STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265860	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottages of Lake St Louis	2885 Technology Drive Lake Saint Louis, MO 63367

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one resident (Resident #75) of 18 sampled residents and one additional resident (Resident #100), were treated in a manner to maintain dignity and respect. Resident #75 said the way staff treated him/her during cares made him/her feel disrespected and discouraged. The facility census was 49. Review of the facility's undated policy, Resident Rights, showed the following: -The community will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the community;-The community will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the community to properly care for its residents. 1. Review of Resident #75's undated face sheet showed he/she had diagnoses that include congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should). Review of the resident's care plan, dated 07/10/25 showed the following: -He/She had an activities of daily living (ADLs) self-care need;-He/She required limited assistance from one staff to turn and reposition in bed, with personal hygiene, for toileting, to move between surfaces and to walk. During an interview on 07/23/25 at 10:42 A.M., the resident said the following: -He/She was abruptly awakened by staff about 2:00 A.M on 07/23/25; -The staff blasted into his/her room, turned on the overhead light and was very loud and announced bed check time;-He/She went ahead and went to the restroom and the (unidentified) Certified Nurse Assistant (CNA) told the resident he/she needed to be using his/her legs more, insinuating the resident was not doing enough to help staff; -It was very disrespectful for this staff to barge into his/her room and treat the resident in this manner, the resident felt discouraged;-He/She had a rough day, was in significant pain due to a physician's appointment where his/her stitches were removed and x-rays taken, and it took him/her some time to fall asleep again. During an interview on 07/24/25 at 10:10 A.M., the resident said the following: -Last night was rough again;-The CNA was just as gruff and did not act like he/she had much patience;-He/She was not sure if it was the same staff as the night before;-It was not very respectful;-The way staff treated him/her the past two nights made him/her feel like a burden and it was very disheartening. 2. Review of Resident #100's face sheet showed he/she had diagnoses that include bilateral primary osteoarthritis of the knee (a type of arthritis that occurs when flexible tissue at the ends of the bones wears down causing pain in the joints). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 05/14/25, showed the following: -Cognitively intact;-Adequate hearing, makes self understood and understands others;-No behaviors or rejection of cares;-Dependent on staff for toileting hygiene;-Needs substantial/maximum staff assistance for rolling left to right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer and toilet transfer;-Occasionally incontinent of bladder. Review of the resident's care plan, dated 06/08/25, showed the following: -Extensive assistance by one staff for personal hygiene and transfers between surfaces;-Extensive assistance from two staff members for toilet use. During an interview on 05/20/25 at 9:15 A.M., the resident said the evening of 05/19/25 a caretaker, came into his/her room and threw the sheet off him/her and touched his/her private area. He/She asked the caretaker what he/she was doing, and the caretaker said, checking to see if you're wet. The resident told the caretaker to ask next time instead of just throwing the sheet off him/her. The resident did not feel like there was anything sexual about the incident and was not scared. The caretaker told the resident he/she did not want to wake the resident. During an interview on 07/24/25, at 3:49 P.M., the Director of Nursing (DON) said the following: -She would expect staff to speak to residents respectfully;-She would expect staff to treat residents with dignity and respect;-Bed check should be completed during the night by knocking lightly on the door, wake the resident up to provide needed care and not to scare or startle the resident; -During the night, the overhead light should not be flipped on, and staff should not announce themselves in a loud manner;-A resident should never be told by staff that they should be doing more than they are doing or be made to feel like they are not doing enough;-Covers should never be pulled back to do a bed check and a hand should never be placed on an incontinent product without telling the resident what was occurring;-Staff should not be gruff or short with a resident while providing care, the residents should always be treated with respect and kindness. During an interview on 07/24/25 at 4:06 P.M., the administrator said the following:-She would expect staff to speak to all residents with respect;-All residents should be treated with dignity and respect;-Bed check should be completed during the night with respect, dignity and with common decency;-The light should not be flipped