Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33581N	A. BUILDING: _____ B. WING _____	C 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(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
A4512	19 CSR 30-86.045(3)(A)(10) Comply with All Req.of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to ensure residents who needed more than minimal assistance due to physical or cognitive impairments had an individualized evacuation plan (IEP) in the resident's individual service plan (ISP), that the IEP listed the responsibilities of specific staff positions in an emergency specific to the individual, that the IEP included specific interventions needed to ensure the safety of the resident, that the IEP included the resident's location within the facility including proximity to exits and areas of refuge and risk of resistance, mobility, and need for additional staff support, that employees with specific responsibilities received training regarding their duties and responsibilities under the resident's evacuation plan, and that the written IEP be readily available to all staff for two residents (Resident#4 and #6) who required more than minimal assistance to evacuate of 22 residents selected for review. The facility census was 56. Review of the undated facility policy for Assessments and Evaluations showed the following:	A4512		

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A4512	Continued From page 1 -The Community will conduct initial assessments, evaluations, and reassessments for residents in accordance with applicable law to determine individual's suitability for residence in the Community and to determine the services needed by residents in an effort to support their heath, safety, and overall quality of life; -Assessments will be thorough and timely to support the identification of resident care needs and the maintenance of an individualized service plan; -Services will be accurately reflected on the resident's service plan; -If, during the comprehensive assessment, the resident is assessed as needing more than minimal assistance to safely evacuate the Community, the residents service plan will include an individualized evacuation plan that consists of: the responsibilities of specific team member positions in an emergency specific to the resident, the fire protection interventions needed in an effort to ensure the safety of the resident and an evaluation of the resident for their location within the facility and the proximity to exits and areas of refuge and, as applicable, their risk of resistance, mobility, need for additional tam member support, consciousness, response to instructions, response to alarms and fire drills; -The team members with specific responsibilities in the resident evacuation plan will be informed of their responsibilities at least every six months and upon any significant change in the plan; -A copy of the resident's evacuation plan will be readily available to all team members. 1. Review of Resident #4's face sheet showed the following: -Move in date of 10/30/24;	A4512		

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A4512	Continued From page 2 -Diagnoses of history of falling, coronary artery disease (CAD a common condition where plaque buildup (atherosclerosis) narrows or blocks the arteries supplying oxygen-rich blood to the heart), and dementia. Review of the resident's Service Plan/ISP for Emergency Preparedness and Evacuation Plan dated 4/29/25 showed the following: -Resident is not able to self-preserve during emergency condition as resident lacks the physical, mental or cognitive capability to recognize danger, a signal or alarm requiring evacuation from community, initiate and complete the evacuation without requiring more than minimal assistance; -Interventions: ED (executive director) is responsible for executing Emergency Preparedness and Response Program. Incident Commander is assigned in seniority order from community leadership members and is responsible for team member assignments during evacuation. -There were no interventions for the number of staff required to evacuate the resident, how to evacuate the resident or where to evacuate the resident in the event of an emergency. During an interview on 01/13/26 at 2:00 P.M. Nurse Aide (NA) E said the following: -Resident #4 required assistance of two staff members to transfer and the resident could not walk; -The resident would require help in the event of an emergency; -He/She did not know what an IEP was or where it might be located. 2. Review of Resident #6's face sheet showed	A4512		

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A4512	Continued From page 3 the following: -Move in date of 11/10/24; -Diagnoses of stroke, seizure activity, Alzheimer's disease, anxiety disorder and dementia. Review of the resident's Service Plan/IEP with a revision date of 5/20/25 showed the following: -Goal: Resident will be evacuated safely; -Intervention: ED is responsible for executing Emergency Preparedness and Response Program. Incident Commander is assigned in seniority order from community leadership members and is responsible for team member assignments during evacuation. There were no interventions for the number of staff required to evacuate the resident, how to evacuate the resident or where to evacuate the resident in the event of an emergency. During an interview on 01/13/26 at 2:30 P.M. Caregiver E said the following: -He/She was not aware of which residents were on an IEP or where the IEP was kept; -He/She documents in the resident's EMR how much assistance the resident required; -He/She was not able to see any other part of the resident's EMR (electronic medical record). During an interview on 01/13/26 at 2:30 P.M. Concierge F said the following: -He/She will come back to the Memory Care Unit and do activities a couple times a week; -He/She did not have access to residents' EMRs; -He/She did know what an IEP was or where to find the IEP. During an interview on 01/13/26 at 2:45 P.M.	A4512		

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A4512	Continued From page 4 Licensed Practical Nurse (LPN) G said the IEPs were located with the Service Plan in the resident's EMR. During an interview on 01/13/26 at 3:00 P.M. the Director of Nursing said the following: -The Service Plan included the resident's IEP and was in the resident's EMR; -Not all staff had access to the resident's EMR; -There were no printed ISP's, everything was located in the EMR; -The ISP contained all of the information that staff needed to provide care, including where to evacuate the resident and the staff responsible; --LIMA's and caregivers have access to the resident's EMR and service plans; -When shown what staff see when they open a resident's record, she said she was unaware that this was the only thing that the staff could see. During an interview on 01/13/26 at 6:00 P.M. the Administrator said the following: -She was not aware that staff could not see residents' service plans; -All staff should be aware of who was on an IEP and where the IEP's were kept.	A4512		
A3235	19 CSR 30-86.032(34) Hot Water 105-120 Degrees F Plumbing fixtures which are accessible to residents and which supply hot water shall be thermostatically controlled so that the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C) and the water shall be at a temperature range between one hundred five degrees Fahrenheit (105°F) (41°C) and one hundred	A3235		

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A3235	Continued From page 5 twenty degrees Fahrenheit (120°F) (49°C). I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure staff maintained hot water temperatures between 105 degrees Fahrenheit (°F.) and 120 °F. The facility census was 56. Review of the undated facility policy for Boilers and Heating Equipment showed the environmental services director (ESD) or designee will: conduct water temperature readings throughout the Community to include checking common area water temperatures weekly to verify they meet state standards and documenting using the water temperature log and checking apartment water temperatures weekly to verify they are within 10% of all apartments and documenting using the apartment turnover checklist. 1. During an interview on 1/12/26 at 10:00 A.M. the ESD said the following: -The circulating pump went out on 12/17/25 and was replaced by the end of the day on 12/19/25. He then went on vacation until 01/05/26; -While he was gone, it was discovered the mixing valves in apartments were not functioning correctly, so there was still cold water; -Individuals were informing the Administrator of this while he was gone; -The Administrator contacted plumbers who came out to fix the individual mixing valves as they were reported; -Residents or staff had to inform the administrator, no one was checking each apartment or shower room to see if there was hot	A3235		

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A3235	Continued From page 6 water; -He does not check water temperatures in individual apartments, he only checks the water temperatures in the common areas, like the public bathrooms and kitchenettes. No water temperatures have been taken on the Memory Care Unit; -Staff are to let him know via a text message or logging the problem into the computer and he will then assess and fixes any problems. Observation on the Memory Care Unit on 1/12/26 at 10:30 to 11:30 showed the following: -Room 27 A: the temperature of the hot water after two minutes was 104.5 degrees at the bathroom sink; -Room 27 B: the temperature of the hot water after two minutes was 102 degrees at the bathroom sink; -Public use sink in the hallway by room 27: the temperature of the hot water after two minutes was 88 degrees; -Room 25 A: the temperature of the hot water after two minutes was 100 degrees at the bathroom sink; -Room 25 B: the temperature of the hot water after two minutes was 100.4 at the bathroom sink. Observation on 1/12/26 at 2:40 P.M. of the hand-held shower wand in the bathroom of unoccupied resident room #343 showed a water temperature of 95.4 degrees. Observation on 1/12/26 at 5:00 P.M. of unoccupied resident room #337 showed a kitchen sink water temperature of 71 degrees and a bathroom sink temperature of 97 degrees.	A3235		

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A3235	Continued From page 7 During interview on 1/12/26 at 11:35 A.M., Resident #23 said that he/she had experienced issues with a lack of hot water in the bathroom and kitchen sink and had to report it to maintenance to get it fixed. During interview on 1/12/26 at 2:05 P.M., Resident #24 said that he/she had experienced some difficulty with hot water in the kitchen sink and the shower would get warm enough if you waited for a long time. During an interview on 01/12/26 at 2:00 P.M. Level One Medication Aide (LIMA) D said the following: -They have had to wait along time to get the water to warm up before they could give a bath or shower; -He/She did not know how to complete a work order. During an interview on 1/13/26 at 3:00 P.M. the ESD said the following: -He was not aware that the water temperatures were so low on the Memory Care Unit; -No one had reported there was a problem. During an interview on 1/13/26 at 6:00 P.M. the Administrator said the following: -Once staff made her and the ESD aware of no hot water, the mixing valves were repaired; -No staff members notified her or the ESD of no hot water on the Memory Care Unit; -She would expect the water temperatures to be checked and monitored per the policy. MO259906	A3235		

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A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to implement a safe and effective system of medication control and use when staff pre-set medications for multiple residents rather than preparing medications for residents individually for five residents (Residents #2, #3, #8, #9, and #10) of 22 sampled residents.	A4797		

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A4797	Continued From page 9 The facility also failed to ensure expired medications were removed from the medication carts and not available for administration, and failed to ensure medications were properly labeled for administration. The census was 56. Review of the Level One Medication Aide student guide revision dated November, 1993, Lesson Plan 10 Unit IV for guidelines and procedures for preparation, administration, reporting, and recording of oral medications showed the following: -Staff should compare the label of the medication bottle or unit dose package with the medication card or medication sheet to verify information matches; -Staff should prepare and administer one resident's medication at a time; -All medications should be clearly identified; -Staff should not remove medication from a medication bottle or unit dose package until they see the resident; -Staff should administer medication to the resident with adequate water and observe consumption; -Staff should record immediately after giving each resident's medication (unit dose) by the person who administered the medication. Review of the Level One Medication Aide student guide revision dated November, 1993, Lesson Plan 14 Unit V for types of drug storage systems, drug preservation, drug disposal, and drug distribution systems showed the following: -Drugs are to be disposed if they become contaminated, unused, discontinued, outdated, or deteriorated; -Drugs are to be disposed of by destroying them in the facility;	A4797		

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A4797	Continued From page 10 -Disposal of drugs is to be recorded on a medication sheet or other document by two persons with at least one of the persons being a Level One Medication Aide. Review of the undated facility policy for Medication Administration showed the following: -Team members who are appropriately licensed or who, where allowable by law, have been trained, evaluated for competency, and delegated/authorized by a licensed nurse will administer medication to residents receiving medication and treatment management services in accordance with provider orders, applicable law, and Company policy and procedure and applicable law; -For each administration of medication, med passers will follow the seven rights: right resident, right medication, right dose, right route, right time and day, right reason and right documentation; -The licensed nurse or med passer will open the resident's electronic medication administration record (eMAR) and compare the medication listed in the eMAR to the medication label, gather needed supplies for medication administration, remove the medication from the bottle or multi dose packaging and place the medication in a medication cup; -Check the expiration date on the medication label to verify the medication has not expired, following the Medication Disposition policy and procedure as warranted; -After preparing the medication for administration, the licensed nurse or med passer will introduce themselves to the resident and administer the medication; -Medication is never to be left at the resident's bedside or within the resident's apartment for the	A4797		

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A4797	Continued From page 11 resident to self-administer unless the resident has a provider order stating that the resident can self-administer medication; -Document medication administration in the resident's eMAR. 1. Observation on 01/13/26 at 1:00 P.M. of Medication Cart three on the Memory Care Unit showed the following: -An opened bottle of fluticasone (a corticosteroid used primarily as a nasal spray (e.g., Flonase) to relieve seasonal allergies, congestion, sneezing, and itchy/watery eyes, and via inhaler for asthma and chronic obstructive pulmonary disease management) 100 micrograms (mcg)/ 10 milligrams (mg) that did not have a pharmacy label identifying who to administer to or when to administer; -Another opened bottle of fluticasone with an expiration date of 12/17/25; -An opened bottle of Maxitussin DM (a cough medication) with a dispense date of 01/8/25 and an expiration date of 01/07/26; -An opened bottle of lorazepam (used to treat anxiety) give 0.5 milliliters every two hours as needed with a discard date of 11/14/25; -An opened bottle of Refresh eye drops (used to treat dryness in the eyes) with no name on the bottle; -An opened bottle of Latanoprost (eye drop used to lower high eye pressure in open-angle glaucoma or ocular hypertension by increasing natural fluid outflow) with a label to refrigerate after opened in the top drawer of the medication cart and not refrigerated. 2. Observation and interview on 1/12/26 at 3:05 P.M. showed the following: -Care Coordinator (CC), who held certification as	A4797		

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A4797	Continued From page 12 a Level One Medication Aide (LIMA), was responsible for administering resident medications for the shift; -CC held a stack of five disposable plastic drinking cups in which the stack of five plastic medication cups contained various pills; -CC said he/she prepared the medications in the cup for the residents from the medication cart that did not have the laptop computer attached; -CC pushed the medication cart with the laptop attached down the hallway, stopping at Resident #2's door; -CC removed the top medication cup from the stack of disposable plastic drinking cups; -The top medication cup contained four pills without packaging; -The top medication cup was not labeled with a resident's name, room number, or medication names; -CC said the four medications in the cup where the four medications identified in Resident #2's eMAR; -CC knocked on Resident #2's room, entered, and administered the medication from the cup by handing the cup to the resident and observing the resident's consumption of the medication; -CC returned to the medication cart and documented administration of the medications. Record review of Resident #2's electronic face sheet showed the following: -Resident was admitted to the facility on 9/14/25; -Resident's diagnoses included congestive heart failure (heart disease), atrial fibrillation (heart disease), diabetes mellitus type 2 (blood sugar disorder), and hypertension (high blood pressure). Record review of Resident #2's physician orders	A4797		

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NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(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
A4797	Continued From page 13 (POS) for January, 2026 showed the following to be administered twice per day with the second dose administered during the evening meal hours: -Eliquis (medication to prevent blood clots), 25 milligrams (mg), one tablet twice per day; -Famotidine (medication to treat heartburn), 20 mg, one tablet twice per day; -Glipizide (medication to lower blood sugar), 10 mg, one tablet twice per day; -Senexon (combination of two medications to treat constipation), 8.6 mg and 50 mg combined tablet twice per day. 3. Observation of CC's medication pass on 3:11 P.M. showed the following: -CC pushed the medication cart with the laptop attached down the hallway, stopping at Resident #8's door; -CC removed the top medication cup from the stack; -The top medication cup contained three oral medications without packaging; -The top medication cup was not labeled with a resident's name, room number, or medication name; -CC said the three oral medications in the cup were the three oral medications identified in Resident #8's eMAR; -CC knocked on Resident #8's room, entered, and administered the medication from the cup by handing the cup to the resident and observing the resident's consumption of the medication; -CC returned to the medication cart and documented administration of the medications. Record review of Resident #8's electronic face sheet showed the following: -Resident was admitted to the facility on	A4797		

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A4797	Continued From page 14 10/15/25; -Resident's diagnoses included Parkinson's disease (a disorder characterized by tremors, balance issues, and slow movement). Record review of Resident #8's POS for January, 2026 showed the following to be administered at 4:00 P.M.: -Carbidopa/levodopa ER (medication to treat Parkinson's disease)(extended release tablets to slow absorption of the medication), 25-100 mg, two (2) tablets four times daily; -Carbidopa/levodopa, 25-100 mg, one (1) tablet four times a day. 3. Observation of CC's medication pass on 3:22 P.M. showed the following: -CC pushed the medication cart with the laptop attached down the hallway, stopping at Resident #9's door; -CC removed the top medication cup from the stack; -The top medication cup contained four oral medications without packaging; -The top medication cup was not labeled with a resident's name, room number, or medication name; -CC said the four oral medications in the cup were the four oral medications identified in Resident #9's eMAR; -CC knocked on Resident #9's room, entered, and administered the medication from the cup by handing the cup to the resident and observing the resident's consumption of the medication; -CC returned to the medication cart and clicked on Resident #9's medications in the eMAR; -When questioned regarding the eMAR, CC said there were five medications listed on Resident #9's eMAR instead of four medications;	A4797		

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A4797	Continued From page 15 -CC removed an opened strip pack from a basket on top of the medication cart and found one additional medication in the strip pack labeled for Resident #9; -CC placed the medication from the strip pack into a medication cup, returned to Resident #9's room, administered the medication to the resident, and documented the administration of all five medications in the resident's eMAR. Record review of Resident #9's electronic face sheet showed the following: -Resident was admitted to the facility on 7/18/25; -Resident's diagnoses included anxiety disorder, hypertension, congestive heart failure (heart disease when the heart cannot pump blood efficiently), history of malignant neoplasm of the prostate (cancer). Record review of Resident #9's POS for January, 2026 showed the following to be administered at 5:00 P.M.: -Buspirone (medication to treat anxiety), 5 mg, one tablet twice daily; -Carvedilol (medication to treat high blood pressure), 6.25 mg, one tablet twice daily; -Potassium chloride (mineral to offset effects of medications to treat congestive heart failure), 20 milliequivalents (meq), one tablet twice daily; -Tamsulosin (medication to treat prostate disorders), 0.4 mg, one tablet every evening; -Loperamide (medication to treat diarrhea), 2 mg, one capsule four (4) times per day. 4. Observation of CC's medication pass on 3:27 P.M. showed the following: -CC did not move the medication cart as Resident #9 and Resident #10 shared an apartment;	A4797		

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A4797	Continued From page 16 -CC removed the top medication cup from the stack; -The top medication cup contained one oral medication without packaging; -The top medication cup was not labeled with a resident's name, room number, or medication name; -CC said the one medication in the cup was the one oral medication identified in Resident #10's eMAR; -CC knocked on Resident #10's room, entered, and administered the medication from the cup by handing the cup to the resident and observing the resident's consumption of the medication; -CC returned to the medication cart and documented administration of the medications. Record review of Resident #10's electronic face sheet showed the following: -Resident was admitted to the facility on 7/18/25; -Resident's diagnoses included Alzheimer's disease and epilepsy (brain disorder which causes seizures). Record review of Resident #10's POS for January, 2026 showed an order levetiracetam (medication to treat seizures), 750 mg, one tablet twice daily. 5. Observation of CC's medication pass on 3:35 P.M. showed the following: -CC pushed the medication cart with the laptop attached down the hallway, stopping at Resident #3's door; -CC picked up a medication cup with two oral medications without packaging; -The medication cup was not labeled with a resident's name, room number, or medication name;	A4797		

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A4797	Continued From page 17 -CC said the two oral medications in the cup where the two oral medications identified in Resident #3's eMAR; -CC knocked on Resident #3's room, entered, and administered the medication from the cup by handing the cup to the resident and observing the resident's consumption of the medication; -CC returned to the medication cart and documented administration of the medication. Record review of Resident #3's electronic face sheet showed the following: -Resident was admitted to the facility on 7/31/25; -Resident's diagnoses included hypertension, history of cerebral infarction (stroke), and presence of heart-valve replacement. Record review of Resident #3's POS for January, 2026 showed the following to be administered at 4:00 P.M.: -Tamsulosin, 0.4 mg. one capsule twice daily; -Carbidopa-levodopa ER, 36.25-145 mg, one tablet three (3) times a day. During interview on 1/12/26 at 3:05 P.M., the Care Coordinator said the following: -He/She pre-popped the medications for the residents who lived on one hall because their medications were stored in a different medication cart that did not have a laptop attached for charting the administration of medications; -He/She was the lead Level I Medication Aide and responsible for making sure other staff properly passed medication; -He/She thought he/she was following proper protocol for administering medications; -He/She administered medications early and had to find ways to hurry during the administration of medications because he/she was responsible for	A4797		

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A4797	Continued From page 18 administering all the medications for residents on two floors. 6. Observation on 1/13/26 at 10:35 A.M. showed LIMA A was standing at the medication cart with the laptop attached with a stack of opened and emptied strip packs; -LIMA A said he/she was entering the documentation of the medications that had been in the strip packs in the residents' eMAR; -LIMA A said he/she had personally administered these medications to the residents; -There was an unknown blue -green pill on top of the other locked medication cart; -LIMA A said that he/she did not know the origin of the pill and left to report it to the director of nursing. During an interview on 01/13/26 at 6:00 P.M., the Director of Nursing said: -Pharmacy checks each medication cart and removes the expired medication; -The pharmacy was just here; -She would expect the pharmacy to check the medication carts and remove all expired medication and medication that is not labeled or stored correctly. -She expected staff to pass all medications as ordered by the physician using acceptable nursing techniques which included administering medications to each resident individually and not pre-popping medications.	A4797		
A4817	19 CSR 30-86.047(51)(A)(1) Schedule II Meds-Reconcile Each Shift, Record Records shall be maintained upon receipt and disposition of all controlled substances and shall be maintained separately from other records, for	A4817		

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A4817	Continued From page 19 two (2) years. (A) Inventories of controlled substances shall be reconciled as follows: 1. Controlled Substance Schedule II medications shall be reconciled each shift; II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to ensure inventories of Schedule II controlled substances (medications which have a high potential for abuse) were documented as reconciled each shift. The facility census was 56. Review of the undated facility policy for Medication Management/Managing Controlled Medications showed the following: -Controlled medication must be counted at the end of each shift and when medication cart keys are handed off between team members; -Two Level One Medication Aides (LIMA) med passers are required for the count: the med passer coming off duty/handing off med cart key and the med passer coming on duty/receiving med cart key; -The two med passers will together count the controlled medication, verify the count my comparing the last recorded "amount remaining" in the electronic Medication Administration Record (eMAR) for each controlled medication against the actual number remaining in the applicable punch-card or container, and document and attest to the count in the eMAR. 1. Review of the Controlled Medication Count	A4817		

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A4817	Continued From page 20 Verification form for the Memory Care number three medication cart on 01/13/26 at 1:00 P.M. showed no signatures for the following: -12/01/25 for the first and second witness for both the first and second shift; -12/02/25 for the first witness for the first shift; -12/05/25 for the second witness for the first shift; -12/09/25 the first witness for the second shift; -12/13/25 the first witness for the second shift; -12/16/25 for the first and second witness for both the first and second shift; -12/19/25 for the second witness for the first shift and the first witness for the second shift; -12/22/25 the first witness for the second shift; -12/23/25 for the second witness for the first shift and the first witness for the second shift; -12/25/25 for the first and second witness for the second shift; -12/26/25 the first witness for the second shift; -12/29/25 for the second witness for the first shift and the first witness for the second shift; -Hand written on the bottom of the 01/01/26 the first witness for the second shift; 01/02/26 the first witness for the second shift; -On the back of the Controlled Medication Count Verification form showed one signature with no indication of what shift for 01/03/26 with a staff signature; -01/04/26 signed by three staff signatures with one signature indicating "day shift", no indication what shift the other two signatures were for; -01/05/26 one staff signature with no shift; -01/06/26 two staff signatures with only one indicating "day shift"; -01/07/26 one staff signature with no shift; -01/08/26 one staff signature with 7a-7p and another staff signature with no shift indicated; -No staff signatures for 01/09/26, 01/10/26, and 01/12/26;	A4817		

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A4817	Continued From page 21 -01/13/26 one staff signature with no shift indicated. 2. Review of the Controlled Medication Count Verification form for the Memory Care number four medication cart on 01/13/26 showed no signatures for the following: -12/01/25 for the first and second witness for both the first and second shift; -12/02/25 the first witness for the second shift; -12/12/25 the first witness for the second shift; -12/16/25 the first witness for the first shift; -12/22/25 the second witness for the second shift; -12/26/25 the first witness for the second shift; -12/29/25 for the second witness for the first shift and the first witness for the second shift; -Hand written on the bottom of the 01/01/26 the first witness for the second shift; 01/02/26 the first witness for the second shift and 01/03/26 the first witness for the second shift; -On the back of the Controlled Medication Count Verification form showed one signature with no indication of what shift for 01/03/26 with a staff signature; -01/04/26 signed by one with no indication of what shift; -01/05/26 one staff signature with no shift; -01/06/26 two staff signatures with only one indicating "day shift"; -01/07/26 no staff members signatures for any shift; -01/08/26 one staff signature with 7a-7p and another staff signature with no shift indicated; -No staff signatures for 01/09/26 or 01/12/26; -01/13/26 one staff signature with no shift indicated. 3. Review of the Controlled Medication Count	A4817		

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A4817	Continued From page 22 Verification form for the number five medication cart on 01/13/26 showed no signatures for the following: -01/01/26 through 01/04/26 no signatures for day or night shift on-coming or off-going; -01/05/26 no signatures for 1st and 2nd shifts and only on-coming signature for 3rd shift; -01/06/26 no on-coming signature for 1st; -01/07/26 no off-going signature for 2nd shift; -01/11/26 no off-going signature for 1st shift; -01/13/26 no off-going signature for 1st shift. 4. Review of the Controlled Medication Count Verification form for the number six medication cart on 01/13/26 showed no signatures for the following: -01/01/26 through 01/04/26 no signatures for any shift changes; -01/05/26 no signatures for on-coming or off-going for 1st and 2nd shifts and no off-going signature for 3rd shift; -01/06/26 no signatures for off-going for 1st shift and 2nd shift, and no signatures for 3rd shift; -01/07/26 through 01/10/26 no signatures for any shift changes; -01/11/26 no signatures for 1st shift and 3rd shift, only one signature for 2nd shift; -01/12/26 no signatures for 1st shift and 3rd shift, only one signature for 2nd shift; -01/13/26 no off-going and on-coming signature for 1st shift. 5. Review of the Controlled Medication Count Verification form for the number seven medication cart on 01/13/26 showed no signatures for the following: -01/01/26 no signatures for 2nd and 3rd shift and one signature for 1st shift; -01/02/26 no on-coming signature for 2nd shift	A4817		

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A4817	Continued From page 23 and no signatures for 3rd shift; -01/03/26 through 01/05/26 no signatures for any shift changes; -01/06/26 no off-going signature for 1st shift; -01/13/26 no on-coming and no off-going signatures for 1st shift. 6. Review of the Controlled Medication Count Verification form for the number eight medication cart on 01/13/26 showed no signatures for the following: -01/01/26 through 01/04/26 no signatures for any shift changes; -01/05/26 only one signature for 1st shift and no signatures for 2nd or 3rd shift; -01/06/26 no off-going signature for 1st shift; -01/11/26 no off-going signature for 2nd shift; -01/13/26 no off-going signature for 1st shift. During an interview on 01/13/26 at 1:30 P.M. LIMA D said the following: -Narcotics should be counted by the oncoming and off going shifts every day before the medication cart keys are passed to the next shift; -They did not have a Controlled Medication Count Verification form for January, so the staff just wrote on the back of the one for December. During an interview on 01/13/26 at 6:00 P.M. the Wellness Director and Administrator said the following: -They would expect staff to count the narcotics at shift change and document when the narcotic count was done; -They would expect the staff to ask for a new Controlled Medication County Verification form if they did not have one.	A4817		

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A4836	Continued From page 24	A4836		
A4836	19 CSR 30-86.047(58)(A) Resident Record Admission Info The facility shall maintain a record in the facility for each resident, which shall include the following: (A) Admission information including the resident ' s name; admission date; confidentiality number; previous address; birth date; sex; marital status; Social Security number; Medicare and Medicaid numbers (if applicable); name, address and telephone number of the resident ' s physician and alternate; diagnosis, name, address and telephone number of the resident ' s legally authorized representative or designee to be notified in case of emergency; and preferred dentist, pharmacist and funeral director; III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to ensure resident records included a preferred funeral director for four residents (Residents #1, #2, #3, and #4) of 22 sampled residents. The facility census was 56. 1. Review of Resident #1's face sheet showed the following: -Admitted to the facility on 10/1/24; -No designated funeral director listed. 2. Review of Resident #2's face sheet showed the following: -Admitted to the facility on 9/14/25; -No designated funeral director listed. 3. Review of Resident #3's face sheet showed the following:	A4836		

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A4836	Continued From page 25 -Admitted to the facility on 7/31/25; -No designated funeral director listed. 4. Review of Resident #4's face sheet showed: -Admitted to the facility on 10/30/24; -No designated funeral director listed. During interview on 1/13/25 at 6:00 P.M., the Administrator said that she expected the resident's records to include all required information including the preferred funeral director.	A4836		
A7016	19 CSR 30-87.030(14) Food-Clean Containers, Storage, Covers Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be impervious and nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers. III This regulation is not met as evidenced by: Class III Based on observation, and interview, the facility failed to ensure food items were stored in a clean covered container if removed from its original container or package. The facility census was 57. Review of the undated facility policy for Proper Storage of Food policy showed the following: -This policy establishes proper storage procedures for food to ensure food safety, prevent cross-contamination, and maintain a safe working environment for staff and residents;	A7016		

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A7016	Continued From page 26 -All stored food must be covered, labeled and dated with both the received date and use-by date. 1. Observation on 01/13/26 at 10:00 A.M. showed the following: -In a refrigerator in the main kitchen by the stove, a large plastic container of mayonnaise with the top of the container cut off and a metal spatula inside the container. The container did not have a date when opened. -In the same refrigerator a metal container with thick brown liquid dated 1/3. There was no label identifying the contents or a discard date. A metal container of mushrooms dated 1/4, with no discard date; three small metal containers labeled BF gravy with a date of 1/3, with no discard date. A metal container with sliced tomatoes with no preparation date or discard date; -On a metal table by the steam table containers of tomatoes, oranges, sliced cheese, diced pieces of chicken, and lettuce that was uncovered; -In the walk-in cooler containers of peeled and separated oranges that that were not covered or dated, and a container of sliced red potatoes sitting in water, uncovered an not dated; -On the bottom shelf of the cooler in a metal container packages of raw chicken sitting in a reddish color liquid with no date or when to use; -A prepared cake uncovered with no date prepared, or use by date. Observation on 01/13/26 at 10:45 A.M. of a refrigerator on the Memory Care Unit in a dining room showed two metal containers each containing an unidentified type of meat, unlabeled and with no discard date that	A7016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33581N	A. BUILDING: _____ B. WING _____	C 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

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A7016	Continued From page 27 contained some type of meat with no label to identify the meat or discard date. During an interview on 01/13/26 at 9:30 A.M. Cook C said the following: -All food should be labeled with the date it was opened and when to discard the food; -Food can be stored in the refrigerator up to seven days before discarding. During a telephone interview on 01/16/26 at 10:00 A.M. the Dietary Manager said dietary staff should be following the facility policy and labeling and dating food that has been opened and discard food if it had been in the refrigerator for seven days or more. During an interview on 01/13/26 at 6:00 P.M. the Administrator said dietary staff should be following the facility policy for storing food.	A7016		
A7066	19 CSR 30-87.030(64) Grills/Griddles/Microwaves/Other-Clean Daily The food-contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day, except that this shall not apply to hot oil-cooking equipment and hot oil-filtering systems. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. III This regulation is not met as evidenced by: Class III Based on observation and interview, the facility failed to clean food preparation equipment to	A7066		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7066	Continued From page 28 lessen the chance of bacterial contamination, in accordance with professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 57. Review of the undated facility policy for Cleaning and Sanitizing showed: -This policy established guidelines for the cleaning and sanitizing of the kitchen and dining room to ensure food safety, compliance with health regulations, and a sanitary environment for residents and team members. Adhering to these procedures helps prevent food borne illness, ensures proper sanitation, and maintains a professional culinary operation. -All kitchen and dining room areas must be cleaned and sanitized regularly throughout the day and at the end of each shift; -Cleaning tasks will be assigned daily, and a cleaning checklist must be completed and signed off by the assigned team member; -Surfaces, equipment, and food contact areas must be free of food debris, grease, and residue to prevent contamination; -Countertops, shelving, dish areas, appliances, and stainless steel surfaces must be kept clean and free of visible dirt, mold, or grease; -Food prep surfaces: clean and sanitize before and after each use. 1. Observation on 01/12/26 at 10:00 A.M. of the main kitchen showed: -Four slice toaster showed a build up of grime and crumbs on the outside; -Stove top with a build up of grease and food debris; -The fryer had a layer of brown food debris	A7066		

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A7066	Continued From page 29 covering the top of the grease; -Small freezer, by the steamtable there was a build up of dried food and splatter of food, inside the freezer were food crumbs; -The tray of the juice machine was full of liquid. 2. Observation on 01/13/26 at 9:30 A.M. of the main kitchen showed: -Floor by the main steam table with food particles, dried food and under the table were several gloves and a slice of bread; -There were french fries on the floor of the walk-in freezer. 3. During an interview on 01/13/26 at 9:30 A.M. Cook B said: -There is not a cleaning schedule that they follow; -Everybody should sweep and pick up as needed. 4. During an interview on 01/13/26 at 9:30 A.M. Cook C said: -There is not a routine cleaning schedule; -The countertops are wiped off at the end of the day. 5. During an interview on 01/13/26 at 6:00 P.M. the Administrator said: -The dietary department should follow the facility policy for cleaning the kitchen; -The kitchen should be cleaned. 6. During an interview on 01/16/26 at 10:00 A.M. the Dietary Manager said: -The surface tops should be sanitized every four hours and after each service; -The stove top should be cleaned as needed.	A7066		

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A7067	Continued From page 30	A7067		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Based on observation and interview, the facility failed to ensure non-food contact surfaces were kept clean from dirt and debris. The facility census was 57. Review of the undated facility policy for Cleaning and Sanitizing showed: -This policy established guidelines for the cleaning and sanitizing of the kitchen and dining room to ensure food safety, compliance with health regulations, and a sanitary environment for residents and team members. Adhering to these procedures helps prevent food borne illness, ensures proper sanitation, and maintains a professional culinary operation. -All kitchen and dining room areas must be cleaned and sanitized regularly throughout the day and at the end of each shift; -Cleaning tasks will be assigned daily, and a cleaning checklist must be completed and signed off by the assigned team member; -Floor must be thoroughly cleaned and mopped daily. 1. Observation on 01/12/26 at 10:00 A.M. of the main kitchen showed: -Floor by the main steam table with food particles, dried food and under the table were	A7067		

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A7067	Continued From page 31 several gloves and a slice of bread; -The floor of the main walk-in cooler had particles of food; -There were french fries on the floor of the walk-in freezer. 2. Observation on 01/13/26 at 9:30 A.M. of the main kitchen showed: -Floor by the main steam table with food particles, dried food and under the table were several gloves and a slice of bread; -There were french fries on the floor of the walk-in freezer. 3. During an interview on 01/13/26 at 9:30 A.M. Cook B said: -There is not a cleaning schedule that they follow; -Everybody should sweep and pick up as needed. 4. During an interview on 01/13/26 at 9:30 A.M. Cook C said: -There is not a routine cleaning schedule; -The floors are swept at the end of each shift and mopped about one time a week. 5. During an interview on 01/13/26 at 6:00 P.M. the Administrator said: -The dietary department should follow the facility policy for cleaning the kitchen; -The kitchen should be cleaned. 6. During an interview on 01/16/26 at 10:00 A.M. the Dietary Manager said: -The kitchen floors should be swept and mopped every other day.	A7067		

STATE PLAN OF CORRECTION

Agency Name	New Perspective Weldon Spring
STREET ADDRESS, CITY, ZIP:	400 Siedentop Road, Weldon Spring, MO 63304
Provider Number	33581N
Exit Date	1/13/20206

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERRENCED TO THE APPROPRIATE DEFICIENCY)		
Tag Number	**The Administrator signing and dating the first page of the STATE FORM is indicating their approval of the plan of correction being submitted on this form.**	**(X5) COMPLETION DATE**
A4512	**Weldon POC 2.2026** **A4512 – Emergency Preparedness / Individualized Evacuation Plans** The Community immediately reviewed all residents identified as requiring more than minimal assistance during evacuation. Individualized Emergency Preparedness (IEP) plans were updated to clearly identify evacuation needs, staff roles, evacuation routes, and prioritization during an emergency. Staff were re-educated on resident-specific evacuation needs and where IEP information is located in the electronic health record. A facility-wide audit of all resident Emergency Preparedness and Evacuation Plans was completed to identify any additional residents requiring more than minimal assistance or whose plans lacked sufficient detail. All identified plans were corrected accordingly. The Executive Director will provide retraining to the nursing team regarding the requirement for individualized evacuation plans and the requirements for documentation. Re-education will be conducted by 2/15/2026 with all direct care team on accessing IEPs in the service plan. The Health and Wellness Director or designee will conduct quarterly audits of resident Individualized Evacuation Plans to verify completeness and accuracy. Audit results will be reviewed by leadership, and corrective action taken as needed. Completed by 02/15/2026.	2/15/2026
A3235	**A3235 – Hot Water Temperature Monitoring** The Community immediately assessed hot water temperatures in resident units and common areas identified in the survey findings. Repairs and adjustments were completed to restore water temperatures within acceptable ranges. Residents impacted by temperature concerns were assessed, and maintenance interventions were documented. A full building-wide hot water temperature audit was conducted to identify any	2/10/20206

	additional units outside acceptable temperature ranges. All findings were addressed promptly. The Executive Director provided education on the standardized water temperature monitoring protocol requiring routine temperature checks of representative resident units. The Environmental Services Director or designee will conduct routine temperature monitoring per policy and review results monthly. Findings will be tracked, and follow-up actions documented. Completion Date Completed by 02/10/2026.	
A4797	**A4797 – Medication Management and Administration** The Community immediately reviewed medication administration records, storage practices, labeling, disposal processes, and documentation for residents identified in the survey. Any discrepancies were corrected, including proper labeling, disposal of discontinued or expired medications, and reinforcement of medication administration procedures. The Pharmacy will provide an additional audit to include medication carts, resident medication storage areas, MAR documentation, and the medication disposal process. Any identified issues will be corrected at the time of the review. The Community reinforced medication administration standards through staff re-education, including the "rights" of medication administration, proper medication labeling and packaging, disposal procedures, accurate and timely documentation in the MAR. A licensed nurse will observe all med passers and complete re-delegation of duties to support ongoing compliance. The Director of Nursing or designee will complete routine medication audits, including observation of medication passes and review of MAR documentation at least 2x per month for the next 60 days. Findings will be reviewed with staff, and corrective action implemented as needed. Completion Date Completed by 02/20/2026.	2/20/2026
A7016	**A7016 – Food labeling / dating / covered storage** Dietary leadership immediately removed or discarded any foods that were not labeled/dated, lacked discard dates, or were not appropriately covered per policy. Dietary staff were re-educated the same day on labeling, dating (prep/open), discard dating, and covered storage expectations for all food items in refrigerators/coolers, including memory care dining refrigerators. Dietary leadership completed an immediate audit of all refrigeration units (main kitchen, walk-in cooler/freezer, and satellite/memory care refrigerators) to identify any additional unlabeled/undated/uncovered food items. Noncompliant items were corrected at the time of audit. The Community re-educated and implemented the Storage of food, Chemicals	2/20/2026

	and Equipment policy that includes the following information: required label fields (item name, prep/open date, discard date, initials), a designated responsibility by shift for label verification, a "no label/no date = discard" standard, reinforcement of covered storage requirements for all ready-to-eat and stored foods, dietary staff training was documented, and expectations were added to orientation for new dietary staff. The Culinary Services Director (or designee) will complete daily label/date/cover checks of all refrigerators, with a weekly documented audit. Results will be reviewed with the Administrator/ED and corrective action completed for any findings. Completion date Completed by: 02/20/2026	
A7066	**A7066 – Food-contact equipment/surfaces cleaned daily** Dietary leadership immediately cleaned and sanitized all identified food-contact equipment and areas (including toaster exterior, stovetop, fryer surfaces, juice machine tray, freezer interior, and any affected prep/steam table areas). Dietary staff were re-educated on required cleaning frequency and expectations for food-contact surfaces. Dietary leadership completed an immediate environmental audit of the kitchen, walk-in cooler/freezer, and equipment to identify additional food-contact surfaces requiring cleaning/sanitizing. Items were corrected at the time of review. The Community implemented the Company's written daily cleaning schedule and shift-assigned responsibilities for food-contact equipment/surfaces, including documented sign-off by the assigned staff member and supervisor verification. Cleaning expectations were clarified for: daily cleaning requirements by equipment type, "clean as you go" standards during service, end-of-shift deep-clean expectations, dietary leadership will maintain the schedule and retrain staff as needed. The Culinary Services Director (or designee) will complete daily end-of-shift verification of kitchen cleanliness and review cleaning logs weekly. Administrator/ED will complete monthly spot checks with documented follow-up. Completion date Completed by: 02/20/2026	2/20/2026
A7067	**A7067 – Nonfood-contact surfaces cleaned as needed** Dietary leadership immediately cleaned nonfood-contact surfaces and areas cited (including floors by steam table, under equipment/tables, walk-in cooler/freezer floors, and general debris accumulation). Dietary staff were re-educated on required routine cleaning frequency and expectations for sweeping/mopping and maintaining floors free of food debris and trash. Dietary leadership conducted an immediate audit of all nonfood-contact kitchen areas (floors, shelving, exterior surfaces, cooler/freezer floors, under equipment, storage areas) and corrected findings at the time of audit.	2/20/2026

	The Community implemented a routine cleaning schedule that includes: assigned duties by shift for sweeping, mopping, and spot-cleaning, required frequency standards (daily and "as needed" during service), including documentation/sign-off and supervisor verification. The Culinary Services Director (or designee) will complete daily walkthroughs of kitchen and storage areas and verify completion of cleaning logs. Administrator/ED will complete monthly environmental rounds with documented follow-up. Completion date Completed by: 02/20/2026	
A4817	**A4817 – Controlled medication count verification / missing witness signatures** Nursing leadership immediately reviewed controlled medication count verification records for all medication carts and corrected documentation gaps where possible, including reinforcing required double-signature/witness expectations and shift designation requirements. Staff responsible for controlled medication counts were re-educated on the controlled count process and documentation requirements. The Community completed an audit of controlled medication count documentation for all carts and all shifts to identify any additional missing signatures, missing shift identifiers, or incomplete count verification records. Any identified issues were addressed through immediate coaching and corrective action. The Community will initiate an electronic narcotic count feature within the EHR for compliance and immediate auditing capabilities of narcotic count documentation. The Health and Wellness Director or designee will review controlled medication count verification weekly for completeness and accuracy. Any trends will be addressed with re-education and progressive corrective action as indicated. Completion date Completed by: 02/20/2026	2/20/2026
A4836	**A4836 – Resident record admission information** The Community immediately reviewed the identified resident record(s) and updated missing required admission information elements per regulation/policy, as applicable. Staff responsible for admissions documentation were re-educated on required admission record elements and where documentation is maintained in the electronic record. The Community completed an audit of active resident records to verify required admission information is present and appropriately filed in the EHR. Any missing elements were corrected based on available source documentation and follow-up with responsible parties. The Health and Wellness Director or designee with audit all new move ins within 48 hours to verify all required admission documentation is present and	2/20/2026

	appropriately filled out in the EHR for the next 60 days. Any missing elements will be corrected immediately. Completion date Completed by: 02/20/2026	

Missouri Department of Health and Senior Services

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	33581N	A. BUILDING: _____ B. WING _____	R-C 03/11/2026

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NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

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{A3235}	19 CSR 30-86.032(34) Hot Water 105-120 Degrees F Plumbing fixtures which are accessible to residents and which supply hot water shall be thermostatically controlled so that the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C) and the water shall be at a temperature range between one hundred five degrees Fahrenheit (105°F) (41°C) and one hundred twenty degrees Fahrenheit (120°F) (49°C). I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 01/13/26. Class II Based on observation, interview, and record review, the facility failed to ensure water temperatures at plumbing fixtures accessible to residents were maintained in a range between one hundred five degrees Fahrenheit (105°F) and one hundred twenty degrees Fahrenheit (120°F). The facility census was 55. Review of the water temperature logs conducted by the environmental services director and provided by the facility showed the following: -Temperatures on 01/15/26 with no time specified for memory care rooms #01 through #13a, which did not designate if the temperatures were taken at the sink or shower, showed the hot side of the single-handle faucet for five of 15 faucets measured below 105°F, with the lowest being the memory care room #07 faucet registering 96°F; -Temperatures on 01/22/26 with no time specified for memory care rooms 13b through 23a, which did not designate if the temperatures were taken	{A3235}		

Missouri Department of Health and Senior Services

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{A3235}	19 CSR 30-86.032(34) Hot Water 105-120 Degrees F Plumbing fixtures which are accessible to residents and which supply hot water shall be thermostatically controlled so that the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C) and the water shall be at a temperature range between one hundred five degrees Fahrenheit (105°F) (41°C) and one hundred twenty degrees Fahrenheit (120°F) (49°C). I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 01/13/26. Class II Based on observation, interview, and record review, the facility failed to ensure water temperatures at plumbing fixtures accessible to residents were maintained in a range between one hundred five degrees Fahrenheit (105°F) and one hundred twenty degrees Fahrenheit (120°F). The facility census was 55. Review of the water temperature logs conducted by the environmental services director and provided by the facility showed the following: -Temperatures on 01/15/26 with no time specified for memory care rooms #01 through #13a, which did not designate if the temperatures were taken at the sink or shower, showed the hot side of the single-handle faucet for five of 15 faucets measured below 105°F, with the lowest being the memory care room #07 faucet registering 96°F; -Temperatures on 01/22/26 with no time specified for memory care rooms 13b through 23a, which did not designate if the temperatures were taken	{A3235}		

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{A3235}	Continued From page 1 at the sink or shower, except for the shared showers, showed the hot side of the single-handle faucet for six of 15 faucets measured below 105°F, with the lowest being memory care room #13's shared shower which registered 87.1°F. Review of invoices and supporting documents from the contracted plumbing company to the facility showed the following: - Invoice dated 02/16/26 showed on 01/30/26, a plumber walked the facility with the environmental services director and identified several rooms without hot water; - The 02/16/26 invoice noted several circuit valves were opened and closed, and hot water was returned to all rooms with the suspicion that a 1/2" check valve may have been defective; - The 02/16/26 invoice instructed the facility to monitor water temperatures and the plumbers would replace the check valve if the problem persisted; - An undated invoice from the same plumbing company showed the plumber walked the building and cleared debris to adjust for proper water temperature and pressure. Observation on 03/09/26 at 12:50 P.M., of the men's common restroom on the first floor adjacent to the elevator and memory care access doors showed the following: -The hot water temperature from the faucet on the left side of the sink counter measured 84°F by a stem type digital thermometer under running water for two minutes; -The hot water temperature from the faucet on the right side of the sink counter measured 80°F by a stem type digital thermometer under running water for two minutes.	{A3235}		

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{A3235}	Continued From page 2 Observation on 03/09/26 at 1:00 P.M., of the men's common restroom on the second floor adjacent to the activities area, showed the hot water temperature from the faucet on the left side of the sink counter measured 97.4°F by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 1:12 P.M., of the sink located on the second floor near the medication cart storage and accessible to residents, on the hot side of the faucet showed a temperature of 98°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 1:33 P.M., of the hot water side of the single-handle kitchenette sink faucet in the third floor activities area showed a maximum temperature of 102.4°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 1:37 P.M., of the third floor common restroom showed the hot water side water temperature at the sink faucet of 73.5°F measured with a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 1:39 P.M., of the third floor common restroom on the left the hot water side of the sink faucet showed a temperature of 72.4°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 2:08 P.M., of the hot side of the single-handle shower faucet in memory care room #16 showed a temperature of	{A3235}		

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NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(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
{A3235}	Continued From page 3 103.8°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 2:19 P.M., of memory care room #15 showed the hot side of the single-handle sink faucet of 101.7°F and the hot side of the single-handle shower faucet temperature of 102.6°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 3:16 P.M., of memory care room #30 shared shower showed the hot side of the single-handle faucet temperature of 101.5°F measured by a stem type digital thermometer under running water for two minutes. Observation on 03/09/26 at 3:30 P.M., of memory care room #36 of the hot side of the single-handle shower faucet showed a temperature of 100.4°F measured by a stem type digital thermometer under running water for two minutes. During interview on 03/09/26 at 2:11 P.M., a family member who was preparing to shower a resident in memory care #10 said he/she had contacted the facility maintenance personnel on that day to adjust the temperature in the resident's shower so that it was warm enough to shower the resident comfortably. During interviews on 03/09/26 at 5:41 P.M. and 03/11/26 at 1:27 P.M., the administrator said the following: - Maintenance staff had been testing faucet temperatures to identify and correct water temperatures; - It was her expectation that all	{A3235}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33581N	A. BUILDING: _____ B. WING _____	R-C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE – WELDON SPRING	400 SIEDENTOP ROAD WELDON SPRING, MO 63304

(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
{A3235}	Continued From page 4 resident-accessible faucets in the facility provide water within regulation temperatures.	{A3235}		

STATE PLAN OF CORRECTION

Agency Name	New Perspective Weldon Spring
STREET ADDRESS, CITY, ZIP:	400 Siedentop Road, Weldon Spring, MO 63304
Provider Number	33581N
Exit Date	4/8/26

PROVIDER'S PLAN OF CORRECTION (EACH CORR
CROSS - REFERRENCED TO THE APPROPR

Tag Number	The Administrator signing and dating the first page of the STATE FORM is indicating their approval of the plan of correction being submitted on this form.	(X5) COMPLETION DATE
A3235	**A3235 – Hot Water Temperature Monitoring** The Community immediately assessed hot water temperatures in resident units and common areas identified in the survey findings. Repairs and adjustments were completed to restore water temperatures within acceptable ranges. Residents impacted by temperature concerns were assessed, and maintenance interventions were documented. A full building-wide hot water temperature audit was conducted to identify any additional units outside acceptable temperature ranges. All findings were addressed promptly. The Executive Director provided education on the standardized water temperature monitoring protocol requiring routine temperature checks of representative resident units. The Environmental Services Director or designee will conduct routine temperature monitoring per policy and review results monthly. Findings will be tracked, and follow-up actions documented. Completed by 2/10/26. During routine water temperature checks on 2/24/26 it was discovered that several rooms were falling back out of temperature guidelines and a call was made to local plumber for repair. 3/9/26 Plumber on-site to clean mixing valves under sinks, adjust shower cartridges and cleaned valves. This repair was in-progress during the re-inspection that took place 3/9/26-3/11/26. Plumber continued on-site work 3/16/26, 3/17/26 and again 3/30/26. On 4/1/26 all work complete and temperatures recorded within guidelines. Documentation of work as well as water temps are attached for reference. Facility to continue routine temperature checks and any findings will be tracked, and follow-up actions documented.	4/1/26