/26/24, at 12:25 P.M., showed: - Resident eating in his/her room while laying bed; - The head of the bed was raised to an upright position; - No staff were in the room while the resident was eating. Observation on 3/27/24 at 12:42 P.M., showed: -The resident eating in his/her room while setting in bed; - The head of the bed was raised to an upright position; - No staff were in the room while the resident was eating. During an interview on 03/27/24, at 02:32 P.M Registered Nurse (RN) A said: - The resident has dysphagia and is choking hazard and requires supervision at meals; - The resident has had a choking episode in the past and he/she is care planned to have supervision while eating; - The Certified Nurses Aide (CNA)'s supervise him/her at meals; - If the CNA's cannot do it they are supposed to come and get the nurse but sometimes that does not happen; - The resident should not eat without staff supervision. Observation on 03/28/24 12:53 P.M., showed: -Nurses Aide (NA) A took the resident's lunch meal into the resident's room and set in the bedside table; (continued on next page)

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 04/05/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident starting eating his/her meal while laying in bed; - The head of the bed was raised to an upright position; -NA A left the room and did not supervise the resident while he/she ate his/her meal; - No other staff came in to supervise the resident while eating. During an interview on 03/28/24, at 1:07, P.M., NA A said: -He/she just started in January; -The resident gets up sometimes for meals and sometimes not; -Staff are supposed to set with the resident while he/she eats; -He/she did not give a reason why he/she did not set with the resident today while the resident ate his/her meal. During an interview on 3/28/24, at 02:02 P.M CNA A said: - The resident usually eats in his/her room; - The resident comes to the dining room sometimes; - The resident can feed his/her self; - He/she was not sure if the resident needed to be supervised at meals or not. During an interview on 3/28/24, at 06:58 P.M the Director of Nursing (DON) said: - Residents who are risk for choking should not eat alone and must be supervised by staff; - The charge nurse should be in charge of ensuring that is done; - Resident's who are choking hazards and require supervision are listed in the Kardex (a worksheet that includes a summary of resident information).

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 04/05/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44395 Based on observation, interview and record review, the facility failed to prevent significant weight loss of more than 10% of the resident's body weight in a 3 month period for one sampled resident who was at nutritional risk and received dialysis (Resident #3) out of 16 sampled residents. The facility census was 62 residents. Review of the facility provided policy Weight Monitoring, dated 9/1/22 showed: -Based on the resident's comprehensive assessment the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual or desirable body weight. -Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status. -A significant change in weight is defined as: 5% change in weight in 1 month (30 days), 7.5% change in weight in 3 months (90 days), 10% change in weight in 6 months (180 days). -The physician should be informed of a significant change in weight, and may order nutritional interventions. Review of the Resident #3's Annual Minimum Data Set (MDS: a federally mandated assessment tool completed by the facility) dated 11/6/23 showed: -Brief Interview of Mental Status (BIMS) of 11, indicated some cognitive loss; -Independent for Activities of Daily Living (ADL's:fundamental skills used to care for oneself, such as eating, bathing, and mobility); -Continent of bowel and bladder; -Weight of 149 pounds (lb); -No weight loss; -Therapeutic Diet; -Dialysis not indicated; -Diagnoses of End Stage Renal Disease (a terminal (leading to death) disease in which the kidneys no longer work to meet the body's needs), major depressive disorder (persistently low mood and decreased interest in things), weakness, unsteadiness, anemia (a condition in which the body does not have enough healthy red blood cells) and unspecified protein calorie malnutrition (the state of inadequate intake of food; as a source of protein, calories, and other essential nutrients). (continued on next page)

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 04/05/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Order sheets for March 2024 showed: -Order date of 12/21/22 : Multivitamin Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for supplement; - No Added Salt diet (NAS) , Renal diet-Regular texture, Regular/Thin consistency liquids, Low phosphorus (a mineral naturally occurring in foods that are a key element in bones, teeth and cells) , limited to 1 serving per day. Avoid food containing very high phosphorus; -Order date of 12/29/23: Sevelamer Hydrochloride (HCL: a medication used to control phosphorous levels in the blood)) 800 milligrams (MG); 2 tablets by mouth daily with meals for dialysis. Review of the resident's comprehensive Care Plan dated 4/24/23 showed: -The resident had altered nutrition related to anemia, hyperkalemia (high potassium level in the blood), Stage 3 kidney disease. Avoids beans and tomatoes. -Chewing difficulty as related to complete edentulism (no teeth), he/she was unable to eat steak or peanuts. -He/She has had a weight loss. (added on 2/28/24) -He/She will consume 75-100% of 2 meals per day to meet nutrient requirements through the review date. -Give diet as ordered: Fortified Meal Plan diet, Regular texture, Regular/Thin consistency, Low phosphorus, limit to 1 serving per day. Avoid food containing very high phosphorus. -Monthly weights monitored. Report significant changes to physician. -Offer alternative meal when he/she eats less than 50% of meal. Review of the resident's weights showed: -On 1/4/24 he/she weighed 147.6 lbs - On 2/5/24 he/she weighed 132 lbs with a 15.6 lb loss or 10.57% loss in 30 days. - On 3/5/24 he/she weighed 124.9 lbs with a 7.7 lb loss or 5.38% loss in 30 days. - A total of 23.1 lbs loss or 15.38% loss in 90 days. During an interview on 3/27/24 at 1:35 P.M. The resident said: -The food was always cold, he/she can only have certain foods, he/she had lost weight because he/she did not like the food. Review of the Resident's nutrition/dietary progress notes showed: (continued on next page)

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 04/05/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/2/2024 Continued to follow weights as he/she was now on dialysis three times per week. Diet was listed as NAS/Renal with 1200 milliliters (ml) fluid restriction. -1/10/2024 Continued to follow weight changes as he/she remained on dialysis treatments. -1/17/2024: Discussed weight change, food preferences and goals. The resident has been very upset with all the restrictions. The resident was OK with not using fluid milk or beans, but would not skip cheese. The resident said he/she did try to watch fluid intake. The resident agreed to a Nepro supplement (a nutritional drink for people on dialysis) at bedtime. He/She will recommend the above changes and continue to follow. - 1/29/2024 Followed for weight change. He/She had eaten 75% average of a NAS Renal diet, and was on a 1200 ml fluid restriction. Medical management included Sevelamer with meals. Recommend to discontinue Renal diet as this was usually more compatible with predialysis need. -2/27/2024 He/She was eating 75% average of a NAS/Renal diet with double entrees. Recommended changing diet to liberal renal as he/she had made multiple comments about not wanting to be constantly hounded about what he/she ate and drank. -3/4/2024 Following as weight continued to decline. He/She has eaten a varied amount of a NAS/Renal diet. Current weight was 126.4 lbs; He/She would request discontinuation of renal restriction, and add Nepro at bedtime. Registered Dietician (RD) had called and left message for dialysis team for recent labs or other suggestions. - 3/25/2024 Continued to monitor weight. The resident told the RD he/she did not want to follow the renal diet. He/She would continue to counsel and support the resident. Review of the Dialysis center communication showed: -2/20/24 lab report showed Albumin (protein) level of 2.9 g/dL (grams per deciliter) with a goal of greater than or equal to 4. g/dL -The resident was to eat more fish, eggs and meat. Review of the Resident's medical record showed: -3/8/24 He/She was seen by his/her primary care physician. -No mention of weight loss. During an interview on 3/27/24 at 9:54 A.M. the primary care physician's nurse said: -He/She was not aware of any weight loss for this resident. -He/She did not find any notes in the system about the resident's weight loss. -He/She would leave a note for the Nurse Practitioner. (continued on next page)

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 04/05/2024
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 10:28 A.M. the Advanced Practice Registered Nurse (APRN) said: -He/She did not specifically recall staff notifying him/her of the resident's weight loss. -He/She was aware the resident had declined in his/her ability and health over the last couple of months. During an interview on 3/27/24 at 12:42 P.M. the Registered Dietician (RD) said: -He/She has seen the resident's weights. -The resident did not like the Nepro. -The dialysis dietician was working to get the resident renal prostat., a different supplement. -The resident received double portions protein at breakfast and dinner. -He/She has sent recommendations to liberalize the resident's diet to the Director of Nursing. -Attempted interventions, non compliance and failures should be documented. During an interview on 3/28/24 at 10:23 A.M. Licensed Practical Nurse (LPN) A said: - Multiple residents have complained to him/her about small portions at meals and they are loosing weight because of it. -This resident has had a large weight loss. -He/She was not sure how much the resident had lost . -The resident asked for lasagna one day when it was served and dietary would not give it to him/her. -The resident was on a renal diet and could not have several things. -The resident did not like the renal diet and would ask for something , but dietary staff would not give it to him/her. The resident was on dialysis but should be allowed to have what he/she wants. -He/she had told administration about the small portions and not allowing residents to have what they want. Nothing has been done that he/she is aware of. During an interview on 3/28/24 at 6:55 P.M. the Director of Nursing said: -The Registered Dietician reviewed the resident's weights monthly, and would give any recommendation. (continued on next page)

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recommendations are given to the DON then she passes them to the PCP or the NP. -He/she believed if the resident's goal was living their best life then they should have liberalized diet. If the resident wants dialysis to work best then the resident should stick to the restricted diet. During an interview on 3/28/24 at 7:03 P.M. the Administrator said: -He/She expected food to be served hot or cold, as intended. -There should be enough food for residents to have seconds or alternates. -He/She expected portion sizes to be adequate. -He/She did not recall any complaints recieved or voiced concerns by the residents about portion sizes. -He/she would expect the PCP or NP to address weight loss.

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 04/05/2024
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment from bed rails prior to installation and failed to ensure the bed's dimensions were appropriate for the resident's size and weight, and failed to ensure scheduled maintenance of the bed rail, for two of 16 sampled residents (Resident #5 and Resident #19) who used side rails. The facility census was 62. Review of the facility ' s undated Side Rails Policy showed: -After an attempted alternative to side rails have been made, the facility shall: -Assess the resident for risk of entrapment and other risks; -Obtain a physician ' s order for the use of the side rail; -The facility shall ensure correct installation and maintenance of the bed rails prior to use; -Ensuring the bed dimensions are appropriate for the resident; -Inspecting and regularly checking the mattress and bed rails for gaps and areas of possible entrapment; -The maintenance director or designee is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses and rails. 1. Review of the Resident #5's care plan dated 10/23/23, showed: - ADL self-care performance deficit due to right sided hemiplegia; -The resident is dependent on staff for meeting emotional and physical needs related to cognitive deficits; - The resident had a history of falls related to weakness; -The resident has a mobility bar on the right side of his/her bed to assist in mobility. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/24 showed; - Severe cognitive impairment; - Substantial assistance with Activities of daily living (ADLs); (continued on next page)

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 04/05/2024
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed rails were not used daily; - The resident had hallucinations (a false perception of objects or events involving the senses); - Required supervision or touching assistance with eating; -Incontinent of bowel and bladder; - Diagnoses included Schizophrenia, hemiplegia (paralysis of one side of the body, stroke, high blood pressure. Review of the resident ' s Physicians Order Sheet (POS) dated March 2024 and April 2024 showed no order for bed rails. Observation on 03/26/24, at 12:25 P.M., showed: -The resident laying in bed with the bed rail in the up position on the right side of the bed. Observation on 3/27/24 at 12:42 P.M., showed: -The resident laying in bed with the a bed rail in the up position on the right side of the bed. During an interview on 03/28/24, at 1:07, P.M., Nurses Aid A said: -He/she just started in January 2024; -He/she is not sure why the resident had a rail on his/her bed; -The resident used the rail to position himself/herself; -The resident uses a mechanical lift to get out of bed. 2. Review of Resident #19 ' s Annual MDS, dated [DATE] showed; - Moderate cognitive impairment; - Substantial assistance with ADLs; -Incontinent of bowel and bladder; -Bed rails used daily; - Diagnoses included heart failure, dementia and seizure disorder or Epilepsy (brief episodes of involuntary movement that may involve a part of the body). Review of the resident ' s undated care plan, showed: - ADL self-care performance deficit due to activity intolerance; (continued on next page)

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 04/05/2024
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident requires extensive assistance of two staff for bed mobility; -The resident has bars on both sides of his/her bed to assist with bed mobility; -The resident is at risk for falls related to seizures. Review of the resident ' s POS dated March 2024 and April 2024 showed no order for bed rails. Observation on 03/26/24, at 12:25 P.M., showed: -The resident lying in bed with rails in the up position on both sides of the bed. Observation on 3/27/24 at 12:42 P.M., showed: -The resident lying in bed with rails in the up position on both sides of the bed. During an interview on 3/27/24 at 1:24 P.M., Physical Therapy Assistance (PTA) A, said: -The therapy department looks at this as part of the admit process and if the resident would like a rail for positing therapy assesses this and lets nursing know if a rail would be appropriate for the resident; - Therapy does not do the entrapment assessments or any measuring of the bed or mattress; - The nurses do the assessments for the side rails; -He/she is not sure who does the entrapment assessments at the facility; -After the initial admitting assessment therapy is no longer involved in the side rails. During an interview on 03/27/24, at 02:12 P.M Registered Nurse (RN) A said: -The resident uses the bed rail for mobility; -The therapy department assesses the resident for the use of side rails then they will give the nursing department an order for the side rail; -An entrapment assessment should be done on residents using a side rail; -He/she was not sure who did the entrapment assessments; -He/she was not sure when the resident ' s last entrapment assessment was done. - During an interview on 3/28/24, at 02:02 P.M CNA A said: -He/she is not sure why the resident had a rail on his/her bed; -He/she used the rail to position himself/herself; (continued on next page)

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident uses a mechanical lift to get out of bed with assist of two people. During an interview on 3/28/24 at 2:32 P.M., the Maintenance Supervisor said: -He/she has been here for three months; -He/she is not sure who measures of the bed frames, bed rails or mattresses; -Maintenance installs the bed rails; -He/she had not installed or measured the beds, rails or mattresses since he/she has been here; -Entrapment assessments should be done but he/she was not sure when; -There should be a record of the measurements and entrapments assessments at the facility but he/she did not know where they were because he/she just started; -He/she could find no documentation indicate entrapment assessments had been completed for residents with side rails. During an interview on 3/27/24 at 2:445 P.M., the Regional Maintenance Supervisor said: -In other buildings it is the maintenance department installs the bed rails and does the measuring for the entrapment assessments; -He/she was not sure if that was the case at this facilty; -He/she did not find the facility ' s entrapment assessments; -Entrapment assessments should be done; -There should be a record of the measurements and entrapments assessments at the facility; -He/she could find no documentation indicate entrapment assessments had been completed for residents with side rails. During an interview on 3/28/24, at 06:58 P.M the Director of Nursing (DON) said: -Anyone who sees a need makes a recommendation to therapy and evaluations is done and then a physician ' s order is obtained; - Maintenance measures and then reassessed quarterly; -The same procedure is followed with the hospice beds; -He/she is not sure what the policy says; -He/she is not sure where maintenance documents the measurements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The administrator concurred with the DON.

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on interview and record review, the facility failed to monitor the monthly Medication Regimen Review (MRR) reports for November 2023 and January 2024, completed by the pharmacist, and additionally the facility failed to ensure they addressed recommendations with Resident #5's physician by midnight of the next calendar day. This affected three out of 16 sampled residents, (Resident #5, #19 and # 39). The facility census was 62. Review of the facility's Medication Regimen Review and Reporting policy dated, January 2024, showed: -Resident specific Medication Regimen Review (RR) recommendations and findings are documented and acted upon by the nursing care center and/or physician; -A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians and the care planning team with 48 hours of RR completion; -For those issues that require a physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale; -If prescriber intervention is required, facility staff will ensure proper communication is proved to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next calendar day. 1. Review of Resident #5's pharmacist medication regimen review, dated November 2023, showed: - On 11/13/23 the resident received Clozapine 175 milligrams (mg) daily for Schizophrenia (a serious mental disorder in which people interpret reality abnormally) and draw complete blood count (CBC - a blood test, that shows abnormalities in the production, life span, and destruction of blood cells) monthly; - On 3/4/24, the physician signed it and ordered a complete blood count (CBC - a blood test, that shows abnormalities in the production, life span, and destruction of blood cells) to be obtained monthly; -The facility failed to ensure they addressed the recommendation to obtain a CBC monthly with the resident's physician by midnight of the next calendar day. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/24, showed: - Cognitive skills moderately impaired; (continued on next page)

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 04/05/2024
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Substantial assist with toilet use, showers, dressing, personal hygiene and transfers; - Diagnoses included high blood pressure, hemiplegia (paralysis that affects one side of the body) and Schizophrenia; - Takes antipsychotic medications, diuretics, and antidepressants. 2. Review of Resident #19's pharmacist medication regimen review, dated January 2024, showed: - On 1/23/24 no lab results for a Valproic Acid level could not be located in the resident's chart. The lab was due to be drawn in December 2023; - On 3/12/24, the physician ordered a Valproic Acid level to be drawn now and every six months; -The facility failed to ensure they addressed the recommendation to obtain a Valproic Acid level every six months with the resident's physician by midnight of the next calendar day. Review of the resident's Annual MDS, dated [DATE], showed: - Cognitive skills moderately impaired; - Substantial assist with toilet use, showers, dressing, personal hygiene and transfers; - Diagnoses included seizure disorder, dementia and heart failure; - Takes antipsychotic medications, diuretics, and anti-platelet medication. Review of the resident's POS dated March, 2024 showed: - Start date: 3/18/24: Valproic Acid level every 6 months. 3. Review of Resident #39's pharmacist medication regimen review, dated January 2024, showed: - On 1/23/24 the resident received Hydroxyzine 25 mg every 8 hours as needed for anxiety. The pharmacist recommended a discontinuation of the medication; - On 3/12/24 the order was noted by staff and faxed to the physician; -The facility failed to ensure they addressed the recommendation to discontinue Hydroxyzine 25 mg every 8 hours as needed for anxiety with the resident's physician by midnight of the next calendar day. Review of the resident's Quarterly MDS, dated [DATE], showed: - No cognitive impairment; - Moderate assist with toilet use, showers, dressing, and personal hygiene; (continued on next page)

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 04/05/2024
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Substantial assist with transfers; - Diagnoses included high blood pressure, stroke and anxiety; - Takes antidepressant, opioid, and anti-platelet medications. Review of the resident's POS dated March, 2024 showed: -Hydroxyzine 25 mg every 8 hours as needed for anxiety was discontinued on 3/12/24. During an interview on 03/28/24, at 02:55 P.M., the Director of Nursing (DON) said: -The pharmacy comes in and does the medication reviews every week and they email them to him/her - He/she puts the emails in a folder for the physician to review when he/she comes in on Friday; -The physician comes to the facility every Friday and reviews the emails containing the pharmacy recommendations; -When the pharmacy sends recommendations after the physician has been to the facilty on a Friday, the physician addresses them the following Friday; -It can take 7 to 10 days from the time the pharmacy makes recommendations until the physician signes off on them; -The process needs to be faster; -He/she has been here since May 2023 and is trying to fix the time frame.

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 04/05/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observations, interviews and record review, the facility failed to serve food to the residents that was palatable, attractive, and served at a safe and appetizing temperature. This affected three out of 16 sampled residents residents (Resident #33, #34, and #47). The facility census was 62. Review of the facility's Food Temperatures at Point of Service, reviewed 7/14/23, showed: -Food will be prepared, held and served in a manner that preserves nutritive value and palatability; -Hot foods will be held at 135 degrees Fahrenheit or above and cold foods will be held at 41 degrees Fahrenheit or below prior to serving to maintain food safe; -Best efforts will be made to present hot food hot and cold food cold at point of service by using thermal lids and bases, heated or chilled plates and thermal pellets as necessary; -Food service staff will monitor palatability of food at point of service by periodic test tray evaluation and review of resident council concerns. 1. Review of the resident's #34's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/3/24 showed; - No cognitive impairment; - Set up help with meals (the helper sets up and cleans up after the activity); - Independent with dressing, toileting and bathing; - Diagnoses included high blood pressure, diabetes mellitus (a metabolic disease, involving elevated blood glucose levels) and anxiety. Review of the resident's care plan, revised 1/15/24 showed: -The resident is independent with ADLs; -The resident has diabetes mellitus; -The resident is at risk for malnutrition related to diabetes mellitus; - Provide and serve diet as ordered. Observation and interview on 3/26/24 at 12:22 P.M., showed: -The resident was served bowl of dumplings; (continued on next page)

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 04/05/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The bowl was only 1/4 full; -The resident said the food was cold and he/she did not get enough to eat. 2. Review of Resident #47's care plan, revised 1/15/24 showed: -The resident has an ADL self care performance deficit; -The resident has impaired cognitive function; -The resident is dependent on staff for meeting motional, intellectual, physical and social needs; -The resident requires extensive assistance with dressing. Review of the resident's Quarterly MDS, dated [DATE] showed: - Severe cognitive impairment; - Required partial assistance with dressing upper body: - Required substantial assistance with dressing lower body; - Lower extremity impaired on one side; - Occasionally incontinent of urine; - Diagnoses included stroke, dementia and high blood pressure. Observation and interview on 03/25/24 at 12:25 P.M. through 1:37 P.M., showed: - The resident was brought to the dining room by hospice staff; - The resident was not offered a tray by staff; - 01:06 P.M. house keeping staff were cleaning the the in the dining room; - 01:16 P.M. the resident remains sitting in dining room while house keeping staff are cleaning; - 01:23 P.M. the resident left the dining room to his/her room; -01:28 P.M. the resident wheeled down the hall using his/her walker and went into his/her room and sat on the bed; - 01:37 P.M. the resident started eating from the uncovered plate of food setting on the table next to his/her bed; - The resident said well it is cold but I will eat it because I am hungry. (continued on next page)

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 04/05/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of meal preparation for lunch on 03/27/24 at 11:03 A.M., showed: - Cook A prepared the pureed lunch meal; - He/she placed two cups of cooked green beans into the food processor; - He/she then turned on the food processor and blended until it was the desired consistency; - The mixture was thin like liquid. Observation of the pureed and regular lunch test trays on 3/28/24 at 01:15 P.M., showed: - The pureed green beans was 97 degrees Fahrenheit; - The regular hamburger was 98 degrees Fahrenheit; - The pureed chicken was 105 degrees Fahrenheit; - The pureed green beans were very thin and ran off the spoon like water. During an interview on 03/27/24 at 1:36 P.M., Cook A said: - The residents should always get a full serving that fills the bowl; - Temperature of hot food a the time of service should be135 degrees Fahrenheit; - Pureed food should not be runny like liquid. During an interview on 03/27/24 at 1:47 P.M., the Dietary Manager said: - The residents get a full serving of the food according to the scoop sizes; - Temperature of hot food a the time of service should be above 135 degrees Fahrenheit; - Pureed food should not be runny like liquid. 31102 3. Review of Resident #33's Quarterly MDS, dated [DATE] showed: - Cognitive skills intact; - Lower extremities impaired on both sides; - Required set up and clean up with eating, personal hygiene, and oral hygiene; - Dependent on staff for toilet use and transfers; (continued on next page)

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 04/05/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Had a urinary catheter (sterile tube inserted into the bladder to drain urine); - Always incontinent of bowel; - Diagnoses included congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), neurogenic bladder (dysfunction that results from interference with the normal nerve pathways associated with urination), chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and peripheral vascular disease (PVD, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the resident's care plan, revised 2/29/24 showed: - The resident had an ADL self - care performance deficit; - The resident required extensive to total staff assistance with ADLs related to weakness, limited range of motion (ROM), morbid obesity, wounds, and COPD; - The resident required staff to set up meal. The resident is able to feed him/herself. During an interview on 3/26/24 at 8:05 A.M., the resident said:- The resident received room trays and the food was usually cold. During an interview on 3/28/24 at 10:17 A.M., Licensed Practical Nurse (LPN) A said: - It's a common complaint with the resident's about cold food and the small portions; - It's not any specific resident who complains, just all the residents across the board; - It's a constant problem. During an interview on 3/28/24 at 10:34 A.M., Certified Medication Technician (CMT) A said: - They have regular complaints about cold food and the portion size being too small. During an interview on 3/28/24 at 12:53 P.M., Certified Nurse Aide (CNA) A said: - The residents complain about the food being cold pretty much all the time; - They report it to the Charge Nurse and the Director of Nursing (DON); - The residents complain about the portion size for breakfast and lunch being too small. During an interview on 03/28/24 at 10:28 A.M., the Registered Dietitian said: - The residents should receive full serving of the food at meals according to the scoop sizes; - Depending on the food the bowl should be over 1/4 full; (continued on next page)

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 04/05/2024
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Temperature of hot food a the time of service should be above 135 degrees Fahrenheit; - Pureed food should not be runny like liquid.

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 04/05/2024
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observation, interview, and record review, the facility failed to ensure staff prepared foods in a consistency designed to meet the needs of individual residents, when they did not ensure the pureed (a texture-modified diet in which all foods have a soft, pudding-like consistency) food had a smooth and appropriate consistency. This affected three out of 16 sampled residents (Residents #5, #19, and #47) by causing a choking hazard. The facility census was 62. The facility did not provide the requested policy on pureed food preparation. Review of the facility's Medical Provider Orders Policy, revised 4/7/22, showed: Staff should follow all medical provider orders timely. Review of the facility's undated Therapeutic Diets Policy showed: -Mechanically altered diets will be considered therapeutic diets; -A therapeutic diet must be prescribed by the physician. 1. Review of the Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/24, showed: - Cognitive skills moderately impaired; - Substantial assist with toilet use, showers, dressing, personal hygiene and transfers; - Supervision with meals; - Coughing or choking during meals; - Mechanically altered diet; - Diagnoses included high blood pressure, hemiplegia (paralysis that affects one side of the body) and schizophrenia. A review of the resident's undated care plan, showed: -The resident has had a choking episode while eating related to dysphagia (the inability to swallow safety because of a stroke). - The resident is to be monitored by staff while eating; - The resident has oral health problems related to edentulous (having no teeth); -The resident is to have a pureed diet. (continued on next page)

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 04/05/2024
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Physician's Order Sheet (POS), dated March 2024, showed the resident had an order for a pureed diet. 2. Review of Resident #19's Annual MDS, dated [DATE], showed: - Cognitive skills moderately impaired; - Substantial assist with toilet use, showers, dressing, personal hygiene and transfers; - Partial assist with eating; - Coughing or choking during meals; - Complaints of difficulty or pain with swallowing; - Mechanically altered diet; - Diagnoses included seizure disorder, dementia and heart failure. A review of the resident's undated care plan, showed: -The resident has a swallowing problem; -The resident is to eat only with supervision; -The resident had no upper teeth; -The resident needed a pureed diet. A review of the resident's POS, dated March 2024, showed the resident had an order for a pureed diet. 3. Review of the Resident #47's Significant Change MDS dated [DATE], showed: -Severe cognitive impairment; -Substantial assist with toilet use, showers, dressing, personal hygiene and transfers; -Supervision at meals; -Mechanically altered diet; - Diagnoses included dementia, arthritis, high blood pressure and stroke. A review of the resident's undated care plan, showed: -The resident has dysphagia and at risk for aspiration pneumonia; (continued on next page)

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 04/05/2024
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident has impaired chewing/swallowing related to dysphagia; -The resident needed a pureed diet. A review of the resident's POS, dated March 2024, showed the resident had an order for a pureed diet. 4. Observation of meal preparation for lunch on 03/27/24 at 11:03 A.M., showed: - The dietary manager prepared the pureed lunch meal; - He/she placed two cups of cooked green beans into the food processor; - He/she then turned on the food processor and blended until it was the desired consistency; - The mixture was thin like liquid. Observation of lunch service on 03/27/24 at 12:45 PM., showed: -Staff served Residents #5, #19, and #47 their pureed meals. Observation of the pureed lunch test tray on 09/12/23 at 01:15 P.M., showed: - Pureed green beans were very thin, and ran off the spoon like water. During an interview on 03/27/24 at 1:36 P.M., Cook A said: - Pureed food should be a smooth, pudding-like consistency and should not run off the spoon like water. - He/she did not realize the pureed food was too thin; - Sometimes it is hard to tell how the green beans will turn out. During an interview on 03/27/24 at 1:47 P.M., the Dietary Manager said: - Pureed food should be a smooth, pudding-like consistency; - Pureed food should not be runny like liquid. During an interview on 03/28/24 at 10:28 A.M., the Registered Dietitian said: - Pureed food should not be too thin like water; - Pureed food should be a smooth, pudding-like consistency with no chunks or particles.

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46706 Based on observation, interviews, and record review, the facility failed to ensure staff stored food in a sanitary manner and failed to maintain the kitchen in a sanitary manner when the ceilings, walls, floors, and vents were covered in dirt and debris, and when the walls, floors and ceilings were not in good repair, and when the freezers were not clean, and contained opened and undated food. This could potentially impact all residents by dirt or debris coming in contact with food and food preparation areas. Additionally food that is open and undated can be potentially hazardous due to spoilage. The facility census was 62. Review of the facility's undated Cleaning Ceilings policy showed: -Ceilings will be cleaned to avoid soil build-up; -Vacuum ceilings; -Remove all cobwebs; -All light shields shall be cleaned and cleared of all debris; -Ceilings shall be cleaned as necessary or at a minimum of twice a year. Review of the facility's undated Sanitation of the Dietary Department showed: -The dietary staff shall maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule; -The dietary manager shall record all cleaning and sanitation tasks for the department; -All tasks shall be addressed as to the frequency of cleaning; -A cleaning schedule shall be posted weekly for all cleaning tasks and employees will initial tasks as completed. 1. Observation on 03/25/24 at 09:09 A.M., showed: -The floor under the three compartment sink covered with dirt and debris; -Ceiling above the three compartment sink is covered with dust and dirt; -Top of the dishwasher is covered with dirt and debris; -Base board and tiles missing under the dishwasher; -Vents in the ceiling above the coolers covered with dirt and debris; (continued on next page)

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 04/05/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wheels of the meal carts covered with dirt and debris. 2. Observation on 03/27/24 at 11:03 A.M., showed: -Vent and window by the handwashing sink covered with dirt and debris; -Plate warmer with food spatters on the sides; -Paint peeling from the ceiling in the kitchen; Dry Storage: -Bugs in the light on the ceiling; -Floor covered with debris; Chest Freezer: -Undated open bag of beef steak fritters; -Undated open bag of burritos; -Dirt and debris inside the bottom of the freezer; -Undated open package of scrambled eggs; Upright Freezer: -Dirt and debris on the sides and bottom of the inside; -The drawers in the bottom are cracked and chipped with dirt and debris on the inside of the drawers. During an interview on 03/28/24 at 9:48 A.M., the Dietary Manager (DM) said: -The kitchen should be clean and in good repair; -Food should be labeled and dated; -There should be no open containers or open bags of food in the refrigerator or the freezer; -The freezers and refrigerators should be clean on the inside and outside and in good repair; -The kitchen is responsible for the clearing of the kitchen, including the freezers and refrigerators; -The vents are cleaned by maintence; (continued on next page)

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 04/05/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she verbally notifies the maintence department of repairs that need to made in the kitchen and when the vents are dirty During an interview on 03/28/24 at 02:32 P.M., the Maintence Director said: -Maintenance is responsible for the repairing the floors, and ceilings in the kitchen; -There kitchen is responsible for cleaning the vents in the kitchen; -The kitchen writes any repairs in the maintence book; -The maintence book is at the nurses desk; -He/she has only been here three weeks and he/she is not sure the last time any repairs were made in the kitchen; -He/she was not sure the the last time the vents in the kitchen had been cleaned; -He/she was not aware repairs were needed in the kitchen; -He/she was not aware the vents needed cleaned in the kitchen. Review of the maintence book at the nurse's desk did not show any repair or cleaning requests for the kitchen. During an interview on 03/28/24, at 3:27 P.M., the Registered Dietitian (RD) said: -He/she expects the kitchen to be maintained in a clean and sanitary manor; -He/she expects the kitchen to be in good repair; -He/she expects the kitchen staff to be responsible for the cleanliness of the kitchen; -He/she expects food should be labeled and dated; -There should be no open containers or open bags of food in the refrigerator or the freezer; -He/she expects freezers and refrigerators should be clean on the inside and outside and in good repair; -He/she expects the DM to monitor to ensure the kitchen is maintained in a clean and sanitary manner. During an interview on 3/28/2024 at 07:03P.M., the Administrator said: -He/she expects the kitchen staff to keep the kitchen clean and sanitary; -He/she expects the kitchen staff to make sure the food is stored properly; (continued on next page)

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 04/05/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she expects the kitchen to be in good repair; -The kitchen staff is responsible for reporting any repairs to maintenance.

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 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44395 Based on record review and interviews the facility failed to maintain quarterly quality assessment committee (QAA) meetings with the required members. The facility census was 62. Review of the facility policy Quality Assurance and Performance Improvement (QAPI) dated 9/1/2021 showed: -The Quality Assessment and Assurance (QAA) committee shall be interdisciplinary and shall consist of a minimum of the Director of Nursing, the Medical Director or his/her designee, the infection preventionist and at least three other members of the facility staff. Shall meet at least quarterly Review of the facility provided sign in sheets for April 2023 through March 2024 showed: -The committee had meetings April 2023, June 2023, October 2023, January 2024 and March 2024 -The Medical Director signed as attending June 21, 2023 and March 1, 2024. -There was no sign in sheet for the quarter between June 2023 and October 2023 During an interview on 3/28/24 at 4:57 P.M. the Director of Nursing said: -She does not know who is responsible for QAA and QAPI as the coordinator. -She attends meetings and performance improvement plans are initiated from those meetings. -Areas under a performance improvement plan (PIP) were: Do Not Resuscitate status, Preadmission Screening and Resident Review (PASRR), and services for psychiatric diagnosed residents. During an interview on 3/28/24 at 5:00 P.M. the Corporate Compliance Nurse said: -The Administrator is in charge of QAA and QAPI. -This facility is in flux since a new Administrator had not started and the current Administrator was an interim. -He was not aware the Medical Director had not attended meetings.

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 04/05/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Observation, record review and interview showed the facility failed to follow infection control standards and guidelines for medication administration when staff touched medications with ungloved hands for two residents (Resident #41 and #36). Additionally staff failed to provide annual tuberculosis testing for three residents (Resident #20, #24 and #47)) of 16 sampled residents. the facility census was 62. Review of the facility provided policy Medication Administration, revised 9/1/22 showed: - Medications are administered by licensed nurses, or other staff who are 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; - Remove medication from source, taking care not to touch medication with bare hand. Review of the facility provided policy Infection Prevention and Control Program, reviewed/revised 5/15/23 showed: -This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. -Licensed staff shall adhere to safe medication administration practices as described in relevant facility policies. 1. Review of Resident #41's Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) showed: -Brief Interview of Mental Status (BIMS) of 13, indicated little to no cognitive deficits. -Moderate assistance with Activities of Daily Living (ADL's: skills required to care for oneself, such as eating, bathing, and mobility); -Always incontinent of bladder and bowel; -Diagnoses of: Obsessive Compulsive Disorder (OCD: a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both), Cerebralvascular Accident (Stroke: blood flow to the brain is impaired), Paranoid Schizophrenia (a type of mental disorder where the mind doesn't agree with reality and the person may have hallucinations (seeing, smelling or tasting things that are not there) or delusions (a false belief of reality despite evidence), Heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident #41's March 2024 Physician Order Sheet showed: (continued on next page)

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 04/05/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order date 9/16/22 Vitamin D 3 tablet, give one tablet by mouth one time a day for supplement; -Order date 4/13/23 Cranberry oral tablet 500 milligram (MG), give two tablets by mouth in the morning for odor control. Observation on 3/28/24 at 9:12 A.M. showed: -The resident was sitting in his/her room; -Certified Medication Technician (CMT) C removed a bottle of Vitamin D 3 25 micrograms (mcg) from the top drawer of the medication cart; -He/She read the label of the bottle and the electronic Medication Administration Record (MAR).; -He/She opened the bottle of Vitamin D, tapped the bottle on the side of the medication cup, used his/her thumb to pull the pill forward in the bottle until it expelled from the bottle into a small cup; -He/She then returned the bottle of Vitamin D to the top drawer of the medication cart; -He/She removed a bottle of Cranberry caps from the top drawer of the medication cart, tapped the edge of the bottle on the edge of the medication cup then used his/her bare thumb to pull the pills from the bottle into the cup; -He/She read the label of the bottle and the electronic MAR. -He/She opened the bottle of Cranberry, tapped the bottle on the side of the medication cup, used his/her thumb to pull two pills forward in the bottle until they expelled from the bottle into a small cup. -He/She then returned the bottle to the top drawer of the medication cart. During an interview on 3/28/24 at 9:15 A.M. Certified Medication Technician C said: -Medication should not be touched without gloves. -He/She did not realize he/she had touched the medications. 2. Review of Resident #20's Annual MDS dated [DATE] showed: - Long and short term memory problems; - Dependent on staff for ADL's; - Always incontinent of bowel and bladder; (continued on next page)

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 04/05/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included aphasia (a language disorder that affects a person's ability to communicate), stroke, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), seizure disorder, anxiety, depression, hemiplegia (paralysis affecting one side of the body) and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Review of the resident's electronic medical record showed: -A tuberculin (Tb) skin test (a test used to indicate if a person has tuberculosis: a bacterial lung infection) was administered on 3/2/22. 3. Review of Resident #24 Quarterly MDS dated [DATE] showed: -No long or short term memory impairment; -Moderate assistance for ADL's; -Frequently incontinent of bowel and bladder; -Diagnoses of Coronary Artery Disease (CAD happens when coronary arteries struggle to supply the heart with enough blood, oxygen and nutrients.) heart failure, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), anxiety and depression. Review of the resident's electronic medical record showed -A (Tb) skin test was administered on 3/2/22. 4. Review of the Resident #47's Significant Change MDS dated [DATE], showed: -Severe cognitive impairment; -Substantial assist with ADL's; - Diagnoses included Dementia, arthritis, Hypertension (high blood pressure) and stroke. Review of the resident's electronic medical record showed -A (Tb) skin test was administered on 3/2/22. During an interview on 3/27/24 at 12:23 P.M. the Infection Preventionist (IP) said: -He/She became the IP around 2020; -He/She was not responsible for immunizations or any education; -The Assistant Director of Nursing was responsible for all immunizations; -He/She does not know why the Tb test documentation would not be in the chart; (continued on next page)

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 04/05/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/ She was responsible for the surveillance portion of the Infection Prevention Program, not the whole thing. 31102 5. Review of Resident #36's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/1/24 showed:- Long and short term memory problems; - Required supervision or touching assistance with eating, toilet use, showers, dressing and personal hygiene; - Partial to moderate assistance with transfers; - Frequently incontinent of bowel and bladder; - Diagnoses included stroke, aphasia (a language disorder that affects a person's ability to communicate), diabetes mellitus and Parkinson's disease (a progressive disorder of the nervous system marked by muscle tremors, muscle rigidity, decreased mobility, stooped posture, slow voluntary movements and a mask - like facial expression). Review of the resident's physician order sheet (POS), dated March 2024, showed: - Start date: 1/8/23 - Depakote Sprinkles (Divalproex Sodium) delayed release 125 mg., give four capsules three times a day for restlessness and agitation. Review of the resident's medication administration record (MAR), dated March 2024, showed: - Depakote Sprinkles (Divalproex Sodium) delayed release 125 mg., give four capsules three times a day for restlessness and agitation. Observation on 3/28/24 at 7:59 A.M., showed: - Certified Medication Technician (CMT) A placed the Divalproex Sodium capsules directly on the surface of the medication cart; - CMT A used his/her bare hands and pulled the capsules apart and placed them in a clear medication cup; - At 8:09 A.M., CMT A administered the medication to the resident. During an interview on 3/28/24 at 10:31 A.M., CMT A said: - He/she should have placed the capsules on a clean surface; - He/she should have worn gloves when handling the medication. During an interview on 3/28/24 at 6:55 P.M., the DON said: (continued on next page)

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 04/05/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff should not handle medication with their bare hands; - Staff should not place pills directly on the medication cart without using something for a barrier. -The Assistant Director of Nursing is responsible for Tb testing for residents. -She is unsure when annual Tb testing is done for residents. -She does not know why these resident's did not have current Tb testing.

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 04/05/2024
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program to prevent gnats facility wide and mice droppings in two residents' rooms (Resident #24 and Resident #55), potentially effecting all residents. The facility census was 62. Review of the facility provided policy Pest Control reviewed/revised 9/1/22 showed: -It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents (e.g. mosquitos, flies, mice and rats). Observation on 3/25/24 at 11:47 A.M., showed on the 200 hallway there were multiple gnats in various resident's rooms. Observation on 3/25/24 at 12:02 P.M. showed there were multiple gnats in the dining room. Observations on 3/27/24 at 10:18 A.M. showed there were multiple gnats in the hall, the beauty shop, and front office area. During an interview on 3/28/24 at 10:03 A.M. Certified Nurse Aide A said: - He/She picked up wet sheets that morning and there were a million gnats; -The gnats were all over the floor and in the sheets.; -They are always in the building. During an interview on 3/27/24 at 4:58 P.M. the Administrator said: -It had taken three days to get someone in the facility who could do something about the gnats; -Pest control was in the facility twice and there were still gnats; - Pest control found them nesting in a drain while on site 3/27/24; -The drain was treated. Surveyor: [NAME], [NAME] Observation on 3/27/24 at 09:32 A.M., showed mice droppings on the floor in room [ROOM NUMBER] on Resident #24's bedside table, dresser, floor and on the top of the refrigerator. Observation on 3/27/24 at 2:12 P.M., showed mice droppings on the floor in room [ROOM NUMBER] on Resident #24's bedside table, dresser, floor and on the top of the refrigerator and on the floor under Resident #55's bed. There were also mice droppings in the corner of entrance to the bathroom. (continued on next page)

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 04/05/2024
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/28/24 at 8:24 A M. showed a mouse running out of room [ROOM NUMBER] down the hall along the wall and ran through the hole under the exit doors at the end of the hall. Observation and interview on 3/28/24 at 10:18 A M. showed: - Mice droppings remaining on the floor in room [ROOM NUMBER] on Resident #24's bedside table, dresser, floor and on the top of the refrigerator; - Resident #55 said he/she has seen a mouse in her room several times; - He/she has told the administrator but nothing gets done and the mice droppings are bad. During an interview on 3/28/24 at 10:25 A.M., Registered Nurse (RN) A said: -The residents have complained to him/her about the mice; -He/she has wrote it in the book to have the maintence department take care of it; -The book is usually at the nurses station but it is not here right now; -He/she has seen mice in the facility. During an interview on 3/28/24 at 10:45 P.M., the maintence supervisor said: -He/she has set out knew traps and the exterminator came out yesterday to cleaned the drains because of the gnats and that has helped; -This is an old building and it is going to take a while to get it back into shape; -The facilty should be free of pests. During an interview on 03/28/24, at 11:11 A.M., The manager of facility's the pest control company said: -He came out yesterday to treat the the drains. When the facility first sees signs of gnats the drains need to checked and treated. The traps in the drains he/she treated yesterday were dirty and stopped up and that caused the gnats. He would recommend checking and treating the drains monthly. During an interview on 03/28/, at 11:24 A.M., the facility's local exterminator said: (continued on next page)

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 04/05/2024
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He said he has been servicing the facility for 4 months. He has told them since he started providing services, they needed to fix the gaps in the doors from room to room and the holes and gaps under exit doors and to the exterior doors. The facility did not follow his recommendations. The doors are still gapping. He also told the facility that there were holes in the walls in the residents' rooms that the mice have chewed through that they needed to fix, and that would prevent the mice from traveling from room to room. The facilty did not do that either. He said he fixed the holes with rodent-proof foam the first of this month. He came out yesterday and set out more traps for mice. If the facilty would have patched the holes when he first identified the issue the rodent problem would be better by now. 46706