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

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store and serve food in accordance with professional standards for food service safety. The facility failed to ensure food items were dated and covered and failed to remove dented cans from the storage room. The facility also failed to maintain kitchen equipment in a clean condition during three of four days of observation and failed to ensure a sheet of ice was removed from the threshold of the walk-in freezer. In addition, the facility failed to utilize safe and sanitary food handling techniques when staff handled food from the steam table using gloved hands instead of utensils, used the steam table line as a cutting board, and mashed food for mechanical soft diets with gloved hands during one of two kitchen meal service observations. The facility also failed to ensure hall trays were transported in a manner to prevent contamination when not all food items were covered during three of three hall tray meal observations. The census was 89.1. Review of the facility's Refrigeration policy dated 3/31/21 and revised 8/21/21;-Subject Refrigeration:-Policy: Ensure food storage and safety practices are maintained and monitored and comply with Federal and State regulations governing food storage and safety;-Responsibility: Directory Aide, Dietary Cook, and Directory Manager;-Procedure: -Foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labeled and dated with an expiration date of no more than three days unless otherwise indicated by the manufacturer; -Refrigerators shall be checked daily by the Dietary Manager and/or his/her designee to ensure leftovers or discarded before expiration date and all food is properly stored; -Storage of food should follow a FIFO (first in, first out). 2. Review of the facility's Dry Storage policy dated 3/31/21 and last reviewed 8/21/24, showed:-Subject: Dry Storage;-Policy: All food shall be stored according to regulatory guidelines governing food safety and sanitation and within established facilities guidelines;-Responsibility: Dietary Aide, Dietary Cook, and Dietary Manager;-Procedure: -All supplies must be 6 inches off floor and 18 inches from the ceiling; -All leftovers or opened packages shall be labeled, dated with open date then stored in a properly sealed container; -Food transferred from its original container, the container must be cleaned and sanitized refilled labeled and dated; -Dented cans shall be removed from storage. See Dented Can Policy; 3. Review of the facility's Dented Cans policy showed policy dated 8/20/22 and last reviewed, 8/24/24, showed:-Subject: Dented Cans-Policy: The Dietary Manager/ Designee will monitor cans in food storage for signs of rusting, dents or swollen seams; Damaged cans would not be used;-Responsibility: Dietary Aide, Dietary Cook, and Dietary Manager;-Procedure: -Dented or damaged cans upon observation will be removed from stock; -Directory Manager/ Designee will follow up with grocery vendor(s) to receive credit for returning the cans. 4. Observation of the kitchen on 2/17/25 at 9:50 A.M., 2/18/26 at 7:58 A.M, and 2/19/26 at 8:15 A.M., showed:-Walk in freezer: -Two (2) opened boxes of cookie dough exposed to air; -An opened box of puffed pastry sheets exposed to air; -An opened box of homestyle biscuits exposed to air; -An opened box of dinner rolls exposed to air; -A frozen meat item in a zip lock bag and without a date; -A frozen meat item wrapped in plastic wrap and without a date; -Hash browns in a plastic bag and without a date;-Dry storage room: -Five dented cans that sat on the floor. -An opened container of bay leaves, with plastic wrap over the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	opening. -A hole in the plastic and exposed to air; -An opened container of parsley, without a date; -An opened container of cinnamon without a date; -A box of salt opened on the side and exposed to air; -A package of cheerios, wrapped in plastic wrap and without a date -An opened bottle of honey without a date; -The sugar bin, both sides of the lids pushed to the opposite sides of the bin; sugar exposed to air; -The flour bin, lid not properly on bin; opened bag of flour inside bin, exposed to air;-The deep fryer: -Old grease in the fryer; -Old batter caked along the inside of the fryer; -Baked on grease on strainers and along the inside of the fryers;-Stove: -Caked-on stains along the front and on the sides of the stove; -Heavy caked-on stains along the front and on the side in between the grill;-Oven: -Heavy caked-on stains along the front inside doors; -Heavy caked-on stains along the bottom, and sides of oven;-Floor: -Noticeably dirty with food crumbs, dirt, debris and stains. 5. Observation of the kitchen walk in freezer on 2/17/25 at 9:50 A.M. and 2/18/26 at 7:58 A.M, showed a sheet of ice at the threshold of the freezer. 6. During an interview on 2/19/26 at 3:08 PM the Registered Dietitian (RD) said that she would expect for all food items to be properly labeled, dated and stored. It is everyone's responsibility to ensure that all food items are properly labeled, dated and stored. The kitchen should be cleaned daily. She wasn't sure how often deep cleaning was done but deep cleaning should be done more than what it was being done. She expected for ice to have not accumulated on the floor in the walk-in freezer. 7. During an interview on 2/20/26 at 2:31 P.M., the Director of Nursing (DON) said she would expect for all food items to be properly labeled, dated and stored. There is not a Dietary Manager. The Dietician was filling in at this time. It is her expectation that the kitchen floor should be clean, swept, and mopped. It was everyone's responsibility to ensure that the kitchen equipment is clean and that food items were properly labeled and stored. There should not have been ice at the threshold of the freezer. The Dietary Manager and Maintenance is responsible for ensuring that the ice was not on the floor. It was her expectation that the dented cans to have been removed from the storage room. 8. Observation of lunch hall tray meal service on the 300-hall on 2/17/26, showed at 1:02 P.M., hall trays were transported on an open-to-air wire rack from the main dining room to the 300-hall. The cart passed several residents in the dining room and staff walked past the cart. The cart contained 16 food trays. The plates were covered with a lid. A bowl of Fruit Crisps for desert sat on the trays, not covered. Nursing staff served the trays to the residents. 9. Review of the facility's breakfast menu for the date of 2/18/26, showed juice of choice, cereal of choice, egg, biscuit, sausage gravy, skim milk, and coffee or hot tea. 10. Observation of the kitchen breakfast meal service on 2/18/28 at 9:20 A.M., showed [NAME] I plated the trays, and a dietary staff passed the trays out one or two at a time to residents in the main dining room. The dietary staff served residents a cup of juice, a biscuit with gravy, and a sausage patty. At 9:37 A.M., the first tray was placed on the 300-hall cart. At 9:51 [NAME] I cut up sausage for the mechanical hall trays. He/She picked up the sausage from the steam table with gloved hands and placed them directly on the metal surface of the tray line. He/She cut the pieces with a knife, scooped them up with his/her hands and placed them on a plate. He/She picked up more sausage with his/her gloved hands from the steam table, placed them directly on the tray line and cut them up. He/She then scooped up some of the sausage and placed it on one plate and scooped up the rest and placed it on a different plate. [NAME] I then picked up a biscuit from the steam table with his/her gloved hands, placed them on one of the plates with the cut-up sausage and mashed it up with his/her hands. He/She did the same for all the mechanical plates made. After the last hall tray was plated, Dietary Aide E asked [NAME] I to plate a test tray. [NAME] I said he/she could not plate any extra trays because he/she was out of food. Observation of the steam table showed 1 biscuit and approximately 5 pieces of sausage remained. No gravy remained. 11. Observation of the breakfast hall tray meal service on the 300-hall on 2/18/26 at 10:01 A.M., showed the hall trays were delivered on an open-to-air wire cart from the kitchen, through the back corridor, down the main hall, and to the 300-hall. The lids over the plates were elevated and balanced on a bowl placed on the plate. The lids tilted off to one side and exposed a gap of approximately 2 inches, that left the food open to air. Staff began to pass the trays. 12. Observation of the lunch hall (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect when staff spoke to one resident in an undignified manner (Resident #81), when the facility failed to provide adequate utensils at meals (Residents #24 and #79), and when staff stood over a resident while providing feeding assistance for one resident (Resident #9). The sample was 18. The census was 89. Review of the facility's Resident Rights policy, dated 1/28/26, showed the facility shall treat residents with kindness, respect and dignity and ensure Resident Rights are being followed. Review of the facility's admission Agreement, undated, showed:-Resident Rights:--Residents Be Treated with Respect: Residents have the right to be treated with dignity and respect, as well as make their own schedule and participate in the activities their choose;-- Residents Free from Abuse and Neglect: Residents have the right to be free from verbal, sexual, physical, and mental abuse. 1. Review of Resident #81's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/18/25, showed:-Severe cognitive impairment;-Diagnoses included diabetes with diabetic chronic kidney disease;-No behaviors exhibited. Review of the resident's care plan, undated and in use at the time of the survey, showed:-Focus: Resident self-care performance deficit related to cognitive deficit requires total care with toiling he/she is incontinent of bowels and bladder and required one person assist with transfers as he/she is non ambulatory;--Goal: Will be free of body odor well-groomed and appropriately dressed through next review;--Interventions: Resident is totally dependent of one staff to provide bath/shower and as necessary. Observation on 2/17/26 at 2:06 P.M., showed the resident's door opened with full view of the room. From the hallway, Certified Nurse Aide (CNA) H was overheard telling the resident, Come on, you need to do this yourself. You are killing my back. During an interview on 2/17/26 at 12:04 P.M., the resident said the way the CNA H spoke to him/her made him/her feel like he/she was a child and he/she was humiliated. If he/she could do these things on their own, he/she would. During an interview on 2/19/26 at 3:10 P.M., CNA G said he/she just received an in-service on resident rights and resident abuse. He/She defined mental abuse as speaking to a resident in a demeaning and/or degrading manner. During an interview on 2/20/26 at 2:31 P.M., the Administrator said CNA H's comments were inappropriate. She expected the staff to treat all residents with dignity and respect. 2. Review of Resident #24's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Required supervision with eating;-Diagnoses included Alzheimer's disease, multiple sclerosis (causes breakdown of the protective covering of nerves), and anxiety. Observation on 2/17/26 at 12:46 P.M., showed lunch trays arrived in the dining room on Grace Hall. The residents were served baked chicken. The residents were provided either metal spoons or plastic forks. Residents were not provided knives. Observation on 2/17/26 at 12:57 P.M., showed the resident used his/her hands to tear off pieces of chicken to eat. During an interview, the resident said the food was good but he/she needed a knife. He/She preferred to cut chicken with a knife. Review of Resident #79's admission MDS, dated [DATE], showed:-No cognitive impairment;-Required supervision with eating;-Diagnoses included heart failure, hypertension (high blood pressure) and diabetes. Observation on 2/18/26 at 9:11 A.M., showed the resident seated at a table in the main dining room. The resident served breakfast, consisting of a bowl of oatmeal, sausage patties, biscuits and gravy, and orange slices. No knives were provided. The resident picked up a sausage patty and began tearing it apart with his/her hands and then put in the bowl of oatmeal. During an interview, the resident said he/she would have preferred to have a knife to cut up food. They were never given knives. Observation of breakfast on 2/18/26 at 9:16 A.M., showed CNA L used a fork to cut sausage patties into pieces to feed to a resident. During an interview, CNA L said it would be easier to assist residents if knives were provided to cut their food. Knives were never provided at breakfast, but sometimes they would (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be provided at lunch or dinner if something like pork was served. During an interview on 2/17/26 at 1:12 P.M., CNA K said sometimes residents were given forks and other times they were given spoons. A knife was needed to cut chicken. Knives were never provided. During an interview on 2/19/26 at 4:35 P.M., the Registered Dietician (RD) said residents should be given forks, spoons, and knives at meals. She was not aware of there being any issues with insufficient utensils prior to the start of the survey. More utensils were purchased this week. She believed the former Dietary Manager was made aware of the issue but never ordered anything. The issue could have been avoided if staff would have told the managers. During an interview on 2/20/26 at 2:20 P.M., the Administrator said it was more homelike for utensils to be provided at meals so residents could cut their food. 3. Review of Resident #9's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Required supervision with eating;-Diagnoses included coronary artery disease, hypertension, high cholesterol, stroke, epilepsy, and chronic obstructive pulmonary disease. Review of the resident's care plan, undated and in use at the time of the survey, showed:-Focus: Resident on a regular diet. Resident independent with supervision. Eats in dining room on locked unit with staff and peers;-Goal: Resident will maintain weight related to baseline and will continue to have adequate nutritional intake through next date;-Interventions: Provide and serve diet as ordered. RD to evaluate and make diet change recommendations as needed (PRN). Observation on 2/17/26 at 1:16 P.M., showed Assistant Director of Nurse (ADON) A stood next to the resident while feeding the resident his/her food. During an interview on 2/20/26 at 11:20 A.M. CNA S said when feeding residents, staff should sit next to the resident and feed them. It makes residents more comfortable when staff are seated next to them. When standing over a resident, it would generally make them feel uncomfortable or they may feel forced. Staff want to be considerate of the residents and make them feel comfortable. No one should be standing over residents while feeding them. It is also a dignity issue. During an interview on 2/20/26 at 11:37 A.M., ADON A said staff are supposed to be sitting when feeding residents. He/She thought about that after he/she was standing while feeding the resident. When feeding residents, there should be eye contact. Staff want the residents to feel comfortable and not rushed. There should be no hovering over the residents because it could take their attention away from eating or they could be distracted. It is also a dignity issue as well. During an interview on 2/20/26 at 2:31 P.M., the Director of Nursing (DON) said she would expect for Staff to be sitting down next to the residents when feeding the residents. This should be done for monitoring for swallowing issues and engaging with the resident and this could be a dignity factor.

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	265883	A. Building B. Wing	02/20/2026

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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. Based on interview and record review, the facility failed to ensure general accounting principles were followed by failing to complete monthly resident trust fund (RTF) reconciliations, resulting in the inability to accurately account for money held in the RTF account. In addition, the facility failed to provide quarterly statements to residents and their representatives. The facility held funds for 44 residents. The census was 89.Review of the facility's Resident Trust policy, undated, showed:-Policy: The facility shall provide a RTF cash box and a separate bonded interest-bearing bank account for all residents who choose to have their personal money safeguarded and managed by the facility. The resident or their legal guardian are the only ones who can designate what the monies are spent on and have the right to request their RTF ledger at any time;-Procedures: --An internal audit of the RTF will be completed on a quarterly basis by the corporate office. --The RTF is to be reconciled monthly and balanced to the bank statement;-- Upon admission, each resident shall sign Resident Funds Management System's (RFMS) authorization to handle RTF. Should any resident desire to designate a person other than themselves to act as a Responsible Party Designee to receive their quarterly RTF account statements, and/or designated to someone to make expenditures for and on their behalf form their personal money, they will do so in writing. 1. Review of the facility's RTF reconciliation documentation from February 2025 through January 2026, showed no documentation of trial balances, bank statements, and reconciliations completed for nine of 12 months.2. Review of the facility's RTF records, showed no documentation of the facility providing quarterly statements to residents or their representatives for January through March 2025, April through June 2025, July through September 2025, and October through December 2025. 3. During an interview on 2/19/26 at 8:20 A.M., the Regional Business Office Manager (RBOM) said the facility provided quarterly statements to the residents and/or the residents financial Power of Attorney (POA). When the new ownership took over on 10/1/25, the prior ownership failed to provide January through September 2025 RTF reconciliation reports and quarterly statements for January through March 2025, April through June 2025, and July through September 2025,. The facility's current Business Office Manager (BOM) started three days ago, and the prior BOM failed to upload the facility's signed quarterly statements for October through December 2025. 4. During an interview on 2/20/26 at 11:45 A.M., the Administrator said she expected the facility to reconcile resident trust accounts monthly and to provide quarterly statements to residents or their responsible parties each quarter.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and/or resident representatives a bed hold policy at the time of transfer or as soon as practicable when residents were transferred to the hospital for two residents (Resident #83 and #8). In addition, the facility failed to send a copy of discharge notices to the representative of the Office of State Long Term Care (LTC) Ombudsman. The census was 89.Review of the facility's Resident Bed Hold policy, dated revised on 9/16/25, showed:-The Facility shall have a process in place to notify residents and/or their representatives in writing of the facility's bed-hold policy in advance of being transferred to the hospital or when taking therapeutic leave of absence from the facility. In the event of an emergency transfer, the notice shall be provided within 24 hours.1. Review of Resident #83's medical record, showed:-discharged to the hospital on [DATE];-No documentation staff notified the Ombudsman of the discharge;-No documentation the bed hold notice was provided to the resident or his/her representative prior to the discharge. 2. Review of Resident #8's medical record, showed:-discharged to the hospital on1/27/26;-No documentation staff notified the Ombudsman of the discharge;-No documentation the bed hold notice was provided to the resident or his/her representative prior to the discharge. During an interview on 2/24/26 at 1:00 P.M. the Ombudsman Representative said he/she has not been receiving the discharge notices. The last one received was in January 2025. During an interview on 2/20/26 at 2:30 P.M., the Administrator said she did not have the bed holds or a copy of the discharge notices. She would expect for the nurse to provide the resident/resident representative the bed hold policy at the time of transfer or as soon as practicable and the Social Worker should follow up. The facility should maintain a copy for the medical record. The Ombudsman should receive a copy of the discharge notices monthly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored in accordance with acceptable standards of practice. The facility identified three medication rooms and seven medication/treatment carts. Two medication rooms and four medication/treatment carts were sampled for medication storage. Issues were found with both medication rooms and three out of four medication/treatment carts when staff failed to remove/discard expired medication and failed to label medications with a resident's name on it. The census was 89. Review of the facility's Medication Storage in the Facility policy, dated 1/26, showed:-Medications labeled for individual residents are stored separately from floor stock medications;-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists. 1. Observation on [DATE] at 9:25 A.M., inside the drawers on the treatment cart, located on the 500 halls, showed:-One tube of jock itch cream, opened with an expiration date of 5/24;-One tube of hydrocortisone 1% cream (steroid medicine used to treat eczema, insect bites and other skin conditions) opened with an expiration date of 11/24;-One tube of triamcinolone 0.1 % cream (a prescription-strength topical corticosteroid) opened with an expiration date of 4/25;-One tube of Thera honey (medication used for wound care) opened with an expiration date of [DATE];-One bottle of Dakin's (topical antiseptic) opened with an expiration date of 5/25. Observation on [DATE] at 9:30 A.M., of the medication room located on the 200 halls, showed:-Inside the refrigerator, there was a bottle of latanoprost 0.005% eye drop (prescription eye medication used to treat pressure in the eye) with no name on it;-In the back of the refrigerator stuck between the shelf and the back of the refrigerator was a box with a vial of medication inside it. The label on the medication was faded and unreadable and the box was falling apart. The manufactures instruction was frozen onto the vial of medication. Registered Nurse (RN) Q said the frozen vial of medication was something insulin related. -Inside the cabinet located next to the sink, there were two boxes of DuoNeb nebulizer medication (prescription inhalation solution). One box was opened had an expiration date of [DATE]. The second box was open had an expiration date of 2/25;-One bottle of Geri Lanta (antiacid), opened with an expiration date of 10/24;-One Breo Ellipta (used to treat long term asthma), opened with an expiration date of 4/25;-On the shelf rack, was a large bottle of stool softener, docusate 100 milligrams (mg), opened with an expiration date of 12/25. During an interview on [DATE] at 9:25 A.M. RN Q said he/she did not know who was responsible for checking the expiration dates. The facility recently switched pharmacies and he/she would have expected the pharmacy to have checked the medications for expiration dates. 2. Observation on [DATE] at 6:55 A.M. of the treatment cart, located on the 200 hall, showed one tube of ice cold (pain relieving gel), opened with an expiration date of 6/25. Observation on [DATE] at 7:05 A.M., of the medication room located on the 200 halls, showed:-Inside the refrigerator was a box of Trulicity 0.75mg/0.5 milliliter (mL) (medication used to lower blood sugar) opened with an expiration date of [DATE];-A plastic bag with two insulin pens with no name on them. Licensed Practical Nurse (LPN) R said he/she did not know who the insulin belonged to; it looked like it was pulled from the stat kit. The nurse should check the expiration date before administering the medication. 3. Observation of the treatment cart located on the 100 hall on [DATE] at approximately 10:25 A.M., showed a box of Hydrofera Blue (used for wound care), opened with an expiration date of [DATE]; one tube of moisture barrier opened with an expiration date of [DATE]. During an interview on [DATE] at approximately 10:25 A.M., Certified Medication Technician (CMT) D said it had been a while since he/she checked for expirations dates. All CMT's and nurses should check for expiration dates as they (continued on next page)

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	go. 4. During an interview on [DATE] at 11:00 A.M., the Director of Nursing (DON) said the CMT's should check the medications on the carts, medication rooms and refrigerators for expiration dates daily. The refrigerator should be cleaned weekly by the night nurse. The DON said she would expect for the medications to be stored and labeled properly and the carts to be audited daily and as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow proper infection control procedures when staff used non-medical-grade disinfectant wipes to clean the glucometer (device used to measure how much glucose (sugar) is present in the bloodstream) used on three residents (Residents #28, #46, and #48). In addition, the facility failed to store one resident's nebulizer tubing and mask per policy, creating a potential risk for cross-contamination and infection (Resident #52). The sample was 18. The census was 89. Review of the facility's Communicable Disease Management Policy, revised 10/2022, showed:-The Facility will establish Infection Prevention & Control Guidelines to prevent the transmission of infections, communicable diseases and healthcare associated infections (HAI) to ensure the safety of residents and employees;-Employees shall utilize barriers to avoid direct contact;-Employees shall implement Isolation barriers beyond standard precautions (precautions used to care of all residents regardless of their diagnosis or presumed infections status) as indicated in the following Centers for Disease Control and Prevention (CDC) Guidelines: (left blank). 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/10/26, showed:-Moderately impaired cognition;-Diagnoses included diabetes. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's physician order summary (POS), dated 2/20/26, showed a physician order, dated 8/20/25 for Novolog (rapid-acting insulin) 100 unit/milliliter (ml) flex pen, inject per sliding scale: if 151 to 250 = 3 units; 251 to 350 = 6 units; 351 to 450 = 9 units; 451 to 500 = 12 units and call physician, subcutaneously (under the skin) four times a day related to diabetes. Observation on 2/18/26 at 7:50 A.M., showed Licensed Practical Nurse (LPN) J cleaned a glucometer with a lemon-scented disinfecting wipe and placed the glucometer on a barrier on top of the medication cart. The nurse performed a blood sugar test (a small drop of blood obtained from a finger prick with a lancing device, which is placed on a disposable test strip inserted into the meter) on the resident. He/She cleaned the glucometer with the lemon-scented disinfecting wipe and placed the glucometer on the barrier on top of the medication cart. 2. Review of Resident #46's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Will be free from any signs and symptoms of hypoglycemia (low blood sugar) through the review date and will be free from any signs and symptoms of hyperglycemia (high blood sugar) through the review date;-Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's POS, dated 2/20/26, showed, an order, dated 8/5/25, for insulin lispro (rapid-acting insulin) 100 unit/ml (1 unit dial) pen, inject as per sliding scale: if 149 or less, no insulin; 150 to 199 = 1 unit; 200 to 249 = 2 units; 250 to 299 = 3 units; 300 to 350 = 4 units notify provider; 351+ = 5 units notify provider, subcutaneously (under the skin) with meals related to diabetes. Observation on 2/18/26 at 8:08 A.M., showed LPN J performed a blood sugar test on the resident using the same glucometer used on Resident #27. He/She cleaned the glucometer with a lemon-scented disinfecting wipe and placed the meter on the barrier on top of the medication cart. 3. Review of Resident #48's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes. Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's POS, dated 2/20/26, showed an order, dated 2/2/26, to please notify physician if blood sugar is less than 70 and more than 400 with meals for blood glucose monitoring. Observation on 2/18/26 at 8:20 A.M., showed (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN J performed a blood sugar test on the resident using the same glucometer used on Residents #27 and #46. He/She cleaned the glucometer with the lemon scented disinfecting wipe and placed the meter on the barrier on top of the medication cart. 4. During an interview on 2/20/26 at approximately 2:30 P.M., the Director of Nursing (DON), Administrator, and Corporate Nurse said staff should not use lemon-scented disinfecting wipes to clean multi-use equipment. The facility did not buy scented wipes for cleaning medical equipment. Staff should use the purple top Sani Wipes equipped with germicide content per infection control guidelines. 5. Review of Resident #52's annual MDS, dated [DATE], showed:-Diagnoses included dysphagia (swallowing disorder) following unspecified cerebrovascular disease (stroke), chronic systolic (congestive) heart failure, and muscle weakness;-Moderate depression.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has emphysema/chronic obstructive pulmonary disease with (COPD, lung disease) exacerbation;-Goal: Resident will be free of signs and symptoms of respiratory infections through review date;-Interventions included: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Monitor for difficulty breathing on exertion and for signs and symptoms of acute respiratory insufficiency.Review of the POS, dated 2/18/26, showed:-An order, dated 12/14/25, for budesonide inhalation suspension 0.5 milligrams (mg)/2 ml, 0.5mg inhaled orally two times a day for COPD exacerbation;-An order, dated 5/7/24, for arformoterol tartrate inhalation nebulization solution, 15 micrograms (mcg)/2 ml, 15 mcg inhaled orally two times a day for COPD exacerbation. Observation on 2/17/26 at 9:46 A.M., showed the resident on his/her back in bed, with the head of bed elevated approximately 30 degrees. A nebulizer mask laid across his/her lap with nebulizer machine turned on. Observations on 2/18/26 at 7:27 A.M. through 12:35 P.M., showed soiled clothing on top of the nebulizer tubing, machine, and mask, which were balled up on a chair. During an interview on 2/19/26 at approximately 3:18 P.M., LPN F said the Certified Medication Technician (CMT) or Nurse should remove the nebulizer mask from a protective pad, place the medication in the cup, apply the mask to the resident, turn on the machine, and remain nearby to observe for nosebleeds or excessive coughing. No formal monitoring was required. During an interview on 2/20/26 at approximately 2:45 P.M., the DON said she expected the nebulizer to be stored on a clean surface and for the mask and tubing to be in a plastic bag with a date and changed every week. 6. During an interview on 2/20/25 at 9:22 A.M. the facility's Corporate Nurse said the facility did not have a policy that specified best practices for cleaning and storing nebulizer masks or glucometers. 2737724

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	265883	A. Building B. Wing	02/20/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure one of one resident sampled for a Level Two Pre-admission Screening/Resident Review (PASARR) had the services and supports recommended, and failed to ensure the services and supports were on the care plan (Resident #8). The census was 89.Review of the facility's PASARR policy, revised 2/24/26, showed residents should have required PASARRs. Information obtained from the PASARR should be documented on the care plan, including needed services. Review of Resident #8'squarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/1/25, showed:-Should the staff assessment for mental status be conducted? No;-Is there evidence of an acute change in mental status? No;-Diagnoses included: Schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression)). Review of the resident's PASARR level two summary of findings, dated 12/19/24, showed:-PASARR related disability: yes; specify, does have serious mental illness;-The PASARR level two evaluation indicated the following supports and services are to be provided by the facility: behavioral support plan; structured environment, crisis intervention services, medication therapy, Activities of Daily Living (ADL, grooming, dressing, bathing) and personal support network. Review of the care plan, in use at the time of survey, failed to show the resident had a level two PASARR and what the recommended supports and services were. During an interview on 2/19/26 at 4:30 P.M. Certified Nurse Aide (CNA) T said the resident sometimes called the staff names and last week he/she tried to hit him/her. When the resident had behaviors, he/she ignored them and reported it to the nurse. CNA T did not know what the resident's support plan was or what type of crisis interventions services the resident had in place. During an interview on 2/19/26 at 4:40 P.M. Licensed Practical Nurse (LPN) M said the resident never wanted to get up, and he/she was a hit or miss for allowing staff to provide his/her care. The resident's personal support network was his/her family. LPN M did not know what the resident's behavioral support plan or crisis intervention services was. During an interview on 2/19/26 at 4:45 P.M. the Social Services Designee (SSD) said she just started working at the facility on 2/16/26 and she did not know the resident. The MDS Coordinator was helping social services before she started, and she may know. During an interview on 2/19/26 at 4:50 P.M., the MDS Coordinator said level two PASARR supports and services should be on the resident's care plan. The facility had no residents who currently had a level two PASARR. The MDS Coordinator reviewed the resident's PASARR level two summary of findings and said the resident had a level two PASARR and she would update the care plan today. The MDS Coordinator did not know what the resident's behavioral plan or crisis intervention service was and said social services would know what services and supports the resident had. During an interview on 2/20/26 at 10:30 A.M. the Director of Nursing (DON) said if a resident had a level two PASARR, their recommended support and services should be included on the care plan. During an interview on 2/20/26 at 2:30 P.M. the Administrator said she would expect for the facility to provide the recommended services and support recommended on the level two PASARR, and it should be on the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care needs were met for a dependent resident. The facility failed to ensure the resident received assistance in the dining room during meals and failed to ensure the resident's hands and nails were cleaned (Resident #3). The sample was 18. The census was 89. Review of the facility's policy titled ADL Care Shaving, reviewed on 07/21/22, showed: ADL care will include shaving to promote cleanliness and dignity; Review of the facility's policy titled Nail Care, reviewed on 07/21/22, showed: -The purpose of nail care is to clean the nail bed, trim nails and prevent infection;-Nails may be cleaned during bathing; -Nail care includes daily cleaning and regular trimming Review of the Resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/16/25, showed:-Severe cognitive impairment;-Dependent on staff for bathing and personal hygiene; -Functional impairment in range of motion to upper extremities on both sides;-Rejection of care exhibited: No;-Diagnoses included aphasia (a brain disorder that affects how you speak and understand language), dementia, paraplegia (paralysis to the lower half of the body), multiple sclerosis (MS, an autoimmune disease that affects the brain and spinal cord), and depression. Review of the resident's care plan, last revised on 02/06/26, showed:-Focus: Resident has paraplegia.-Goal: Resident will remain free of complications or discomfort related to paraplegia;-Interventions included: Assist with ADLs as required. Encourage resident to perform as much as possible of these activities;-Staff did not address the resident's preferences regarding personal hygiene such as shaving or nail care. Review of the resident's progress notes, showed no documentation the resident refused to be shaved or have his/her nails cleaned and trimmed. Observations of the resident on 02/18/26 at 8:10 A.M., 02/19/26 at 8:28 A.M. and at 12:35 P.M., showed the resident had significant gray stubble on and under his/her chin. The resident's nails were long with chipped red nail polish and a substantial amount of brown matter accumulated under his/her fingernails. During an interview on 02/19/26 at 9:50 A.M., Certified Nurse Aide (CNA) T said he/she was the resident's assigned aide. The resident did not resist care and preferred bed baths. When bathing residents, CNA T said he/she always offered to shave and provide nail care. The resident preferred long nails and liked to have them painted. The resident needed to be shaved. His/Her hair grew back fast. CNA T was going to give the resident a bath today and would shave him/her and provide nail care. Observation and interview on 02/20/26 at 9:00 A.M., showed the resident's chin was shaved, but whiskers under his/her chin remained. The resident's nails were long with chipped red nail polish and visible dark matter remained under his/her fingernails. The resident said he/she preferred to not have whiskers and preferred to have clean, long nails that were painted. During an interview on 02/20/26 at 9:03 A.M., CNA V said he/she was the shower aide. He/She did not offer resident's a shave when giving baths or showers. CNA V was not sure why he/she didn't offer. He/She did provide nail care during showers and baths. During an interview on 02/20/26 at 2:29 P.M., the Administrator said she would expect staff to offer to shave residents and clean their nails per the resident's preferences. If a resident refused staff should have documented it.

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	265883	A. Building B. Wing	02/20/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to transcribe a treatment order into the medical record timely and failed to follow physician orders when staff failed to administer the treatment as ordered for one resident sampled with wounds. The facility also failed to implement care plan interventions for pressure relief (Resident #3). The census was 89. Review of the facility's Physician Orders policy, dated 09/28/22, showed:-Physician orders shall be provided by licensed practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe orders;-Orders must be recorded in the medical record by the licensed nurse authorized to transcribe such orders;-Physician orders will be transcribed to the appropriate Administration Record Medication (MAR/eMAR) or Treatment Administration Record (TAR/eTAR);- Telephone/verbal orders: the licensed nurse is required to transcribe the order accurately in the medical record/ physician order sheet (POS) and on the appropriate MAR/TAR. Review of the facility's Wound Management policy, dated 11/15/22, showed: Wound treatment will be provided in accordance with physician's order. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/12/25, showed:-Severe cognitive impairment;-Functional limitations in range of motion in both upper and lower extremities;-Dependent on staff for Activities of Daily Living (ADL, grooming, dressing and bathing), rolling left to right and for transfers;-Diagnoses included non-Alzheimer's dementia, aphasia (language disorder that impairs a person's ability to speak, understand, read, and write), paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs) and multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue);-Three stage 3 pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed. Slough (soft, moist, stringy, and yellow or white tissue that forms on the surface of a wound) may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). Review of the care plan, last revised on 02/06/26, and in use at the time of survey, showed:-Focus: Resident has unavoidable pressure ulcer (the resident developed a pressure ulcer eventhough the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; andrevised the approaches as appropriate) bilateral lower extremities;-Goal: Will have no complications related to (specify skin injury type) of the (specify location) through the review date;-Interventions: Perform treatment to wound per current treatment order. Assess wound for signs and symptoms of infection with each dressing change/treatment Report positive findings of redness warmth, swelling increased drainage, increased pain; pressure reducing mattress (specialized mattress designed to prevent pressure ulcers) while in bed. Review of the physician order summary dated 02/19/26, showed:-A physician order dated 02/07/26, for left foot site 6: Cleanse with normal saline/wound cleanser (NS/WC), apply skin prep (protective barrier) to peri-wound (wound edges), calcium alginate (highly absorbent dressing, used in managing heavy exudate (drainage) in non-infected, chronic wounds),triple antibiotic ointment (TAO), apply abdominal pad (ABD, soft absorbent dressing), wrap with gauze roll and secure with tape daily and as needed everyday shift for wound care;-A physician order dated 02/07/26, for left lateral (side) ankle site 9: Cleanse with NS/WC, pat dry, apply TAO, apply skin prep to peri-wound, apply calcium alginate silver (highly absorbent dressing, with broad-spectrum antimicrobial protection, used to manage infected or high-risk, heavily exuding wounds) and cover with gauze, wrap with gauze roll and secure with tape daily and as needed every day shift for wound care. Review of the wound physician notes dated 02/17/26, showed:-Site 6: Stage 3 pressure wound of the left, first metatarsal head(s) (MTH, rounded, bony end of the five long metatarsal bones in the foot that connect to the toes) foot full thickness; dressing treatment plan: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alginate calcium with silver, once daily and as needed if saturated, soiled or dislodged; -Skin tear wound of the left, lateral ankle- exacerbated due to infection, hospital, wounds worse on return, full thickness: alginate calcium with silver once daily and as needed if saturated, soiled or dislodged. Review of the progress notes dated 02/17/26 through 02/19/26 showed no documentation the treatment was changed. Observation on 02/19/26 at 2:00 P.M., showed Licensed Practical Nurse (LPN) M and Assistant Director of Nursing (ADON) A entered the resident's room and performed hand hygiene, put on a gown and gloves. The resident was lying in bed on his/her back. The resident had a blue mattress on his/her bed. The mattress did not have a pump located on the end of the bed. LPN M held the resident's leg up while ADON A provided the wound care. ADON A removed the dressing on the left foot, cleaned the left first MTH and left ankle with wound cleanser, pated the areas dry, applied skin prep to the edges of the wounds, applied TAO to the calcium alginate. ADON A applied calcium alginate to both sites. She then applied an ABD pad to the first MTH and gauze pads to the left ankle, wrapped the areas with gauze and secured the dressing with tape. ADON A said she used plain calcium alginate. During an interview on 02/20/26 at approximately 8:30 A.M., ADON A said the facility's wound care physician visited the facility on Tuesday evenings. She was responsible for rounding with the physician and entered any new orders into the medical record. The wound physician usually completed about 90% of his notes while he was in the facility. Once ADON A received the wound physician notes, usually the next day, she was responsible for reviewing them for any new orders. Calcium alginate and calcium alginate with silver were not interchangeable. ADON A reviewed the wound note for 02/17/26 and said the treatment should have been calcium alginate with silver for both wounds and she should have used calcium alginate with silver. ADON A said she thought the resident had an air mattress on his/her bed. During an interview on 2/20/26 at 10:35 A.M. the Director of Nursing (DON) said the wound physician visited the facility weekly and the ADON rounded with him. He wrote the orders on a log, and the log was left with ADON A who was responsible for entering the orders into the medical record. Once the wound notes were obtained ADON A should review the orders to verify the orders matched the orders in the medical record. Calcium alginate and calcium alginate with silver were not interchangeable. The DON would have expected staff to follow physician orders and provide the treatment as ordered. If the resident had a wound, a specialized mattress would be an air loss mattress. During an interview on 2/20/26 at 2:30 P.M., the Administrator said she would have expected for staff to follow physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to keep residents free of accidents when a Certified Nurse Aide (CNA) left a resident unattended in a filled whirlpool to gather supplies. (Resident #83). While the CNA exited the spa and another staff member entered, the resident slipped down into the water. The other staff member had to pull the resident up. The resident said water got in his/her mouth. The resident told another CNA that staff tried to kill him/her and said he/she was now too scared to go back into the whirlpool. The mechanical lift the CNA said he/she used was not assessed for safety concerns after the incident occurred. The facility also failed to ensure safe smoking practices when staff failed to ensure residents disposed of cigarettes in an appropriate receptacle during two of two smoke breaks observed (Residents #53, #69, #68, and #50), the facility identified 14 residents who smoked. The sample was 18. The census was 89. Review of the facility's policy tilted, ADL (activities of daily living) Care Bathing, revised 07/21/22, showed:-Stay with the resident throughout the bath: Do NOT leave the resident unattended;-Use emergency call signal to summon assistance if needed;-While assisting in/out of the tub, instruct the resident to hold onto the safety bars;-Place supplies within reach. 1. Review of Resident #83's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 01/02/26, showed:-Moderate cognitive impairment;-Rejection of care: behavior not exhibited;-Required substantial assistance for shower/bathing;-Required supervision for tub/shower transfer;-Diagnoses included diabetes mellitus, high blood pressure and dementia. Review of the resident's care plan, last reviewed on 01/15/26, showed:-Focus: Resident has history of resistance to care related to refuses to bathe;-Goal: Resident will cooperate with care;-Interventions included: Allow resident to make decisions about treatment regime, to provide sense of control;-Focus: Resident has a rash to his/her head and back with diagnosis of psoriasis vulgaris (chronic scaly, inflamed skin);-Goal: Resident will have no signs or symptoms of infection of the rash;-Interventions included: Give medication as ordered, monitor skin rashes for increased spread or signs of infection;-Focus: Resident requires max assistance with personal hygiene, toileting and showering. Can walk with rollator;-Goal: Resident will maintain proper hygiene without odor;-Interventions included: Encourage resident to participate to fullest extent possible with each interaction. Review of the resident's most recent Fall Risk Evaluation, dated 01/15/26, showed the resident was at moderate risk for potential falls. Review of the resident's February 2026 Order Summary, showed an order dated 05/31/24: Shower or Whirlpool Bath every evening shift every Monday, Wednesday and Friday for chronic psoriasis. Ensure ointment is applied after skin has been cleansed. Review of the resident's progress notes, showed:-On 02/05/26 at 6:27 P.M., late entry, Resident remains on monitoring for fearfulness for slipping in whirlpool. Resident has no complaint of pain or fearfulness at this time;-On 02/06/26 at 7:22 A.M., Resident remains on observation for slip/fall in whirlpool. Rested through the night, no complaints;-On 02/06/26 at 6:26 P.M., Resident remains on monitoring for fearfulness for slipping in whirlpool. Resident has no complaint of pain or fearfulness at this time;-No further documentation related to the resident's fearfulness after slipping in the whirlpool or any interventions to address the resident's fearfulness. Review of the facility's 11/01/25 to Current Incidents/Accidents log, showed the resident was listed. During an interview on 02/19/26 at 1:36 P.M., Certified Nurse Aide (CNA) H said the resident took baths in the whirlpool three times a week and was compliant with care. CNA H bathed the resident frequently. Staff were supposed to stay with residents the entire time the resident was in the whirlpool in case anything happened. CNA H had heard a few weeks ago that a CNA on the evening shift put the resident in the whirlpool and left the resident alone. CNA H saw the resident the next day. The resident said the CNA tried to kill the resident. The resident said, they won't get me in there no more. The resident was talking about the whirlpool. The resident had refused to get in the whirlpool since the incident. CNA H said he/she went (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and told the Director of Nursing (DON) after the resident told him/her about the incident. Staff were educated on leaving residents alone in the whirlpool. Review of the facility's Investigation, dated 02/04/26, showed:-On 02/04/26, the resident was receiving his/her scheduled bath with assistance from CNA V. During the bath process, CNA V asked the Environmental Services Director (ESD) to watch the resident for a moment while he/she grabbed some soap. Before CNA V stepped away from the area, the resident shifted his/her weight unexpectedly and started to slip. ESD immediately assisted and repositioned the resident. Charge nurse performed pain/skin evaluation with no new findings;-Upon completion of the investigation, the facility responded appropriately. The resident was safely secured and removed from the bathtub. The resident remains at baseline and staff will continue his/her plan of care. The following interventions have been put into place: -CNA provided 1:1 Coaching; -Inservice: ADL Care Bathing; -Inservices return demonstration bathing; -Monitor resident for fearfulness; -Updated care plan. Review of CNA V's witness statement, undated, showed: I stepped out the shower room to get the supply while the resident was in the whirlpool, but there was staff standing at the door. The resident started to slide in the whirlpool. Me and the staff member pulled him/her up immediately. Review of the ESD's witness statement, dated 02/04/26 at 5:00 P.M., showed: When I peeked in the shower room, I saw the resident slipping under and I pulled him/her up. Review of CNA V's Notice of Violation: Safety Requirements form, dated 02/04/26, showed:-Scheduled shift start: 3:00 P.M., scheduled shift end: 11:00 P.M.,-Incident description: Employee failed to gather all supplies before bath, stay with resident, requested assistance form another staff to oversee resident while gathering supplies.During an interview on 02/19/26 at 1:45 P.M., Licensed Practical Nurse (LPN) F said there was a recent incident involving the resident in the whirlpool. He/She believed the resident slipped. Staff came and got him/her and said the resident had slipped and needed to be looked at. When LPN F saw the resident, the tub had been drained. The resident was sitting in the tub facing out. The resident said he/she slipped. CNA V was the one who was bathing the resident when the incident occurred. Staff should be with a resident the entire time they were in the whirlpool. The DON was made aware and said to check on the resident every one to two hours. The resident was a little afraid. The resident had been getting showers ever since the incident occurred. During an interview on 02/19/26 at 2:04 P.M., the DON said they had recently completed education with staff about leaving residents alone in the whirlpool after a staff member stepped out to get towels. CNA V asked ESD to watch the resident while he/she stepped out. The DON was not sure if the ESD had CNA training or not. During an interview on 02/19/26 at 2:51 P.M., CNA V said when a bath was given, you should gather all needed supplies before taking the resident into the shower room. He/She used the bathtub Hoyer lift (mechanical lift used to transfer in/out of a bathtub) for the whirlpool. If a resident did not have good trunk control, they could slide down. A resident would not be able to slide completely out of the chair because the strap (belt) would be under their armpits. He/She thought there needed to be another strap that went over the lap too. CNA V's understanding was that a resident should not be left alone in the whirlpool. He/She had observed the resident seemed weaker in the days leading up to the incident. The resident used to be able to help but was now full contact for care. The day the incident happened, the resident looked weaker and told CNA V, I can't do it today, but CNA V was not aware the resident couldn't sit up properly. He/She gathered the resident's clothes, but did not have the special soap the resident used for his/her skin condition. CNA V took the resident into the spa around 3:30 P.M. or 4:00 P.M. CNA V strapped the resident into the Hoyer lift chair and lowered him/her into the whirlpool. CNA V needed the resident's special soap and had to get it from the nurse. The ESD came around the corner and CNA V asked her to watch the resident, who remained in the water filled whirlpool, while he/she went and got the soap. As the ESD walked into the spa and CNA V walked out, the ESD said the resident was sliding down. CNA V had his/her back to the resident when this happened. The strap of the Hoyer chair was under the resident's armpits. The ESD and CNA V pulled the resident up and repositioned him/her on the seat of the chair. The resident said he/she was scared and thought he/she was going down into the (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water. CNA V got the soap and finished the resident's bath. LPN F then came in and assessed the resident. Then the DON came in and assessed the resident. Afterwards, CNA V took the resident back to his/her room. He/She then went to the DON's office and the DON told him/her the correct way to provide a bath in the whirlpool. CNA V was then sent home and was off for a couple of days. When he/she came back, CNA V told the resident he/she was sorry for the fright. Observation on 02/19/26 at 3:20 P.M., showed the Faith Hall Spa had a bathtub Hoyer lift and a wall mounted call light pull station with string. The chair of the Hoyer lift had a belt bolted in the back at the top of the chair to go around the torso area. There was not a belt at the bottom to go over the lap area. During an interview on 02/19/26 at 3:20 P.M., the DON came into the spa room and looked at the bathtub Hoyer lift with the surveyor. The DON said the lift was used for residents who had poor trunk control. The DON said the belt at the top of the chair went around the waist area. Review of the bathtub Hoyer lifts Using the Invacare 1900 Lift For Non-Ambulatory Residents instructional video, showed the chair should have had a belt at the top to go around the torso and at the bottom to go over the lap. During an interview 02/20/26 at 8:30 A.M., the ESD said she was working late the day the incident took place. CNA V asked her to stand by in the whirlpool room so he/she could go get the resident's soap. She did not really feel comfortable being left with the resident, but said since she was a manager, she felt like she needed to do what was needed to help. The resident was sitting in the whirlpool. CNA V left and the ESD was alone with the resident. The resident then began to slide down into the water. She did not see a strap or belt around the resident. She grabbed the resident under his/her arms and pulled him/her up. The resident said he/she was ok, but his/her feelings were hurt. When CNA V returned, the ESD had already pulled the resident up. CNA V called for another staff member. The ESD backed out of the room to give space. The DON asked her to write a statement. She was present at the education, but did not participate. She would not put herself in that position again if asked to help. During an interview on 02/20/26 at 9:34 A.M., the resident said one of the CNAs left him/her alone in the whirlpool. The resident said he/she was going under the water, and water went in his/her mouth. It was for a short period of time. He/She was scared. The resident said he/she was not belted into a chair. One of the staff got him/her out of the water. The resident was scared to go back into the whirlpool now. There was nothing they could do to make him/her feel safe in the whirlpool. During an interview on 02/20/26 at 10:35 A.M., the DON said CNA V should have had all necessary supplies gathered prior to starting the bath. If CNA V needed help, he/she should have used the call light and asked another nursing staff to get the soap. LPN F made her aware of the incident. LPN F said the resident slipped but was not in distress. The resident was dressed and sitting in a chair when she saw and assessed the resident. Nursing staff told the DON the resident didn't want to go in the whirlpool anymore because he/she didn't want to deal with it. The DON was not aware CNA V said he/she used the bathtub Hoyer lift. The chair had not been assessed for safety concerns. The DON was not aware the chair should have had a lap belt. Any new interventions should have been included on the care plan. During an interview on 02/20/26 at 3:00 P.M., the Administrator said she expected staff to stay with residents the entire time when showering or bathing. If staff needed help, they should have used the call light and asked nursing staff for assistance. She was not aware the resident was afraid after the incident occurred. Any interventions should have been included on the care plan. The bathtub Hoyer lift had been removed and would not be used anymore. 2. Review of the facility's Smoking Protocol policy, dated 7/11/25, showed:-The facility shall maintain safety for residents who request to smoke/vape, as well as for those who do not;-Residents and resident representatives will be notified of the smoking protocol during the admission process and updated as needed;-Designated Smoking Area: Fireproof ashtray in which all smoking material will be disposed. No smoking material will be disposed of in waste cans, floors, or other inappropriate areas. Ashtrays will be emptied by maintenance/designee and will be placed in a fireproof metal container and emptied routinely. Smoking areas are to be maintained in such a manner that minimizes risk of fire hazards. Observation on 02/17/26 at 9:37 A.M., of the resident smoking area between the 200-hall and (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	300-hall, showed many cigarette butts on the ground, in the grass and on the concrete, too numerous to count. A large plastic flowerpot/planter filled with what appeared to be sand, contained a large number of cigarettes and a variety of trash items including a plastic cup, candy wrapper, and an empty pack of cigarettes. A red fireproof metal container contained a mix of medical gloves, a blunt wrapper and paper towels mixed with cigarettes butts. Two trash cans stood on either end of the smoking area filled with a variety of trash and cigarette butts. One cigarette butt rested against the facility siding. A walkway out to the garden was littered with cigarettes in the grass and on the walkway. Two smokeless ash trays were located near the back of the smoking area. Review of Resident #53's medical record, showed:-Diagnoses included hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body) following a stroke affecting right dominate side and cognitive communication deficit;-A care plan showed focus initiated 01/22/26, the resident was a smoker:--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Review of Resident #69's medical record, showed:-Diagnoses included lung disease and cognitive communication deficit;-A care plan showed focus initiated 10/14/24, the resident was a smoker;--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Observation on 02/17/26 at 9:53 A.M., showed Housekeeper C entered the smoking area along with several residents. Housekeeper C passed cigarettes to the residents and assisted residents to light their cigarettes. He/She placed a smoking apron on Resident #53 and then lit his/her cigarette. At 10:08 A.M., Resident #53 placed his/her cigarette in the flowerpot/planter, and it continued to smoke. Housekeeper C did not intervene or educate the resident on the proper disposal of cigarettes. A second cigarette lay next to the flowerpot/planter on the ground and smoked. At 10:10 A.M., the cigarette on the ground stopped smoking but the one in the planter continued to smoke. At 10:11 A.M., Resident #69 threw his/her cigarette in the flowerpot/planter. Housekeeper C did not respond or educate the residents on the proper disposal of cigarettes. At 10:17 A.M., the cigarettes in the planter continued to smoke as the staff member assisted residents back into the facility. During an interview on 02/17/26 at 11:07 A.M., Housekeeper C said the Activity Director let staff know which residents had special needs, such as needing a smoking apron. Staff were to monitor residents who could not hold cigarettes safely or who accidentally dropped cigarettes. If a resident appeared to need more help than before, he/she would tell the Activity Director. There was not really any other reason why staff would intervene with residents smoking. Review of Resident #68's medical record, showed:-Diagnoses included lung disease and schizoaffective disorder (a disorder characterized by disorganized thinking);-A care plan showed focus initiated 11/17/23, the resident was a smoker:--Goal: Will not smoke without supervision and will not sustain any injuries from unsafe smoking practices;--Interventions included: Instruct on the facility policy on smoking: location, times, and safety concerns. Requires a smoking apron. Required supervision while smoking. Review of Resident #50's medical record, showed:-Diagnoses included muscle weakness and lung disease;-A care plan showed focus initiated 01/08/24, the resident was a smoker:--Goal: Will not smoke without supervision;--Interventions included: Must smoke with smoking apron. Instruct on the facility policy on smoking: location, times, and safety concerns. Required a smoking apron. Requires supervision while smoking. Observation of the resident smoke break on 02/18/26 At 7:47 A.M., showed residents headed to the smoking area and staff passed cigarettes. At 7:55 A.M., Resident #68 stood up and placed his/her cigarette in the flowerpot/planter. He/she then went inside. Staff monitoring the smoke break did not educate the resident on the proper way to dispose of a cigarette. At 7:57 A.M., Resident #50 sat in a Broda chair (medical reclining chair) and wore a smoking apron as he/she held his/her own cigarette. A staff person stood next to him/her and held a new, unlit cigarette out to the (continued on next page)

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	265883	A. Building B. Wing	02/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. Resident #50 flicked his/her cigarette at the flowerpot/planter. It hit the edge and bounced back at him/her and landed under his/her Broda chair. The staff person handed him/her another cigarette and assisted him/her to light it. The staff person did not pick up the cigarette or educate the resident on the proper way to dispose of cigarettes. During an interview on 02/19/26 at 11:45 P.M., the Administrator said the staff monitoring resident smoke breaks were responsible to supervise the residents while they were smoking, pass out cigarettes and ensure residents were safe while smoking. Cigarettes should have been disposed of in the self-closing ash can. The flowerpot/planter and trash cans were not appropriate areas to dispose of cigarette butts. No one should throw their cigarette butts onto the ground. There should not be any trash in the self-closing ash cans or the cigarette receptacles. Housekeeping and Maintenance were responsible for maintaining the smoking areas. It should be cleaned at least daily. If the cigarette butts were not disposed of appropriately, it could lead to a fire. She expected staff to educate residents about the proper way to dispose of cigarette butts and show them where to dispose of them correctly. 27439252737724

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors for two residents (Resident #52 and #71). The failure placed both residents at risk for adverse effects and compromised therapeutic outcomes when Resident #52 was not monitored during a scheduled nebulizer treatment resulting in the treatment mask falling off the resident and Resident #71 had lidocaine patches applied for longer than recommended by the manufacturer. Sample size 18. The census was 89.1. Review of the state of Missouri Certified Medication Technician (CMT) Student Manual showed administering medications using a nebulizer: The CMT may administer inhaled medications using a nebulizer if permitted by facility policy. Due to variances in equipment, the facility must provide the CMT with training on the operation of the nebulizer system(s) being used in the facility. Documentation of the training and competency in use of the equipment must be placed in the employees' record. During an interview on 2/20/25 at 9:22 A.M., the Corporate Nurse said the facility does not have a policy to address the administration of nebulized medications. Review of Resident #52's care plan, in use at the time of survey, showed:-Focus: resident has chronic obstructive pulmonary disease (COPD, lung disease) with acute exacerbation;-Goal: resident will be free of signs and symptoms of respiratory infections through review date;-Interventions included: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Monitor for difficulty breathing (dyspnea) on exertion and for signs and symptoms of acute respiratory insufficiency.Review of the resident's physician order summary, showed an order dated 5/7/24, for Arformoterol Tartrate (medication used to treat COPD) inhalation nebulization solution 15 micrograms (mcg) inhale orally two times a day for COPD exacerbation. Review of the resident's medication administration record, showed CMT D documented the administration of the resident's Arformoterol Tartrate nebulizer treatment on 2/17/26 at 8:00 A.M.Observation on 2/17/26 at 9:46 A.M., showed the resident lay in bed on his/her back, with the head of bed elevated approximately 30 degrees. A nebulizer mask lay across his/her lap with the nebulizer machine running. The resident had noisy respiration with a rattling quality. During an interview on 2/20/26 at approximately 2:45 P.M., the Director of Nursing (DON) said she would expect the nursing staff to follow physician orders. The CMT should remain with the resident during the duration of the nebulizer treatment and report any changes to the nurse. 2. Review of the Lidoderm: Package Insert/Prescribing Information, dated 1/15/26, showed:-Generic name: lidocaine;-Dosage form: patch;-Lidoderm Dosage and Administration: Apply Lidoderm to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24-hour period. Review of the Lidocaine Transdermal Patch: MedlinePlus Drug Information, showed:-How should this medicine be used: Prescription lidocaine transdermal comes as a 5% patch and as a 1.8% topical system to apply to the skin. Prescription lidocaine transdermal is applied only once a day as needed for pain. Never apply more than 3 of the lidocaine 5% patch or lidocaine 1.8% topical systems at one time and never wear them for more than 12 hours per day (12 hours on and 12 hours off). Follow the directions on your prescription label carefully and ask your doctor or pharmacist to explain any part you do not understand;-In case of emergency/overdose: If you wear too many lidocaine transdermal patches or topical systems or wear them for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose. Review of Resident #71's medical record, showed:-Diagnoses included dementia and muscle weakness;-An order dated 1/29/26, for Lidoderm Patch 5 % (Lidocaine). Apply to painful area topically in the morning for pain;--No direction to remove the patch after 12 hours of use. Observation on 2/18/26 at 8:45 A.M., showed Certified Medication Technician (CMT) D obtained a Lidoderm 5% patch and entered the resident's room. CMT D pulled back the resident's blanket and exposed his/her right knee. The resident had 2 other Lidoderm patches in place. One dated 2/17/26 over the top of the resident's knee. The second patch dated 2/15/26 located to the inner aspect of the resident's knee. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CMT D removed the old patches and applied the new patch to the top of the resident's right knee and said yesterday's patch was the patch over the front of the knee. The second patch he/she is not sure why it was still there. During an interview on 2/20/26 at 2:30 P.M., with the Administrator, DON and Corporate Nurse they said medications, such as a Lidoderm patch, should be given per manufacturer's recommendations. A Lidoderm patch can remain on for up to 12 hours. If the order is for one Lidoderm patch to be applied, a second patch should not be applied.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to follow physician orders when staff failed to obtain labs and an x-ray timely for one resident (Resident #3). The sample was 18. The census was 89.Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/12/25, showed:-Severe cognitive impairment;-Functional limitations in range of motion in both upper and lower extremities;-Dependent on staff for Activities of Daily Living (ADL, grooming, dressing and bathing);-Diagnoses included non-Alzheimer's dementia, aphasia (language disorder that impairs a person's ability to speak, understand, read, and write), paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs) and multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells);-One stage 2 pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister);-Three stage 3 pressure ulcers ((full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling);-Five unstageable, deep tissue injuries (a severe wound where the true depth of damage cannot be immediately determined). Review of the care plan, in use at the time of the survey, showed,-Focus: Resident has unavoidable pressure ulcer (the resident developed a pressure ulcer eventhough the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; andrevised the approaches as appropriate) bilateral lower extremities;-Goal: Will have no complications related to (specify skin injury type) of the (specify location) through the review date;-Interventions: Perform treatment to wound per current treatment order. Assess wound for signs and symptoms of infection with each dressing change/treatment. Report positive findings of redness, warmth, swelling, increased drainage, increased pain. Review of the progress notes dated 12/18/25 through 01/5/26, showed:-On 12/1/25 at 3:15 P.M., late entry, Wound Care provider gave an order for resident to have a wound culture (a laboratory test that identifies bacteria, fungi, or viruses causing infection in a wound, allowing for targeted antibiotic treatment) performed for right ankle for non-healing wound, this nurse notified the pharmacy that we currently do not have the wound swabs (a diagnostic procedure used to collect samples of fluid, pus, or tissue from a wound using a sterile swab) needed to perform culture;-On 12/22/2025 at 7:31 P.M., late entry, second nursing attempt to call the lab requesting wound swabs for culture order received from Wound Care provider. The nurse spoke with dispatch who stated that he/she would reach out to his/her manager to see if a phlebotomist could drop some off to facility;-On 01/1/26 at 4:54 P.M. provider gave new order for Doxycycline (antibiotic) 100 milligrams by mouth twice daily for 10 days;-Staff did not document when the facility received the swabs, when the wound culture was obtained, when the lab was notified the specimen was ready for pick up or the results. During an interview on 02/20/26 at approximately 8:30 A.M. and 12:50 P.M. Assistant Director of Nursing (ADON) A said the lab visited the facility on Mondays and Thursdays. When a new order for a lab was needed, the nurse should enter the order into the chart and complete a lab requisition. Wound cultures should be obtained the same day they are ordered, if the facility had the supplies. Once the culture was collected, the lab should be called for a pickup. The facility was out of swabs so the ADON called the lab two or three times to try to obtain the swabs. The ADON was told the lab would talk with dispatch to have someone drop some swabs off. The ADON did not recall when the swabs were dropped off. She obtained the culture on 12/29/25 or 12/30/25. She called the lab on 01/01/26 but the lab was closed. The lab did not pick up the swab until 01/05/26. The physician was aware, and he started the resident on an antibiotic because he suspected the resident had an infection. Review of the wound physician notes dated 02/17/26, showed:-Skin tear wound of the left, lateral ankle- exacerbated due to infection, hospital, (continued on next page)

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

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds worse on return, full thickness:-Additional recommendations related to performed expanded evaluation: white blood count (WBC, blood test, measures the number of white blood cells), Erythrocyte Sedimentation Rate (ESR, blood test used to detect and monitor inflammation or infection), C-reactive protein (CRP, blood test used to detect infections, and monitor chronic diseases) , x-ray left ankle evaluate for osteomyelitis (infection in the bone);-Investigation: Recommended and/or reviewed:-Deep wound culture pending on skin tear wound of the ankle as of 02/08/26; -WBC (CBC) recommended on 02/17/26;-ESR recommended on 02/17/26;-CRP recommended on 02/17/26;-X-ray recommended (left ankle x-ray eval for osteomyelitis) on 02/17/26. Review of the progress notes dated 02/08/25 through 02/20/26, showed:-On 02/19/26 at 10:42 A.M. osteo panel (bone profile, blood and/or urine tests to evaluate bone health, assess the risk of osteoporosis, and monitor the effectiveness of treatments for bone diseases) ordered by wound care provider, lab tech in this morning to draw lab. Doctor has been updated;-Staff did not document when the deep wound culture or x-ray were completed. During an interview on 2/20/26 at 12:50 P.M., the ADON A said the deep culture pending from 02/08/26 was not obtained and would be obtained today. On 02/17/26, the wound physician ordered an osteo panel. ADON A wrote osteo panel on the lab requisition. The lab technician did not know what an osteo panel was and a thyroid panel (a group of blood tests used to evaluate how well your thyroid gland is functioning by measuring hormone levels), parathyroid hormone (blood test that measures the level of a hormone produced by the four, small, pea-sized parathyroid glands in the neck) and a vitamin D-25 hydroxy (measures how much vitamin d is in the body) was drawn. ADON A reviewed the lab results with the physician who said to draw the WBC, ESR and CRP on 02/23/26. ADON A said she was not aware the resident had an order for the x-ray before today because she did not scroll all the way down the wound note. The x-ray of the ankle will be completed today. During an interview on 02/20/26 at 10:35 A.M. the Director of Nursing (DON) said the lab provided swabs used for wound cultures. Wound cultures should be obtained within 24 hours, and the lab should be called for pick up. If the facility was out of swabs the nurse should call the lab and request some. If the swabs were not delivered within 24 hours, staff should notify the DON, and she would call the lab supervisor. The physician should also be notified if the culture was not obtained because the physician might extend the length of time to obtain the culture. If the physician was notified it should be documented in the progress notes. The DON was not aware there was an issue with the facility obtaining swabs from the lab. She would have expected documentation to show what follow up was done between 12/18/25 and 12/22/25. During an interview on 2/20/26 at 2:30 P.M., the Administrator said she would expect for staff to follow physician orders, and she would expect labs to be completed timely. If there was an issue with obtaining the lab timely, she would expect for it to be documented.

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	265883	A. Building B. Wing	02/20/2026

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to provide sufficient dietary support personnel to effectively carry out the functions of the food and nutrition services. During one of two kitchen meal service observations, meals were served late and dietary staff failed to follow the menu and serve all menu items due to not having enough dietary staff. The census was 89.During an interview on 2/17/26 at 9:59 A.M., the Assistant Administrator, Director of Nursing (DON), and Corporate Nurse said mealtimes are scheduled for 8:00 A.M., 12:30 P.M., and 6:00 P.M. Review of the Schedule of Mealtimes, showed breakfast in the dining room scheduled at 8:00 A.M., lunch in the dining room scheduled for 12:30 P.M., and supper in the dining room scheduled for 6:00 P.M. Review of the facility's breakfast menu for the date of 2/18/26, showed juice of choice, cereal of choice, egg, biscuit, sausage gravy, skim milk, and coffee or hot tea. Observation of the breakfast meal service on 2/18/26 at 9:06 A.M. showed staff passed drinks in the main dining room. Meal service began at 9:20 A.M., when staff served the first food tray. Observation in the kitchen showed [NAME] I plated the trays, and a dietary staff passed the trays out one or two at a time to residents in the main dining room. The dietary staff served residents a cup of juice, a biscuit with gravy, and a sausage patty. No eggs were cooked or served, no cereal served, and no milk served. One cook and one dietary aide worked in the kitchen. During an interview on 2/18/26 at 7:58 A.M., [NAME] I said it was only him/her and another dietary aide working in the kitchen that day. He/she could not say when the hall cart would be sent to the floor. During an interview on 2/18/26 at 9:37 A.M., Dietary Aide E said the residents should also receive milk and cereal, but the kitchen is short staffed they could not serve everything on the menu. During an interview on 2/19/26 at 3:08 P.M., the Registered Dietician said she is overseeing the dietary manager position until someone is hired. The facility currently does not have a dietary manager. She would expect menus to be followed. Not having enough staff is not a sufficient reason to not follow the menu.