STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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. Based on observation, interview, and record review, the facility failed to keep residents free of accidents when a Certified Nurse Aide (CNA) left a resident unattended in a filled whirlpool to gather supplies. (Resident #83). While the CNA exited the spa and another staff member entered, the resident slipped down into the water. The other staff member had to pull the resident up. The resident said water got in his/her mouth. The resident told another CNA that staff tried to kill him/her and said he/she was now too scared to go back into the whirlpool. The mechanical lift the CNA said he/she used was not assessed for safety concerns after the incident occurred. The facility also failed to ensure safe smoking practices when staff failed to ensure residents disposed of cigarettes in an appropriate receptacle during two of two smoke breaks observed (Residents #53, #69, #68, and #50), the facility identified 14 residents who smoked. The sample was 18. The census was 89. Review of the facility's policy tilted, ADL (activities of daily living) Care Bathing, revised 07/21/22, showed:-Stay with the resident throughout the bath: Do NOT leave the resident unattended;-Use emergency call signal to summon assistance if needed;-While assisting in/out of the tub, instruct the resident to hold onto the safety bars;-Place supplies within reach. 1. Review of Resident #83's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 01/02/26, showed:-Moderate cognitive impairment;-Rejection of care: behavior not exhibited;-Required substantial assistance for shower/bathing;-Required supervision for tub/shower transfer;-Diagnoses included diabetes mellitus, high blood pressure and dementia. Review of the resident's care plan, last reviewed on 01/15/26, showed:-Focus: Resident has history of resistance to care related to refuses to bathe;-Goal: Resident will cooperate with care;-Interventions included: Allow resident to make decisions about treatment regime, to provide sense of control;-Focus: Resident has a rash to his/her head and back with diagnosis of psoriasis vulgaris (chronic scaly, inflamed skin);-Goal: Resident will have no signs or symptoms of infection of the rash;-Interventions included: Give medication as ordered, monitor skin rashes for increased spread or signs of infection;-Focus: Resident requires max assistance with personal hygiene, toileting and showering. Can walk with rollator;-Goal: Resident will maintain proper hygiene without odor;-Interventions included: Encourage resident to participate to fullest extent possible with each interaction. Review of the resident's most recent Fall Risk Evaluation, dated 01/15/26, showed the resident was at moderate risk for potential falls. Review of the resident's February 2026 Order Summary, showed an order dated 05/31/24: Shower or Whirlpool Bath every evening shift every Monday, Wednesday and Friday for chronic psoriasis. Ensure ointment is applied after skin has been cleansed. Review of the resident's progress notes, showed:-On 02/05/26 at 6:27 P.M., late entry, Resident remains on monitoring for fearfulness for slipping in whirlpool. Resident has no complaint of pain or fearfulness at this time;-On 02/06/26 at 7:22 A.M., Resident remains on observation for slip/fall in whirlpool. Rested through the night, no complaints;-On 02/06/26 at 6:26 P.M., Resident remains on monitoring for fearfulness for slipping in whirlpool. Resident has (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
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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	no complaint of pain or fearfulness at this time;-No further documentation related to the resident's fearfulness after slipping in the whirlpool or any interventions to address the resident's fearfulness. Review of the facility's 11/01/25 to Current Incidents/Accidents log, showed the resident was listed. During an interview on 02/19/26 at 1:36 P.M., Certified Nurse Aide (CNA) H said the resident took baths in the whirlpool three times a week and was compliant with care. CNA H bathed the resident frequently. Staff were supposed to stay with residents the entire time the resident was in the whirlpool in case anything happened. CNA H had heard a few weeks ago that a CNA on the evening shift put the resident in the whirlpool and left the resident alone. CNA H saw the resident the next day. The resident said the CNA tried to kill the resident. The resident said, they won't get me in there no more. The resident was talking about the whirlpool. The resident had refused to get in the whirlpool since the incident. CNA H said he/she went and told the Director of Nursing (DON) after the resident told him/her about the incident. Staff were educated on leaving residents alone in the whirlpool. Review of the facility's Investigation, dated 02/04/26, showed:-On 02/04/26, the resident was receiving his/her scheduled bath with assistance from CNA V. During the bath process, CNA V asked the Environmental Services Director (ESD) to watch the resident for a moment while he/she grabbed some soap. Before CNA V stepped away from the area, the resident shifted his/her weight unexpectedly and started to slip. ESD immediately assisted and repositioned the resident. Charge nurse performed pain/skin evaluation with no new findings;-Upon completion of the investigation, the facility responded appropriately. The resident was safely secured and removed from the bathtub. The resident remains at baseline and staff will continue his/her plan of care. The following interventions have been put into place: -CNA provided 1:1 Coaching; -Inservice: ADL Care Bathing; -Inservices return demonstration bathing; -Monitor resident for fearfulness; -Updated care plan. Review of CNA V's witness statement, undated, showed: I stepped out the shower room to get the supply while the resident was in the whirlpool, but there was staff standing at the door. The resident started to slide in the whirlpool. Me and the staff member pulled him/her up immediately. Review of the ESD's witness statement, dated 02/04/26 at 5:00 P.M., showed: When I peeked in the shower room, I saw the resident slipping under and I pulled him/her up. Review of CNA V's Notice of Violation: Safety Requirements form, dated 02/04/26, showed:-Scheduled shift start: 3:00 P.M., scheduled shift end: 11:00 P.M.,-Incident description: Employee failed to gather all supplies before bath, stay with resident, requested assistance form another staff to oversee resident while gathering supplies.During an interview on 02/19/26 at 1:45 P.M., Licensed Practical Nurse (LPN) F said there was a recent incident involving the resident in the whirlpool. He/She believed the resident slipped. Staff came and got him/her and said the resident had slipped and needed to be looked at. When LPN F saw the resident, the tub had been drained. The resident was sitting in the tub facing out. The resident said he/she slipped. CNA V was the one who was bathing the resident when the incident occurred. Staff should be with a resident the entire time they were in the whirlpool. The DON was made aware and said to check on the resident every one to two hours. The resident was a little afraid. The resident had been getting showers ever since the incident occurred. During an interview on 02/19/26 at 2:04 P.M., the DON said they had recently completed education with staff about leaving residents alone in the whirlpool after a staff member stepped out to get towels. CNA V asked ESD to watch the resident while he/she stepped out. The DON was not sure if the ESD had CNA training or not. During an interview on 02/19/26 at 2:51 P.M., CNA V said when a bath was given, you should gather all needed supplies before taking the resident into the shower room. He/She used the bathtub Hoyer lift (mechanical lift used to transfer in/out of a bathtub) for the whirlpool. If a resident did not have good trunk control, they could slide down. A resident would (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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	not be able to slide completely out of the chair because the strap (belt) would be under their armpits. He/She thought there needed to be another strap that went over the lap too. CNA V's understanding was that a resident should not be left alone in the whirlpool. He/She had observed the resident seemed weaker in the days leading up to the incident. The resident used to be able to help but was now full contact for care. The day the incident happened, the resident looked weaker and told CNA V, I can't do it today, but CNA V was not aware the resident couldn't sit up properly. He/She gathered the resident's clothes, but did not have the special soap the resident used for his/her skin condition. CNA V took the resident into the spa around 3:30 P.M. or 4:00 P.M. CNA V strapped the resident into the Hoyer lift chair and lowered him/her into the whirlpool. CNA V needed the resident's special soap and had to get it from the nurse. The ESD came around the corner and CNA V asked her to watch the resident, who remained in the water filled whirlpool, while he/she went and got the soap. As the ESD walked into the spa and CNA V walked out, the ESD said the resident was sliding down. CNA V had his/her back to the resident when this happened. The strap of the Hoyer chair was under the resident's armpits. The ESD and CNA V pulled the resident up and repositioned him/her on the seat of the chair. The resident said he/she was scared and thought he/she was going down into the water. CNA V got the soap and finished the resident's bath. LPN F then came in and assessed the resident. Then the DON came in and assessed the resident. Afterwards, CNA V took the resident back to his/her room. He/She then went to the DON's office and the DON told him/her the correct way to provide a bath in the whirlpool. CNA V was then sent home and was off for a couple of days. When he/she came back, CNA V told the resident he/she was sorry for the fright. Observation on 02/19/26 at 3:20 P.M., showed the Faith Hall Spa had a bathtub Hoyer lift and a wall mounted call light pull station with string. The chair of the Hoyer lift had a belt bolted in the back at the top of the chair to go around the torso area. There was not a belt at the bottom to go over the lap area. During an interview on 02/19/26 at 3:20 P.M., the DON came into the spa room and looked at the bathtub Hoyer lift with the surveyor. The DON said the lift was used for residents who had poor trunk control. The DON said the belt at the top of the chair went around the waist area. Review of the bathtub Hoyer lifts Using the Invacare 1900 Lift For Non-Ambulatory Residents instructional video, showed the chair should have had a belt at the top to go around the torso and at the bottom to go over the lap. During an interview 02/20/26 at 8:30 A.M., the ESD said she was working late the day the incident took place. CNA V asked her to stand by in the whirlpool room so he/she could go get the resident's soap. She did not really feel comfortable being left with the resident, but said since she was a manager, she felt like she needed to do what was needed to help. The resident was sitting in the whirlpool. CNA V left and the ESD was alone with the resident. The resident then began to slide down into the water. She did not see a strap or belt around the resident. She grabbed the resident under his/her arms and pulled him/her up. The resident said he/she was ok, but his/her feelings were hurt. When CNA V returned, the ESD had already pulled the resident up. CNA V called for another staff member. The ESD backed out of the room to give space. The DON asked her to write a statement. She was present at the education, but did not participate. She would not put herself in that position again if asked to help. During an interview on 02/20/26 at 9:34 A.M., the resident said one of the CNAs left him/her alone in the whirlpool. The resident said he/she was going under the water, and water went in his/her mouth. It was for a short period of time. He/She was scared. The resident said he/she was not belted into a chair. One of the staff got him/her out of the water. The resident was scared to go back into the whirlpool now. There was nothing they could do to make him/her feel safe in the whirlpool. During an interview on 02/20/26 at 10:35 A.M., the DON said CNA V should have had all necessary supplies gathered prior to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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	starting the bath. If CNA V needed help, he/she should have used the call light and asked another nursing staff to get the soap. LPN F made her aware of the incident. LPN F said the resident slipped but was not in distress. The resident was dressed and sitting in a chair when she saw and assessed the resident. Nursing staff told the DON the resident didn't want to go in the whirlpool anymore because he/she didn't want to deal with it. The DON was not aware CNA V said he/she used the bathtub Hoyer lift. The chair had not been assessed for safety concerns. The DON was not aware the chair should have had a lap belt. Any new interventions should have been included on the care plan. During an interview on 02/20/26 at 3:00 P.M., the Administrator said she expected staff to stay with residents the entire time when showering or bathing. If staff needed help, they should have used the call light and asked nursing staff for assistance. She was not aware the resident was afraid after the incident occurred. Any interventions should have been included on the care plan. The bathtub Hoyer lift had been removed and would not be used anymore. 2. Review of the facility's Smoking Protocol policy, dated 7/11/25, showed:-The facility shall maintain safety for residents who request to smoke/vape, as well as for those who do not;-Residents and resident representatives will be notified of the smoking protocol during the admission process and updated as needed;-Designated Smoking Area: Fireproof ashtray in which all smoking material will be disposed. No smoking material will be disposed of in waste cans, floors, or other inappropriate areas. Ashtrays will be emptied by maintenance/designee and will be placed in a fireproof metal container and emptied routinely. Smoking areas are to be maintained in such a manner that minimizes risk of fire hazards. Observation on 02/17/26 at 9:37 A.M., of the resident smoking area between the 200-hall and 300-hall, showed many cigarette butts on the ground, in the grass and on the concrete, too numerous to count. A large plastic flowerpot/planter filled with what appeared to be sand, contained a large number of cigarettes and a variety of trash items including a plastic cup, candy wrapper, and an empty pack of cigarettes. A red fireproof metal container contained a mix of medical gloves, a blunt wrapper and paper towels mixed with cigarettes butts. Two trash cans stood on either end of the smoking area filled with a variety of trash and cigarette butts. One cigarette butt rested against the facility siding. A walkway out to the garden was littered with cigarettes in the grass and on the walkway. Two smokeless ash trays were located near the back of the smoking area. Review of Resident #53's medical record, showed:-Diagnoses included hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following a stroke affecting right dominate side and cognitive communication deficit;-A care plan showed focus initiated 01/22/26, the resident was a smoker:--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Review of Resident #69's medical record, showed:-Diagnoses included lung disease and cognitive communication deficit;-A care plan showed focus initiated 10/14/24, the resident was a smoker;--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Observation on 02/17/26 at 9:53 A.M., showed Housekeeper C entered the smoking area along with several residents. Housekeeper C passed cigarettes to the residents and assisted residents to light their cigarettes. He/She placed a smoking apron on Resident #53 and then lit his/her cigarette. At 10:08 A.M., Resident #53 placed his/her cigarette in the flowerpot/planter, and it continued to smoke. Housekeeper C did not intervene or educate the resident on the proper disposal of cigarettes. A second cigarette lay next to the flowerpot/planter on the ground and smoked. At 10:10 A.M., the cigarette on the ground stopped (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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	smoking but the one in the planter continued to smoke. At 10:11 A.M., Resident #69 threw his/her cigarette in the flowerpot/planter. Housekeeper C did not respond or educate the residents on the proper disposal of cigarettes. At 10:17 A.M., the cigarettes in the planter continued to smoke as the staff member assisted residents back into the facility. During an interview on 02/17/26 at 11:07 A.M., Housekeeper C said the Activity Director let staff know which residents had special needs, such as needing a smoking apron. Staff were to monitor residents who could not hold cigarettes safely or who accidentally dropped cigarettes. If a resident appeared to need more help than before, he/she would tell the Activity Director. There was not really any other reason why staff would intervene with residents smoking. Review of Resident #68's medical record, showed:-Diagnoses included lung disease and schizoaffective disorder (a disorder characterized by disorganized thinking);-A care plan showed focus initiated 11/17/23, the resident was a smoker:--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Review of Resident #50's medical record, showed:-Diagnoses included muscle weakness and lung disease;-A care plan showed focus initiated 01/08/24, the resident was a smoker:--Goal: Will not smoke without supervision;--Interventions included: Must smoke with smoking apron. Instruct on the facility policy on smoking: location, times, and safety concerns. Required a smoking apron. Requires supervision while smoking. Observation of the resident smoke break on 02/18/26 At 7:47 A.M., showed residents headed to the smoking area and staff passed cigarettes. At 7:55 A.M., Resident #68 stood up and placed his/her cigarette in the flowerpot/planter. He/she then went inside. Staff monitoring the smoke break did not educate the resident on the proper way to dispose of a cigarette. At 7:57 A.M., Resident #50 sat in a Broda chair (medical reclining chair) and wore a smoking apron as he/she held his/her own cigarette. A staff person stood next to him/her and held a new, unlit cigarette out to the resident. Resident #50 flicked his/her cigarette at the flowerpot/planter. It hit the edge and bounced back at him/her and landed under his/her Broda chair. The staff person handed him/her another cigarette and assisted him/her to light it. The staff person did not pick up the cigarette or educate the resident on the proper way to dispose of cigarettes. During an interview on 02/19/26 at 11:45 P.M., the Administrator said the staff monitoring resident smoke breaks were responsible to supervise the residents while they were smoking, pass out cigarettes and ensure residents were safe while smoking. Cigarettes should have been disposed of in the self-closing ash can. The flowerpot/planter and trash cans were not appropriate areas to dispose of cigarette butts. No one should throw their cigarette butts onto the ground. There should not be any trash in the self-closing ash cans or the cigarette receptacles. Housekeeping and Maintenance were responsible for maintaining the smoking areas. It should be cleaned at least daily. If the cigarette butts were not disposed of appropriately, it could lead to a fire. She expected staff to educate residents about the proper way to dispose of cigarette butts and show them where to dispose of them correctly. 27439252737724

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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** Based on observation, interview, and record review, the facility failed to follow proper infection control procedures when staff used non-medical-grade disinfectant wipes to clean the glucometer (device used to measure how much glucose (sugar) is present in the bloodstream) used on three residents (Residents #28, #46, and #48). In addition, the facility failed to store one resident's nebulizer tubing and mask per policy, creating a potential risk for cross-contamination and infection (Resident #52). The sample was 18. The census was 89. Review of the facility's Communicable Disease Management Policy, revised 10/2022, showed:-The Facility will establish Infection Prevention & Control Guidelines to prevent the transmission of infections, communicable diseases and healthcare associated infections (HAI) to ensure the safety of residents and employees;-Employees shall utilize barriers to avoid direct contact;-Employees shall implement Isolation barriers beyond standard precautions (precautions used to care of all residents regardless of their diagnosis or presumed infections status) as indicated in the following Centers for Disease Control and Prevention (CDC) Guidelines: (left blank). 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/10/26, showed:-Moderately impaired cognition;-Diagnoses included diabetes. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's physician order summary (POS), dated 2/20/26, showed a physician order, dated 8/20/25 for Novolog (rapid-acting insulin) 100 unit/milliliter (ml) flex pen, inject per sliding scale: if 151 to 250 = 3 units; 251 to 350 = 6 units; 351 to 450 = 9 units; 451 to 500 = 12 units and call physician, subcutaneously (under the skin) four times a day related to diabetes. Observation on 2/18/26 at 7:50 A.M., showed Licensed Practical Nurse (LPN) J cleaned a glucometer with a lemon-scented disinfecting wipe and placed the glucometer on a barrier on top of the medication cart. The nurse performed a blood sugar test (a small drop of blood obtained from a finger prick with a lancing device, which is placed on a disposable test strip inserted into the meter) on the resident. He/She cleaned the glucometer with the lemon-scented disinfecting wipe and placed the glucometer on the barrier on top of the medication cart. 2. Review of Resident #46's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Will be free from any signs and symptoms of hypoglycemia (low blood sugar) through the review date and will be free from any signs and symptoms of hyperglycemia (high blood sugar) through the review date;-Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's POS, dated 2/20/26, showed, an order, dated 8/5/25, for insulin lispro (rapid-acting insulin) 100 unit/ml (1 unit dial) pen, inject as per sliding scale: if 149 or less, no insulin; 150 to 199 = 1 unit; 200 to 249 = 2 units; 250 to 299 = 3 units; 300 to 350 = 4 units notify provider; 351+ = 5 units notify provider, subcutaneously (under the skin) with meals related to diabetes. Observation on 2/18/26 at 8:08 A.M., showed LPN J performed a blood sugar test on the resident using the same glucometer used on Resident #27. He/She cleaned the glucometer with a lemon-scented disinfecting wipe and placed the meter on the barrier on top of the medication cart. 3. Review of Resident #48's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes. Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included diabetes medication as ordered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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	by doctor. Monitor/document for side effects and effectiveness. Review of the resident's POS, dated 2/20/26, showed an order, dated 2/2/26, to please notify physician if blood sugar is less than 70 and more than 400 with meals for blood glucose monitoring. Observation on 2/18/26 at 8:20 A.M., showed LPN J performed a blood sugar test on the resident using the same glucometer used on Residents #27 and #46. He/She cleaned the glucometer with the lemon scented disinfecting wipe and placed the meter on the barrier on top of the medication cart. 4. During an interview on 2/20/26 at approximately 2:30 P.M., the Director of Nursing (DON), Administrator, and Corporate Nurse said staff should not use lemon-scented disinfecting wipes to clean multi-use equipment. The facility did not buy scented wipes for cleaning medical equipment. Staff should use the purple top Sani Wipes equipped with germicide content per infection control guidelines. 5. Review of Resident #52's annual MDS, dated [DATE], showed:-Diagnoses included dysphagia (swallowing disorder) following unspecified cerebrovascular disease (stroke), chronic systolic (congestive) heart failure, and muscle weakness;-Moderate depression.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has emphysema/chronic obstructive pulmonary disease with (COPD, lung disease) exacerbation;-Goal: Resident will be free of signs and symptoms of respiratory infections through review date;-Interventions included: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Monitor for difficulty breathing on exertion and for signs and symptoms of acute respiratory insufficiency.Review of the POS, dated 2/18/26, showed:-An order, dated 12/14/25, for budesonide inhalation suspension 0.5 milligrams (mg)/2 ml, 0.5mg inhaled orally two times a day for COPD exacerbation;-An order, dated 5/7/24, for arformoterol tartrate inhalation nebulization solution, 15 micrograms (mcg)/2 ml, 15 mcg inhaled orally two times a day for COPD exacerbation. Observation on 2/17/26 at 9:46 A.M., showed the resident on his/her back in bed, with the head of bed elevated approximately 30 degrees. A nebulizer mask laid across his/her lap with nebulizer machine turned on. Observations on 2/18/26 at 7:27 A.M. through 12:35 P.M., showed soiled clothing on top of the nebulizer tubing, machine, and mask, which were balled up on a chair. During an interview on 2/19/26 at approximately 3:18 P.M., LPN F said the Certified Medication Technician (CMT) or Nurse should remove the nebulizer mask from a protective pad, place the medication in the cup, apply the mask to the resident, turn on the machine, and remain nearby to observe for nosebleeds or excessive coughing. No formal monitoring was required. During an interview on 2/20/26 at approximately 2:45 P.M., the DON said she expected the nebulizer to be stored on a clean surface and for the mask and tubing to be in a plastic bag with a date and changed every week. 6. During an interview on 2/20/25 at 9:22 A.M. the facility's Corporate Nurse said the facility did not have a policy that specified best practices for cleaning and storing nebulizer masks or glucometers. 2737724