

PRINTED: 05/14/2026
FORM APPROVED

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/29/2026
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NAME OF PROVIDER OR SUPPLIER BARATHAVEN MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1030 BARATHAVEN DRIVE DARDENNE PRAIRIE, MO 63368
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A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/I This regulation is not met as evidenced by: Class II Based on interview, and record review, the facility failed to follow the facility's policy and procedures for three residents (Resident #4, #5, and #3), who experienced falls, in a review of eight sampled residents. Staff failed to consistently review/revise interventions and provide adequate supervision to prevent a recurrence of falls after the residents fell. The facility failed to ensure two residents (Residents #6 and #7) were free from falls when one resident (Resident #2), who staff placed on the floor as an intervention to prevent the resident from falling, pulled the residents to the floor as he/she sat on the floor. The facility's census was 53. Review of the facility policy, Fall Risk Assessment, revised 7/01/19, showed the following: -All residents in the facility will be considered at risk for falls; -The Wellness Director or designee provides education in minimizing the risk of falls; -If a resident is determined to be at high risk for falls, an action plan that includes specific interventions will be developed by the Wellness Director/designee and included in the resident Service/Wellness plan;	A4776		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tina Galt

TITLE

Consultant, NLS

(X6) DATE

5/27/26

Missouri Department of Health and Senior Services

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A4776	Continued From page 2 -If a resident has hit their head or reports hitting their head, or if a head injury is noted post fall, the resident will be transported to the emergency room for further evaluation; -After every fall, the nurse or supervisor will complete an Incident Reporting Form and document all care given in the resident's record, along with a list of individuals notified; -Place the resident on 72-hour follow-up charting. Review of the facility policy, Interdisciplinary Wellness Team, revised 7/01/19, showed the following: -The facility will establish an Interdisciplinary Wellness Team (IDT) to identify resident specific challenges and to develop problem solving strategies to address the challenges; -The IDT will meet weekly to discuss resident specific challenges to include frequent fallers and specific action items and tasks assigned with weekly follow-up using the wellness conference weekly plan. 1. Review of Resident #4's undated face sheet showed the following: -Admission date 2/23/24; -Diagnosis of Alzheimer's disease. Review of the resident's July 2025 fall risk assessment showed a fall risk score of 16. A score of 10 or more indicated the resident was at a high risk for falls. Review of the resident's October 2025 fall risk assessment showed a fall risk score of 18. Review of resident's community based assessment (CBA), dated 10/06/25, showed the following: -Does not use any assistive device;	A4776			

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A4776	Continued From page 3 -Has had five falls in the last three months; -Can transfer independently; -The resident is at high risk of falls; -The resident has poor safety awareness, but ambulates on his/her own; -Staff to keep apartment and common area free of clutter and well lit; -Staff to assist. Review of the resident's nurse's note, dated 1/03/26 at 6:29 A.M., showed Certified Nurse Assistant (CNA) H documented the resident fell in front of the nursing station and hit the left side of his/her head. The resident had a small knot on the back, left side of the head. Emergency medical services (EMS) transported the resident to the hospital. The resident did not have any complaints of pain and refused to have vital signs checked. Review of the resident's nurse's note, dated 1/03/26 at 10:09 P.M., showed Level I Medication Aide (LIMA) C documented at 5:00 P.M., the resident wandered into the room and attempted to sit on a chair. He/She missed the chair and fell onto his/her bottom and back and made contact with the wall. Care staff assisted the resident up using a gait belt, and the resident ambulated to the dining room for dinner. The resident reported no pain. Review of the resident's nurse's note, dated 1/10/26 at 9:11 P.M., showed LIMA D documented staff observed the resident on the floor in the sun room. The resident appeared to be sleeping. Staff checked the resident for bruises, bumps, and abrasions and nothing was found. Staff assisted the resident to get up, walk to his/her room, and assisted the resident to the bathroom and into bed.	A4776			

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A4776	Continued From page 4 Review of the resident's nurse's note, dated 1/20/26 at 4:20 P.M., showed LIMA J documented the resident fell, causing another resident to fall in front of the Health Services Director's office. The resident struck his/her head, causing a laceration to the left outer corner of his/her eye. The resident complained of left arm and shoulder pain. Staff contacted EMS and the resident was transported to the emergency room (ER). The resident sustained a fracture to the left humerus and his/her arm was placed in a sling. Four absorbable sutures were placed over the eye laceration. Review of the resident's Individualized Service Plan (ISP) showed no updated fall interventions following the resident's falls on 1/3/26, 1/10/26 and 1/20/26. Review of resident's ISP, dated 3/18/26, showed the following: -The resident spent most of the day in a Broda chair (specialized, adjustable medical wheelchair or positioning chair); -The resident required staff assistance with transfers; -The resident required verbal and physical direction from staff for safety; -Staff to keep the resident's apartment and common area free of clutter and well lit. Review of the resident's nurse's note, dated 3/23/26 at 9:42 P.M., showed LIMA J documented at 4:20 P.M., staff observed the resident lying on the floor in the hallway on his/her left side with no visible injuries. Staff notified EMS who transported the resident to the hospital at 4:38 P.M. The resident did not complain of pain. The resident returned to the facility at 9:00 P.M.	A4776			

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A4776	Continued From page 5 via EMS. Review of the resident's ISP, updated on 3/23/26, showed the resident fell. Staff were to encourage the resident to take breaks during the day to reduce fatigue and falls. Review of the resident's nurse's note, dated 3/24/26 at 7:12 A.M., showed LIMA C documented staff observed the resident lying in the common area in front of the bathrooms on his/her left side. The resident had a raised area on the left side of his/her forehead. The resident was sent out via EMS to the hospital. The resident returned to the facility at 9:30 A.M. with clear scans. Review of the resident's ISP, updated on 3/24/26, showed the resident fell. Staff were to ensure the resident's apartment was free and clear of clutter and well lit (repeated intervention). (The resident fell in the common area on 3/24/26. The intervention identified following the fall on 3/24/26 addressed ensuring the resident's apartment was free and clear of clutter and well lit.) Review of the resident's nurse's note, dated 4/01/26 at 11:30 A.M., showed LIMA B documented the resident fell at approximately 10:50 A.M. in the sun room. The resident tripped on a furniture leg and lost his/her balance, striking his/her head. The resident sustained a laceration on the right side of his/her head. The resident was transported via EMS to the emergency room. Review of the resident's ISP, updated on 4/01/26, showed the resident fell. Staff were to ensure pathways and common areas were free of clutter and well lit (repeated intervention).	A4776		

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A4776	Continued From page 6 Review of the resident's nurse's note, dated 4/08/26 at 2:32 P.M., showed LIMA B documented the resident was attempting to sit down in a chair and slid off the edge of the chair, landing on the floor. No injuries were observed. Review of the resident's ISP, updated on 4/08/26, showed the resident fell. Staff were to ensure the resident wore properly fitting shoes that were non-skid. Review of the resident's nurse's note, dated 4/09/26 at 4:24 P.M., showed LIMA A documented the resident walked out of a room, holding onto the hand rail. Another resident was walking along the wall holding the rail. Resident #4 let go of the rail to let the other resident pass. Both residents bumped into each other and fell. Resident #4 lay on his/her left side with his/her hand under his/her head. Review of the resident's nurse's note, dated 4/09/26 at 10:14 P.M., showed LIMA J documented the resident fell at 3:55 P.M. when he/she and another resident collided in the hallway. Resident #4 sustained a golf-ball sized bump to the left forehead and complained of right leg pain. Staff notified EMS and transferred the resident to the hospital at 4:10 P.M. At 6:16 P.M., the hospital nurse informed the facility the resident had a brain bleed. The resident was transported to another hospital for treatment of a subdural bleed (a critical, often life threatening collection of blood between the brain and it's outer lining, typically caused from a head injury). Review of the resident's ISP, updated on 4/09/26, showed the resident fell. Staff were to encourage the resident to participate and attend activities, and one-on-one staff engagement, when able, to	A4776			

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A4776	Continued From page 7 prevent falls. Review of the resident's nurse's note, dated 4/12/26 at 11:06 A.M., showed LIMA B documented the hospital nurse and social worker called the facility at 10:30 A.M. and 10:50 A.M. to report they were working to admit the resident to hospice services. The resident would be discharged when the hospice admission was completed. During an interview on 5/6/26 at 2:21 P.M., the resident's family member said staff placed a low hospital bed and a fall mat in the resident's apartment on 4/13/26. Review of the resident's nurse's note, dated 4/19/26 at 2:18 P.M., showed Caregiver K documented the resident had a witnessed fall at the front nurse's station at 1:55 P.M. The resident was attempting to get out of the wheelchair and slid onto the floor. There were no visible injuries. Review of the resident's ISP, updated on 4/24/26, showed staff were to ensure proper body positioning when seated. Staff to provide close supervision during high risk time (early morning, evening), and staff to maintain a clutter free environment and clear pathways in the resident's apartment and common areas as needed. Observation on 4/28/26 at 11:30 A.M. showed the resident sat in a Broda chair with his/her feet elevated. The resident had a C-shaped laceration on his/her forehead above the right eye. The resident had a fading bruise from his/her left temple area that extended down to his/her cheek bone. During an interview on 4/28/26 at 11:39 A.M., the	A4776			

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A4776	Continued From page 8 resident's family member said the following: -The resident had 17 falls since November 2025. The facial bruising was from a recent fall; -The resident went to the emergency room (ER) six times for the 17 falls; -The resident had injuries from the previous falls including a brain bleed and a fractured arm; -Before the falls, the resident was always up and walking. The resident declined following the falls to a wheelchair and now used a Broda chair. The resident could not currently stand without assistance and required staff assistance for transfers to the Broda chair. During an interview on 4/28/26 at 12:08 P.M., the resident's hospice nurse said the following: -The resident had a subdural brain bleed following a fall; -The resident fell one time since going on hospice; -He/She was not aware of what the facility had done to address the resident's 17 previous falls. -There should be a process to prevent falls for residents. 2. Review of Resident #5's undated face sheet showed the following: -Admission date 2/9/26; -Diagnoses of Alzheimer's disease, dementia, and hip fracture. Review of the resident's CBA, dated 2/10/26, showed the following: -The resident was non-ambulatory; -The resident had generalized weakness and difficulty walking on his/her own, staff to assist; -The resident had several falls during his/her hospitalizations; -The resident required physical assistance from staff to transfer in and out of a wheelchair, as well	A4776			

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A4776	Continued From page 9 as to propel around the facility. Staff to assist the resident; -The resident had several falls during his/her stay. His/Her most recent fall resulted in a hip fracture. Review of the resident's ISP, dated 2/10/26 showed the following: -Hip precautions (restrictions of movement following hip surgery); -Required staff assistance with transfers; -High fall risk due to weakness and poor safety awareness; -Required verbal and physical direction from staff for safety. Review of the resident's nurse's note, dated 2/10/26 at 11:07 A.M., showed LIMA G documented the resident attempted to get out of his/her wheelchair and fell forward, landing on his/her side with no injury. Review of resident's ISP showed no updated fall interventions following the fall on 2/10/26. Review of the resident's nurse's note, dated 2/15/26 at 8:06 P.M., showed LIMA B documented the resident attempted to stand from the wheelchair while staff transported the resident to the dining room. The resident fell on the floor onto his/her right shoulder. No injuries were noted. Review of the resident's ISP showed no update following the fall on 2/15/26. Review of the resident's nurse's note, dated 3/4/26 at 9:10 P.M., showed LIMA B notified the facility nurse the resident complained of right leg and hip pain. Staff observed the resident's right	A4776			

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A4776	Continued From page 10 leg was rotated outward with swelling and bruising. EMS transported the resident to the emergency room. Review of resident's ISP, dated 3/12/26 showed the following: -Hip precautions; -Required staff to assist with transfers, maintaining hip precautions; -High fall risk due to weakness and poor safety awareness. Most recent fall resulted in a hip fracture. -There were no interventions added to the ISP to address the resident's fall on 3/04/26. Review of the resident's nurse's note, dated 3/21/26 at 1:44 P.M., showed Caregiver K documented the resident had an unwitnessed fall at 7:18 A.M. The resident sat on the edge of the bed and fell backwards, hitting his/her head on the wheelchair. There were no visible injuries. Review of the resident's ISP showed no update to address the resident's fall on 3/21/26. Review of the resident's nurse's note, dated 3/22/26 at 2:00 P.M., showed Caregiver K documented the resident fell at 10:41 A.M. at the front nurse's station. The resident tried to stand up from the wheelchair and fell on his/her bottom. There were no visible injuries. Review of the resident's ISP showed no update to address the resident's fall on 3/22/26. Review of the resident's nurse's note, dated 3/23/26 at 3:02 P.M., showed LIMA B documented the resident attempted to stand from the wheelchair and slid down to the floor. No injuries noted.	A4776		

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A4776	Continued From page 11 Review of the resident's ISP showed no update to address the resident's fall on 3/23/26. Review of the resident's nurse's note, dated 3/27/26 at 10:47 P.M., showed LIMA D documented staff alerted him/her of a fall in the resident's room. LIMA D observed video footage and saw the resident stand up out of bed and fall to his/her right side into the wall pretty hard. The resident was sent out via EMS to the hospital for observation. Review of the resident's ISP showed no update to address the resident's fall on 3/27/26. Review of the resident's nurse's note, dated 3/28/26 at 4:54 A.M., showed CNA H documented the resident fell. The video showed the resident stand from bed and fall to the right side of his/her body onto the floor. Staff assisted the resident to the wheelchair. There were no visible injuries. Review of the resident's ISP showed no update to address the resident's fall on 3/28/26. Review of the resident's nurse's note, dated 4/17/26 at 9:10 A.M., showed LIMA B documented a caregiver assisted the resident with toileting. The caregiver stepped out of the bathroom to retrieve an incontinence brief and left the resident seated on the toilet with pants pulled down. When the caregiver returned, the resident was on the floor with his/her pants pulled up. There were no injuries noted. There were no interventions added to the ISP to address the resident's fall on 4/17/26.	A4776			

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A4776	Continued From page 12 Observation on 4/28/26 showed the following: -At 4:00 P.M., the resident lay directly on the floor in the common area near the nurses' desk on his/her right side with his/her face directly on the floor. The resident's walker was near his/her head. The resident sat up and used his/her hands and feet to scoot down the hall approximately 12 feet on his/her buttocks. The resident turned around and scooted back toward his/her walker. The resident attempted to lay down directly on the floor and then sat back up. The resident remained on the floor while multiple staff members walked past the resident and side-stepped around the resident while he/she scooted around on the floor. Multiple residents either walked past the resident or maneuvered a walker or wheelchair around the resident while the resident either laid directly on the floor or scooted around the hall on his/her buttocks; -At 4:12 P.M., the resident was in front of the nurse's station using his/her hands and feet to slide across the floor on his/her buttocks. The resident attempted to lay on his/her side multiple times. Multiple staff members walked by the resident on the floor and did not acknowledge him/her; -At 4:15 P.M., the resident lay down directly on the floor on his/her right side with his/her head and face directly on the floor. Caregiver M obtained a wheelchair. The resident said, "thank you." Caregiver M and Caregiver N applied a gait belt and lifted the resident off the floor. The resident stood with his/her knees bent and leaned forward at his/her waist. Caregiver M and Caregiver N sat the resident in a wheelchair. During an interview on 4/28/26 at 4:13 P.M., Caregiver E said staff put the resident on the floor to prevent him/her from falling.	A4776		

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A4776	Continued From page 13 During an interview on 4/28/26 at 4:20 P.M., Caregiver N said the resident on the floor was the safest option to prevent falls. The resident fell when he/she tried to walk and leaned forward when sitting and fell out of the wheelchair. Staff tried to monitor the resident frequently. Caregiver N was not aware of any other fall prevention interventions for the resident. During an interview on 4/28/26 at 4:25 P.M., LIMA A said staff put the resident on the floor to keep the resident from falling. The resident tried to walk, used a walker and fell. The resident leaned forward in the wheelchair and fell forward out of the wheelchair onto the floor, so staff put the resident on the floor instead of the resident falling. When the resident hollered, staff got the resident off the floor and placed the resident in a wheelchair. The resident scooted around the facility on his/her buttocks. 3. Review of Resident #3's undated face sheet showed the resident's diagnoses included Alzheimer's disease, depression, and insomnia (inability to sleep). Review of the resident's Fall Risk Assessment, dated 7/13/25, showed the following: -Disoriented to person, place and time; -History of falls in the previous three months; -Ambulatory and incontinent; -Incontinent of bowel and bladder; -Prescribed types of medications that increased fall risk; -Score of 14, indicating high fall risk (a score of 10 or more indicated high risk for falls). Review of the resident's ISP, dated 10/6/25, showed the following: -The resident had memory problems, depression	A4776			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/29/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BARATHAVEN MEMORY CARE

**1030 BARATHAVEN DRIVE
DARDENNE PRAIRIE, MO 63368**

(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
A4776	Continued From page 14 and dependent on others to make decisions; -Ambulated independently with no assistive device required; -Transferred independently; -Poor safety awareness and at risk for falls. Staff to keep room and common areas free of clutter. Staff to assist as needed. Review of the resident's nurses' note, dated 1/6/26 at 9:57 P.M., showed LIMA F documented the resident experienced a witnessed fall at 6:35 P.M. in his/her room while staff assisted the resident to the toilet. The resident had aggressive behavior toward a caregiver and struck the caregiver's left arm, lost balance, fell backwards and landed on his/her buttocks. Staff assisted the resident up and placed him/her into bed. No visible injuries were noted. Review of the resident's ISP, dated 1/22/26, showed no updates or new interventions for fall prevention following the resident's fall on 1/06/26. Review of the resident's nurses' note, dated 2/09/26, showed the following: -At 12:27 P.M., LIMA B documented the resident fell at 12:05 P.M. The resident was getting up from a chair to go to the dining room for lunch. The resident lost his/her balance, fell forward, hit his/her head and sustained a laceration that bled. Staff transferred the resident to the hospital by ambulance; -At 4:00 P.M., LIMA F documented the hospital reported the resident received stitches for the laceration. Hospice services were discussed for the resident; -At 9:27 P.M., LIMA F documented he/she spoke with the hospital nurse who reported the resident was admitted to the hospital.	A4776		

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A4776	Continued From page 15 Review of the resident's nurses' note, dated 2/10/26 at 10:00 P.M., showed LIMA F documented the resident returned to the facility at 3:00 P.M. The hospice nurse assessed the resident. The resident was weak with an unsteady gait and sat in a wheelchair. Two staff members assisted the resident with toileting and returned the resident to the wheelchair near the nurses' desk. The resident attempted to transfer himself/herself to a nearby chair from the wheelchair but lacked the strength to complete the transfer. Review of the resident's nurses' note, dated 2/13/26 at 2:01 P.M., showed LIMA B documented the resident was gaining strength and awareness of surroundings. The resident was on a low mattress as fall deterrence and moved himself/herself onto the bedside fall mat. Review of the resident's ISP, updated on 2/13/26, showed staff to increase rounding frequency due to poor safety awareness and high risk for falls. Staff to actively assist with transfers due to the resident's high fall risk. The ISP did not include a low bed mattress and fall mats beside the resident's bed. Review of the resident's Fall Risk Assessment, dated 2/13/26, showed the following: -Disoriented to person, place and time; -Three or more falls in the previous three months; -Wheelchair dependent; -Balance problem while standing and walking, decreased muscular coordination, change in gait pattern when walking through a doorway, jerking or unstable when making turns and required assistance, (person, furniture/walls or device); -Incontinent of bowel and bladder; -Prescribed types of medications that increased	A4776			

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A4776	Continued From page 16 fall risk; -Score of 20, indicating high fall risk (six points higher than the previous assessment completed 7/13/25). Review of the resident's nurses' note, dated 3/25/26 at 11:10 A.M., showed LIMA B documented the resident fell from his/her wheelchair at 10:40 A.M. Staff observed the resident in front of his/her wheelchair, with his/her head on the floor. The resident sustained a cut with active bleeding. Staff provided immediate care to control the bleeding with a bandage. Review of the resident's ISP showed no updates or new interventions for fall prevention following the resident's fall on 3/25/26. Review of the resident's nurses' note, dated 4/04/26 at 9:50 P.M., showed LIMA D documented the resident had a witnessed fall in the back television room. The resident stood up from his/her wheelchair holding onto a regular chair. The resident lost his/her balance and fell to his/her side. Staff assisted the resident back to the wheelchair and took him/her to his/her room for toileting. No visible injury was noted. Review of the resident's ISP, updated 4/4/26, showed staff should encourage the resident to participate in activities and one-on-one encouragement with staff when available. Review of the resident's nurses' note, dated 4/11/26 at 11:41 A.M., showed LIMA B documented at about 7:00 A.M., the resident was on the floor in front of his/her wheelchair by the kitchen door. The resident sustained a laceration to the bridge of his/her nose. The laceration bled along with a nosebleed. The bleeding was	A4776		

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A4776	Continued From page 17 contained by applying a cold towel. Staff notified the hospice nurse, cleaned the resident's wound and applied an adhesive dressing. Review of the resident's ISP, updated 4/11/26, showed staff were to ensure proper seating if the resident was in the wheelchair, feet flat on the floor, lowering the back of the seat with the seat cushion properly secured. Review of the resident's nurses' note, dated 4/14/26 at 10:15 A.M., showed LIMA G documented staff assisted the resident to the toilet and noted weakness while standing. Upon standing, the resident was unable to bear weight with two-person assistance and would not stand on his/her own. Review of the resident's nurses' note, dated 4/27/26 at 7:59 P.M., showed LIMA D documented the resident fell while attempting to get up and slid down onto his/her buttocks from the wheelchair. Staff observed redness on the resident's buttocks. Review of the resident's ISP, updated 4/27/26, showed staff were to ensure the resident had proper fitting footwear with non-skid soles/socks, worn at all times when the resident was out of bed. Observations on 4/28/26 showed the following: -At 11:45 A.M., the resident's room contained a regular height full size bed approximately 15 inches off the floor. There was no fall mat in the room; -From 3:20 P.M. to 3:45 P.M., the resident sat in the wheelchair in the back hall television room with six other residents. No staff was present. The resident's wheelchair had no foot pedals and	A4776			

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A4776	Continued From page 18 the resident's feet were on the floor. The resident propelled himself/herself back and forth in a rocking motion. The resident repositioned himself/herself in the wheelchair, tried to push up on the arms of the chair and moved backward in the seat. The wheelchair rolled backward as the resident made the movement; -At 3:45 P.M., the resident rolled his/her wheelchair closer to the television. The resident and six other residents were in the television room. No staff was present; -From 3:46 P.M. to 3:55 P.M., the resident remained in the back television room with no staff present. The resident continued to roll the wheelchair back and forth in a rocking motion. During an interview on 4/28/26 at 4:20 P.M., Caregiver N said staff should watch the resident closely to keep the resident safe. Staff should keep the resident near caregivers or the nurses' desk where staff was available and should not leave the resident unattended. The resident fell and hit his/her head, hard one day while walking. The resident had not been the same since; he/she was no longer able to walk. The resident was strong and hard to manage. During an interview on 4/28/26 at 4:25 P.M., LIMA A said the resident fell frequently and sustained a brain bleed after falling in the hallway. Staff sent the resident to the hospital and he/she returned to the facility on hospice care. Staff should keep an eye on the resident all the time, keep the resident within eyesight, and provide assistance with toileting every two hours. Observations on 4/28/26 showed the following: -At 4:30 P.M., the resident remained in the back television room with no staff present. The resident rolled the wheelchair back and forth in a rocking	A4776			

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A4776	Continued From page 19 motion. The resident attempted to scoot closer to the edge of the wheelchair seat and tried to push up and reposition himself/herself in the wheelchair. The wheelchair rolled backwards as the resident pushed up with his/her feet and arms; -At 4:35 P.M., LIMA F passed medications in the television room where the resident sat in his/her wheelchair. LIMA F walked past the resident as the resident repeatedly tried to scoot himself/herself back in the wheelchair seat. The resident leaned back into the back rest; -At 4:45 P.M., a caregiver entered the television room and took residents to the dining room for supper. The resident tried repositioning in the wheelchair. A large lump of the resident's incontinence brief hung down between the resident's legs catching on the wheelchair seat and preventing the resident from scooting back in the wheelchair. 4. Review of Resident #2's Individual Service Plan (ISP), dated 4/13/26, showed the following: -Diagnoses of Alzheimer's disease, anxiety disorder and major depressive disorder; -Ambulated independently; staff to redirect the resident as needed; -Dependent on others to make decisions with difficulty concentrating, feeling angry, irritable and anxious; -Disoriented to date and time, location of room, but can recognize family and friends; -Episodes of agitation, anxiety and crying at times. The resident was resistive to care from staff at times. Review of the resident's nurses' notes showed the following: -On 3/29/26 at 9:17 P.M., LIMA F documented at 3:25 P.M., the resident sat on the floor in the	A4776			

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A4776	Continued From page 20 hallway. The resident pulled Resident #6 down causing Resident #6 to land onto his/her right side. No visible injuries; -On 4/18/26 at 3:17 P.M., LIMA L documented the resident sat on the floor in the hallway. The resident grabbed Resident #7's foot and pulled the resident to the ground. LIMA L had a hold of Resident #7's hand at the time. Resident #7 fell on his/her buttocks/back. During an interview on 4/29/26 at 2:55 P.M., LIMA L said on 4/18/26, the resident sat on the floor as a fall prevention method and scooted around and down the hallway. LIMA L held Resident #7's hand while walking down the hall. The resident reached out and pulled Resident 7's foot and pulled the resident to the floor. The charge nurse completed an incident report after a fall. No fall prevention interventions were implemented to prevent additional falls. The resident caused Resident #7's fall. The resident continues to sit on the floor and scoot down the hallway while other residents walked past. During an interview on 4/28/26 at 4:25 P.M., LIMA A said the resident was aggressive. He/She reached out and grabbed other residents' legs or walkers while he/she sat on the floor. The resident caused other residents to fall by tripping the other residents or pulling the other residents down. Observation on 4/28/26 from 11:10 A.M. to 11:25 A.M. showed the resident sat on the floor in the hallway and wiped the floor with his/her hand. Staff walked around and past the resident as he/she remained on the floor. Residents walked around and past Resident #2, maneuvering walkers or walking around the resident. The resident scooted across the floor and down the	A4776			

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A4776	Continued From page 21 hall two doors and leaned up against the wall. 5. During an interview on 4/15/26 at 12:02 P.M. and 4/29/26 at 11:00 A.M., LIMA B said the following: -Following a fall, staff was to assess the resident, take vital signs, contact the physician and responsible party, and document the incident as soon as possible. Staff then notified the on-call administrative staff and continued to assess the resident; -Staff should not place residents on the floor as a fall prevention intervention. Putting residents on the floor was not appropriate; the floor was not safe. Resident #2 became a fall risk for other residents when he/she reached out and tripped or pulled other residents down onto the floor. Another resident hit and kicked Resident #5 while he/she sat on the floor; -Resident #3 was at risk for falls and fell several times. On 2/9/26, the resident fell and sustained a head injury and laceration on his/her head. LIMA B assessed the resident and sent him/her to the hospital by ambulance. The resident came back to the facility on hospice care; -Staff should never leave residents in the back hall television room unattended. Staff should provide supervision. If Resident #3 was left unattended, he/she tried to stand up from the wheelchair and fell. During an interview on 4/29/26 at 2:55 P.M., LIMA L said after a resident fell, staff assessed the resident for injuries, sent the resident out to the hospital if the resident hit his/her head, completed an incident report and notified the family and physician of the fall. If the resident was on hospice care, staff should notify the hospice nurse. Staff did not identify interventions to prevent falls after every fall. Staff should just	A4776			

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A4776	Continued From page 22 watch the residents and encourage participation in activities. The Wellness Director updated the residents' ISPs and communicated with the charge nurses electronically. The charge nurses verbally informed caregiver staff at the change of shift huddle meetings. It was safer for Resident #5 to sit on the floor following his/her hip surgery to avoid falls. The resident would not stay in one place or in a wheelchair. During an interview on 4/24/26 at 2:41 P.M., the Director of Wellness said the following: -To try to prevent falls, staff should encourage residents to participate in activities, provide one-on-one care, encourage hydration, frequent toileting, and interact with residents while doing rounds; -The facility had high risk meetings every Thursday to address residents with high risk needs; -The Executive Director, Assistant Executive Director, Director of Wellness, Wellness Coordinator, nursing staff, and therapy staff attended these meetings; -High risk times were following meals, in the evening, at night, shift changes, and while toileting; -To address high risk times, staff were to do purposeful rounding, which was making certain to go inside the resident's room to check on the resident. Staff were to engage with the resident or look more closely than just a glance. When residents were moving around the facility, staff should find time to engage one-on-one with residents; -During high risk times, nursing staff tried to be out with the care staff. During an interview on 4/29/26 at 8:30 A.M., the Executive Director said staff should follow the	A4776			

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A4776	Continued From page 23 facility fall policy and provide protective oversight for the residents. Staff should revise fall interventions after a resident falls and communicate any new fall interventions to the staff through electronic communication and group huddle meetings. Staff should not place residents on the floor as a fall intervention. Resident #2 tripped other residents and caused them to fall while he/she sat on the floor. MO261563 MO262050	A4776			
A4778	19 CSR 30-86.047(37) Appropriate Action & Notification In case of behaviors that present a reasonable likelihood of serious harm to himself or herself or others, serious illness, significant change in condition, injury or death, staff shall take appropriate action and shall promptly attempt to contact the person listed in the resident 's record as the legally authorized representative, designee or placement authority. The facility shall contact the attending physician or designee and notify the local coroner or medical examiner immediately upon the death of any resident of the facility prior to transferring the deceased resident to a funeral home. I/I This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to notify one resident's (Resident #3's) power of attorney (POA) of the correct hospital destination following the resident's fall with head injury that required emergency transfer to the hospital for care. The resident had diagnoses of	A4778			

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A4778	Continued From page 24 Alzheimer's disease and confusion, and he/she was unable to make his/her own decisions. The facility census was 53. Review of the facility policy, Provider Communication, revised 07/01/19, showed the following: -The facility will notify a resident's primary care physician (PCP) and family of a condition change, accident or incident involving the resident; -The nurse or certified medication technician (CMT) on duty at the time of the accident or when a condition change is noted, will promptly notify the resident's PCP and family of the change or accident; -The team member providing the communication will provide all relevant information; -A notation will also be included on the 24-hour communication log for follow up. 1. Review of Resident #3's Individual Service Plan (ISP), dated 1/22/26, showed the following: -Diagnoses of Alzheimer's disease and depression; -The resident had memory problems, depression, and was dependent on others to make decisions. Review of the resident's undated face sheet showed the resident had a POA. Review of the resident's nurses' note, dated 2/9/26 at 12:27 P.M., showed Level I Medication Assistant (LIMA) B documented the resident fell at 12:05 P.M. The resident was getting up from a chair to go to the dining room for lunch. The resident lost his/her balance, fell forward, hit his/her head and sustained a laceration that bled. The bleeding was contained. The resident left the facility at 12:25 P.M. by ambulance and transferred to the emergency room at a trauma	A4778			

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A4778	Continued From page 25 care center. At 12:10 P.M., 12:25 P.M., and 1:28 P.M., LIMA B called the resident's POA and left a voicemail notification stating the resident was transferred to the hospital following a fall. At 1:28 P.M., the resident's POA answered the call. Review of the resident's Provider Notification of Incident or Change of Condition, dated 2/09/26, showed LIMA B documented the resident fell in the hallway and sustained a laceration to the head. The resident was sent to a trauma care center emergency room. Review of the resident's Emergency Medical Services (EMS) Patient Care Report, dated 2/09/26 at 12:13 P.M., showed the ambulance staff documented they were dispatched to an emergency call with a head laceration. The facility staff gave a history as the resident was mostly non-verbal and had Alzheimer's disease. A 3-inch laceration was noted on the resident's left temple. EMS transported the resident to the hospital (trauma care center) due to the trauma specialty. They arrived at the trauma care center hospital at 12:52 P.M. During a phone interview on 4/16/26 at 2:29 P.M., Resident #3's responsible party/POA said the resident fell in February of 2026 which caused a brain bleed and EMS transported the resident to the hospital. The facility did not contact him/her following the fall and did not notify him/her which hospital the resident was taken. During an interview on 4/29/26 at 11:00 A.M., LIMA B said the resident fell out of his/her wheelchair on 02/09/26 and sustained a laceration on his/her head. LIMA B called EMS and the resident was sent out with a head injury. LIMA B called the resident's POA multiple times	A4778			

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A4778	Continued From page 26 and left voice mail messages the resident was transferred to a local hospital emergency room. The local hospital was the usual destination for emergency room care. LIMA B never called and informed the resident's POA the resident was transferred to a trauma care center hospital and not to the local hospital. LIMA B became aware of the change in destination after the resident left the facility by ambulance. He/She spoke to the resident's POA at 1:28 P.M. and did not tell the POA of the change in hospital destination. During an interview on 4/29/26 at 4:25 P.M., the Administrator said staff should notify the resident's responsible party of any incident, accident or change in condition and document the responsible party was notified in the resident's medical record. EMS usually transported residents to the local hospital emergency room for treatment. EMS arrived and decided the trauma care center was needed due to the head injury. EMS transported Resident #3 to the trauma care center hospital due to the head injury. Staff should have called the resident's POA and informed the POA of the change in hospital destination. MO00261563	A4778			
A8016	19 CSR 30-88.010(16) Reasons to Transfer/Discharge A resident may be transferred or discharged only for medical reasons or for his or her welfare or that of other residents, or for nonpayment for his or her stay. II This regulation is not met as evidenced by: Based on interview and record review, the facility	A8016			

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A8016	Continued From page 27 failed to ensure staff did not issue an inappropriate discharge notice to one resident (Resident #3), in a review of eight sampled residents, when staff planned to discharge the resident from the facility due to the resident's Durable Power of Attorney (DPOA) refusing to sign a contract with the new ownership of the facility. The facility census was 53. Review of the facility policy, Resident Discharge, revised 7/1/19, showed the Executive Director and Wellness Director will follow all state regulations related to discharge of a resident. Review of the Missouri State Regulation, 19 CSR 30-52.020(2), showed the facility shall permit each resident to remain in the facility unless: (A) The transfer or discharge is appropriate because the resident's welfare and the resident's needs cannot be met by the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge that resident only allowable charges under Medicaid; or (F) The facility ceases to operate Record review of Resident #3's undated face sheet showed the resident's family member was listed as the resident's DPOA.	A8016			

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A8016	Continued From page 28 Review of the discharge notice the facility issued to the resident's DPOA, dated 04/03/26, showed the following: -The proposed discharge date was 05/06/26; -The resident was to be discharged because the responsible party had not signed an agreement with the facility after the facility was purchased by a new owner. During interviews on 4/14/26 at 10:04 A.M. and 4/15/26 at 2:45 P.M., the Administrator said the following: -The facility recently changed ownership, and all residents or their responsible parties had to sign new contracts; -The facility sent multiple letters and emails regarding the new contract to the resident's responsible party with no response; -The facility sent a final letter to the resident's responsible party on 3/25/26. The facility received a tracking receipt on 3/30/26 that showed the resident's responsible party requested the letter be held at the post office, then on 3/31/26 showed the responsible party refused the letter; -The facility sent a 30-day discharge letter on 04/03/26 stating the resident would be discharged because the responsible party was unwilling to complete a signed agreement with the facility after a new owner purchased the facility; -The facility should only discharge residents under the circumstances listed in the state regulation 19 CSR 30-82.050 (2)(A)-(E); -He realized the reason listed for the resident's discharge was not one of the circumstances listed in the state regulation, 19 CSR 30-82.050 (2)(A)-(E) at the time the discharge letter was issued, but believed the responsible party was out of regulation for failure to sign the new contract, therefore, he felt justified to issue the discharge	A8016			

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A8016	Continued From page 29 notice. MO261563	A8016			
A8022	19 CSR 30-88.010(22) Free From Abuse Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion. I This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of eight sampled residents, was free from abuse when Resident #2, who had diagnoses of Alzheimer's disease and anxiety disorder and history of being physically aggressive towards other residents at the facility, pushed Resident #1 down on 4/28/26. Resident #1 fell and hit his/her head. The facility census was 53. Review of the facility Resident Abuse Policy, dated 7/1/19, showed the following: -It was the facility policy to ensure procedures were in place to prevent any incident of abuse, neglect, of mistreatment of residents; -Physical abuse was the willful infliction of injury or harm to the resident's body. It includes controlling behavior through corporal punishment. This includes slapping, hitting, scratching, pinching, kicking, handling roughly, pushing, tripping; -Abuse in a long-term care facility can occur in three ways, family member to resident, staff to resident, resident to resident. Review of the facility policy, Resident to Resident Abuse, dated 7/1/19, showed the following:	A8022			

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A8022	Continued From page 30 -Abuse of a resident by another resident will not be tolerated. All allegations and reported incidents will be appropriately investigated; -For witnessed incidents, steps will be taken immediately to separate the residents involved and to minimize the likelihood of reoccurrence; -A serious physical or mental/emotional injury is a physical injury requiring medical or nursing intervention or frequent physical or verbal attacks with in a two-week period (resident repeatedly attacks others or is repeatedly attacked), or a single verbal attack that is extraordinarily vicious, derogatory or humiliating to a person of ordinary sensitivity; -The involved residents are to be assessed and the resident service/wellness plans are to be updated with appropriate interventions and appropriate referrals; -When there is an allegation or incident of resident-to-resident abuse that does not result in serious injury or does not involve sexual abuse, a licensed nurse will assess each resident and document the assessment in the clinical record; -Steps will be implemented immediately to address any physical or mental harm suffered by either resident. 1. Review of Resident #2's Individual Service Plan (ISP), dated 4/13/26, showed the following: -Diagnoses of Alzheimer's disease, anxiety disorder, and major depressive disorder; -Ambulates independently; -Staff to redirect the resident as needed; -Dependent on others to make decisions with difficulty concentrating, feeling angry, irritable and anxious; -Disoriented to date and time, location of room, but can recognize family and friends; -Episodes of agitation, anxiety and crying at times. The resident was resistive to care from	A8022		

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A8022	Continued From page 31 staff at times. Review of the resident's nurses note, dated 4/14/26 at 2:09 P.M., showed Level I Medication Aide (LIMA) G documented the resident sat in a chair and grabbed Resident #5's arms. The resident pulled and hit Resident #5's forearms. Staff separated the residents, assessed both residents for injuries, and no injuries were found. During an interview on 5/6/26 at 3:15 P.M., LIMA G said on 4/14/26, he/she witnessed the incident between Resident #2 and Resident #5. Resident #2 sat in a chair when Resident #5 rolled his/her wheelchair next to Resident #2's chair. Resident #2 did not like aggressive behavior. Resident #5 was too close to Resident #2 who took that as aggressive behavior. Resident #2 yelled at Resident #5, grabbed Resident #5's wrists and arm. There were no injuries. Staff separated the two residents and moved Resident #5 away from Resident #2's chair. LIMA G completed an incident report. Review of the resident's medical record showed no documentation staff followed the facility policy to update the resident's individual service plan (ISP) with interventions after the resident was physically aggressive with Resident #5 to ensure resident-to-resident abuse did not occur. Review of the resident's nurses' note, dated 4/25/26 at 9:11 P.M., showed LIMA J documented at 5:50 P.M., staff witnessed a physical altercation. Resident #2 pushed another (unnamed) resident and caused the unnamed resident to fall backward and hit his/her head on the wall. Resident #2 lost his/her balance and fell forward onto the unnamed resident. No injuries occurred. (No staff members were able to identify	A8022			

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A8022	Continued From page 32 the unnamed resident). Review of the resident's medical record showed no documentation staff followed the facility policy to update the resident's individual service plan (ISP) with interventions after the resident was physically aggressive with another resident to ensure resident-to-resident abuse did not occur. Review of the resident's nurses' note, dated 4/28/26 at 2:34 P.M., showed LIMA G documented at 1:12 P.M. Resident #2 passed Resident #1 in the hallway. Resident #1 stuck his/her hand in Resident #2's face and made rude comments. Resident #2 attempted to keep walking when Resident #1 grabbed Resident #2's arm. Resident #2 turned and attempted to free himself/herself. Resident #1 lost his/her balance and fell. Resident #2 had no injuries or complaints of pain. Review of the facility surveillance camera footage for 4/28/26 at 1:00 P.M., showed Resident #1 and Resident #2 walked toward each other in the hall as LIMA G pushed the medication cart around the corner and disappeared from camera view. No other staff were present in the camera view. Resident #1 and Resident #2 conversed (no audio, both residents looked at each other with mouths moving) with each other. Resident #2 turned away. Resident #1 reached for Resident #2 and held Resident #2's arm with one hand and pointed towards Resident #2's face with the other hand. Resident #1 pushed Resident #2 away. Resident #2 then pushed Resident #1 who fell backwards to the floor and hit his/her head on the floor. Resident #1 rolled to his/her side, scooted to a chair and pulled himself/herself up to a standing position. LIMA L turned the corner and entered into camera view.	A8022		

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A8022	Continued From page 33 Review of Resident #1's hospital emergency department discharge summary, dated 4/28/26, showed diagnoses of fall, head injury, abrasion of scalp, and dementia with agitation. Cleanse abrasion with soap and water. During an interview on 5/6/26 at 3:15 P.M., LIMA G said the following: -The staff should deescalate, distract and keep an eye on any resident who was agitated or aggressive. Staff should keep the agitated resident out of the path of other residents to prevent altercations and administer as needed medication if available. Resident #1 liked to get into other residents' business and was verbally aggressive towards other residents. Resident #1 did not say nice things to anyone; -On 4/28/26 LIMA G passed medications and was the staff in charge on the residents' hall when the altercation occurred between Resident #2 and Resident #1. LIMA G did not witness the altercation, but watched the surveillance video after the incident. LIMA G did not hear any verbal exchange or yelling prior to the altercation while the residents were in the hallway. He/She was paged to the hall after Resident #1 fell and his/her head was bleeding. EMS was called and Resident #1 went to the hospital -After any altercation, staff completed an incident report and notified the physician, family and administration of the altercations. If new interventions were initiated in the resident's care plan, administration implemented the new interventions and notified the charge nurse either verbally or electronically in the medical record, care plan and communication board. The charge nurse or Wellness Coordinator was responsible for updating the care giver staff; -Staff should follow the facility abuse policy.	A8022			

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A8022	Continued From page 34 Resident to resident altercations were abuse and included physical and verbal abuse. Staff were responsible for protecting residents from abuse. During an interview on 4/28/26 at 1:30 P.M., LIMA L said Resident #2 pushed Resident #1 to the floor. Resident #1 was verbally aggressive. Resident #2 would not take anyone being aggressive toward him/her without responding. Both residents wandered all the time. During an interview on 4/28/26 at 3:15 P.M., the Wellness Coordinator said Resident #1 was verbally aggressive. Resident #2 would not tolerate Resident #1 in Resident #2's space, pointing his/her finger. Resident #2 pushed Resident #1. Resident #1 fell backward and hit his/her head on the floor. Resident #1's head was bleeding and staff transferred him/her to the emergency department by ambulance. During an interview on 4/28/26 at 4:25 P.M., LIMA A said Resident #2 was aggressive. Staff should keep Resident #2 and Resident #1 away from each other. Resident #1 was verbally aggressive toward other residents. Resident #2 did not like anyone in his/her face or space. During an interview on 4/29/26 at 10:00 A.M., the Administrator said the incident (on 4/28/26) met the facility's definition of abuse. Resident #2 pushed Resident #1 to the floor. Resident #2 reached toward other residents often. Resident #2's behaviors increased in the past two to three weeks with no updated interventions implemented to prevent abuse. Staff should complete the incident report, investigate any allegation of abuse and implement new interventions to prevent abuse. Staff should try to find the root cause of the resident's behavior.	A8022			

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A8022	Continued From page 35 NOTE: At the time of the 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. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the imminent danger was removed. MO262050	A8022			
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to follow the facility's resident abuse policy for three residents (Residents #2, #1 and #8), in a review of eight sampled residents, when staff failed to investigate allegations of	A8023			

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A8023	Continued From page 36 resident-to-resident abuse. The facility census was 53. Review of the facility Resident Abuse Policy, dated 7/1/19, showed the following: -It was the facility policy to ensure procedures are in place to prevent any incident of abuse, neglect, or mistreatment of residents. If any actual or alleged incidents occur there is a process in place for the reporting and investigation pursuant to the instruction in Long-Term statutes; -All personnel will be instructed/educated on the importance of identifying events. Anyone witnessing abuse and/or hearing an allegation of abuse must report the incident immediately to their immediate supervisor and the nursing supervisor, the supervisor will then report to the Executive Director (Administrator) and Wellness Director (Director of Nursing), each incident will be investigated by interviewing the resident and staff/family member/witness present at the time; -Upon receiving notice of an abuse allegation, the Executive Director/Designees must initiate the investigation of the alleged abuse as soon as practical, but within 24 hours of notice; -The investigation must include interview with the individual reporting the alleged abuse, the alleged victim, any potential witnesses including other residents, team members, family, visitors. -The community will analyze the occurrences to determine what changes are needed, if any, to current policy and procedure to prevent any further occurrence; -Documentation of the investigation is completed and submitted to the Executive Director within four working days; -Immediately following the investigation, the Executive Director must notify the resident, the resident's representative and health care practitioner of the results of the investigation;	A8023		

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A8023	Continued From page 37 -Physical abuse was the willful infliction of injury or harm to the resident's body. This includes slapping, hitting, scratching, pinching, kicking, handling roughly, pushing, tripping; -Verbal abuse refers to any oral, written or gestured language that includes disparaging and derogatory terms to residents or within their hearing distance to describe them, regardless of their age, ability to comprehend or disability; -Abuse in a long-term care facility can occur in three ways, family member to resident, staff to resident and resident to resident. Review of the facility Resident to Resident Abuse policy, dated 7/1/19, showed the following: -Abuse of a resident by another resident will not be tolerated. All allegations and reported incidents will be appropriately investigated; -All witnessed incidents of resident-to-resident abuse must be reported immediately by any team member to his/her supervisor; -Further, if a team member does not believe that his/her supervisor is taking prompt action in response to their concerns, the team member must raise such concerns to the Wellness Director, continuing up the organizational chain of command until responsible action is taken; -For witnessed incidents, steps will be taken immediately to separate the residents involved and to minimize the likelihood of reoccurrence; -A serious physical or mental/emotional injury is a physical injury requiring medical or nursing intervention or frequent physical or verbal attacks within a two-week period (resident repeatedly attacks others or is repeatedly attacked), or a single verbal attack that is extraordinarily vicious, derogatory or humiliating to a person of ordinary sensitivity; -The involved residents are to be assessed and the resident service/wellness plans are to be	A8023			

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A8023	Continued From page 38 update with appropriate interventions and appropriate referrals; -When there is an allegation or incident of resident-to-resident abuse that does not result in serious injury or does not involve sexual abuse, a licensed nurse will assess each resident and document the assessment in the clinical record; -Steps will be implemented immediately to address any physical or mental harm suffered by either resident; -The investigation is to be completed expeditiously in a manner respectful of confidentiality for both residents while obtaining full information for the investigation; -The investigation team will also determine appropriate ongoing interventions or other steps to reduce the likelihood of reoccurrence. 1. Review of Resident #2's Individual Service Plan (ISP), dated 4/13/26, showed the following: -Diagnoses of Alzheimer's disease, anxiety disorder, and major depressive disorder; -Ambulated independently, staff to redirect the resident as needed; -Dependent on others to make decisions with difficulty concentrating, feeling angry and irritable and anxious; -Disoriented to date and time, location of room, but can recognize family and friends; -Episodes of agitation, anxiety, and crying at times. The resident was resistive to care from staff at times. Review of the resident's nurses note, dated 4/14/26 at 2:09 P.M., showed Level I Medication Assistant (LIMA) G documented the resident sat in a chair and grabbed Resident #5's arms. The resident pulled and hit Resident #5's forearms. Staff separated the residents, assessed both residents for injuries, with no injuries found.	A8023		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/29/2026
NAME OF PROVIDER OR SUPPLIER BARATHAVEN MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1030 BARATHAVEN DRIVE DARDENNE PRAIRIE, MO 63368		
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A8023	Continued From page 39 Review of the resident's nurses' note, dated 4/25/26 at 9:11 P.M., showed LIMA J documented at 5:50 P.M. a physical altercation was witnessed. Resident #2 pushed another (unnamed) resident and caused the unnamed resident to fall backward and hit his/her head on the wall. Resident #2 lost his/her balance and fell forward onto the unnamed resident. No injuries occurred. (No staff members were able to identify the unnamed resident). 2. Review of Resident #1's ISP, dated 1/27/26, showed the following: -Diagnosis of dementia; -Ambulates independently without assistive device; -Dependent on others to make decisions with difficulty concentrating. Review of the resident's nurses' note, dated 3/6/26 at 10:02 P.M., showed LIMA F documented the resident and Resident #8 were involved in a verbal altercation that became physical. Resident #1 grabbed Resident #8's arm while exchanging words. Resident #8 used his/her left hand and slapped Resident #1 on the head several times while Resident #1 held Resident #8's arm and a shoe. Resident #8 took the shoe and struck Resident #1 multiple times on the face, head and left side/hip with the shoe. Resident #1 then grabbed Resident #8 by the right shoulder area of his/her shirt, pulled the resident toward a chair and forcefully made Resident #8 sit down. Two staff intervened and separated both residents to different areas of the community. Resident #1 sustained abrasions under the right eye and on the left upper brow. Staff cleaned the areas and applied ice.	A8023			

Missouri Department of Health and Senior Services

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A8023	Continued From page 40 3. During an interview on 4/29/26 at 10:00 A.M., the Executive Director said the incidents involving Residents #1, #2, and #8 were allegations of abuse. Staff completed an incident report following the altercations and he was aware of the incidents. Staff should investigate any resident-to-resident altercation or allegation of abuse. Staff should immediately separate the residents involved and implement measures to prevent further abuse. He was responsible for investigating allegations of abuse and should have investigated the altercations involving Resident #2 toward other residents and the altercation involving Resident #1 and Resident #8. He should try to find the root cause of the residents' behaviors. He did not conduct the investigations or put additional interventions in place to prevent abuse; he just did not spend time doing the investigations. He should follow the facility abuse policy and investigate all allegations of abuse. *The higher classification merited due to the extent of the violation.	A8023		
A8025	19 CSR 30-88.010(25) Report A/N to DHSS/DMH When Needed If the administrator or other employee of a long-term care facility has reasonable cause to believe that a resident of the facility has been abused or neglected, the administrator or employee shall immediately report or cause a report to be made to the department. Any administrator or other employee of a long-term care facility having reasonable cause to suspect that a vulnerable person has been subjected to abuse or neglect or observes such a person being subjected to conditions or circumstances	A8025		

Missouri Department of Health and Senior Services

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A8025	Continued From page 41 that would reasonably result in abuse or neglect shall immediately report or cause a report to be made to the department and to the Department of Mental Health. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to follow facility policy to report allegations of resident-to-resident abuse, involving two residents (Residents #1 and #2) to the State Agency, in a review of eight sampled residents. The facility census was 53. Review of the facility Resident Abuse Policy, dated 7/1/19, showed the following: -It was the facility policy to ensure procedures are in place to prevent any incident of abuse, neglect, or mistreatment of residents. If any actual or alleged incidents occur there is a process in place for the reporting and investigation pursuant to the Long-Term statutes; -Anyone witnessing abuse and/or hearing an allegation of abuse must report the incident immediately to their immediate supervisor and the nursing supervisor, the supervisor will then report to the Executive Director and Wellness Director; -Physical abuse was the willful infliction of injury or harm to the resident's body. This includes slapping, hitting, scratching, pinching, kicking, handling roughly, pushing, tripping; -Verbal abuse refers to any oral, written or gestured language that includes disparaging and derogatory terms to residents or within their hearing distance to describe them, regardless of their age, ability to comprehend or disability; -Abuse in a long-term care facility can occur in three ways, family member to resident, staff to resident, resident to resident;	A8025			

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A8025	Continued From page 42 -It is the responsibility of the Executive Director or designee to report to the Department of Health any reasonable suspicion of a crime against any individual who is a resident. Review of the facility Resident to Resident Abuse policy, dated 7/1/19, showed the following: -Abuse of a resident by another resident will not be tolerated; -All witnessed incidents of resident-to-resident abuse must be reported immediately by any team member to his/her supervisor; -As determined by state-specific laws, the Wellness Director will report allegations and/or findings to the applicable State Agency in the time frame established by the applicable state agency. 1. Review of Resident #1's Individual Service Plan (ISP), dated 1/27/26, showed the following: -Diagnosis of dementia; -Ambulates independently without assistive device; -Dependent on others to make decisions with difficulty concentrating. Review of the resident's nurses' note, dated 3/6/26 at 10:02 P.M., showed Level I Medication Aide (LIMA) F documented the resident and Resident #8 were involved in a verbal altercation that became physical. Resident #1 grabbed Resident #8's arm while exchanging words. Resident #8 used his/her left hand and slapped Resident #1 on the head several times while Resident #1 held Resident #8's arm and a shoe. Resident #8 took the shoe and struck Resident #1 multiple times on the face, head and left side/hip with the shoe. Resident #1 then grabbed Resident #8 by the right shoulder area of his/her shirt, pulled the resident toward a chair and forcefully made Resident #8 sit down. Two staff	A8025		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER BARATHAVEN MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1030 BARATHAVEN DRIVE DARDENNE PRAIRIE, MO 63368
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A8025	Continued From page 43 intervened and separated both residents to different areas of the community. Resident #1 sustained abrasions under the right eye and on the left upper brow. The areas were cleaned with and ice applied. The altercation occurred at 4:22 P.M. Review of the resident's nurses' note, dated 4/14/26 at 10:54 A.M., showed LIMA G documented the resident came up to Resident #5, who sat close by in a wheelchair, and hit Resident #5 in the head several times before staff could intervene. No injuries were noted and no apparent cause led up to the altercation. Review of the resident's nurses' note, dated 4/19/26 at 8:20 P.M., showed LIMA D documented the resident walked up to Resident #5, who sat on the floor near the nurses' desk and hit Resident #5 on the head, nudged/kicked Resident #5 on the leg and hip, and called Resident #5 an idiot, disgraceful and dumb bastard while Resident #5 sat on the floor. Staff removed Resident #1 from the area and situation. Resident #5 did nothing to Resident #1 at all and was minding his/her own business when the incident occurred. 2. Review of Resident #2's Individual Service Plan (ISP), dated 4/13/26, showed the following: -Diagnoses of Alzheimer's disease, anxiety disorder and major depressive disorder; -Ambulated independently, staff to redirect the resident as needed; -Dependent on others to make decisions with difficulty concentrating, feeling angry and irritable and anxious; -Disoriented to date and time, location of room, but can recognize family and friends; -Episodes of agitation, anxiety, and crying at	A8025		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BARATHAVEN MEMORY CARE

1030 BARATHAVEN DRIVE

DARDENNE PRAIRIE, MO 63368

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A8025	Continued From page 44 times. The resident was resistive to care from staff at times. Review of the resident's nurses note, dated 4/14/26 at 2:09 P.M., showed LIMA G documented the resident sat in a chair and grabbed Resident #5's arms. The resident pulled and hit Resident #5's forearms. Staff separated the residents, assessed both residents for injuries with no injuries found. Review of the resident's nurses' note, dated 4/25/26 at 9:11 P.M., showed LIMA J documented at 5:50 P.M. staff witnessed a physical altercation. Resident #2 pushed another (unnamed) resident and caused the unnamed resident to fall backward and hit his/her head on the wall. Resident #2 lost his/her balance and fell forward onto the unnamed resident. No injuries occurred. (No staff members were able to identify the unnamed resident). 3. During an interview on 4/29/26 at 10:00 A.M., the Executive Director said the incidents involving Resident #1 and #2 were allegations of abuse. Staff should investigate and report any resident-to-resident altercation or allegation of abuse to the State Agency within 24 hours following the incident. He was responsible for reporting allegations of abuse to the State Agency. The facility did not report these incidents to the State Agency. He did not spend time reporting to the State Agency. He should follow the facility abuse policy and report all allegations of abuse. Staff completed an incident report following these altercations and he was aware of the incidents.	A8025		

The submission of this Plan of Correction is not an admission of wrongdoing, deficiency, negligence, or violation of any law or regulation by the facility, its employees, agents, or representatives. This Plan of Correction is submitted solely for the purpose of regulatory compliance and to outline the measures the facility will take to address the findings cited during the survey process.

A4776

The facility will provide protective oversight 24 hours a day for Resident #4, #5, #3, #6, #7, #2 as well as all other residents that reside at the facility.

The facility will follow Post Fall Policy and Procedure. Post Fall Policy shall include reviewing each incident and providing appropriate intervention to attempt to reduce the risk of having subsequent falls and/or injuries related to falls.

The facility will complete an audit of all current residents with a history of falls within the last 30 days and their current fall interventions. Any resident identified with inadequate, outdated, or ineffective interventions will have Individual Service Plan reviewed and updated by the interdisciplinary team.

The facility revised and reinforced the Fall Prevention and Protective Oversight policy to include:

- Timely reassessment following each fall
- Documentation and revision of interventions after falls
- Evaluation of effectiveness of interventions
- Resident-specific supervision requirements

Licensed nurses, caregivers, and management staff received education regarding:

- Fall prevention and supervision expectations;
- Post-fall assessment and documentation requirements;
- Timely service plan updates;
- Monitoring effectiveness of interventions; and

The Administrator, Director of Nursing, or designee will audit:

- All resident falls weekly during IDT meetings
- Individual Service Plan updates following falls
- Documentation of intervention revisions

The facility contracted with a consultant for a period of 60 days to assist with evaluation of the overall program of care, including staff education, competency review, and review of policies and procedures to support regulatory compliance, resident-centered care, and resident safety.

Consultant will review weekly for 60 days for any areas of noncompliance identified during audits or observation. Any areas identified through ongoing audits as requiring additional follow-up will be addressed through re-education, corrective action, and additional monitoring as indicated.

A4778

The facility will notify appropriate residents' representatives in the case of a serious illness, significant change in condition, injury or death. Staff will notify during hospital transfer the appropriate resident representative of known destinations and document in resident chart of that notification.

An in-service will be held by 6-5-26 to review policy with all licensed nurses, caregivers, and management staff to ensure compliance.

Executive Director, Director of Wellness or designee will review for compliance in weekly IDT meetings.

A8016

Facility residents will be transferred or discharged only for medical reasons or for his or her welfare or that of other residents, or for nonpayment for his or her stay.

Executive Director reviewed 19 CSR 30-88.010 (16) Reasons to transfer/discharge on 5-27-26 and will follow all regulatory requirements for transfers and discharges for Resident #3 as well as all residents of the facility.

A8022

Each resident, including Resident #1 and Resident # 5, shall be free from abuse.

The facility contracted with a consultant for a period of 60 days to assist with evaluation of the overall program of care, including staff education, competency review, and review of policies and procedures to support regulatory compliance, resident-centered care, and resident safety.

The consultant will review Residents #1, #2, #5 medical record and Individual Service Plans for appropriate interventions and educate staff on any new interventions initiated by 6-5-26.

Licensed nurses, caregivers, and management staff will receive education regarding mandatory abuse reporting requirements, immediate protection of residents during investigations, and documentation expectations per facility policy and state regulation by 6-5-26. Additional education, guidance, and follow-up training will be provided on an ongoing basis as identified through consultation, audits, observations, or regulatory review.

Consultant will review weekly for 60 days for any areas of noncompliance identified during audits or observation. Any areas identified through ongoing audits as requiring additional follow-up will be addressed through re-education, corrective action, and additional monitoring as indicated.

A8023

The facility will follow the resident abuse policy for Residents #2, #1 and #8 as well as all residents of the facility.

The facility contracted with a consultant for a period of 60 days to assist with evaluation of the overall program of care, including staff education, competency review, and review of policies and procedures to support regulatory compliance, resident-centered care, and resident safety.

Consultant will review weekly for 60 days for any areas of noncompliance identified during audits or observation. Any areas identified through ongoing audits as requiring additional follow-up will be addressed through re-education, corrective action, and additional monitoring as indicated.

The consultant will review Residents #1, #2, #8 medical record, Individual Service Plans and visual assessment of the residents for records/signs of any abuse and take appropriate action as per facility policy.

Licensed nurses, caregivers, and management staff will receive education regarding mandatory abuse reporting requirements, immediate protection of residents during investigations, and documentation expectations per facility policy and state regulation by 6-5-26. Additional education, guidance, and follow-up training will be provided on an ongoing basis as identified through consultation, audits, observations, or regulatory review.

A8025

The facility will follow facility policy and report allegations of resident-to-resident abuse to the State Agency.

The facility contracted with a consultant for a period of 60 days to assist with evaluation of the overall program of care, including staff education, competency review, and review of policies and procedures to support regulatory compliance, resident-centered care, and resident safety.

Consultant will review weekly for 60 days for any areas of noncompliance identified during audits or observation. Any areas identified through ongoing audits as requiring additional follow-up will be addressed through re-education, corrective action, and additional monitoring as indicated.

The consultant will review Residents #1, and #2, medical record, Individual Service Plans and visual assessment for any signs of resident-to-resident abuse and report any unreported allegations of abuse by 6-5-26.

Licensed nurses, caregivers, and management staff will receive education regarding mandatory abuse reporting requirements, immediate protection of residents during investigations, and documentation expectations per facility policy and state regulation by 6-5-26. Additional education, guidance, and follow-up training will be provided on an ongoing basis as identified through consultation, audits, observations, or regulatory review.

The Executive Director reviewed 19 CSR 30-88.010(25) regarding reporting requirements to DHSS on 5-27-26 and will ensure ongoing compliance with all regulatory reporting requirements.

The facility alleges substantial compliance as of 7-6-26. The facility will continue ongoing consultation, staff education, auditing, and quality assurance measures for a period of 60 days to support sustained regulatory compliance, resident safety, and operational oversight.