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A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop an individualized service plan (ISP, the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and the goals expected by the resident or the resident's legal representative in partnership with the facility), that was updated quarterly or following each incident or change in condition for one of four sampled residents (Resident #1) who had a history of multiple falls. The resident's most recent fall resulted in a fractured hip. The facility census was 45. Review of the undated facility policy for Plan of Care (POC)/ Individualized Service Plan (ISP) showed the following: -The POC/ISP for the resident should be completed upon admission or re-admission, with a change of condition, and every six months; -The POC/ISP should be completed on all residents within five days of admission and updated every 6 months and when change of condition was identified;	A4754		

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-The ISP should be updated within 24 hours on any resident who has had a hospitalization or Skilled Nursing Facility (SNF) stay. The ISP should outline a resident's needs, preferences, services to be provided and goals expected by the resident or the resident's legal representative.

1. Review of Resident #1's face sheet showed the following:
-Admit date was 9/18/24;
-Diagnoses included repeated falls, dizziness and giddiness, spondylosis without myelopathy (a degenerative condition that affects the spine without causing compression of the spinal cord) or radiculopathy (a condition where nerve roots in the spinal column become compressed or irritated) restless legs syndrome, and osteoarthritis.

Review of the resident's ISP dated 9/18/24 showed the following:
-Resident required some assistance with bathing and dressing;
-Resident used a walker to ambulate;
-Resident is at risk for falls. Had falls at home due to weakness;
-No fall prevention interventions were included in the ISP related to the resident's history of falls or pertinent diagnoses.

Review of the resident's ISP dated 9/22/24 showed the following:
-History of falls;
-Personal care assistance including bathing;
-No fall prevention interventions included.

Review of the resident's Community Based Assessment (CBA) (process that identifies resident's needs, strengths, and preferences with the context of the assisted living community)

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dated 3/6/25 showed the resident ambulated with the use of an assistive device.

Review of the resident's progress note dated 9/23/24 showed on 9/23/24 at 1:15 A.M., resident hit call light button to summon staff because resident was lying on the floor next to recliner with his/her head against the dresser. Resident tripped over blanket and hit head. Resident requested not to go to the hospital. Vitals and range of motion checked. On-call nurse notified. Resident assisted to recliner by two staff using a gait belt.

Review of the resident's ISP showed no updates following the resident's fall on 9/23/24.

Review of resident nurse's note dated 10/15/24 showed at 10:30 AM, resident change in condition, increased restless leg and difficulty sleeping.

Review of the resident's ISP showed no update reflecting the resident's change of condition documented on 10/15/24.

Review of the resident progress note dated 10/27/24 showed at 10:54 A.M., resident used call light button to summon staff due to loss of balance fall in apartment bathroom. Staff contacted on-call nurse for permission to lift resident off the floor. Vitals and range of motion check done. Emergency contact and physician notified. Resident reminded to use walker.

Review of the resident's ISP showed no updates following the resident's fall on 10/27/24.

Review of resident's incident note dated 11/5/24 AM showed at 7:05 PM, resident used the call

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light to summon staff due to loss of balance fall next to the bed in the apartment. Staff assisted the resident to his/her feet using a gait belt and assisted to the bed, and then to recliner. On-call nurse, physician, and emergency contact notified.

Review of the resident's ISP showed no update following the resident's fall on 11/5/24.

Review of resident nurse's note dated 11/22/24 showed at 8:47 PM, resident used call light to summon staff. Staff found the resident on the floor. Vital signs taken and on-call nurse notified. Two staff assisted the resident off the floor using a gait belt.

Review of the resident's ISP showed no update following the resident's fall on 11/22/24.

Review of resident nurse's note dated 12/24/24 showed at 10:55 AM, resident used call light to summon staff due to not using walker to go to the bathroom and falling when coming out of the bathroom. Staff checked vitals and range of motion, notified on-call nurse for permission to lift resident off the floor. Staff assisted resident off floor, gave some Tylenol, and notified emergency contact and physician.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 12/24/24.

Review of resident's incident note dated 12/29/24 showed at 7:08 PM, staff went to resident's apartment to bring dinner and found the resident on the floor. Staff checked vitals and range of motion, used gait belt with two staff to assist to chair, then called the on-call nurse, physician, and family.

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Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 12/29/24.

Review of resident incident note dated 12/28/24 showed at 10:50 PM, staff entered the facility for work and noticed the resident's light was on, but the resident was in in his/her bed or chair. Staff entered resident's room and found the resident on the floor leaning against the heater. Completed vital signs and range of motion checks. Two staff members used a gait belt to assist resident to the chair. On-call nurse was notified at this time, then physician and family.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 12/28/24.

Review of resident nurse's note dated 1/8/25 showed at 12:44 AM staff was assisting resident to his/her room when the resident said his/her knees were about to go out. Staff was not able to maneuver the walker behind the resident before the resident fell to the floor. Staff completed vital signs and range of motion check. Resident's physician and on-call nurse notified.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 1/8/25.

Review of resident incident note dated 1/16/25 showed at 7:00 PM, resident used call light button to summon staff due to loss of control with walker. Resident struck head on TV stand. Two staff members assisted the resident to his/her feet and placed the resident in the recliner. Resident vitals checked, checked for visible

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marks. Nurse on call notified, then family and physician.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 1/16/25.

Review of resident nurse's note dated 2/2/25 showed at 6:46 AM, staff entered the resident's room and found the resident on the bathroom floor. Staff assisted the resident off the floor after completing range of motion assessment and helped the resident into bed. Physician, on-call nurse, and emergency contact notified.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 2/2/25.

Review of the resident's Fall Risk Evaluation dated 3/7/25 at 10:59 AM, showed the following:
-Three or more falls in the last six months;
-Interventions put in place included educate the resident related to safety with transfers;
-Remind resident to use assistive device.

Review of resident nurse's note dated 4/9/25 showed at 2:26 PM, the resident was showering while staff stood by because resident wanted to shower independently. Resident fell in the shower and hit left side on shower bench. Staff called for assistance to lift the resident from the shower floor. On-call nurse, physician, and emergency contact notified.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 4/9/25.

Review of resident's incident note dated 4/10/25

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showed at 10:00 PM, staff entered Resident #1's room to administer medication and the resident was on the floor. Resident's legs gave out returning from the restroom to recliner. Vitals and range of motion checked. Resident then assisted to feet using a gait belt and assisted to bed. On-call nurse, physician, and emergency contact notified.

Review of the resident's ISP showed no interventions for the fall or any changes to the ISP as a result of the fall on 4/10/25.

Review of resident nurse's note dated 4/16/25 showed at 5:56 PM, resident found lying on the floor next to recliner. Resident was returning to recliner after taking food from the microwave. Turned to sit and missed recliner. Staff did range of motion assessment, notified the on-call nurse, physician, and emergency contact.

Review of the resident's ISP showed no interventions for falls or changes to the ISP as a result of the fall on 4/16/25.

Review of the resident nurse's note dated 6/3/25 showed the following:
-On 6/3/25 at 10:17 AM, the resident fell and could not reach the call light. Resident called for assistance and staff heard the distress call. Staff found the resident on the floor near the recliner. Staff asked the resident if he/she could rollover and try to sit up, the resident was unable to stand. Staff assisted the resident to the recliner using a gait belt and resident complained of left hip pain. Resident emergency contact notified and advised that emergency services take resident to the hospital.
-At 1:19 PM informed resident admitted to the hospital and will have surgery due to a fractured

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A4754	Continued From page 7 hip. During an interview on 9/23/25 at 12:08 PM, the Administrator said the following: -Following each resident change in condition the ISP should be updated by the Director of Nursing (DON); -The ISP will list fall/change in condition date and interventions. It will usually be handwritten onto the care plan as things happen; -Staff will be made aware of resident changes in condition verbally by the DON. The change in condition will also be written on communication paperwork/report sheet located in the facility medication room. During interviews on 9/23/25 at 1:56 PM and 9/24/25 at 9:58 A.M., the DON said the following: -She updates the ISPs with dates of incidents and interventions after each fall or change in condition; -The ISP was usually hand written into the care plan as things happened; -Staff are made aware of resident changes in condition verbally by the DON and also by a report sheet located in the medication room; -The care plans are updated by the DON unless the DON is not present at the time of change of condition or fall. If not present, she will inform staff of interventions verbally to use and it will be added to the communication tool; -She thought Resident #1's ISP had been updated after each fall; -It was her responsibility to update the ISPs; -She did not know why updates and interventions were not completed after each of Resident #1's falls. MO257540	A4754		

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A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class I* Based on observation, interview and record review, the facility failed to provide proper care for two residents (Resident #1 and #2), of four sampled residents. Staff found Resident #2 with symptoms of a stroke, left the resident unattended for 30 minutes, and did not call emergency services. When staff returned to the room, the resident was on the floor. Staff then called the resident's responsible party instead of calling 911. The resident's family member came to the facility and transported the resident to the hospital where the resident was admitted with diagnosis of a stroke and fractured pelvis. Resident #1 had a fall and was unable to stand, the facility staff failed to follow their policy and notify the charge nurse for the nurse to assess the resident, instead, the staff picked the resident up off the floor and sat him/her in a chair. The resident complained of hip pain. Resident #1 was admitted to the hospital with a diagnosis of a fractured hip. The facility census was 45. Review of the facility policy for Plan of Care/Individualized Service Place (ISP) with a revision date of 10/2011 showed the following: -The Plan of Care/ISP for the resident should be completed upon admission, readmission, change of condition and every six months. The individualized plan of care is a communication tool among caregivers and it directs the resident's	A4777		

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care:
-The ISP should outline a resident's needs, preferences, services to be provided and goals expected by the resident or the resident's legal representative.

Review of the facility's undated Fall Reduction and Management policy showed the following:
-Evaluate resident's condition before moving;
-Observe for bumps, bruises, cuts, abrasions, scrapes, body misalignment, confusion, loss of consciousness;
-Give range of motion if there is no misalignment to extremities to assess for discomfort, and crepitus;
-Do not stand resident upright, lift bed or chair;
-Cover to prevent chilling;
-Notify physician within an appropriate time frame;
-Notify family or responsible party within an appropriate time frame;
-Initiate neuro checks for any fall where resident hit head or for any resident who has an unwitnessed fall. If the resident is alert and oriented and denies hitting head and there are no obvious signs of head injury, it is not necessary to initiate continued neuro checks. It is extremely important in these cases to document mental state;
-Observe resident, staff and environmental characteristics, which could have contributed to fall.

1. Record review of Resident #2's face sheet showed the following:
-He/She admitted to the facility on 5/7/21;
-Resident's diagnoses included dementia and essential hypertension (high blood pressure).

Review of the resident's ISP dated 3/12/25

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showed the following:
-He/She was independent with bathing, dressing, and oral care;
-Does not use an assistive device with ambulation and does not not require any assistance with mobility.

Review of the resident's Community Based Assessment (CBA - a formal evaluation to understand a community's health needs, identify strengths and weaknesses, and determine eligibility for specific programs) dated 4/28/25 showed the following:
-He/She required assistance with bathing and dressing;
-Independent with mobility and able to transfer self in and out of bed or chair;
-Had some memory lapses;
-Had a diagnosis of dementia and high blood pressure.

Review of facility Incident Report dated 7/27/25 at 7:00 A.M. signed by Level One Medication Aide (LIMA) A showed the following:
-On 7/27/25 at 6:30 A.M. incident occurred in Resident #2's apartment;
-Staff went in at 6:30 A.M. to give the resident his/her 6:00 A.M. medication. The resident was leaning on the couch towards his/her right side. Staff asked the resident to sit there and he/she would be right back to help them get dressed because he/she might need help. Went back to the resident's room, it was a half hour later and the resident had gotten up on his/her own and fallen. The resident sat on the floor on his/her bottom;
-Staff asked the resident what happened. The resident said he/she was going to the bathroom, fell on his/her right knee and then was able to sit on his/her bottom. Called for other staff and was

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able to get the resident up after doing range of motion (ROM);
-LIMA A called for LIMA D, who did the resdient ROM assessment, took vitals, picked resident up off the floor using a gait belt, and assisted resident to the restroom;
-The resident could not hold onto the walker with his/her right hand;
-LIMA A and LIMA D dressed the resident, moved him/her to the couch, and asked if he/she wanted something to eat, the resident said no;
-LIMA A called Resident #2's emergency contact to inform of condition and left a voicemail;
-On-call nurse, Memory Care Director of Nursing (MCDON) was on three-way call with LIMA A and Resident #2's emergency contact. MCDON told emergency contact that Resident #2 needed to go to the emergency room to be checked out;
-Emergency contact said he/she would come to the facility and take the resident to the emergency room.

Review of the resident's nurses notes date 7/27/2025 at 9:31 A.M. showed the following: Staff went in to give the resident his/her 6:00 A.M. pills and the resident was leaning towards his/her right side on the couch. The resident said he/she was going to stay on couch until staff came back to help him/her get dressed, the resident only had a shirt on, and when staff went back in to the room the resident was on the floor by the couch sitting on his/her bottom. Staff asked the resident what happened. The resident said he/she was trying to get up to go the bathroom and lost his/her balance. The resident could not hold onto the walker with his/her right hand, so staff got other staff to come help, and called the on call person, took vitals, and both staff got him/her up to the restroom. Other staff went ahead and left the room this staff got the resident dressed, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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proceeded to walk the resident back to the couch. The resident still could not grab the walker with the right hand. Staff told the resident he/she was going to get him/her something to eat be right back. When back the resident tried getting up again off the bed; staff got the resident into the wheelchair. The resident did not want anything to eat but drank a little. Staff gave the resident the rest of his/her morning medications because the resident's family member was coming to take the resident to emergency room. Staff stayed with the resident until the family member arrived; the resident was unable to use his/her right hand.

Review of Resident #2's local hospital medical records dated 7/27/25 showed the following:
-Resident brought in by family member from an assisted living facility (ALF) for possible stroke and fall. History very limited and obtained entirely by family member, as the resident has dementia and the assisted living personnel were not available for information. The family member reported being called by the ALF with concerns that the resident may have had a stroke and fell from his/her bed overnight. The family member said staff from the ALF told them the resident was found down on the ground and was not able to move his/her right arm, had a facial droop so there was a concern the resident had a stroke and subsequent trauma. The family member said when they went to pick the resident up, he/she had rather significant facial droop and slurred speech.
-Resident also suffered a mechanical fall, unwitnessed and the time cannot be determined. Code stroke initiated. (a medical emergency protocol that is activated when a patient presents with signs and symptoms of a stroke).
-A NIHSS (a standardized, 15-item assessment tool used by medical professionals to quantify the

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	26349	A. BUILDING: _____ B. WING _____	C 09/17/2025

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neurological severity of a stroke and monitor changes in a patient's condition. Developed by the National Institutes of Health (NIH), the NIHSS assesses various neurological functions, including consciousness, language, facial palsy, motor strength in the limbs, and coordination. A higher NIHSS score indicates a more severe stroke) was completed with a score of 11 which was considered a moderate stroke (score of 5-15 is moderate stroke);
-The case was discussed with a virtual neurologist, who recommended admission and transfer for routine stroke evaluation. TNK (acronym for Tenecteplase, drug used to dissolve blood clots, primarily for the treatment of acute ischemic stroke within the initial 4.5 hour window) medication was not an option because the resident was outside the window for effective administration.

Review of regional hospital records showed the following (resident transferred from the local to a regional hospital on 7/27/25):
-Resident has a history of dementia, hypertension and mood disorder who was in their usual state of of health until 7/27/25. The resident's family member said that the resident was "off kilter" the day before, complained of being tired and did not feel well. Today, 7/27/25, the facility called the family member and said "your mom is not acting right, you might want to come and see her". When he went to visit the resident, it looked like he/she had fallen. His/her blood pressure was very high. The facility staff said they had found the resident on the ground earlier in the morning;
-Impression: subcutaneous hematoma within the soft tissue just lateral to the proximal right femur (large bone in the upper leg) with area of internal active hemorrhage (blood pooled under the skin resulting from trauma);

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-Right inferior pubic ramus fracture (a break in the lower portion of the pelvic bone on the right side, known as the inferior pubic ramus) is probably recent with a well visible fracture line and ongoing healing changes;
-Results of the MRI of the brain: acute infarct of the left lentiform nucleus (means a recent stroke (infarct) has occurred in the left lentiform nucleus of the brain, a deep gray matter structure involved in motor control and cognition).

During an interview on 9/2/25 at 8:35 AM, Resident #2's Emergency Contact said the following:
-He/She received a call from facility staff the resident had fallen and the resident had weakness in his/her right leg;
-He/She told LIMA A that he/she would come to the facility and see the resident;
-When he/she arrived at the facility Resident #2 was in a wheelchair in the entrance lobby;
-The resident's mouth looked like it was drooping and he/she could not grip with his/her right hand;
-He/She did not tell the facility not to call 911 or that he/she would transport the resident;
-Emergency room staff told him/her the resident had a stroke;
-The hospital said if Resident #2 had gotten to the hospital within two hours from stroke onset, the stroke effects could have been reversed.

During interviews on 8/7/25 at 1:27 PM, 9/2/25 at 5:10 P.M., and 9/9/25 at 1:18 P.M., LIMA A said the following:
-He/She found Resident #2 slumped to the right on the couch in the resident's apartment;
-He/She was not sure if the resident was having a stroke, but he/she knew the resident was not acting right;
-He/She left the resident's room to complete a

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medication pass then came back about 30 minutes later and the resident was on the floor on his/her knees;
-LIMA A called LIMA B to assist:
-LIMA B came in the room and assisted him/her to get the resident off the floor, he/she noticed the resident could not grip his/her walker with his/her right hand and knew something was not right with the resident;
-LIMA A called the on-call nurse, MCDON;
-LIMA A called Resident #2's emergency contact and left a voicemail;
-LIMA A called the MCDON on his/her personal phone and spoke to the second emergency contact on a work phone simultaneously to determine what to do;
-He/She contacted the resident's emergency contact first because he/she thought it was facility protocol;
-If he/she suspected a resident was having a stroke or medical emergency he/she would call 911;
-He/She had completed training for the signs and symptoms of stroke on 3/27/25.

During an interview on 9/9/25 at 1:18 P.M., LIMA B said the following:
-LIMA A asked him/her to come to Resident #2's room because the resident had fallen;
-The resident sat on the floor and was confused;
-LIMA A and B lifted the resident off the floor using a gait belt;
-While assisting the resident to the restroom the resident had difficulty grasping the walker;
-He/She had completed training for the signs and symptoms of stroke on 3/27/25.

During interviews on 8/7/25 at 1:46 P.M., 9/2/25 at 5:15 P.M., and 9/9/25 at 11:37 A.M., MCDON said the following:

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A4777	Continued From page 16 -On 7/27/25 around 7:00 A.M. he/she received a text message from LIMA A informing him/her that the resident had fallen; -Then about six minutes later, LIMA A called saying he/she entered Resident #2's room to administer medication and assist with toileting and found the resident on the floor; -LIMA A never reported he/she found Resident #2 sitting on the couch slumping to the right and that LIMA A believed Resident #2 was having a stroke; -He/She advised LIMA A to contact emergency services then contact the resident's emergency contact; -LIMA A said Resident #2's emergency contact would transport the resident to hospital because they did not want to pay for ambulance service; -Resident #2's emergency contact arrived at the facility and transported the resident to the Emergency Room (ER); -He/She did not see the resident as he/she was not in the facility at the time of the incident; -Staff are expected to contact the on-call nurse when a change in resident condition occurs; -He/She was not aware LIMA A had left Resident #2 on the sofa for 30 minutes after LIMA had found the resident leaning to the right; -It was not appropriate for LIMA A to leave Resident #2 for 30 minutes if he/she believed the resident was having a stroke or emergency change in condition; -He/She expected LIMA A to have called emergency services first for Resident #2; -He/She did not observe the conversation between LIMA A and Resident #2's emergency contact regarding the family member transporting the resident to the hospital; -It is the expectation that staff follow protocol for residents with emergency needs. 1) Contact DON and give update on resident unless resident had symptoms listed in the emergency needs	A4777		

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protocol. 2) Contact responsible party and give update on resident and where resident is being transported;
-Staff receive training on how to handle a situation in which a resident is experiencing a change in condition;
-Staff are trained to recognize the signs and symptoms of stroke. MCDON was the instructor.

During an interview on 8/7/25 at 12:15 PM, Assisted Living Director of Nursing (ALDON) said the following:
-Staff should call 911 when a resident was in extreme pain or unresponsive;
-If staff felt a situation was serious enough, they can contact 911 with approval from the on-call nurse;
-When a fall occurred, staff are instructed to leave the resident on the floor until they speak to the on-call nurse;
-If a resident has a change in condition staff should call the on-call nurse before taking any further action.

During interview on 9/2/25 at 5:20 P.M., the Administrator said the following: If a resident is experiencing an emergency change in condition and the responsible party requested to transport the resident, staff should follow the protocol for residents with emergency needs and call 911 if an emergency is present. Staff would notify emergency contact after they call 911.

During an interview on 9/11/25 at 10:16 A.M., Resident #2's Primary Care Physician said the following:
-He/She did not receive a call from the facility regarding Resident #2;
-The last call he/she received from the facility was on 4/6/25 due to mental status change;

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-Resident #2 was last seen at his/her office on 10/28/24;
-It is his/her expectation for staff responding to a resident showing signs and symptoms of stroke, or any health emergency is to call emergency medical services first, the physician, then family or responsible party.

2. Review of Resident #1's face sheet showed the following:
-Admit date was 9/18/24;
-Diagnoses included repeated falls, dizziness and giddiness,spondylosis without myelopathy (degenerative condition that affects the spine without causing compression of the spinal cord) or radiculopathy (condition where nerve roots in the spinal column become compressed or irritated) restless legs syndrome, and osteoarthritis.

Review of the resident's ISP dated 9/18/24 showed the following:
-Resident required some assistance with bathing and dressing;
-Resident used a walker to ambulate;
-Resident is at risk for falls. Had falls at home due to weakness;
-No fall prevention interventions included to address resident fall.

Review of resident nurse's note dated 6/3/25 showed the following:
-On 6/3/25 at 10:17 A.M., the resident fell and could not reach the call light. Resident called for assistance and staff heard the distress call. Staff found the resident on the floor near the recliner. Staff asked the resident if he/she could rollover and try to sit up, the resident was unable to stand. Staff assisted the resident to the recliner using a gait belt and resident complained of left hip pain.

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Resident emergency contact notified and advised that emergency services take resident to the hospital.
-At 1:19 P.M. informed resident admitted to the hospital and will have surgery due to a fractured hip.

During interview on 8/7/25 at 1:27 P.M. and 8/26/25 at 11:07 A.M., LIMA A said the following:
-Resident #1 was unable to get off the floor after falling on 6/3/25;
-He/She asked if the resident was able to turn over;
-The resident was able to roll over, but unable to stand;
-LIMA A and LIMA D attempted to have the resident stand, but the resident was unable to bear any weight;
-He/She and LIMA D transferred the resident to the recliner using a gait belt; the resident complained of terrible hip pain;
-The MCDON told staff to contact emergency services;
-Emergency services took the resident to the hospital where it was determined the resident had a fractured hip that required surgery;
-Contacted on-call Director of Nursing (DON), assess for bumps, scraps, bruises, and did range of motion.

During interview on 8/7/25 at 1:46 P.M., the MCDON said the following:
-Staff should contact the on-call nurse when falls occur;
-Staff should follow the fall policy to evaluate the resident before moving, observe for bumps, bruises, scars, misalignment, give range of motion, lift to bed or chair, do not stand upright, cover to prevent chill, notify physician, notify family or responsible party, initiate neuro checks,

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observe resident, staff, and environmental characteristics, which could have contributed to fall.

During an interview on 8/7/25 at 12:15 PM, ALDON said the following:
-When a fall occurs, staff are instructed to leave the resident on the floor until they speak to the on-call nurse;
-She was notified of Resident #1's recent fall;
-She advised staff to call emergency services for Resident #1 due to extreme pain.

During an interview on 9/25/25 at 11:04 AM, the administrator said the following:
-He/She expects staff to follow fall protocol if they are responding to an unwitnessed fall;
-Staff are required to call the on-call nurse to assess the resident;
-Staff should not move or transfer the resident prior to any assessment.

At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. During the onsite visit, the facility in-serviced all staff on the facility policy for emergencies, when to call 911, and the signs and symptoms of a stroke. The facility also reviewed every resident's medical record to address any change in condition. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.

At the time of exit, the severity of the deficiency was lowered to the class II level.

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PLAN OF CORRECTION

Provider/Supplier Name:	Sugar Creek Assisted Living by Americare
Street Address, City, Zip:	161 Professional Parkway Troy, MO 63379
Date of Survey:	09/17/2025
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	26349

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4754	In response to 19CSR 30-86.047(28)(G) Individual Service Plan Develop **Immediate Action:** All incident reports and falls reviewed by Director of Nurses and Individual Service Plans reviewed and updated to reflect most recent fall and interventions added to decrease the opportunity for future falls. All resident Fall Risk Evaluations reviewed all residents found to score at risk for fall have had their Individual Service Plans updated to reflect residents' risk for falls and appropriate interventions added to the ISP to decrease the opportunity of falls. Director of Nursing will provide education to all direct care staff on the following: 1. Utilizing the 24-hour communication log to report to oncoming staff all falls, changes in residents' condition or change in resident orders. 2. Education to reviewing resident's ISP for updated interventions or care service needs. 3. Review of policies and procedures on Fall Follow up Protocols 4. Review of Care Paths including Signs & Symptoms of Stoke as well as other Emergent Diagnosis that may present as Change of Condition 5. Change of Condition Education to be completed on or before 10/20/2025 All falls and change of conditions will be reviewed at Hi5 morning meeting to ensure ISP are updated to reflect residents needs and services, physician, resident, residents responsible party/POA and direct care staff are updated on any falls or other changes in conditions.	10/20/2025

Executive Director 10-13-2025

	Ongoing Compliance: Director of Nurse or designee in absence will ensure ongoing compliance through completing daily review of 24-hour communication log and incident reports to follow up on falls, change of condition, change in orders or other significant events and update Individual Service Plan for any resident who has sustained a new fall, change of condition, order changes or other significant event that impact residents care and services needs or a to ensure appropriate interventions are in place to decrease future falls, and communicate updated interventions to staff. Review will take place at daily Hi5 meeting. **Completion Date:** 10/20/2025	
A4777	In response to 19CSR 30-86.047(36) Proper Care Per Individualized Plan of Care **Immediate Action:** All resident charts and Individual Service Plans (ISP) review including resident #2. Resident #2 was transferred out to ER by family on 7/27/25. No other resident where identified at that time to have any decline or change in condition. In-servicing conducted for all staff prior to allowing staff to work next shift. In-servicing initiated on 09/15/2025 and completed for all staff on or before 09/19/2025. In servicing included education on following policies and procedures: 1. Residents with Emergency Needs 2. Fall Follow Up Protocol 3. Care Paths including Signs & Symptoms of Stoke as well as other Emergent Diagnosis that may present as Change of Condition 4. Change of Condition policy and procedure. In-servicing completed by Director of Nurses and or Director of Nurses on Call. Both on duty and off duty staff received the same in-servicing either through face to face or through the use of crew app and have documentation to support that training was completed prior to the start of their next shift.	10/20/2025

	Ongoing Compliance: DON and or Administrator will continue to educate both current staff and newly hired staff on policies and procedures related to: 1. Residents with Emergency Needs 2. Fall Follow Up Protocol 3. Care Paths including Signs & Symptoms of Stoke as well as other Emergent Diagnosis that may present as Change of Condition 4. Change of Condition policy and procedure. Director of Nurses (DON) and or on Call Director of Nurses in absence of Director of Nursing will assure ongoing compliance through staff immediately notifying the DON of all incidents or change of condition and immediately directing the staff to call 911 and residents' family/responsible party/POA to see what their wishes are on sending resident to ER for further evaluation. The communication with resident's family/responsible party/POA and physician will be documented in the residents EHR as to their directive on transfer to ER for eval, if resident's family/responsible party/POA is unable to be reached the resident will be transferred to ER unless otherwise directed in the ISP developed by facility, resident and or resident's family/responsible party/POA. **Completion Date:** 10/20/2025	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.