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	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Nursing and Rehabilitation 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 0567

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to manage his or her financial affairs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY U4413

Based on record review and interview, the facility failed to ensure resident funds were placed in an account separate from the facility operating account. The facility did not provide residents with refunds of their personal funds from the operating account in a timely manner for six residents (Residents #1016, #1019, #1027, #1028, #1029, and #1030). Secondly, the facility staff failed to obtain written authorization from the resident and/or financial guardian for money withdrawn for 19 residents (Resident #1001, #1002, #1003, #1004, #1005, #1006, #1007, #1008, #1009, #1010, #1011, #1012, #1013, #1014, #1015, #1019, #1020, #1023, and #1025) out of a sample of 20. Thirdly, the facility staff failed to provide the Social Security and/or Medicaid monthly allowance in a timely manner, which did not allow the resident/financial guardian the right to manage all of his/her financial affairs for seven residents (Resident #1001, #1004, #1005, #1008, #1009, #1010, and #1013) out of a sample of 10. Fourthly, the facility staff failed to withdraw the correct monthly surplus for room and board which did not allow the resident/financial guardian the right to manage all of his/her financial affairs for one sampled resident (Resident #1019). Fifthly, the facility failed to not use resident funds for checking account fees deducted from the resident trust account. Additionally, the facility failed to provide a statement explaining the facility's policies and resident's rights regarding resident funds for all residents the facility managed funds for. Lastly, the facility also failed to allow residents access to resident funds on an ongoing basis and failed to keep resident petty cash funds separate from facility funds. This had the potential to affect all residents the facility managed funds for. The facility census was 80.

1. Record review of the facility maintained Accounts Receivable Aging Report, dated [DATE], showed the following residents with personal funds held in the facility operating account.

Resident Amount Held in Operating Account

#1016 $2,243.77

#1019 $2,329.48

#1027 $26.71

#1028 $100.64

#1029 $800.10

(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: 265883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0567

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

#1030 $1,658.00

Total $7,158.70

During an interview on [DATE] at 3:35 P.M., the Business Office Manager said Residents #1027 and #1028 need refunded and was not sure what the credit was from for Residents #1016, #1019, #1029, and #1030.

2. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1001's account:

Date Amount Description

[DATE] $300.00 Cash Withdrawal Xmas

[DATE] $16.63 Cash Withdrawal

[DATE] $16.62 Cash Withdrawal Part D Plan

Record review on [DATE] of the facility maintained paperwork for Resident #1001's Resident Trust Transaction History, showed a check made payable to Resident #1001's guardian for the $300 withdrawal, but had no written authorization by Resident #1001 and/or financial guardian for any of the listed withdrawals.

During an interview on [DATE] at 9:29 A.M., Resident #1001's Guardian said he/she did receive the $300 check to do shopping for Resident #1001, but did not sign any paperwork.

3. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1002's account:

Date Amount Description

[DATE] $150.00 Miscellaneous Withdrawal

[DATE] $100.00 Cash Withdrawal

[DATE] $50.00 Cash Withdrawal

Record review on [DATE] of the facility maintained paperwork for Resident #1002's Resident Trust Transaction History, showed no written authorization by Resident #1002 and/or financial guardian for the withdrawals.

During an interview on [DATE] at 9:31 A.M., Resident #1002's Financial Power of Attorney said he/she did withdrawal money to do shopping for Resident #1002, but did not sign any paperwork.

4. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1003's account:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 Chambers Road Ferguson, MO 63135	

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date Amount Description [DATE] $200.00 Cash Withdrawal [DATE] $200.00 Cash Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1003's Resident Trust Transaction History, showed a check made payable to Resident #1003's family member for the [DATE] withdrawal, but had no documentation for the [DATE] withdrawal and did not have written authorization by Resident #1003 and/or financial guardian for any of the listed withdrawals. During an interview on [DATE] at 9:39 A.M. and 9:57 A.M., Resident #1003's Family Member said he/she did receive the money, but did not sign any paperwork. 5. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1004's account: Date Amount Description [DATE] $300.00 Miscellaneous Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1004's Resident Trust Transaction History, showed a check made payable to Resident #1004's family member for the $300.00 withdrawal, but had no written authorization by Resident #1004 and/or financial guardian for the listed withdrawal. During an interview on [DATE] at 11:05 A.M., Resident #1004's Family Member said he/she did receive the money. 6. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1005's account: Date Amount Description [DATE] $50.00 Cash Withdrawal [DATE] $100.00 Cash Withdrawal [DATE] $100.00 Cash Withdrawal [DATE] $100.00 Cash Withdrawal [DATE] $100.00 Cash Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1005's Resident Trust Transaction History, showed no written authorization by Resident #1005 and/or financial guardian for the withdrawals. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Chambers Road Ferguson, MO 63135	

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:52 P.M., Resident #1005 said he/she does withdraw usually $100 out at a time, but did not say anything about signing any paperwork. 7. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1006's account: Date Amount Description [DATE] $250.00 Cash Withdrawal [DATE] $27.20 Miscellaneous Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1006's Resident Trust Transaction History, showed a check made payable to Resident #1006's family member for the $250.00 withdrawal, but had no written authorization by Resident #1006 and/or financial guardian for any of the listed withdrawals. During an interview on [DATE] at 11:11 A.M., Resident #1006's Financial Power of Attorney said a check was received for $250. 8. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1007's account: Date Amount Description [DATE] $300.00 Miscellaneous Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1007's Resident Trust Transaction History, showed a check made payable to Resident #1007's Financial Power of Attorney for the $300.00 withdrawal, but had no written authorization by Resident #1007 and/or financial guardian for the listed withdrawal. During an interview on [DATE] at 1:24 P.M., Resident #1007's Financial Power of Attorney said a check was received for $300. 9. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1008's account: Date Amount Description [DATE] $3,500.00 Miscellaneous Withdrawal [DATE] $3,508.00 Funeral Home Record review on [DATE] of the facility maintained paperwork for Resident #1008's Resident Trust Transaction History, showed checks made payable to Resident #1008's family member for the $3,500 and $3,508 withdrawals, but had no written authorization by Resident #1008 and/or financial guardian for any of the listed withdrawals. (continued on next page)

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review on [DATE] of the facility maintained copies of cleared checks for Check #1043 in the amount of $3,500 and check #1045 in the amount of $3,508 showed Resident #1008's family member's name signed on both checks.

During an interview on [DATE] at 11:59 A.M., Resident #1008's family member said he/she was told by the Business Office Manager to pick up a $3,500 check due to a back payment.

10. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1009's account:

Date Amount Description

[DATE] $1,855.00 Miscellaneous Withdrawal/Burial

[DATE] $100.00 Cash Withdrawal

Record review on [DATE] of the facility maintained paperwork for Resident #1009's Resident Trust Transaction History, showed a check made payable to a funeral home for $1,855. Review showed no written authorization by Resident #1009 and/or financial guardian for any of the listed withdrawals. Review showed no documentation regarding the $100 withdrawal.

11. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1010's account:

Date Amount Description

[DATE] $1,500.00 Cash Withdrawal

[DATE] $1,000.00 Miscellaneous Withdrawal

[DATE] $500.00 DEPOSIT

[DATE] $141.55 Cash Withdrawal Part D Plan

Record review on [DATE] of the facility maintained paperwork for Resident #1010's Resident Trust Transaction History, showed a check #1042 made payable to Resident #1010's family member for the $1,000 withdrawal and check #1040 dated [DATE], made payable to the Administrator in the amount of $2,000 for Resident #1010's cash.

Record review on [DATE] of the MDS, shows Resident #1010 discharged from the facility on [DATE].

Record review on [DATE] shows a facility prepared typed statement was signed by Resident #1010 on [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 Chambers Road Ferguson, MO 63135	

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:15 P.M., Resident #1010 said the Administrator called him/her at his/her new facility on [DATE]. The resident didn't understand what he was talking about. Then the Business Office Manager called him/her. The resident said the Business Office Manager visited him/her on [DATE] at his/her new facility. The Business Office Manager came with a typed prepared statement which the resident signed. The resident said he/she had just had a bed bath and was asleep when the Business Office Manager arrived to his/her room. The amount typed on the statement was not correct. It was $1,000, not $2,000 that he/she withdrew. He/She does not remember his/her son getting $1,000 from the Business Office Manager. Normally, he/she would sign the receipt and his/her son would be given money at the same time. During an interview on [DATE] at 9:54 A.M., Resident #1010's Financial Power of Attorney said he/she only recalls receiving a $1,000 check and not $1,500 and would think about it. During an interview on [DATE] at 2:34 P.M., Resident #1010's Financial Power of Attorney said he/she only received a $1,000 check and no cash and said the Business Office Manager said the $1,000 could be spent on funeral or anything else. During an interview on [DATE] at 2;56 P.M., Resident #1010's Financial Power of Attorney/Family Member said the following: -He/She only remembers receiving one check for $1,000 from the Business Office Manager. -He/She went to the facility to visit Resident #1010 when the Business Office Manager said Resident #1010 had a backpay and Resident #1010's Financial Power of Attorney/Family Member could have a $1,000 check to use for funeral planning or anything he/she wanted to use it for. -He/She never saw the Business Office Manager at the facility on a weekend when he/she would visit Resident #1010. -He/She checked with his/her spouse and Resident #1010 and he/she did not receive any cash from the Business Office Manager. During an interview on [DATE] at 1:35 P.M., the Business Office Manager said there were no signed documents located for the listed withdrawals. Resident #1010's Family Member came into the office and the Business Office Manager gave him/her the money or was pretty sure he/she gave Resident #1010's family member the cash on a weekend. The Business Office Manager said he/she was not sure how he/she ended up with the cash to give out. During an interview on [DATE] at 3:51 P.M., the Business Office Manager said the Activity Director asked the Co-Owner to write a check for cash for Resident #1010. The Business Office Manager said Resident #1010's family member came into the facility on a Saturday and wanted $500 cash and the Business Office Manager gave the $500 cash to him/her. During an interview on [DATE] at 1:58 P.M., the Activity Director said he/she did not receive a $1,000 or $1, 500 cash for Resident #1010. The Activity Director said $500.00 cash was kept in the office for Resident #1010 to spend. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Chambers Road Ferguson, MO 63135	

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:51 P.M., the Activity Director said he/she did not have a request to withdrawal $1,500 and $500 cash was being kept for Resident #1010 in the office. The Activity Director did not know if the $500 deposit on [DATE] was from the $1,500 withdrawal. 12. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1011's account: Date Amount Description [DATE] $595.00 Miscellaneous Withdrawal Correction [DATE] $595.00 Surplus ,d+[DATE] [DATE] $20.00 Cash Withdrawal [DATE] $20.00 Cash Withdrawal [DATE] $141.55 Cash Withdrawal Part D Plan [DATE] $15.00 Cash Withdrawal [DATE] $20.00 Cash Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1011's Resident Trust Transaction History, showed no written authorization by Resident #1011 and/or financial guardian for any of the listed withdrawals. Record review on [DATE] of the facility maintained paperwork for Resident #1011's Resident Trust Transaction History, showed the Resident's Petty Cash Withdrawal Sheet had Resident #1011's name listed for the [DATE], [DATE] and [DATE] withdrawals with no written authorization. Record review on [DATE] of the facility maintained Admission Face Sheet showed Resident #1011 is his/her own Responsible Party. During an interview on [DATE] at 2:59 P.M., Resident #1011 said he/she does not take any money out. 13. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1012's account: Date Amount Description [DATE] $141.55 Cash Withdrawal Part D Plan Record review on [DATE] of the facility maintained paperwork for Resident #1012's Resident Trust Transaction History, showed no written authorization by Resident #1012 and/or financial guardian for the withdrawal. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1013's account: Date Amount Description [DATE] $22.70 Miscellaneous Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1013's Resident Trust Transaction History, showed no written authorization by Resident #1013 and/or financial guardian for the withdrawal. 15. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1014's account: Date Amount Description [DATE] $200.00 Cash Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1014's Resident Trust Transaction History, showed no written authorization by Resident #1014 and/or financial guardian for the withdrawal. During an interview on [DATE] at 3:04 P.M., Resident #1014 said he/she thinks his/her family member received the $200, but nothing was signed. During an interview on [DATE] at 11:22 A.M., Resident #1014's Family Member said he/she did receive $200. 16. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1015's account: Date Amount Description [DATE] $25.00 Cash Withdrawal Record review on [DATE] of the facility maintained paperwork for Resident #1015's Resident Trust Transaction History, showed no written authorization by Resident #1015 and/or financial guardian for the withdrawal. 17. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed a withdrawal from Resident #1019's account: Date Amount Description [DATE] $5,175.00 Funeral Home (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on [DATE] of the facility maintained documentation showed check #1046 in the amount of $5, 175.00, dated [DATE], made payable to Resident #1019's family member and no written authorization by Resident #1019 and/or financial guardian for the withdrawal. During an interview on [DATE] at 9:14 A.M., Resident #1019's family member said the Business Office Manager called him/her and said there was a backpay that came in for Resident #1019 and Resident #1019's family member could come by the facility and pick up a check. During an interview on [DATE] at 9;34 A.M., Resident #1019's family member said there was no receipt given to Resident #1019's family member. 18. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1020's account: Date Amount Description [DATE] $8,464.00 Misc. Withdrawal Correction Record review on [DATE] of the facility maintained paperwork for Resident #1020's Resident Trust Transaction History, showed no written authorization by Resident #1020 and/or financial guardian for the withdrawal. Record Review also showed the following credited to Resident #1020's Resident Trust Transaction History: Date Amount Description [DATE] $4,182.00 Misc. Withdrawal Correction [DATE] $2,091.00 Misc. Withdrawal Correction During an interview on [DATE] at 1:20 P.M., the Business Office Manager said he/she did not know where the remaining money went and there was no documentation. 19. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawal from Resident #1023's account: Date Amount Description [DATE] $594.00 Surplus Record review of the facility maintained Discharge Report showed Resident #1023 Expired on [DATE]. During an interview on [DATE] at 12:14 P.M., the Business Office Manager said the $594.00 was used for back surplus and he/she did not know the amount should have been reported to the Department of Social Services, Third Party Liability Unit. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following withdrawals from Resident #1025's account: Date Amount Description [DATE] $1,850.00 Miscellaneous Withdrawal [DATE] $152.99 Miscellaneous Withdrawal Correction Record review on [DATE] of the facility maintained paperwork for Resident #1025's Resident Trust Transaction History, showed no written authorization by Resident #1025 for the withdrawals. Record review of the facility maintained Admission Record/Face Sheet showed Resident #1025 was his/her own person. Resident #1025 Expired on [DATE]. During an interview on [DATE] at 2:03 P.M., the Owner and Co-Owner said the $1,850 and $152.99 withdrawals were done in error and the money would be sent to the Department of Social Services, Third Party Liability Unit. 21. During an interview on [DATE] at 1:20 P.M., the Business Office Manager said if a resident could talk, he/she did not obtain the written authorization for withdrawals. 22. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed the following residents did not receive the $50 Social Security/Medicaid monthly allowance timely for ,d+[DATE]: Resident # Amount Received #1001 $0 #1004 $0 #1005 $0 #1013 $0 23. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed Resident #1008 did not receive the $50 Social Security/Medicaid monthly allowance timely for the following months: Month Amount Received ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $24.00 (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	24. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed Resident #1009 did not receive the $30 Social Security monthly allowance timely for the following months: Month Amount Received ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $0 25. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed Resident #1010 did not receive the $50 Social Security/Medicaid monthly allowance timely for the following months: Month Amount Received ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $0 ,d+[DATE] $0 26. During an interview on [DATE] at 12:50 P.M., the Business Office Manager said he/she did not know why residents did not receive the monthly allowance. 27. Record review of the facility maintained Resident Trust Transaction History for the period [DATE] through [DATE], showed Resident #1019 had the incorrect withdrawals for room & board: Date Month Amount Withdrawn [DATE] ,d+[DATE] $929.00 [DATE] ,d+[DATE] $929.00 Record review on [DATE] of the facility maintained Transaction Report by Effective Date, dated [DATE] showed Resident #1019 was billed $553/month for room and board for ,d+[DATE] through ,d+[DATE]. Record review on [DATE] of the Medicaid Nursing Home Surplus History Screen provided by Missouri HealthNet Division on [DATE], showed Resident #1019's Care Cost Surplus amount for room & board should be $553 for ,d+[DATE]. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28. Record review of the facility maintained resident trust bank statement showed the facility did not reimburse the resident trust bank account for bank fees for the following months. Month Amount Description ,d+[DATE] $0.15 Analysis Fee ,d+[DATE] $1.08 Analysis Fee ,d+[DATE] $0.36 Analysis Fee ,d+[DATE] $0.48 Analysis Fee Email correspondence dated [DATE] at 1:09 P.M. to the Business Office Manager, requested documentation showing the fees had been reimbursed back to the resident trust account from the operating account. As of [DATE] the documentation had not been received. 29. Record review of the facility maintained Admission Agreements showed the facility did not obtain documentation showing if the resident wanted their funds managed or not by the facility for the following residents: Resident #1004 #1016 #1017 #1018 During an interview on [DATE] at 3:14 P.M., the Business Office Manager said there was nothing in the Admission Packet regarding resident funds. 30. Observation on [DATE] at 9:54 A.M., showed a paper displayed on the Activity Director's wall named Resident Banking Hours listing the hours of operations when residents can receive funds as Monday - Friday 9:30 A.M. - 10:30 A.M. and 11:30 A.M. - 3:00 P.M. During an interview on [DATE] at 9:47 A.M., the Activity Director said residents can get funds during the hours listed. 31. Observation on [DATE] at 9:47 A.M., showed no resident petty cash available to residents. During an interview on [DATE] at 9:47 A.M., the Activity Director said the resident petty cash had not been replenished and there had been no resident petty cash on hand since [DATE]. The Activity Director also said if residents wanted resident petty cash, he/she would ask the Co-Owner for cash and the Co-Owner would give his/her personal funds to the Activity Director for the residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 Chambers Road Ferguson, MO 63135	

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:00 A.M., the Co-Owner said he/she would give resident petty cash out of the Co-Owner's personal funds.

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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. U4413 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 21 residents. The census was 80. 1. Record review of the facility maintained bank statements for account ending in #5015 for months 03/2023 through 12/2023 and 02/2024 - 03/2024 showed no documentation of reconciliations. Record review of the facility maintained attempted reconciliation forms for account ending in #5015, dated 09/2023 and 03/2024, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of reconciliation. During an interview on 05/10/24 at 3:37 P.M., the Business Office Manager said he/she did not start reconciling the account until 08/2023 and continued to say the accounts were reconciled, but did not have any other documentation to provide.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** U4413 Based on record review and interview, the facility failed to provide a final accounting of resident fund balances within thirty days to the individual or probate jurisdiction administering the resident's estate for one discharged resident (Resident #1020) out of a sample of three discharged and four expired residents (Resident #1019, #1023, #1025, and #1026) out of a sample of five expired. The facility census was 80. 1. Record review of the facility maintained Trust Transaction History Report dated [DATE], showed Resident #1020 discharged on [DATE]. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed Resident #1020 had $30.00 deposited on [DATE] and was not refunded as of [DATE], 33 days after discharge date . During an interview on [DATE] at 1:54 P.M., the Business Office Manager said he/she did not know why the $30 had not been refunded. 2. Record review of the facility maintained Discharge Report dated [DATE], showed Resident #1019 expired on [DATE]. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed Resident #1019 had $50.00 deposited on [DATE] and was not refunded until [DATE], 81 days after expire date. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed a withdrawal in the amount of $50.00 on [DATE] noted to close account. Record review of the facility maintained resident trust documentation on [DATE], showed no documentation showing where the $50.00 went. During an interview on [DATE] at 1:54 P.M., the Business Office Manager said the $50.00 was refunded to Resident #1019's family member, but could not find documentation to show where the funds went and did not know why it was longer than the timeframe to refund the $50.00. 3. Record review of the facility maintained Discharge Report dated [DATE], showed Resident #1023 expired on [DATE]. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed Resident #1023 had a balance of $929.88 as of [DATE] and was not reported to the Department of Social Services, Third Party Liability Unit as of [DATE], 206 days after the expire date. Review showed the following withdrawals after expire date: Date Amount Description (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] $594.00 Surplus [DATE] $335.88 Close Trust Account During an interview on [DATE] at 12:14 P.M., the Business Office Manager said the $594.00 was used for back surplus and the $335.88 went to the facility operating account and did not know the full $929.88 should have been reported to the Department of Social Services, Third Party Liability Unit. 4. Record review of the facility maintained Discharge Report dated [DATE], showed Resident #1025 expired on [DATE]. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed Resident #1025 had a balance of $277.84 as of [DATE] and was not reported to the Department of Social Services, Third Party Liability Unit as of [DATE], 175 days after the expire date. Review showed the following withdrawal after expire date: Date Amount Description [DATE] $277.84 Close Trust Account Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed a withdrawal in the amount of $277.84 on [DATE] noted to close account. Record review of the facility maintained resident trust documentation on [DATE], showed no documentation showing where the $277.84 went. During Email Correspondence dated [DATE] at 2:04 P.M., the Business Office Manager said the money will be sent to the Department of Social Services, Third Party Liability Unit and did not say where the previous $277.84 went. 5. Record review of the facility maintained Discharge Report dated [DATE], showed Resident #1026 expired on [DATE]. Record review of the facility maintained Trust Transaction Report for the period [DATE] through [DATE], showed Resident #1026 had a balance of $402.17 as of [DATE] and was not reported to the Department of Social Services, Third Party Liability Unit as of [DATE], 231 days after the expire date. Review showed the following withdrawal after expire date: Date Amount Description [DATE] $402.17 Close Trust Account During an interview on [DATE] at 1:50 P.M., the Business Office Manager said the $402.17 was transferred to the facility operating account. During an interview on [DATE] at 12:14 P.M., the Business Office Manager said the remaining money for Resident #1026 went to the facility operating account and he/she did not know the amount should have been reported to the Department of Social Services, Third Party Liability Unit.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 30687 Based on interview and record review, the facility failed to maintain an adequate surety bond for the resident trust fund account in the amount of one and one half times the average monthly balance for the past 11 months. The census was 80. Review of the resident trust account for the past 12 months, from March 2023 through February 2024, (excluding the December 2023) showed an average monthly balance of $26,000.00 (this would yield a required bond in the amount of $39,000.00 (one and one half times the average monthly balance)). Review of the bond report for approved facility bonds by the Department of Health and Senior Services (DHSS), showed an approved bond of $4,000.00, dated 8/23/21. Review of the resident trust current balance report for February 2024, showed an amount of $13,782.56 in the trust account. During an interview on 5/7/24 at 11:30 A.M., the Business Office Manager (BOM) said the Administrator was in charge to ensure the surety had the appropriate amount. The BOM did not know how often the Administrator reviewed the surety bond. They do not have a policy for the surety bond. During an interview on 5/9/24 at 11:41 A.M., the Administrator said he was in charge to ensure the bond was the appropriate amount. He was not aware he needed $39,000.00 for the bond. He said he will get it increased.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 36461 Based on observations and interviews, the facility failed to post the location of the state survey results and provide unrestricted access to residents and visitors, resulting in the potential for current residents, visitors, and potential residents not to be able to review the survey results and the facility's plans of correction (POC). Findings include: Observations conducted throughout the facility from 04/29/24 to 05/01/24 revealed no notices posted in the facility to notify residents or visitors where the survey results binder was located. A binder labeled Survey Results was located behind the front desk on 04/29/24 when the survey team entered. Review of the Survey Results binder on 05/01/24 revealed documentation from a Targeted Infection Control survey completed on 04/18/22. The documentation did not contain the facilities POC. During an interview on 04/30/24 at 4:30 PM, the Administrator and Director of Nursing (DON) stated the Survey Results binder was kept behind the receptionist's desk. The Administrator stated a binder had been placed in the lobby area at one time, but .someone took it, so now we keep it behind the front desk . The Administrator was questioned by this surveyor regarding the incomplete survey results in the binder and he stated .I have all of that in my office .

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and facility policy review, the facility failed to issue an accurate Notice of Medicare Non-Coverage (NOMNC) when Medicare Part A service was ending for three of three residents (Residents (R) 1, R25, and R67) reviewed out of a total sample of 24 residents. This failure could have led the residents or their responsible party to miss the deadline to request an expedited appeal and review. Findings include: The facility used the directions for completion of the NOMNC from the Centers for Medicaid and Medicare Services (CMS) form number CMS-10123 as their policy. The directions indicated that in the heading and first two bullet points of the NOMNC the form was to read, .The effective date your {insert type} services will end: {insert effective date}: Fill in the type of services ending, {home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice} and the actual date the service will end. The portion of the NOMNC detailing how to ask for an immediate appeal was to include, .Insert the name and telephone numbers (including TTY) (text to type and phone service for the hearing impaired) of the applicable QIO (Quality Improvement Organization). The facility issued a CMS-10095 to all three residents. Review of the NOMNCs issued to R1, R25, and R67 revealed there was no indication of the type of current services that were ending and that they may have to pay for any of those services received after the last covered day (LCD). All three notices did not include the name, phone number, and TTY number of the QIO. On 05/01/24 at 11:06 AM the MDS Coordinator (MDSC) revealed she was completing and issuing the NOMNC to the resident or their responsible party. She stated she was provided the CMS-10095 by an advisor who was the clinical educator at [NAME] (Missouri University) School of Nursing. She was not aware she was using the incorrect form to notify residents and their representatives.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure two of three residents (Resident (R)54 and R45) reviewed for abuse out of a total sample of 24 did not engage in verbal threats that escalated to physical abuse of kicking and slapping each other. R45 suffered psychosocial harm following the incidents as evidenced by her fearful comments to her psychiatric Nurse Practitioner and to other staff members. Findings include: Review of the facility's policy titled Abuse Prevention Program revised December 2016, revealed .Our residents have the right to be free from abuse, neglect, misappropriation and exploitation. This includes freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse .As part of the abuse prevention the administration will: 1. Protect our residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, vendors, visitors, family members, or any other individual . Review of the facility's reportable incidents with a look back period of January 2023 to May 2024 revealed both verbal and physical altercations occurred between R54 and R45. Once on 11/21/23 and again on 03/24/24, with both residents cursing, kicking and hitting each other. 1. R54 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and history of a traumatic brain injury sustained during an arrest several years ago. Review of R54's Minimum Data Set (MDS) assessments with an Assessment Reference Dates (ARD) of 10/13/23, 01/13/24, and 04/14/24 revealed Brief Interview for Mental Status (BIMS) scores of 10, nine, and 10, respectively which indicated moderate cognitive impairment. During the survey, R54 did not participate meaningfully in interviews when attempted, but he was observed each day of the survey exhibiting disruptive and verbally abusive behavior directed at staff and other residents. R54 was ambulatory via wheelchair and was rarely found in his room. Throughout the five-day survey, R54 was observed yelling and shouting vulgarities towards other residents and staff. Most of his behaviors were focused on his desire to go outside to smoke. Interviews with direct care staff (Certified Nurse Aide (CNA) 1 and Certified Medication Technician (CMT) 1 on 04/30/24 at 11:30 A. M. revealed they were unable to predict and/or prevent R54's behaviors. One intervention on his care plan was to have R54 on 15 minute checks but that intervention usually lasted 48-72 hours, situationally, and in response to his abusive behaviors, not as a deterrent. CNA1 stated .I try to keep him in sight all the time - but I can't watch him if I'm helping another resident that needs to go to the bathroom or whatever they need . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a facility investigation revealed on 11/21/23, R54 propelled himself to R45's room and stated, Suck my dick. R45 hit R54 on the head with her reacher/grabber tool and then R54 kicked R45. Next R45 kicked R54 back and threw water on R54. The kicking went back and forth until the two were separated by staff. After the separation, R54 continued to yell and threaten R45 and stated he will shoot everybody in this building. Cross Reference: F609 Reporting and F610 Investigation of allegations of abuse. Immediately after this incident, the facility transferred R54 to the hospital for a Geri-psychiatric evaluation. He returned the same night with no new orders to manage his behaviors. R54 was moved to a different room and placed on 15-minute checks for 72 hours. The next incident occurred on 03/24/24, when R54 propelled himself to the end of the hall near R45's room. Staff did not hear if any words were exchanged but saw R54 standing over R45 and hitting her on her head. R45 returned blows by hitting R54 with her reacher/grabber tool. Staff separated the residents. When asked by staff why he (R54) was near R45's room, R54 stated that he was looking for his room and then stated, I saw that bitch who threw water on me. She thinks I forgot. I don't forget shit and I hit her . Both residents were assessed and neither had any physical injuries from the incident. 2. R45 was admitted to the facility on [DATE] with diagnosis of vascular dementia and osteoarthritis and a BIMS score of 15 which indicated R45 was cognitively intact. She was ambulatory via specialty wheelchair. R45 was interviewed on 04/30/24 at 12:45 PM and confirmed the incident with R54 as described. She stated . nobody [sic] going to talk to me that way - if he does it again, I'll take care of it again - I take up for myself. R45 stated that her room is on the other side of the building now, but she occasionally sees R54 in the dining room and she stays away from him. When asked directly about the incident she remembered it and stated that she doesn't sleep well now .due to keeping watch on her door -so that man doesn't come in and do something to her . She stated she does feel more secure since her move off the hall where R54 resides, but she still sleeps with an eye on the door . Medical record review revealed that R45 was seen by psychiatry once monthly. Review of a Psychiatric Nurse Practitioner's progress note dated 04/09/24 and found in the Progress Note tab of the EMR revealed . Psych Impression: [R45 name] is an [AGE] year old resident at [facility name]. She complains of not sleeping at night because she has to watch for strange men coming in her room. Staff report she curses at them from time to time. This seems to be her personality and not necessarily a behavior issue addressed with medication . In the prior psychiatric visits, R45 mentioned that she slept well except for one time she complained of pain in her knees when trying to sleep. An interview with the Director of Nursing (DON) on 04/30/24 at 3:15 PM revealed the facility had sought alternate placement for R54 due to his aggressive behaviors, . and no-one will take him [R54] because of his behaviors. He has a sister that can't care for him in her home so he is here, and we have to play it by ear and try to stay between him and trouble .but it's not fair for the other residents to see him get his way every time he wants something by being loud, vulgar, and stubborn - he won't stop until he gets his way . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Medical Director (MD) on 05/03/24 at 12:15 PM by phone, the MD stated he has intermittently provided situational or one-time orders to manage R54's behaviors when he was out of control until he could be re-evaluated by psych. He did not have specific information about the two incidents identified above.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** U4413 Based on record review and interview, the facility failed to ensure three residents (Residents #1008, #1010, and #1019) were free from misappropriation of resident property when the Business Office Manager used resident funds for his/her personal use. The census was 80. 1. Record review of the facility maintained Trust Transaction Report for the period 05/01/23 through 05/07/24, showed a withdrawal from Resident #1019's account: Date Amount Description 10/10/23 $5,175.00 Funeral Home Record review of the facility maintained documentation showed check #1046 in the amount of $5,175.00, dated 10/10/23, made payable to Resident #1019's family member. Record review of the facility maintained documentation showed the Business Office Manager provided a Statement of Funeral Goods and Services Selected from a funeral home in Maplewood, MO showing the following: -Resident #1019's handwritten name at the top of the form -The Statement was originally dated 05/01/2018 at the top of the bill and showed the bill was paid in full on 05/17/23 at the bottom of the bill. -The date signed as 10/07/2023. The year was whited out and 2023 was written in. -The co-signed date also had white out over the last digit of the year and 3 was written to show as 2023. Record review of the facility maintained documentation showed the Business Office Manager also provided a Detailed Customer History Page from the funeral home showing the following: -The date at the top of page 1 showed as 05/17/21 02:28 P.M. -The date as 05/17/2023 showed white out had been used and a 3 written in after the 202X. -The Buyer name and Services For name showed white out in both places and had Resident #1019's name written in both places. -Page 2 showed the date as 05/17/202X with the last digit being whited out with no number written in. -The Buyer name and Services For name also showed white out in both places and had Resident #1019's name written in both places. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/22/24 at 9:14 A.M., Resident #1019's family member said the following: -A different funeral home was used and paid for and did not know anything about any funeral home in Maplewood, MO. -The Business Office Manager called him/her and said there was a backpay that came in for Resident #1019 and Resident #1019's family member could come by the facility and pick up a check. -Resident #1019's family member went to the facility and picked up a check in the amount of $5,175. -He/She was told by the Business Office Manager to cash the check at a Bank & Trust on [NAME] and [NAME] Street and bring $2,000 back to the facility parking lot and call the Business Office Manager's cell phone number. -The Business Office Manager would come out to the car and get the cash. -Resident #1019's family member was going to check phone records to verify the phone number. During an interview on 05/22/24 at 9;34 A.M., Resident #1019's family member said the following: -He/she was unable to locate the Business Office Manager's cell phone number he/she called. -He/She was told by the Business Office Manager to call when he/she was back at the facility parking lot. -Resident #1019's family member did confirm the Business Office Manager's first name and said he/she was the person that worked in the Business Office right before Resident #1019 passed away on 12/10/23. -Resident #1019's family thought it was odd the Business Office Manager wanted the $2,000 cash amount. -The Business Office Manager said the facility needed the $2,000 back. -There was no receipt given to Resident #1019's family member. During Email Correspondence dated 05/24/24 at 9:32 A.M., 9:39 A.M. and on 05/27/24 at 9:32 A.M., Resident #1019's family member said the following: -He/She received a phone call from the Business Office Manager to come and pick up the check and cash it at a Bank and Trust Company on [NAME] and [NAME]. -To bring the cash back and call the Business Office Manager's cell phone when he/she was at the parking lot and the Business Office Manager would come out and get the money. -The Business Office Manager said Resident #1019's family member should keep $3,000 and some dollars and the Business Office Manager was given $2,000 and some dollars. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A receipt was not given by the Business Office Manager. -Resident #1019's family member described the Business Office Manager. During an interview on 05/22/24 at 2:57 P.M., Funeral Home Staff said there was no policy for Resident #1019 and UMB Bank takes care of the funeral policies and would ask someone from UMB Bank to confirm if there was a policy or not for Resident #1019. During an interview on 05/22/24 at 3:00 P.M., UMB Senior Trust Administrator said there was no policy for Resident #1019 and the Statement of Funeral Goods and Services Selected from a funeral home in Maplewood, MO in question belongs to a different person and was dated back in 2018. During an interview on 05/23/24 at 12:14 P.M., the Business Office Manager said he/she had no clue why the funeral home papers were altered and Resident #1019's family gave him/her the funeral papers. The Business Office Manager denied receiving cash from Resident #1019's family member. 2. Record review of the facility maintained Resident Trust Transaction History for the period 05/01/23 through 05/07/24, showed the following withdrawals/deposits from Resident #1010's account: Date Amount Description 08/31/23 $1,500.00 Cash Withdrawal 09/22/23 $1,000.00 Miscellaneous Withdrawal 09/30/23 $500.00 Deposit Record review on 05/07/24 of the facility maintained paperwork for Resident #1010's Resident Trust Transaction History, showed check #1042 dated 09/22/23, made payable to Resident #1010's family member for the $1,000 withdrawal and check #1040 dated 09/18/23, made payable to the Administrator in the amount of $2,000 for the $1,500 withdrawal for Resident #1010's cash. Record review on 05/07/24 and 05/15/24 of facility maintained paperwork for Resident #1010's Resident Trust Transaction History showed a deposit slip dated 09/22/23 depositing $500 cash for Resident #1010 with the following written by the Business Office Manager - Resident #1010 wanted $1500 dollars changed his/her mind and wanted $1,000 so we are putting back $500. Record review on 05/31/24 of the MDS shows Resident #1010 discharged from the facility on 05/09/24. Record review on 05/31/24 shows a facility prepared typed statement taken to Resident #1010, by the Business Office Manager, was signed by Resident #1010 on 05/30/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/24 at 2:15 P.M., Resident #1010 said the Administrator called him/her at his/her new facility on 5/29/24. The resident didn't understand what he was talking about. Then the Business Office Manager called him/her. The resident said the Business Office Manager visited him/her on 5/30/24 at his/her new facility. The Business Office Manager came with a typed prepared statement which the resident signed. The resident said he/she had just had a bed bath and was asleep when the Business Office Manager arrived to his/her room. The amount typed on the statement was not correct. It was $1,000, not $2,000 that he/she withdrew. He/She does not remember his/her son getting $1,000 from the Business Office Manager. Normally, he/she would sign the receipt and his/her son would be given money at the same time. During an interview on 05/15/24 at 9:54 A.M., Resident #1010's Financial Power of Attorney said he/she only recalls receiving a $1,000 check and not $1,500 cash and would think about it. During an interview on 05/15/24 at 2:34 P.M., Resident #1010's Financial Power of Attorney said he/she only received a $1,000 check and no cash and said the Business Office Manager said the $1,000 check could be spent on funeral or anything else. During an interview on 05/15/24 at 1:35 P.M., the Business Office Manager said there were no signed documents located for the listed withdrawals. Resident #1010's Family Member came into the office and the Business Office Manager gave him/her the $1,000 cash on a Saturday, or was pretty sure he/she gave Resident #1010's family member the cash. The Business Office Manager said he/she was not sure how he/she ended up with the cash to give out. During an interview on 05/24/24 at 2;56 P.M., Resident #1010's Financial Power of Attorney/Family Member said the following: -He/She only remembers receiving one check for $1,000. -He/She went to the facility to visit Resident #1010 when the Business Office Manager said Resident #1010 had a backpay. -He/She could have a $1,000 check to use for funeral planning or anything he/she wanted to use it for. -He/She never saw the Business Office Manager at the facility on a weekend when he/she would visit Resident #1010. -He/She checked with his/her spouse and Resident #1010 and he/she did not receive any cash from the Business Office Manager. During an interview on 05/15/24 at 1:58 P.M., the Activity Director said he/she did not receive neither $1,000 or $1,500 cash for Resident #1010. The Activity Director said $500.00 cash was kept in the office for Resident #1010 to spend. During an interview on 05/15/24 at 3:51 P.M., the Activity Director said the following: -He/She did not have a request to withdrawal $1,500 or $2,000 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/27/23 $3,500.00 Miscellaneous Withdrawal 10/31/23 $3,508.00 Funeral Home Record review on 05/28/24 of the facility maintained documentation showed the following: -Check #1043 in the amount of $3,500, dated 09/27/23, made payable to Resident #1008's family member. -Check #1045 in the amount of $3,508, dated 10/05/23, made payable to Resident #1008's family member. -Resident #1008's family member's signature on the back of both cleared checks. During an interview on 05/16/24 at 2:40 P.M., Resident #1008's family member said the following: -He/She received a call from the Business Office Manager regarding a back payment into Resident #1008's account and he/she could pick up a $3,500 check. -He/She was told to bring cash back and give to the Business Office Manager for the facility. -He/She questioned the Business Office Manager why he/she had to bring cash back, but did not remember the response. During Email Correspondence dated 05/28/24 at 8:35 A.M., Resident #1008's family member wrote the following: -After the check was cashed he/she met the Business Office Manager in front of the facility. -The Business Office Manager came out to Resident #1008's family member's truck and the Business Office Manager was given $2,000. -After thinking about this, he/she made a call to the Business Office Manager's cell phone and questioned why the check was written for $3,500 instead of $1,500 since it did not make sense to give cash back to the Business Office Manager. -The Business Office Manager was not at work when Resident #1008's family member called the facility, and the Business Office Manager said the family member could pick the $2,000 back up on Wednesday. -Resident #1008's family member met the Business Office Manager on a Wednesday and the $2,000 was returned to him/her. -Personal bank statement showing $2,200 withdrawal was made on 09/28/23 to give the Business Office Manager $2,000 cash. During an interview on 05/15/24 at 2:45 P.M., the Activities Director said the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There were no withdrawal requests for the listed dates. -The highest amount he/she would request for resident petty cash would be $100. -He/She did not know the process for requesting larger amounts. -A larger withdrawal would be done by the Business Office Manager. During an interview on 05/15/24 at 3:47 P.M., the Business Office Manager said the $3,500 withdrawal was to pay another facility that Resident #1008 owed money to. MO00236578

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30687 Based on interview and record review, the facility failed to ensure newly hired employees were screened to rule out the presence of a Federal Indicator, with the Certified Nurse Aide (CNA) Registry for three staff members. In addition, the facility failed to check for nursing licensing for one Registered Nurse (RN) and three Licensed Practical Nurses (LPN). A sample of 10 employees hired were reviewed. The facility hired at least 200 new employees since the last survey. The census was 80. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy, dated April 2021, showed the following: -Policy: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -Review of the facility's policy showed no documentation regarding employee screening for background check, licensing or CNA registry. 1. Review of Dietary Aide (DA) A's employee file, showed the following: -Hire date: 10/17/23; -No CNA registry check performed. 2. Review of DA B's employee file, showed the following: -Hire date: 11/7/23; -No CNA registry check performed. 3. Review of CNA C's employee file, showed the following: -Hire date: 2/6/24; -No CNA registry check performed. 4. Review of LPN D's employee file, showed the following: -Hire date: 7/17/23; -No licensing check performed. 5. Review of RN E's employee file, showed the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hire date: 1/2/24; -No licensing check performed. 6. Review of LPN F's employee file, showed the following: -Hire date: 1/4/24; -No licensing check performed. 7. Review of LPN G's employee file, showed the following: -Hire date: 2/21/24; -No licensing check performed. 8. During an interview on 5/9/24 at 8:04 A.M., the Business Office Manager/Human Resource Manager (HRM) said he/she should be checking the CNA registry and the checking for nurse's licenses but did not know what website to use. 9. During an interview on 5/9/24 at 12:35 P.M., the Administrator said he was not aware the CNA registry was not being checked for all employees and that the licenses were not being check for nurses. The HRM should be performing these tasks.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, resident and staff interviews, and facility policy review, the facility failed to report to the State Survey Agency (SA) a verbal threat to shoot residents and staff in the facility by one of six residents (Resident (R)54) reviewed for abuse out of a total of 24 sampled residents. This failure increased the risk that additional verbal threats would continue without the SA's knowledge and opportunity to investigate. Findings include: Review of the facility's policy titled Abuse Investigation and Reporting revised December 2016, revealed Policy Statement - All reports of resident abuse, neglect .mistreatment shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . R54 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and history of traumatic brain injury sustained during an arrest. Review of R54's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R54 was ambulatory via wheelchair. He did not participate meaningfully in interviews when attempted, but he was observed each day of the survey exhibiting disruptive and verbally abusive behavior directed at staff and other residents. On 04/29/24 at 12:50 PM and again on 05/01/24 at 10:30 AM, R54 was observed near the nurse's station on the 300-hall. When spoken to, he looked up and cursed, let me out of here! I want a [GD] cigarette .R54 continued to curse as he wheeled away from the nurses station towards the door. Interviews with staff that care for R54 routinely, Certified Nurse Aid (CNA)1 and Certified Medication Tech (CMT) 1 agreed that they were unable to predict or redirect R54's behaviors much of the time. CNA1 stated he eventually gets his way and gets to go smoke to keep his behaviors from escalating and taking out his anger on other residents. CNA1 stated. I try to keep him in sight all day so he doesn't get in trouble - or give nobody [sic] trouble . Review of the electronic medical record (EMR) confirmed intermittent 48-72 hour periods of 15-minute checks documented in the Misc tab of the EMR. Further review of the EMR revealed the 15 minute checks were a care plan intervention used by nursing as needed in attempts to deescalate R54's violent outbursts. Review of a facility investigation revealed on 11/21/23, R54 propelled himself to R45's room (both on 300-hall) and stated, Suck my dick. R45 hit R54 on the head with her reacher and then R54 kicked R45. R45 kicked R54 back and threw water on R54. The kicking went back and forth until the two were separated by staff. After the separation, R54 continued to curse loudly and threaten R45 and stated he will shoot everybody in this building. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff separated the two residents and sent R54 to the emergency room for a Geri-psych evaluation. He returned to the facility a few hours later with no new orders. The Director of Nursing (DON) placed him on 15-minute checks to keep other residents safe from verbal and physical abuse perpetrated by R54. The DON was interviewed on 05/01/24 at 9:00 AM about R54's verbal threat and the DON stated they didn't consider it a credible threat because R54 is in the facility and doesn't have access to a gun . She confirmed R54's aggressive and manipulative behaviors and that he knows very well that the screaming vulgarities will eventually get him what he wants to keep him from disrupting and verbally abusing the other residents on the unit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, resident and staff interviews, and facility policy review, the facility failed to thoroughly investigate a threat to shoot residents and staff in the facility verbalized by one of six residents (Resident (R)54) reviewed for abuse out of a total sample of 24 residents. This failure to thoroughly investigate the verbal threat to shoot staff and residents increased the risk of the threat actually being carried out by R54. In addition, the facility failed to thoroughly investigate an allegation of misappropriation in accordance with their policy. The facility did not suspend the employee promptly and re-instated the employee prior to speaking with all potential witnesses. In addition, the employee accused of misappropriation made contact with one of the residents one more than one occasion, including in person. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised April 2021, showed: -Policy Statement - All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -Reporting: -6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents; -Investigating Allegations: -1. All allegations are thoroughly investigated. The Administrator initiates investigation; -6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete; -7. The individual conducting the investigation at a minimum: -f. Interviews the resident (as medically appropriate) or the resident's representative; -l. Documents the investigation completely and thoroughly; 8. The following guidelines are used when conducting interviews: -b. The purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement; -Reporting Results of Investigations: -1. The Administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident; -2. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Review of the undated Training Policy and Procedure, Attachment A-Abuse Definitions, showed: -8. Misappropriation of Resident's Property is defined as the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money. 1. R54 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and history of traumatic brain injury sustained during an arrest. Review of R54's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R54 was ambulatory via wheelchair. R54 did not participate meaningfully in interviews when attempted, but he was observed each day of the survey with the following disruptive and verbally abusive behavior directed at staff and other residents: On 04/29/24 at 12:50 PM and again on 05/01/24 at 10:30 AM, R54 was observed near the nurse's station on the 300-hall. When spoken to, he looked up and cursed, let me out of here! I want a [GD] cigarette . R54 continued to curse as he wheeled away from the nurses station towards the door. Interviews with staff that care for R54 routinely, Certified Nurse Aid (CNA)1 and Certified Medication Tech (CMT) 1 agreed that they were unable to predict or redirect R54's behaviors much of the time. CNA1 stated he eventually gets his way and gets to go smoke to keep his behaviors from escalating and taking out his anger on other residents. CNA1 stated, I try to keep him in sight all day so he doesn't get in trouble - or give nobody [sic] trouble . Review of a facility investigation revealed on 11/21/23, R54 propelled himself to R45's room (both on 300-hall) and stated, Suck my dick. R45 hit R54 on head with her reacher and then R54 kicked R45. R45 kicked R54 back and threw water on R54. The kicking went back and forth until the two were separated by staff. After the separation, R54 continued to curse loudly and threaten R45 and stated he will shoot everybody in this building. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 05/01/24 at 9:00 AM about R54's verbal threat and the DON stated the facility didn't consider it a credible threat because R54 lived in the facility and didn't have access to a gun . She confirmed R54's aggressive and manipulative behaviors and state R54 knows screaming vulgarities will eventually get him what he wants to keep him from disrupting and verbally abusing the other residents on the unit. The DON stated she did investigate the resident-to-resident abuse incident with R54 and R45 as a whole but did not address the threat to .shoot everybody in the place . because R54 did not have access to a gun. The DON confirmed no search of R54's person nor his room was conducted to definitively rule out the presence of weapons of any kind. She confirmed a thorough investigation would include a search for weapons. 2. During an interview on 05/23/24 at 12:04 P.M., the Administrator was notified Complaint MO00236578 was being investigated for misappropriation related to three residents (Residents #1010, #1008 and #1019) and the Alleged Perpetrator was the Business Office Manager (BOM). The Administrator did not say if the BOM would be suspended but said he would look into the complaint. During an interview on 5/24/24 at 9:47 A.M., the DON said the facility's policy included the suspension of any staff alleged to have abused, neglected or misappropriated from a resident, pending the facility's investigation. The DON was unaware of the allegations of misappropriation by the BOM. The Administrator was not currently in the building. At 10:00 A.M., the DON confirmed she had walked the BOM out, and she was now suspended. During an interview on 5/24/24 at 10:45 A.M., when the Administrator arrived at the facility, he said the BOM normally started at 7:00 A.M. He said he could not access the financial records. During an interview on 5/29/24 at 1:35 P.M., the Administrator said he did not speak with any of the residents' family members. He said he would call them this afternoon or tomorrow. He said he would do the investigation by tomorrow. He said he would get to the bottom of this. During an interview on 5/30/24 at 1:00 P.M., the Administrator said he did the facility's investigation. He made the decision to bring the BOM back to work on 5/28/24. She did absolutely nothing wrong. Review of the BOM's timecard, showed the following: -5/22/24, clocked in at 7:13 A.M. and clocked out at 3:16 P.M.; -5/23/24, clocked in at 6:49 A.M. and clocked out at 3:43 P.M.; -5/24/24, clocked in at 6:47 A.M. and clocked out at 10:47 A.M., handwritten sent home; -5/28/24, clocked in at 6:50 A.M. and clocked out at 4:38 P.M.; -5/29/24, clocked in at 6:45 A.M. and clocked out at 4:55 P.M.; -5/30/24, clocked in at 6:54 A.M. and clocked out at 5:31 P.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Chambers Road Ferguson, MO 63135	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation emailed by the facility Administrator, dated 5/30/24, showed he spoke with two family members/resident representatives on 5/29/24, and left a message for the third family member/resident representative. The document includes the following: -Regarding Resident #1019, the Administrator spoke with the family member on 5/29/24 who said, he/she was asked by the BOM to make a payment and he/she brought back $2002 to the BOM. On further questioning, the family member declined to talk and hung up the phone. Later on numerous calls were made to him/her, from the Administrator's cell phone and facility phone but he/she did not take any calls. -Regarding Resident #1008, the Administrator left messages but the family member had not returned phone calls. He also texted the family member. -Regarding Resident #1010, the family member said he/she had never been approached by any staff member or BOM for any cash back or any payment under the table. -At any time, the facility has never dealt in any cash transactions. All transactions are always made by check only. -Any check written to the Family member/Guardian/Payee regarding any resident for any reason is printed and left at the reception desk. Where it is handed over to the respective individual. -I firmly believe after my investigation that Resident #1019's family member is making absolutely false statement and facility shall make a decision to whether follow it through legal avenues per facility legal advisor. Review of a written statement by the BOM, is dated 5/31/24. The statement addressed the allegation related to Resident #1010. It did not address the allegations regarding Resident #1008 and Resident #1019. Review of a written statement by the Financial Director/Co-Owner, dated 5/31/24, addressed the allegation related to Resident #1010. It did not address the allegations regarding Resident #1008 and Resident #1019. The statement showed, on 9/15/23, the BOM told him/her Resident #1010 requested $2,000. The Financial Director/Co-Owner went to the resident's room and confirmed the request. At that time, the Financial Director/Co-Owner used his/her own funds and took $2,000 to him/her. The resident received $500 and instructed $1,000 to be given to his/her son. Later, $500 was deposited back to his/her trust. Review of a written statement by Activity Director, dated 5/31/24, addressed the allegation related to Resident #1010. It did not address the allegations regarding Resident #1008 and Resident #1019. The statement showed Resident #1010 requested money from his/her account on several occasions during the months of September to December, 2023. The resident signed for each transaction requested for petty cash. He/She also requested $1,500 from the BOM. See attached sheet. Review of Resident #1010's Petty Cash Withdrawal Record, showed no withdrawals on 9/15/23. Review of the six entries showed no withdrawal greater than $100. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility maintained Resident Trust Transaction History for the period 5/1/23 through 5/7/24, showed the following withdrawals/deposits from Resident #1010's account: Date Amount Description 08/31/23 $1,500.00 Cash Withdrawal 09/22/23 $1,000.00 Miscellaneous Withdrawal 09/30/23 $500.00 Deposit During an interview on 5/31/24 at 11:43 A.M., the Administrator said he/she left messages for Resident #1008's family but they hadn't called back. He/She spoke with Resident #1010's son one time to verify if the son gave cash to the BOM, and did not call back to verify if money was given by the BOM to the son. The Administrator said he/she sent the BOM to talk with the resident at his/her new facility and to get a signature for the $1,500 ($2,000) withdrawal. He/She said no fraud has been committed. He/She had not spoken with either #1008's family member or #1010's son a second time, but he/she had completed the investigation. He/She said when the BOM gave money to Resident #1010's son, the BOM should have gotten a receipt. During an interview on 5/31/24 at 2:15 P.M., Resident #1010 said the Administrator called him/her at his/her new facility on 5/29/24. The resident didn't understand what he was talking about. Then the BOM called him/her. The resident said the BOM visited him/her on 5/30/24 at his/her new facility. The BOM came with a typed prepared statement which the resident signed. The resident said he/she had just had a bed bath and was asleep when the BOM arrived to his/her room. The amount typed on the statement was not correct. It was $1,000, not $2,000 that he/she withdrew. He/She does not remember his/her son getting $1,000 from the BOM. Normally, he/she would sign the receipt and his/her son would be given money at the same time. MO00236578

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 21382 Based on interview and record review, the facility failed to issue one of three residents (Resident (R) 1) or responsible party a notice of transfer when R1 was sent to the emergency room . Findings include: Review of R1's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed he was initially admitted on [DATE] for long-term care. Among his diagnoses on his Face Sheet were Type 2 diabetes mellitus and dementia. Review of the Documents tab of the EMR revealed there were no documents uploaded reflecting a transfer notice was provided to R1 when he was sent out on 04/13/24 for a hypoglycemic (low blood sugar) event. An interview was attempted with R1 on 05/01/24 at 1:30 PM however he did not respond. On 05/02/24 at 10:44 AM a second interview was attempted with R1 with no response from him. On 05/02/24 at 2:39 PM an interview with the social worker (SW) verified there was no written transfer provided to R1. The facility was unable to provide a policy for issuing a written notice to residents or their responsible party when transferring to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview and record review, the facility failed to issue one of three residents (Resident (R) 1) or their responsible party out of a total sample of 24 residents a bed hold notice when R1 was sent to the emergency room . Findings include: Review of R1's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed he was initially admitted on [DATE] for long-term care. Among his diagnoses on his Face Sheet were Type 2 diabetes mellitus and dementia. Review of the Documents tab of the EMR revealed there were no documents uploaded reflecting a bed hold form was provided to R1 when he was sent out on 04/13/24 for a hypoglycemic (low blood sugar) event. An interview was attempted with R1 on 05/01/24 at 1:30 PM however he did not respond. On 05/02/24 at 10:44 AM a second interview was attempted with R1 with no response from him. On 05/02/24 at 2:39 PM an interview with the social worker (SW)verified that no bed hold notice was provided to R1 upon transfer to the hospital. The facility was unable to provide a policy for issuing a bed hold form when transferring a resident to the emergency room to residents or their responsible party.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 21382 Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to accurately code one of 24 residents (Resident (R) 61) for restraints. This failure placed the resident at risk for the use of restraints. Findings include: Review of the document titled, MDS (Minimum Data Set) 3.0, Care Assessment Summary and Individualized Care Plans revealed the directions for completing the MDS Section P for restraints. The section stated . discusses the various types of restraints.how to assess a resident for physical restraint. The document was not dated. R61 was observed on 05/01/24 at 3:30 PM in her room sitting on the side of her bed. She was transferring herself to the wheelchair. There were no restraints on the wheelchair or her bed. Interview with the MDS Coordinator on 05/01/24 at 3:45 PM confirmed R61 did not have any restraints at any time during her stay in the facility. She stated, It's an error. Review of the quarterly MDS with an Assessment Reference Date (ARD) of 02/13/24 revealed R61 was coded in the section titled, Used in chair or out of bed indicated R61 was coded for .other . less than daily.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based upon record review, interview, and observations, the facility failed to implement pressure ulcer interventions after surgery for left hip repair and failed to follow physician's treatment orders for one of four residents (Resident (R) 63) reviewed for pressure ulcers out of a total sample of 24 residents. This failure caused actual harm when R63 acquired unstageable pressure ulcers on the left foot. Findings include: Review of the Census tab located in the electronic medical record (EMR) revealed R63 was initially admitted on [DATE] and readmitted to the facility on [DATE]. Review of the Med Diag [Medical Diagnoses] tab located in the EMR revealed R63 was readmitted with diagnoses including surgical repair of the left hip. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/25/23 revealed R63 had a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severe cognitive decline. Review of a Braden Scale for Predicting Pressure Ulcer Risk form located in the EMR and dated 12/15/23 revealed a score of 16/18 indicating R63 was at risk for pressure ulcers. Review of a Skin Observation Tool assessment form located in the EMR and dated 12/23/23 revealed R63 had a left thigh surgical incision with a note stating the, resident has some swelling and a vertical surgical incision to left leg. There was no indication of any other wounds on R63. Review of a Braden Scale for Predicting Pressure Ulcer Risk form located in the EMR and dated 12/23/23 revealed a score of 17/18 indicating R63 was at risk for pressure ulcers. Review of a Braden Scale for Predicting Pressure Ulcer Risk form located in the EMR and dated 01/01/24 revealed a score of 10/18 indicating R63 was now at high risk for pressure ulcers. Review of the Care Plan located in the EMR revealed a concern/intervention related to left heel pressure sores initiated on 01/06/24 including bilateral heel protectors, promoting good nutrition and hydration, and monitoring skin and reporting to the physician. There were no previous interventions initiated after returning from the hospital post-surgery on 12/15/23. No off-loading of extremities or other pressure ulcer preventions/treatments noted before 01/06/24 after the two unstageable pressure ulcers developed. Review of a Skin Observation Tool assessment form located in the EMR and dated 01/06/24 revealed the first documentation of a left heel and left anterior foot scab area with a note stating the, resident has new area to left heel and anterior right side of foot, both areas are closed and have scabbed over. Areas are unstageable at this time. Treatment in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Skin Observation Tool assessment form located in the EMR and dated 01/08/24 revealed R63 had a left heel pressure ulcer measuring 2.0 X 3.0 X 0.2 cm (centimeters) with a note stating the, resident w/o [without] skin issues to remaining body surface. Heel protectors placed bilaterally, tolerated assessment well. Review of an Encounter note located in the EMR dated 01/17/24 revealed a Stage 2, left foot wound with a 4. 0 X 4.5 X 0.2 cm size and deteriorating status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, and elevating extremities. Review of an Encounter note located in the EMR dated 01/31/24 revealed an unstageable, left foot wound with a 4.0 X 3.0 X unable to determine (UTD) cm size and deteriorating status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of the January 2024 electronic medication administration record (eMAR) revealed an order to apply skin prep to the scabbed area on the left foot twice a day that was not documented as completed on 01/07, 01/17, and 01/31/24. Review of an Encounter note located in the EMR dated 02/16/24 revealed an unstageable, left foot wound with a 3.0 X 3.0 X 0.2 cm size and stable status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of an Encounter note located in the EMR dated 02/21/24 revealed an unstageable, left foot wound with a 3.0 X 3.0 X 0.2 cm size and stable status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of the February 2024 eMAR revealed an order to apply skin prep to the scabbed area on left foot twice a day was not documented as followed on 02/02, 02/02, 02/11, 02/13, 02/22, 02/25, and 02/26/24. Another order to cleanse the left heel opening and apply Medi-honey and a foam dressing once daily was not documented as completed on 02/01, 02/03, 02/10, 02/11, 02/13, 02/17, 02/18/, 02/21, 02/23, 02/25, 02/27, 02/28, and 02/29/24. Review of an Encounter note located in the EMR dated 03/01/24 revealed an unstageable, left foot wound with a 2.5 X 2.0 X 0.2 cm size and improving status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of an Encounter note located in the EMR dated 03/06/24 revealed an unstageable, left foot wound with a 3.0 X 2.5 X 0.4 cm size and deteriorating status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of an Encounter note located in the EMR dated 03/13/24 revealed a Stage 4, left foot wound with a 2. 0 X 2.5 X 0.5 cm size and improving status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of an Encounter note located in the EMR dated 03/21/24 revealed a Stage 4, left foot wound with a 2. 2 X 2.3 X 0.4 cm size and stable status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of the March 2024 eMAR revealed an order to apply skin prep to the scabbed area on left foot twice a day was not documented as completed on 03/08, 03/12, 03/17, 03/22, 03/25, 03/26, and 03/27/24. Another order (discontinued on 03/26/24) to cleanse the left heel opening and apply Medi-honey and a foam dressing was not documented as completed on 03/01, 03/02, 03/12, 03/14, 03/15, 03/16, 03/17, 03/18, 03/19, 03/22, and 03/23/23. Another order (initiated on 03/28) to cleanse the area with normal saline, apply collagen, and cover with a dry dressing once daily was not documented as completed on 03/29/24. Review of an Encounter note located in the EMR dated 04/03/24 revealed a Stage 4, left foot wound with a 1. 6 X 1.0 X 0.2 cm size and improving status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of an Encounter note located in the EMR dated 04/10/24 revealed a Stage 4, left foot wound with a 2. 0 X 1.5 X 0.1 cm size and improving status. Orders noted by the physician include applying off-loading boot, off-loading pressure areas, repositioning per facility turning schedule, elevating extremities, and a low-air-loss mattress. Review of a Wound - Weekly Observation Tool located in the EMR and dated 04/24/24 revealed the left heel wound with a size of 1.0 X 3.0 X 0.1 cm, with defined edges and stable progress. Review of the April 2024 eMAR revealed an order to cleanse the area with normal saline, apply collagen, and cover with a dry dressing once daily was not documented as completed on 04/03, 04/04, 04/05, 04/12, 04/13, 04/14, 04/20, 04/21, 04/23, 04/26, and 04/28/24. Review of a Skin Observation Tool assessment form located in the EMR and dated 04/29/24 revealed R63 had a left heel pressure sore measuring 1.0 X 0.3 X 0.1 cm with a note stating, no other skin openings noted. An observation on 04/30/24 at 5:26 PM revealed R63 to be in Geri-chair in common area. R63 had bilateral heel boots on. Observation of R63's room revealed a regular mattress on bed. Observation on 05/03/24 at 12:10 PM revealed the bed of R63 did not have a low-air-loss mattress. In an interview on 05/01/24 at 2:45 PM, the Director of Nursing (DON) stated the low air loss mattress was not ordered for R63 because the administration did not want to pay for it. The DON stated the physician orders should always be followed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/03/24 at 11:45 AM the Director of Nursing (DON) stated the CP should have been updated after hip surgery and interventions should have been implemented. MO00233924 MO00234710

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36461 Based on interviews, review of the Payroll Based Journal (PBJ) staffing report, and nursing schedules from 10/01/23 to 12/31/23, the facility failed to ensure the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 22 of the 92 days reviewed. Failure to have an RN on duty for eight consecutive hours a day has the potential to affect the care provided to residents and the supervision of the unit. Findings include: Review of the PBJ, for the fiscal year quarter one of 2024, revealed no RN hours triggered for four or more days October, November, and December 2023. Review of the facility's Nursing Schedules, dated from 10/01/23 through 12/31/23, revealed no RN coverage on 10/01/23, 10/07/23, 10/15/23, 10/28/23, and 10/29/23. In November 2023 there was no RN coverage for 11/04/23, 11/05/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23. In December 2023 there was no RN coverage for 12/02/23, 12/03/23, 12/09/23, 12/10/23, 12/16/23, 12/23/23, 12/24/23, 12/25/23, and 12/31/23. During an interview on 04/30/24 at 4:00 PM, the Director of Nursing (DON) confirmed there were no RN's on the schedule for the dates in October, November, and December 2023 and that she was aware that an RN was to be scheduled for at least 8 hours in a 24 hour period seven days a week. The DON also stated the licensed nurses on shift were aware she was on-call and if they needed an RN, they would notify her, and she would come to the facility if needed. During the same interview with the DON, the Administrator stated the facility had no RN coverage waivers. The DON also stated she was unable to find a policy that stated an RN was required for eight hours in a 24-hour period seven days a week. During an interview on 05/01/24 at 11:30 AM, Certified Medication Technician (CMT) 1 stated she was aware of how to notify the DON, if needed, especially on the weekends. During an interview on 05/01/24 at 12:05 PM, Certified Medication Technician (CMT) 2 stated she was aware of how to notify the DON, if needed, especially on the weekends.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 36461 Based on observation, interviews, and review of facility policy, the facility failed to ensure daily staffing was posted timely and in a manner that visitors and residents had access to this information. This deficient practice has the potential to affect all residents and visitors. Findings include: Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers revised July 2016, indicated, . Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LPN's) and the number of unlicensed personnel (CNA's) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format . Upon entrance to the facility at 9:00 AM, no daily staff posting of nursing hours was visible anywhere in the building. Tour of the building at 2:00 PM revealed no posting of the daily nurse staffing hours anywhere. During observations on 04/29/24 at 10:30 AM and 2:00 PM, no daily staff posting of nursing hours was visible anywhere in the building. During observations on 04/30/24 at 9:00 AM and 2:00 PM, no daily staff posting of nursing hours was visible anywhere in the building. During observations on 05/01/24 at 8:15 AM and 2:30 PM, no daily staff posting of nursing hours was visible anywhere in the building. During an interview on 05/02/24 at 9:00 AM, the Assistant Director of Nursing (ADON) stated she, or the Director of Nursing (DON), was the responsible person for completing the daily nurse staffing hours and posting them. The ADON stated she had not completed them this week nor were they posted in the facility due to the survey process occurring.

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NAME OF PROVIDER OR SUPPLIER Arbor Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Chambers Road Ferguson, MO 63135	

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, resident and staff interviews, record review, and policy review, the facility failed to reassess interventions for efficacy when the current behavior management interventions (both medications and nonpharmacologic interventions) were not effective in decreasing verbally and physically abusive behaviors towards other residents and staff in one of five residents (Resident (R) 54) reviewed for psychosocial and behavior management out of a total sample of 24 residents. This failure increased the risk of ongoing abusive behaviors towards residents and staff by R54. Findings include: Review of the facility's policy titled Behavioral Health Services revised February 2019 revealed, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident .7. Staff are scheduled in sufficient numbers to manage resident needs during the day, evening and night .11. The DON, or designee, will evaluate whether the staffing needs have changed based on acuity of the residents .Additional staff and/or training will be provided if it is determined that the needs of the residents cannot be met with current staffing levels and/or training . R54 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and history of traumatic brain injury sustained during an arrest. Review of R54's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R54 was ambulatory via wheelchair. He did not participate meaningfully in interviews when attempted, but he was observed each day of the survey exhibiting disruptive and verbally abusive behavior directed at staff and other residents. Observations of R54 were made throughout the survey in the 300-hall, in the common areas, and the porch where residents were allowed to go out to smoke. R54 was observed to go to the nurse's station several times a day and demand to go outside or call his sister. He appeared to be intentionally disruptive and aware that if he screamed loud and long enough, staff would eventually take him outside. The phone calls to his sister were not effective in deescalating R54's behaviors and on one observation on 05/01/24 at 11:00 AM of a phone call revealed the opposite effect in that R54 and his sister were heard screaming vulgarities at each other over the phone. On 05/02/24 at 8:30 AM, Certified Nursing Assistant (CNA) 2 was observed attempting to bring R54 to the dining room for breakfast after he had been up most of the night. He allowed CNA 2 to seat him at the table in his wheelchair. When CNA2 turned to return to the unit to bring other residents to breakfast, R54 started screaming sexually vulgar statements at a female resident seated at a table nearby. CNA2 stopped at the door and when R54 continued his ranting and sexually charged behaviors (grabbing himself) she returned to the table and attempted to redirect R54 without success. She wheeled him back to his room while he screamed for a cigarette all the way. CNA 2 shook her head and stated, I'm taking him back to his room - he can eat in there- so other residents could eat their breakfast in peace . (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews with staff that care for R54 routinely CNA2 and Certified Medication Tech (CMT) 1 agreed that they were unable to predict or redirect R54's behaviors much of the time. CNA1 stated R54 eventually gets his way and gets to go smoke to keep his behaviors from escalating and taking out his anger on other residents. CNA1 stated. I try to keep him in sight all day so he doesn't get in trouble - or give nobody [sic] trouble . An interview with the DON on 04/30/24 at 3:15 PM revealed the facility has sought alternate placement for R54 due to his aggressive behaviors, . and no-one will take him [R54] because of his behaviors. He has a sister that can't care for him in her home so he is here, and we have to play it by ear and try to stay between him and trouble .but it's not fair for the other residents to see him get his way every time he wants something by being loud, vulgar, and stubborn - he won't stop until he gets his way . The DON stated he has had psychiatric services since admission, he has mood stabilizing medications scheduled daily, but they still have to respond to him situationally. Review of R54's Care Plan dated 04/19/24 found in the Care Plan tab in the EMR revealed interventions for behaviors including restless, anxious, attention seeking, vulgar behaviors and comments towards other residents and staff. These behaviors are related to paranoid schizophrenia and history of a traumatic brain injury during an arrest. Nonpharmacologic interventions included: intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed; monitor for behaviors and redirect promptly; 15 minute checks for 48-72 hours when he can't be redirected .medications as ordered . In an interview with the Medical Director (MD) on 05/03/24 at 12:15 PM by phone, the MD stated when he consults with the psychiatric specialists he defers to them for medication or treatment management related to those concerns. He stated he has intermittently provided situational or one-time orders to manage R54's behaviors when he was out of control until he could be re-evaluated by psychiatry. An attempt to contact the psychiatric Nurse Practitioner (NP) by phone was made on 05/03/24. No return call was received prior to exiting the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36461 Based on interview and record review, the facility failed to ensure that monthly medication regimen reviews were completed by the consulting pharmacy for two of 24 sampled residents (Resident (R)22 and R25), resulting in the potential for adverse side effects from unnecessary, or duplicate, medications. Findings include: 1. Review of R22's Admission Record (undated), located under the Profiles tab in the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with diagnoses which included of dementia with agitation, major depressive disorder, and cognitive communication deficit. Review of R22's quarterly Minimum Data Set Assessment (MDS), located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 04/06/24 revealed R22, had a Brief Interview for Mental Status (BIMS) of zero which indicated R22 was severely cognitively impaired. Review of R22's Medication Administration Records (MAR) dated December 2023 revealed R22 had an order for .Haldol 5 milligrams (mg) by mouth every four hours as needed (PRN) for agitation . Review of R22's Progress Notes, located in the EMR, revealed the consultant pharmacist provided recommendations to the facility on [DATE] and 02/14/24 or nursing to follow-up with the doctor to discontinue the PRN Haldol. Continued review of R22's EMR revealed no documentation that indicated the physician had been made aware of the pharmacy recommendation to discontinue the Haldol. As of 05/02/24, the order remained on R22's MAR for the PRN Haldol. R22 received one dose on 01/06/24, and one dose on 03/02/24 and one on 03/03/24. Further review of R22's Progress Notes from March 2024 and April 2024, revealed no pharmacy reviews, or recommendations. 2. Review of R25's Admission Record (undated), located under the Profiles tab in the EMR revealed R25 was admitted to the facility on [DATE] with diagnoses of dementia without agitation and depression. Review of R25's quarterly MDS, located under the MDS tab in the EMR with an ARD of 04/30/24 revealed R25, had a BIMS of 15 out of 15 which indicated R25 was cognitively intact. Review of R25's MAR dated April 2024 revealed R22 had an order, dated 04/06/24, for .Haldol 0.5 milliliters (ml) by mouth every six hours as needed (PRN) for agitation . Review of R25's Progress Notes, located in the EMR, revealed that the consultant pharmacist provided no recommendations to the facility in March or April 2024. R25 had not received any doses of Haldol. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/24 at 3:00 PM the Director of Nursing (DON) stated the physicians for R22 and R25 had not been made aware of the pharmacy recommendations regarding the Haldol orders. During an interview on 05/03/24 at 2:30 PM, the Pharmacy Consultant stated she had completed the March 2024 pharmacy reviews, however .they were not loaded in the EMR yet . and further stated she had not completed the April 2024 reviews. The facility was unable to provide any policies related to pharmacy reviews or expectations prior to exit on 05/03/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36461 Based on interview and record review, the facility failed to ensure that medications ordered on an as needed (PRN) basis for two of 24 sampled residents (Resident (R)22 and R25), included a stop date no later than 14 days after receipt of the order, resulting in the potential for adverse side effects from unnecessary medications. Findings include: Review of the facility's policy titled, Administering Medications, revised 12/12, revealed, .If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated . 1.Review of R22's Admission Record (undated), located under the Profiles tab in the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with diagnoses of dementia with agitation, major depressive disorder, and cognitive communication deficit. Review of R22's quarterly Minimum Data Set Assessment (MDS), located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 04/06/24 revealed R22, had a Brief Interview for Mental Status (BIMS) of zero which indicated R22 was severely cognitively impaired. Review of R22's Medication Administration Records (MAR) dated December 2023 revealed R22 had an order written on 12/29/23 for .Haldol (an antipsychotic) 5 milligrams (mg) by mouth every four hours as needed (PRN) for agitation . No end date was noted for the order. Continued review of R22's MAR's revealed R22 did not receive any doses in December 2023, and he received one dose on 01/06/24. R22 did not receive any doses in February 2024. R22 received a dose on 03/02/24 and 03/03/24. He did not receive any doses in April 2024. Review of R22's Progress Notes, located in the EMR, revealed the consultant pharmacist provided recommendations to the facility on [DATE] and 02/14/24 for nursing to follow-up with R22's physician to discontinue the PRN Haldol, if indicated. Continued review of R22's EMR revealed no documentation that indicated the physician had been made aware of the pharmacy recommendation to discontinue the Haldol. As of 05/02/24, the order remained on R22's MAR for the PRN Haldol. 2. Review of R25's Admission Record (undated), located under the Profiles tab in the EMR revealed R25 was admitted to the facility on [DATE] with diagnoses of dementia without agitation and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's quarterly MDS, located under the MDS tab in the EMR with an ARD of 04/30/24 revealed R25, had a BIMS of 15 out of 15 which indicated R25 was cognitively intact. Review of R25's MAR dated April 2024 revealed R25 had an order dated 04/06/24, for .Haldol 0.5 milliliters (ml) by mouth every six hours as needed (PRN) for agitation . No end date was noted for the order. Continued review of R25's MAR's revealed R25 did not receive any doses in April or May 2024. During an interview on 05/03/24 at 11:00 AM, the Director of Nursing (DON) stated she was aware that PRN medications should be ordered for 14 days and re-evaluated at that time for renewal or discontinuation. The DON also stated there was not any documentation in R22 or R25's EMR that indicated their physician had been made aware to continue or stop the Haldol. During an interview on 05/03/24 at 2:00 PM, the consultant pharmacist stated she documents all pharmacy recommendations in the residents' EMR and will speak directly with the DON for urgent pharmacy related concerns. The pharmacist was aware that R22 and R25's Haldol had not been stopped or that a new order had been written.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 36461 Based on interview and record review, the facility failed to develop, initiate, or revise, if necessary, a facility assessment to determine what resources were necessary to care for its residents competently during day-to-day operations. The lack of an adequate facility assessment had the potential for residents' needs to go unmet and/or result in a lack of services provided by the facility to competently care for 78 residents who resided at the facility at the time of the survey. Findings include: During the entrance conference on 04/29/24 at 10:15 AM with the Director of Nursing (DON), the Facility Assessment was requested. As of 04/30/24 at 4:30 PM, the Facility Assessment had not been provided. During an interview on 04/30/24 at 4:30 PM, regarding the Facility Assessment, with the Administrator and DON, the Administrator asked .What is a Facility Assessment? . This surveyor provided a verbal description of a Facility Assessment and the Administrator stated they did not have one, nor were they asked to provide one during their initial certification in January 2022, or on any of the complaint surveys they have had since. On 05/01/24 at 11:00 AM the DON provided this surveyor a document titled Facility Assessment Tool. The document was not dated when it was initiated, or with any revisions. During an interview on 05/01/24 at 11:15 AM the DON stated the Facility Assessment Tool was initiated . earlier this year [2024] and was revised today, 05/01/24 . The DON added the dates to the document and a new document was provided that revealed it was initiated on January 2024 and revised in May 2024. The DON also stated she put the Facility Assessment together in January 2024 and it had not been reviewed, or approved, by the facilities Quality Assurance committee.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on record reviews and staff interviews, the facility failed to maintain a complete and accurate medical record to include required Preadmission Screening and Resident Review (PASRR) Level I and Level II, if applicable, evaluations for mental illness or intellectual disabilities for three of 24 sampled residents. This failure to have the PASRR screening results increased the risk that residents with mental illness or intellectual disabilities would not get all the required specialized services in the facility. Findings include: 1. R54 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and history of traumatic brain injury sustained during an arrest. Review of R54's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. R54 was ambulatory via wheelchair. He did not participate meaningfully in interviews when attempted, but he was observed each day of the survey exhibiting disruptive and verbally abusive behavior directed at staff and other residents. There was no PASRR found in the medical record review for R54. He did receive psychiatric services monthly by the facility psych consultants, but his behaviors continued to be unmanageable with the facilities current pharmacological and nonpharmacological interventions. Cross Reference: F600 Freedom from Abuse and F742 Treatment and Services for Mental and Psychosocial Concerns. In an interview with the Social Worker (SW) on 05/03/24 at 9:30 AM she stated she had checked her electronic and paper records and no PASRR was located for R54 prior to admission to the facility. Review of a list of residents' PASRR evaluations, provided by the Missouri Department of Health and Senior Services, revealed R54 had a Level II evaluation for Mental Illness on 02/07/23. However, there were no recommendations included on whether R54 required any specialized services for his paranoid schizophrenia diagnosis. 36461 2. Review of the Admission Record, under the Profiles tab located in the EMR, revealed R25 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, dementia without behavioral disturbances, and cognitive communication deficit. Review of the quarterly MDS located in the MDS tab of the EMR, with an ARD of 04/30/24 revealed R25 had a BIMS of 15 of 15 which indicated she was cognitively intact. Review of R25's EMR revealed no documentation for a PASARR level 1 or level 2. During an interview on 05/01/24 at 4:30 PM the Social Worker (SW) stated she was unable to locate any PASARR documentation, level 1 or 2, for R25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a list of residents' PASRR evaluations, provided by the Missouri Department of Health and Senior Services, revealed R25 had a Level II evaluation for Mental Illness on 01/31/23. However, there were no recommendations included on whether R25 required any specialized services for her bipolar disorder. 46592 3. Review of the Census tab located in the electronic medical record (EMR) revealed R39 was admitted on [DATE]. Review of the Med Diag [Medical Diagnoses] tab located in the EMR revealed R39 was admitted with diagnoses including dementia with behavioral disturbance, and idiopathic psychosis. Review of each tab located in the EMR for R39 did not produce a completed and documented Level I Pre-Admission Screen and Resident Review (PASRR). In an interview with the Social Worker (SW) on 05/03/24 at 9:30 AM she stated she had checked her electronic and paper records and no PASRR was located for R39 prior to admission to the facility. Review of a list of residents' PASRR evaluations, provided by the Missouri Department of Health and Senior Services, revealed R39 received a Level I screening on 04/27/21 but the medical record did not include this document.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 36461 Based on interview and policy review, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) program. This had the potential to affect 78 of 78 residents who resided at the facility. Findings include: Review of the facility's Quality Assurance Improvement Plan, dated February 2020, revealed, .The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include A. Tracking and measuring performance, B. Establishing goals and thresholds for performance measurement, C. Identifying and prioritizing quality deficiencies, D. Systematically analyzing underlying causes of systemic quality deficiencies, E. Developing and implementing corrective action or performance improvement activities, and F. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed . During an interview on 05/01/24 at 2:05 PM the Director of Nursing (DON) stated the facility did not have a QAPI plan. During an interview on 05/02/24 at 2:15 PM, the Administrator and DON stated minutes were not kept for the two QAPI meetings the facility has had. The DON stated she gathered information from the daily morning meetings, nursing 24-hour reports, and incident/accident reports and reviewed that information to identify any concerns. The DON stated that information was reviewed during meetings and taken back to the floor staff. During the same interview on 05/02/24 at 2:15 PM, the Administrator and DON were asked how they developed benchmarks for measuring improvement in Performance Improvement Plans (PIPs). The DON stated they have not developed any PIPs. The DON confirmed there were no benchmarks by which to develop or identify potential PIPs. The Administrator and DON were asked how the facility was identifying potential problem areas without having regular meetings, using benchmarks, or using data from consultant reports. The DON stated based on discussions at morning meeting and other concerns identified by reviewing the residents electronic medical record (EMR).

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36461 Based on interview and review of facility documentation, the Quality Assurance (QA) committee failed to identify quality deficiencies, , develop or implement corrective actions, , track, and measured for effectiveness or develop new interventions based on the QA committee discussions. This failure had the potential to affect 78 of 78 residents who resided at the facility. Findings include: Review of facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, dated February 2020, revealed . This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven (QAPI) program that is focused on indicators of the outcomes of care and quality of-life for our residents. and .Provide a means to measure current and potential indicators for outcomes of care and quality of life. During an interview on 05/01/24 at 2:05 PM the Director of Nursing (DON) stated the facility did not have a QAPI plan. During an interview on 05/02/24 at 12:30 PM, the DON stated the QA committee had not identified any specific quality deficiencies for performance measurements. The DON also stated the QA committee had not developed, implemented, tracked, measured, or performed any root cause analysis related to resident care or completed any performance improvement programs (PIPs). Cross Reference: F600 Free from Abuse and Neglect; F609 Reporting allegations of abuse; F610 Investigate allegations of abuse; F686 Treatment to Prevent Pressure Ulcers; F742 Treatment and Services for Mental Health; F756 Drug Regimen Review; F758 Unnecessary Psychotropic Medications; and F842 Resident Records.

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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 - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 36461 Based on interview and review of facility documentation, the Quality Assurance (QA) committee failed to meet, at least quarterly, with the required members resulting in the potential for missed opportunities with identifying, tracking, and measuring quality deficiencies. This failure had the potential to affect 78 of 78 residents who resided at the facility. Findings include: Review of facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, dated February 2020, revealed . The committee meets monthly to review reports, evaluate data, and monitor QAPI related activities and make adjustments to the plan. The DON provided two QA committee sign in sheets for 11/18/22 where the DON, Infection Preventionist (IP), and Medical Director did not attend. The 09/28/23 sign in sheets revealed the Administrator and Medical Director did not attend. During an interview on 05/02/24 at 12:30 PM, the DON confirmed there have only been two QA meetings since the initial certification survey in January 2022. The DON also stated there have not been any QA meetings for 2024, nor has there been any planned yet. The DON further stated she had reached out to the Medical Director for his availability and was informed by the Medical Director he would not be attending any QA meetings until he had been paid by the facility. During the same interview on 05/02/24 at 12:30 PM the Administrator stated the QA committee meets quarterly. The Administrator was not aware that the facility policy stated the QA committee meets monthly, nor was he able to provide any rationale why the Medical Director had not attended the meetings on 11/18/22 and 09/28/23. During an interview on 05/03/24 at 12:15 PM, the Medical Director confirmed he would not be attending any QA meetings, or anything extra, until he was paid by the facility. The Medical Director stated he, and his medical group, continue to attend to the needs of their residents, accept new admissions and respond to calls from the nursing staff regarding their residents.