STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4505	19 CSR 30-86.045(3)(A)(5) Individual Evacuation Plan - In Resident ISP 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: 5. Include an individualized evacuation plan in the resident ' s individual service plan; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents who required more than minimal assistance to safely evacuate the facility had an individual evacuation plan (IEP) in the residents' individualized service plan (ISP), for five of six residents who required an IEP (Residents #8, #6, #4, #7, and #2). The census was 79. 1. Review of Resident #8's medical record, showed the facility admitted the resident on 10/6/23, with diagnoses which included high cholesterol, dementia and high blood pressure. Review of the resident's undated IEP, showed the resident required one person assistance to pivot transfer into a wheelchair and be escorted to an area of refuge. Review of the resident's ISP dated 12/5/25, showed no documentation of the resident's need for an IEP. 2. Review of Resident #6's medical record, showed the facility admitted the resident on 3/24/24, with a diagnoses which included vascular dementia and high blood pressure.	A4505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4505	Continued From page 1 Review of the resident's ISP dated 10/6/25, showed the resident had a need of emergency services. The goal for the resident was to maintain and/or maximize current level of functioning with evacuation. The resident required total assistance for evacuation. The resident required physical assistance to evacuate the residence safely during an emergency due to physical and cognitive limitations. The resident would be safely evacuated during emergencies with appropriate equipment and staff assistance. Review of the resident's undated IEP, showed the following: -The resident required two staff to assist with a Hoyer lift; -The resident required an assistive device of a wheelchair or Broda chair. Review of the resident's ISP dated 10/6/25, showed the ISP did not address the resident's need of an IEP. 3. Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with a diagnoses which included chronic kidney disease, anemia and muscle weakness. Review of the resident's ISP dated 12/7/25, showed the resident had a need of emergency services. The goal was for the resident to maintain and/or maximize current level of functioning with evacuation. The level of assistance the resident required was moderate assistance. The resident required some physical assistance to evacuate residence or to request emergency assistance. Review of the resident's undated IEP, showed the	A4505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4505	Continued From page 2	A4505		

following:
-The resident required one staff member to assist with a pivot transfer;
-The resident required an assistive device of a wheelchair.

Review of the resident's ISP dated 12/7/25, showed the ISP did not address the resident's need of an IEP.

4. Review of Resident #7's medical record, showed the facility admitted the resident on 5/12/25, with diagnoses which included Parkinson's disease, hallucinations, and depression.

Review of the resident's undated IEP, showed the resident required one person assistance to pivot transfer into a wheelchair and be escorted to an area of refuge.

Review of the resident's ISP dated 10/29/25, showed no documentation of the resident's need for an IEP.

5. Review of Resident #2's medical record, showed the facility admitted the resident on 11/13/25, with diagnoses which included Parkinson's disease, chronic pain, lower back pain, cataract and heart disease.

Review of the resident's undated IEP, showed the resident required assistance to transfer from bed/chair/commode to a wheelchair and escort to the area of refuge.

Review of the resident's ISP dated 12/15/25, showed no documentation of the resident's need for an IEP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4505	Continued From page 3 6. During an interview on 2/3/26 at 10:03 A.M., the Director of Nursing said she was responsible for the residents' IEPs. She said she missed putting the residents IEP into his/her ISPs. 7. During an interview on 2/3/26 at 10:03 A.M., the Administrator said she was aware the IEPs had to be included in the ISP but she was not aware it was not being done.	A4505		
A4506	19 CSR 30-86.045(3)(A)(6)(A) Individual Evacuation Plan-Staff Requirements 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: 6. At a minimum the evacuation plan shall include the following components: A. The responsibilities of specific staff positions in an emergency specific to the individual; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide the responsibilities of a single staff position who would be responsible for the resident in an emergency on the Individual Evacuation Plan (IEP), for six of eight sampled residents (Residents #8, #6, #4, #7, #2, and #1). The census was 79. 1. Review of Resident #8's medical record, showed the facility admitted the resident on 10/6/23, with diagnoses which included high cholesterol, dementia, and high blood pressure.	A4506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4506	Continued From page 4 Review of the resident's undated IEP, showed the following: -The resident required one staff to provide a pivot transfer into a wheelchair and escort the resident 14' 4" to the right from the residents' room to the area of refuge; -The IEP did not address which specific staff position was assigned to the resident in an evacuation. 2. Review of Resident #6's medical record, showed the facility admitted the resident on 3/24/24, with a diagnoses which included vascular dementia and high blood pressure. Review of the resident's undated IEP, showed the following: -The resident required two staff to assist with a Hoyer lift; -The resident required an assistive device of a wheelchair or Broda chair; -The IEP did not specify which staff member was responsible for evacuating the resident in an emergency. 3. Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with a diagnoses which included anemia, chronic kidney disease and muscle weakness. Review of the resident's undated IEP, showed the following: -The resident required one staff member to assist with a pivot transfer; -The resident required an assistive device of a wheelchair; -The IEP did not specify which staff member was responsible for evacuation the resident in an emergency.	A4506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4506	Continued From page 5 4. Review of Resident #7's medical record, showed the facility admitted the resident on 5/12/25, with diagnoses which included Parkinson's disease, hallucinations, and depression. Review of the resident's undated IEP, showed the following: -The resident required one staff to provide a pivot transfer into a wheelchair and escort the resident 7' 4" from the residents' room to the area of refuge; -The IEP did not address which specific staff position was assigned to the resident in an evacuation. 5. Review of Resident #2's medical record, showed the facility admitted the resident on 11/13/25, with diagnoses which included Parkinson's disease, chronic pain, lower back pain, cataract and heart disease. Review of the resident's undated IEP, showed the following: -The resident required one staff to provide transfer assistance and escort to the left of the resident's room 43' 3" to the area of refuge; -The IEP did not address which specific staff position was assigned to the resident in an evacuation 6. Review of Resident #1's medical record, showed the facility admitted the resident on 11/30/25, with diagnoses which included vascular dementia, osteoarthritis and gastro-esophageal reflux. Review of the resident's undated IEP, showed the following: -The resident required one staff to provide verbal	A4506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4506	Continued From page 6 direction and handheld guidance 34' 10" to the left of the residents' room to the area of refuge; -The IEP did not address which specific staff position was assigned to the resident in an evacuation. 7. During an interview on 2/3/26 at 10:03 A.M., the Director of Nursing said she was responsible for the residents' IEPs. She said she did not know to put the specific staff position on the IEP sheet. 8. During an interview on 2/3/26 at 10:03 A.M., the Administrator said she was aware the IEPs had to have the specific staff position on the IEP but didn't know it was missing from the facility IEP sheets.	A4506		
A2257	19 CSR 30-86.022(10)(B) Combustible Materials, Unnecessary Storage Of Protection from Hazards. (B) The storage of unnecessary combustible materials in any part of a building in which a licensed facility is located is prohibited. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to ensure the facility did not store unnecessary combustible material, when resident rooms had an unnecessary amount of oxygen tanks. The census was 79. Review of the facility's "Oxygen Administration" policy dated 8/1/22, showed the following: -Concentrators: -Concentrator should be 6 inches from drapes, bedding or walls. Use an outlet which is not	A2257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A2257	Continued From page 7 controlled by a wall switch. -Each community is to contact their supplier for instructions regarding concentrator care and connecting the cylinders to the regulators. Obtain a copy of the instruction booklet and refer to it for specific instructions; -Clean the concentrator filters with hot water weekly (wring out well after rinsing), to remove dust; -Portable Tanks: -Portable takes should be upright in a secure holder at all times; -Portable tanks must be kept away from flammable, highly combustible and corrosive substances. 1. Observation on 2/2/26 between 10:16 A.M. and 3:50 P.M., of resident room 210, showed the following: -Two concentrators in the living room; -Twelve tall oxygen tanks in the left side of the bedroom in a metal crate; -Two medium sized oxygen tanks behind the metal cart, leaned up against the wall and unsecured; -Three tall oxygen tanks beside the metal cart, unsecured. 2. Observation on 2/2/26 between 9:39 A.M. and 3:50 P.M., of resident room 224, showed six small oxygen tanks in a metal crate in the left corner of the room by the door. 3. During an interview on 2/2/26 at 3:55 P.M., the Administrator said she did not know there was an excessive amount of oxygen in resident rooms and did not know residents could not have that many oxygen tanks.	A2257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4748	Continued From page 8	A4748		
A4748	19 CSR 30-86.047(28)(E) Premove-in Screening Requirements The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (E) The premove-in screening shall be completed prior to admission with the participation of the prospective resident and be designed to determine if the individual is eligible for admission to the assisted living facility and shall be based on the admission restrictions listed at section (29) of this rule; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to complete a premove-in screening for prospective residents to determine if the individual was eligible for admission to the facility, for three of eight sampled residents (Residents #7, #1, and #5). The census was 79. 1. Review of Resident #7's medical record, showed the following: -Admit date 5/12/25; -Diagnoses included Parkinson's disease, hallucinations, and depression; -No documented pre-screening completed before 5/12/25. 2. Review of Resident #1's medical record, showed the following: -Admit date 11/30/25; -Diagnoses included vascular dementia, osteoarthritis and gastro-esophageal reflux; -No documented pre-screening completed before 11/30/25.	A4748		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4748	Continued From page 9 3. Review of Resident #5's medical record, showed the following: -Admit date 1/7/26; -No documented pre-screening before the admission date of 1/7/26. 4. During an interview on 2/4/26 at 10:10 A.M., the Director of Nursing said she was responsible for completing the residents' pre-screenings. She said the pre-screening is being done up to 30 days before the resident enters the building, but they are using a paper form for that and have not uploaded any of them to the resident files. The pre-screening is also done as a part of the approved alternate Community Based Assessment, so the system appears to have them completed after the resident has been admitted to the facility. 5. During an interview on 2/4/26 at 10:10 A.M., the Administrator said she knew the facility needed to complete the pre-screening before the resident enters the facility, but she was not aware the staff were not scanning in the paper form to the resident charts.	A4748		
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 10 the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop complete individualized service plans (ISP), which included resident needs and services to be provided by staff, when ISPs failed to address specific interventions for the most recent falls of a resident, suicidal ideation, aggressive behaviors, transfer assistance and skin conditions for four of eight sampled residents (Residents #4, #7, #13, and #2). The census was 79. Review of the facility's "Service Plan" policy dated 8/1/22, showed the following: -Policy: -To provide a process to guide the development, implementation, and monitoring of each resident's service plan; -Purpose: -To ensure quality care; -Procedure: -The resident service plan would be created by the Wellness Director and/or designee; -Residents and their families would be invited to participate in the resident service plan creation; -The resident service plan would detail the residents care needs, preferences, and schedule implementation of services; -The resident's care would be provided in accordance with his/her service plan; -Service plans would be reviewed and updated at admission, 30-days after admission, bi-yearly, and as needed upon change of condition; -After finalization of the service plan, a service plan meeting would be hosted to review services with the resident/resident representative; -Residents unable or unwilling to attend	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 11	A4754		

meetings to develop the service plan should be represented by their power of attorney and results should be shared in language that the resident can understand;
-Regardless of a resident's cognitive state, he or she should always be invited to attend the service plan meetings and attempts should be made to elicit preference about care;
-Completed service plans would be printed and signed by the Wellness Director, Executive Director, and resident/resident representative;
-Completed service plans would be stored in the resident chart;
-The service plan review will be noted in the resident progress notes;
-The staff will be notified of the service plan review and edits via communication log;
-A copy of the most current service plan will be available for all staff to review.

1. Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with diagnoses which included chronic kidney disease, anemia and muscle weakness.

Review of the resident's ISP dated 12/7/25, showed the following:
-Need: Post incident interventions: The resident had a fall on 1/21/26 and there was a medication review with the hospice team;
-Need: Psychosocial: the resident had no behavior issues. The resident did not have a current or history of disruptive, aggressive, verbal or socially inappropriate behavior. The staff were to report to the Nurse if the resident was observed to have a change in behavior. The resident did not have a psychosocial support need that required staff intervention;
-Need: Neurocognitive No impairment. The resident was able to communicate effectively and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 12	A4754		

make his/her needs known, with or without assistive devices. The staff were to report to the Nurse if the resident was observed to have a change in the ability to communicate.

Review of the resident's progress notes, showed the following:
-On 1/20/26 at 7:20 A.M., Certified Medication Technician (CMT) I did rounds and found the resident on the floor in the kitchen area of his/her apartment. Staff found the resident seated on the floor with his/her legs crossed. The resident said he/she rolled off the bed and onto the floor. The cameras in the room did not pick up what happened;
-On 1/20/26 at 3:59 P.M., another resident came and got staff and said the resident fell. Nurse K responded and found the resident on the floor against the door frame. The resident was up with his/her walker, lost his/her balance and fell. The resident denied pain at this time. The resident was pleasant and cooperative with care. Nurse K notified the resident's hospice team, Medical Director, and family member. There were no new orders at this time;
-On 1/22/26 at 11:09 A.M., the resident was anxious due to worried about sleeping and what he/she would do when he/she woke. The resident asked staff to stay with him/her due to anxiety. The staff were required to stop in his/her room and check on him/her frequently;
-On 1/22/26 at 11:32 A.M., the resident had a visit from hospice today. Nurse K had a conference call with the resident's family member about the resident's decline, being weaker and being lonely. The resident was very anxious about sleeping;
-On 1/24/26 at 8:20 P.M., the resident told the hospice Nurse no one cared for him/her, and he/she did not want to live. "The resident did not state in pain or lonely". The hospice Nurse told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 13	A4754		

the resident he/she was cared for, and people love him/her. The resident mentioned getting off hospice and living with his/her family member. The resident stabbed a container with a fork and said, "I wish that was me." The staff removed sharp objects from the room. Nurse K notified the Director of Nursing and Executive Director. Nurse K called the resident's family member and encouraged the resident's family members to call the resident. Nurse K spoke with the resident again and the resident said "I lost it earlier. I do not have a plan for self-harm. My grandchildren mean so much to me, they have been calling me." The hospice Nurse called and gave a new order;
-On 1/24/26 at 11:19 P.M., the resident laid in bed with complaint of not being able to sleep. The Medication Technician gave a Benadryl (used to treat allergies) and Trazodone (used as a sedative) at 8:00 P.M. The resident said it had been over an hour and the medicine was not working. The resident wanted more medication. The resident said he/she had not been sleeping at night. Staff reminded the resident he/she had been sleeping the last few nights from 8:00 P.M. to 4:00 A.M., but he/she denied it. The resident's family member spoke through the camera and said, "you have been sleeping last few nights." The resident denied it. The family member gave permission to give the resident a Lorazepam (used as a sedative). The Medication Technician gave the medication and afterwards the resident laid down.

During an interview on 2/2/26 at 7:47 A.M., Resident Aide A said the resident said he/she "wanted to be with God."

During an interview on 2/2/26 at 7:54 A.M., LIMA B said the resident had been experiencing dark

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 14	A4754		

thoughts and saying suicidal things like "wanting to be with God" to the staff. The LIMA said the resident was requesting staff stay with him/her for long periods of time, but they could not because they had other residents to care for. The LIMA said he/she thought the management knew this.

Review of the resident's ISP dated 12/7/25, showed the following:
-The ISP did not address the resident's most recent falls and new interventions for those falls;
-The ISP did not address the resident's suicidal ideation;
-The ISP did not address staff's interventions for the resident's suicidal ideation.
-The ISP did not address the resident's request of longer visits from staff.

2. Review of Resident #7's medical record, showed the facility admitted the resident on 5/12/25, with diagnoses which included Parkinson's disease, hallucinations, and depression.

Review of the resident's ISP dated 10/29/25, showed the need for toileting assistance. Resident incontinent of bladder. Staff were to report any changes in bladder continence to nurse. Level of Assistance-Toileting: Extensive. The resident required some physical assistance with parts of toileting tasks. Staff were to report changes in toileting needs to the nurse. Resident utilized a mattress protector for incontinence episodes. Staff were to monitor cleanliness and integrity of mattress protector. Staff were to report any concerns to nurse. The resident was usually continent of bowel. Resident had recurring behavioral expression of urinating or defecating in areas other than commode. Staff were to provide redirection and regular toileting. Staff were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 15	A4754		

report changes in the resident frequency of urinating or defecating in areas other than commode to the nurse.

Review of the resident's progress notes, showed the following:
-On 1/2/26 at 7:05 A.M., Licensed Practical Nurse (LPN) M noted, staff aide reported an open area to sacral area (the area just above the tailbone) and excoriation. The resident refused care or assessment by the nurse. No signs and symptoms of acute distress noted. Plan of care was ongoing;
-On 1/3/26 at 5:26 A.M., LPN M noted the resident exercised his/her rights of refusal to have skin assessment performed due to reported excoriation and open area to his/her gluteal area (buttocks). The resident denied pain or discomfort. The resident was educated by LPN M if they provided care to skin irritation, breakdown could be prevented. LPN M educated staff to utilize barrier creams as much as the resident would tolerate, and offer repositioning every two hours while resident was in bed. No signs and symptoms of acute distress were noted. Plan of care was ongoing.

Observation on 2/2/26 at 2:16 P.M., of the resident, showed the resident seated in his/her wheelchair in his/her room. The resident was wearing shorts and had multiple scabbed spots approximately 1 cm round on his/her legs.

Review of the resident's ISP dated 10/25/25, showed the ISP did not address the resident's excoriated areas or the scabbed areas on his/her legs, instructions on what the staff should watch for and report to the nurse, or how to care for the resident's skin to prevent further breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 16 3. Review of Resident #13's medical record, showed the facility admitted the resident on 7/28/25, with diagnoses which included chronic kidney disease, high blood pressure, morbid obesity and diabetes. Review of the resident's ISP dated 8/28/25, showed the following: -Need: Neurocognitive. The resident had no impairment. The resident was able to communicate effectively and make his/her needs known with or without assistive devices. The staff were to report to the Nurse if the resident was observed to have a change in the ability to communicate; -Need: Psychosocial. The resident had no behavior issues. The resident did not have a current or history of disruptive, aggressive, verbal or socially inappropriate behavior. The staff were to report to the Nurse if the resident was observed to have a change in behavior. The resident did not have a history or current psychosocial support need that required staff intervention; -Need: Medication. The resident required total assistance with medication. The community assisted with medication administration per Physician orders The staff were to report if any unauthorized medication were found within the resident suite. The staff were to report to the Nurse if the resident had changes in ability to make medications as prescribed. Review of the resident's progress notes, showed the following: -On 12/11/25 at 6:37 A.M., the resident refused his/her medication; -On 12/15/25 at 6:58 A.M., the resident refused his/her medication; -On 12/16/25 at 5:24 P.M., the resident refused	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 17	A4754		

his/her medication;
-On 12/21/25 at 6:54 A.M., the resident refused his/her medication;
-On 12/23/25 at 7:01 A.M., the resident refused his/her medication;
-On 12/25/25 at 7:10 A.M., the resident refused his/her medication;
-On 1/4/26 at 5:59 A.M., the resident refused his/her medication and said he/she was tired of people sticking his/her hands and arms;
-On 1/5/26 at 6:48 A.M., the resident refused his/her medication;
-On 1/11/26 at 6:34 A.M., the resident refused his/her medication;
-On 1/14/26 at 6:56 A.M., the resident refused his/her finger stick and said his/her finger hurt;
-On 1/14/26 at 5:20 P.M., the resident refused his/her medication;
-On 1/16/26 at 6:57 A.M., the resident refused his/her medication;
-On 1/18/26 at 5:36 P.M., the resident had a very challenging day with behavioral escalation, including inappropriate statements, entering other resident's rooms, and attempting to call 911. The resident was unable to be redirected. The resident was sent to the hospital for an evaluation. The resident's family member was notified;
-On 1/19/26 at 7:07 P.M., the resident refused his/her medication;
-On 1/24/26 at 6:38 A.M., the resident refused his/her medication;
-On 1/15/26 at 5:36 A.M., the resident refused his/her medication;
-On 1/18/26 at 5:47 P.M., the resident refused his/her medication.

During an interview on 2/2/26 at 2:18 P.M., the Memory Care Director (MCD) said the resident's confusion can get "very bad" and the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 18	A4754		

would become agitated with his/her family and the facility "taking his/her money." The MCD said the resident got the other resident's upset because he/she would talk to them and tell them the facility was "stealing" his/her money. The MCD said last Friday, the resident said he/she wanted to "jump out of the window." The MCD said the resident stated that before and, in the past, the staff have been instructed to provide one on one with the resident and call his/her family for him/her. Also, the staff were to take the resident to an activity or do a one on one activity with him/her. The MCD said the resident did well with one on one conversation with the staff. The MCD said the resident had an altercation with another resident where he/she grabbed the other resident's walker and aggressively shook it. She said the resident would scream at the staff and call them "Bitches." She said the resident could be verbally aggressive and the other day there was a music play on the unit. The assisted living residents came up to the memory care unit to listen to the music and the resident yelled at them telling them they did not live on the unit and could not be there.

During an interview on 2/2/26 at 3:00 P.M., Resident Aide (RA) F said the resident would call the staff "Bitches" and to "shut up." The RA said the resident would also say things like "get out of my face" and "move back" when the staff were trying to assist the resident. The RA said last week the resident said he/she thought his/her family would be happy if he/she died. The RA said the resident got into a physical altercation with another resident last week which consisted of the resident grabbing the other resident's walker and aggressively shaking it.

Review of the resident's ISP dated 12/7/25,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 19	A4754		

showed the following:
-The ISP did not address the resident's medication refusal;
-The ISP did not address the resident's physical altercation he/she had with another resident and ways to prevent another altercation from occurring;
-The ISP did not address the resident's verbal aggression towards staff and the names he/she would call the staff;
-The ISP did not address ways to intervene with the resident upsetting other residents;
-The ISP did not address ways to redirect the resident when he/she was upset.

4. Review of Resident #2's medical record, showed the facility admitted the resident on 11/13/25, with diagnoses which Parkinson's disease, chronic pain, lower back pain, cataract and heart disease.

Review of the resident's ISP dated 12/15/25, showed the following:
-Level of Assistance - Evacuation: Independent, resident does not require assistance with evacuation;
-Mobility/ambulation/escorts - Level of assistance mobility/ambulation/escorts, extensive. Resident has assistive device requires staff hands on assistance while ambulating with assistive device. Resident is not able to walk, climb stairs, or self propel wheelchair. Resident requires the use of a gait belt for safe transfers.

Review of the resident's undated IEP, showed the resident required assistance to transfer from bed/chair/commode to a wheelchair and escort to the area of refuge.

During an interview on 2/4/26 at 10:12 A.M., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4754	Continued From page 20 Director of Nursing (DON) said the resident requires an Individual Evacuation Plan (IEP) and the facility did create a plan for the resident. The DON said the ISP was not updated to reflect the IEP but it should have been done by her immediately upon creating the IEP. 5. During an interview on 2/3/26 at 9:55 A.M. the DON said her and Nurse K are responsible for the resident's ISPs. She said any time a resident consistently saying negative things, the ISP needs to be updated with those behaviors and interventions the staff could use. She said if a resident said they wanted to jump out of a window the staff should send the resident to the hospital and ensure the resident's Physician was notified. Also, the resident's ISP should have an updated intervention for this. She said if a resident refused medication, if there were issues regarding a resident's skin condition, falls and new interventions for each fall, should be addressed in the ISP. She said if a resident continued to refuse medication, the staff should report that to her so she could talk to the resident's Physician and get a medication review. MO00260207	A4754		
A4755	19 CSR 30-86.047(28)(H) Individual Service Plan - Review Requirements The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (H) Reviews the ISP with the resident, or legal representative of the resident, at least annually or when there is a significant change in the resident	A4755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4755	Continued From page 21 ' s condition which may require a change in services; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to review a resident's individualized service plan (ISP) with the resident or legal representative for five of eight sampled residents (Residents #8, #6, #4, #7 and #5). The census was 79. Review of the facility's "Service Plan" policy dated 8/1/22, showed the following: -Policy: -To provide a process to guide the development, implementation, and monitoring of each resident's service plan; -Purpose: -To ensure quality care; -Procedure: -The resident service plan would be created by the Wellness Director and/or designee; -Residents and their families would be invited to participate in the resident service plan creation; -The resident service plan would detail the residents care needs, preferences, and schedule implementation of services; -The resident's care would be provided in accordance with his/her service plan; -Service plans would be reviewed and updated at admission, 30-days after admission, bi-yearly, and as needed upon change of condition; -After finalization of the service plan, a service plan meeting would be hosted to review services with the resident/resident representative; -Residents unable or unwilling to attend meetings to develop the service plan should be represented by their power of attorney and results should be shared in language that the resident can understand;	A4755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4755	Continued From page 22 -Regardless of a resident's cognitive state, he or she should always be invited to attend the service plan meetings and attempts should be made to elicit preference about care; -Completed service plans would be printed and signed by the Wellness Director, Executive Director, and resident/resident representative; -Completed service plans would be stored in the resident chart; -The service plan review will be noted in the resident progress notes; -The staff will be notified of the service plan review and edits via communication log; -A copy of the most current service plan will be available for all staff to review. 1. Review of Resident #6's medical record, showed the facility admitted the resident on 3/24/24, with diagnoses which included vascular dementia and high blood pressure. Review of the resident's ISP dated 10/6/25, showed no documented review of the ISP with the resident and/or resident's representative. 2. Review of Resident #7's medical record, showed the facility admitted the resident on 5/12/25, with diagnoses which included Parkinson's disease, hallucinations, and depression. Review of the resident's ISP dated 10/29/25, showed no documented review of the ISP with the resident and/or resident's representative. 3. Review of Resident #8's medical record, showed the facility admitted the resident on 10/6/23, with diagnoses which included high cholesterol, dementia, and high blood pressure.	A4755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4755	Continued From page 23 Review of the resident's ISP dated 12/5/25, showed no documented review of the ISP with the resident and/or resident's representative. 4. Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with diagnoses which included chronic kidney disease, anemia and muscle weakness. Review of the resident's ISP dated 12/7/25, showed no documented review of the ISP with the resident and/or resident's representative. 5. Review of Resident #5's medical record, showed the facility admitted the resident on 1/7/26, with diagnoses which included altered mental, anemia and cirrhosis of the liver. Review of the resident's ISP dated 1/8/26, showed no documented review of the ISP with the resident and/or resident's representative. 6. During an interview on 2/3/26 at 9:55 A.M. the Director of Nursing said the ISPs should include a signature from the resident or resident's representative to show the ISP was reviewed with the resident or resident's representative. 7. During an interview on 2/3/26 at 9:34 A.M., the Administrator said they meet with the residents and/or legal representative when the ISPs are reviewed. They have them sign the review at that time. She was not aware there was no documentation of the reviews.	A4755		
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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 24 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 ensure a Level One Medication Aide (LIMA) completed a safe and effective medication pass when he/she did not hold the inner canthus of a resident after administering eye drops and when the LIMA did not watch a resident consume their medication before leaving the resident's apartment, for three of eight observed residents, during the morning medication pass. The census was 79.	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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 25 1. Observation on 2/2/26 between 8:08 A.M. and 8:13 A.M., of the morning medication pass, showed the following: -At 8:08 A.M., LIMA B prepared Resident #10's medication which consisted of the following medications; -Calcium, 500 milligrams (mg); -Aspirin, (used as a blood thinner), 81 mg; - Balsalazide (used to treat inflammatory bowel disease), 750 mg; -Carvedilol (used to treat high blood pressure), 6.25 mg; -Losartan (used to treat high blood pressure), 100 mg; -Spironolactone (used to treat high blood pressure), 25 mg; -At 8:11 A.M., the LIMA entered the resident's room, and the resident sat in his/her recliner. The LIMA sat the medication cup on the resident's side table by the recliner; -At 8:13 A.M., the LIMA left the resident's apartment. The resident had not taken the medication yet and the LIMA did not tell the resident to take the medication. Review of the resident's Physician order sheet (POS) dated 2/1/26, showed no order to self-administer medication. 2. Review of Resident #11's medical record, showed the facility admitted the resident on 4/10/23, with diagnoses which included depression and chronic kidney disease. Review of the resident's POS dated 2/1/26, showed the resident had an order for Polymyxin B-TMP eye drops, (used to treat bacterial infections of the eye), 10 Krebs units every six hours.	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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 26 Observation on 2/2/26 at 9:35 A.M., showed the resident tilted his/her head back and LIMA B administered one eye drop in each eye. The resident used a tissue to wipe the medication that streamed down his/her cheeks. The LIMA did not hold the inner canthus after the medication administration and did not instruct the resident to do so either. 3. Review of Resident #9's medical record, showed the facility admitted the resident on 3/22/25, with diagnoses which included chronic kidney disease, high blood pressure and diabetes. Review of the resident's POS dated 2/1/26, showed the resident had an order for Difluprednate Ophthalmic Emulsion (used to reduce inflammation and pain in the eye), 0.05 %. Give one drop four times per day. Observation on 2/2/26 at 10:35 A.M., showed the resident administered his/her own eye drop medication by tilting his/her head back and squeezing one drop in each eye. The resident immediately wiped his/her eyes with a tissue and gave the medication back to LIMA B. The LIMA did not instruct the resident to hold the inner canthus after the medication administration. 4. During an interview on 2/3/26 at 9:43 A.M., the Director of Nursing said staff should always watch residents finishing taking all the medications before they walk out of the room. She said after the staff administer eyedrops the staff should hold the inner canthus of the eye or instruct the resident to do so themselves.	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4798	Continued From page 27	A4798		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure physician's orders were followed when a Level One Medication Aide (LIMA) administered medication later than the prescribed order, crushed medication without an order to do so and allowed a resident to administer their own medication without an order to do so, for three observed residents during the morning medication pass (Residents #11, #9 and #5). The census was 79. 1. Observation on 2/2/26 between 9:17 A.M. and 9:22 A.M., of the morning medication pass, showed the following: -At 9:17 A.M., LIMA B prepared Resident #11's medication which consisted of the following: -Atorvastatin (used to treat high cholesterol), 10 milligrams (mg); -Lexapro (used to treat depression), 10 mg; -Fludrocortisone (used to treat adrenal insufficiency), 0.1 mg; -Memantine (used to treat dementia), 10 mg; -Tab-A-Vite (vitamin); -Turmeric, (used as an anti-inflammatory/joint health), 500 mg; -At 9:22 A.M., the LIMA crushed the above medication and mixed it with chocolate pudding.	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4798	Continued From page 28 During an interview on 2/2/26 at 9:23 A.M., LIMA B said he/she crushed the medications for the resident because the resident liked to chew the medication instead of swallowing. Review of the resident's Physician's order sheet (POS) dated 2/1/26, showed no order to crush medication. 2. Review of Resident #9's medical record, showed the facility admitted the resident on 3/22/25, with diagnoses which included chronic kidney disease, high blood pressure and diabetes. Review of the resident's POS dated 2/1/26, showed the resident had an order for Difluprednate Ophthalmic Emulsion (used to reduce inflammation and pain in the eye), 0.05 %. Give one drop four times per day. Observation on 2/2/26 at 10:35 A.M., showed the resident administered his/her own eye drop medication by tilting his/her head back and squeezing one drop in each eye. The resident immediately wiped his/her eyes with a tissue and gave the medication back to LIMA B. The LIMA did not instruct the resident to hold the inner canthus after the medication administration. Review of the resident's POS dated 2/1/26, showed no order to self-administer his/her own medication. 3. Review of Resident #5's medical record, showed the facility admitted the resident on 1/7/26, with diagnoses which included altered mental status, anemia and cirrhosis of liver. Review of the resident's POS dated 2/1/26,	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4798	Continued From page 29 showed the following: -Combivent Respimat (inhaler, used for asthma), 20-100 micrograms. Inhale one puff by mouth four times daily, at these times 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M.; -Cyclosporine (used to treat chronic dry eyes), 0.05%. Instill one drop into both eyes, twice daily at these times, 8:00 A.M. and 4:00 P.M.; -Lactulose (used to treat chronic constipation), 15 milliliters (ml). Take 30 ml four times daily at these times, 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M.; -Ondansetron (used to treat nausea), 4 mg. Take one tablet by mouth three times daily, before meals at these times, 8:00 A.M., 12:00 P.M. and 4:00 P.M.; -Sildenafil (used to treat high blood pressure), 20 mg. Take one tablet by mouth three times daily at these times, 8:00 A.M., 12:00 P.M. and 4:00 P.M. Observation on 2/2/26 at 11:40 A.M., showed LIMA B administered the resident's 8:00 A.M., medications at 11:40 A.M., which was not within one hour of the prescribed time. During an interview on 2/2/26 at 11:43 A.M., the resident said he/she had a coughing fit earlier. The resident looked at the time and said "he/she could see why" he/she had a coughing fit because the inhaler was later than the scheduled administration time. 4. During an interview on 2/3/26 at 9:45 A.M., the Director of Nursing said staff can administer medications for one hour before the order time and one hour after. She said the staff should notify her and then call the Physician and ask if they should administer the medication still if it is past the window time. She said residents should not be administering their own medications	A4798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4798	Continued From page 30 unless the residents have an order to do so. She said no medication should be crushed without an order to do so. *The higher the classification merited due to the extent of the violation.	A4798		
A4799	19 CSR 30-86.047(47)(B) Physicians Orders Requirements Medication Orders. (B) Physician ' s written and signed orders shall include: name of medication, dosage, frequency and route of administration and the orders shall be renewed at least every three (3) months. Computer generated signatures may be used if safeguards are in place to prevent their misuse. Computer identification codes shall be accessible to and used by only the individuals whose signatures they represent. Orders that include optional doses or include pro re nata (PRN) administration frequencies shall specify a maximum frequency and the reason for administration. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, facility staff failed to ensure physician's orders were signed by a physician every three months for five of eight sampled resident (Resident #8, #6, #4, #7 and #3). The census was 79. 1. Review of Resident #8's medical record, showed the facility admitted the resident on 10/6/23, with diagnoses which included high cholesterol, dementia, and high blood pressure.	A4799		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4799	Continued From page 31 Review of the resident's Physician's order sheets (POS) dated 11/2025, 12/2025 and 1/2026, showed no Physician's signature. 2. Review of Resident #6's medical record, showed the faciltiy admitted the resident on 3/24/24, with diagnoses which vascular dementia and high blood pressure. Review of the resident's POS dated 8/2025 and 11/2025, showed no Physician's signature. 3. Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with diagnoses which included chronic kidney disease, anemia and muscle weakness. Review of the resident's POS dated 8/2025 and 11/2025, showed no Physician's signature. 4. Review of Resident #7's medical record, showed the facility admitted the resident on 5/12/25, with diagnoses which included Parkinson's disease, hallucinations, and depression. Review of the resident's POS dated 11/2025, 12/2025 and 1/2026, showed no Physician's signature. 5. Review of Resident #3's medical record, showed the facility admitted the resident on 9/17/25, with diagnoses which included heart failure, kidney failure and type 2 diabetes. Review of the resident's POS dated 11/2025, 12/2025 and 1/2026, showed no Physician's signature. 6. During an interview on 2/3/26 at 9:34 A.M., the	A4799		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4799	Continued From page 32 Administrator said they have the physician's sign when they come to the facility or they will fax the orders to the physicians who do not come. She said she is aware they have a hard time getting some signatures but keep the confirmation faxes that they sent the orders and tried to attempt to get their signature. She was not aware there was no documentation of signed physician orders. *higher classification merited due to the extent of the violation.	A4799		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III This regulation is not met as evidenced by: Based on interview and record review, the facility	A4837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4837	Continued From page 33 failed to ensure all accidents and incidents were documented in a resident's medical record, when the facility did not document a physical altercation between two residents in one resident's medical chart (Resident #13). The census was 79. Review of Resident #13's medical record, showed the facility admitted the resident on 7/28/25, with a diagnoses which included chronic kidney disease, high blood pressure, morbid obesity and diabetes. During an interview on 2/2/26 at 2:18 P.M., the Memory Care Director (MCD) said the resident had an altercation with another resident when the resident was with another in the dining room and the two started yelling at each other, telling each other to move. The resident grabbed the another resident's walker and aggressively shook the walker. Neither resident was injured, and staff intervened immediately and separated the residents. During an interview on 2/2/26 at 3:00 P.M., Resident Aide (RA) F said the resident got into a physical altercation with another resident last week which consisted of the resident grabbing the other resident's walker and aggressively shaking it because that resident did not get out of the way of Resident #13. He/she said the there were no injuries, and staff were able to intervene immediately. Review of the resident's medical record, showed no documentation regarding the altercation. During an interview on 2/3/26 at 10:05 A.M., the Administrator said the incident should have been documented because it was a sign of aggression.	A4837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4837	Continued From page 34 MO00260207	A4837		
A4841	19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety Staffing Requirements. (A) The facility shall have an adequate number and type of personnel for the proper care of residents, the residents ' social well being, protective oversight of residents and upkeep of the facility. At a minimum, the staffing pattern for fire safety and care of residents shall be one (1) staff person for every fifteen (15) residents or major fraction of fifteen (15) during the day shift, one (1) person for every twenty (20) residents or major fraction of twenty (20) during the evening shift and one (1) person for every twenty-five (25) residents or major fraction of twenty-five (25) during the night shift. I/II Time Personnel Residents 7 a.m. to 3 p.m. (Day)* 1 3-15 3 p.m. to 9 p.m. (Evening)* 1 3-20 9 p.m. to 7 a.m. (Night)* 1 3-25 *If the shift hours vary from those indicated, the hours of the shifts shall show on the work schedules of the facility and shall not be less than six (6) hours. III This regulation is not met as evidenced by: Class II Based on interview and record review, the facility care staff failed to notify a nurse for an assessment after a resident fell. The staff	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4841	Continued From page 35	A4841		

transferred the resident off the floor without an assessment by a qualified person, for one of eight sampled residents (Resident #4). The census was 79.

Review of Resident #4's medical record, showed the facility admitted the resident on 6/13/24, with diagnoses which included chronic kidney disease, anemia and muscle weakness.

Review of the resident's progress notes dated 1/20/26 at 7:20 A.M., showed Certified Medication Technician (CMT) I did rounds and found the resident on the floor in the kitchen area of his/her apartment. The resident was found sitting on the floor with his/her legs crossed. The resident said she rolled off the bed and onto the floor. The cameras in the room did not pick up what happened.

During an interview on 2/2/26 at 3:53 P.M., Caregiver J said the resident fell and was not sure how the resident fell but he/she answered the resident's call light and found the resident on the floor in the kitchen area of the apartment. The Caregiver said him/her and another Caregiver assisted the resident off the floor by getting on each side of the resident and assisting him/her to a standing position with use of a gait-belt. The Caregiver said before the staff assisted the resident off the floor, he/she asked the resident if he/she was in pain and the resident denied pain. The Caregiver said the resident may have had a bruise at the time but did not remember. The Caregiver said the fall protocol was to have the Medication Technician do a "clearance" to lift the resident. The Caregiver said he/she had been told in the past to not lift a resident before a Nurse's assessment was completed. He/she thought this was covered in an online training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A4841	Continued From page 36 course he/she completed for the facility. During an interview on 2/2/26 at 3:15 P.M., CMT I said he/she remembered the fall occurring and said the camera in the resident's room did not pick the fall up. The CMT said the resident was already off the floor when he/she checked on the resident after the Caregiver reported to him/her the fall occurred. The CMT could not remember where the resident was in the room when he/she went into the room. The CMT said all staff had been trained to get a Nurse's assessment prior to lifting residents and did not know why the resident was lifted without a Nurse's assessment. During an interview on 2/2/26 at 3:57 P.M., Nurse K said she told the staff members all the time to contact a Nurse before assisting a resident off the floor after a fall. She said the staff members should have contacted her before moving the resident to ensure the resident had no injuries.	A4841		
A7002	19 CSR 30-87.030(2) Wash Hands/Arms & Clean Fingernails Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean and after smoking, eating, drinking or using the toilet. Employees shall keep their fingernails clean and trimmed. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all staff washed their hands and/or wore gloves when plating and serving food	A7002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A7002	Continued From page 37	A7002		

in the kitchen and when passing medications. The census was 79.

1. Observation on 2/6/26 between 8:10 A.M. and 8:20 A.M., of the breakfast plating and service, showed the following:
-At 8:10 A.M., Cook L donned a pair of gloves and with his/her right hand, stirred eggs with a spatula and poured them onto the stove top. With his/her same gloved hand, cracked three eggs on to the stove top. With his/her right gloved hand, used a spatula to flip pancakes. With his/her right gloved hand, grabbed the handle of the skillet and flipped an omelet. With his/her right gloved hand, turned a knob on the stove, grabbed the handle and opened the oven. With his/her same gloved hand, and grabbed the handle of a spoon and stirred the oatmeal. With his/her right hand, grabbed a spatula and moved an omelet from the skillet to a plate. With his/her same gloved hand, grabbed bacon and placed it on a plate. With his/her right hand, grabbed a spatula, stirred the eggs, and poured them onto the skillet top. With his/her same gloved hand, cracked three eggs onto the stove top. With his/her right hand, used a spatula to transfer the eggs from the skillet top to a plate, placed the plate in the window, and used his/her same gloved hand, grabbed a pancake from the warmer and placed it on the plate. With his/her same gloved hand, grabbed two slices of bacon and placed it on the plate. With his/her right gloved hand, grabbed another pancake and placed it into a container for room delivery, and grabbed bacon and placed into the same container. With his/her right hand, poured eggs onto the stove top, used a spatula to flip the eggs, and grabbed a spoon and scooped oatmeal into a bowl. With his/her same gloved hand, opened a package of bread, pulled out a slice, dipped it in and egg mixture, and placed it on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A7002	Continued From page 38	A7002		

stove top. Removed gloves and washed hands;
-At 8:13 A.M., Server C donned a set of gloves and rested his/her hands on the counter top of the servery. With his/her right hand, he/she removed a piece of toast from the toaster, placed it on a cutting board, used a brush to spread butter on the toast, and sliced the toast in half. He/she placed the toast on a plate and carried it to the dining room and set the plate in front of a resident. He/she walked back into the kitchen, placed his/her hands on the counter top of the servery while he/she waited for more toast to finish. With his/her right hand, he/she removed the toast from the toaster, placed it on a cutting board, used a brush to butter the toast, and cut the bread in half. He/she then placed the toast on a plate for service. Removed his/her gloves and washed hands.

During an interview on 2/3/26 at 9:42 A.M., the Administrator said she expected the dining staff to change gloves anytime they are preparing food, any time they are touching food, and after each event. If they go from one food to another, or touch a resident's plate, they should change gloves. She said they should not be touching food with hands unless they wash their hands first. She said if they touch any surface before they touch any food or prepare food, they have to wash their hands. She said when touching utensils, or a surface, they have to wash their hands before they touch food. She did not know they were not washing their hands between tasks.

2. Observation on 2/2/26 between 8:09 A.M. and 8:16 A.M., of the morning medication with Level One Medication Aide (LIMA) B, showed the following:
-At 8:09 A.M., the LIMA prepared a resident's medication, knocked on his/her door and opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A7002	Continued From page 39 the door. When the LIMA left the room, he/she opened and closed the door; -At 8:12 A.M., the LIMA returned to the medication cart and opened the cart drawers and prepared Resident #14's medication without cleansing his/her hands; -At 8:14 A.M., the LIMA picked a hair out of his/her mouth with his/her right hand; -At 8:16 A.M., the LIMA prepared Resident #14's medication and with his/her uncleansed and ungloved hand, by retrieving the following medications out of the bottle with his/her right and left fingers: -Metoprolol, (used to treat high blood pressure) 100 milligrams (mg); -Potassium, 20 milliequivalent; -Vitamin D3. During an interview on 2/3/26 at 9:34 A.M., the Director of Nursing said the staff should be washing their hands between each resident's medication pass. She also said the staff should not have retrieved a resident's medication with his/her uncleansed hand after knocking/opening/closing doors and putting his/her fingers in his/her mouth. *The higher classification merited due to the extent of the violation.	A7002		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by:	A7003		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A7003	Continued From page 40 Based on observation and interview, the facility failed to ensure the proper use of hairnets when one employee wore a hairnet with hair exposed during preparation and service of food, for one observed meal preparation and service. The census was 79. Observation on 2/2/26 between 8:05 A.M. and 8:40 A.M., showed Server C prepare resident plates for breakfast service to include toasting and buttering bread, gathering appropriate condiments for residents, and serving plates to the resident's in the dining room. He/she wore a hair net with the front of his/her bangs exposed. The length of his/her bangs was approximately 3 inches. During an interview on 2/3/26 at 9:42 A.M., the Administrator said she expected the kitchen staff to have a hair net on at all times. She expected tem to have one on any time they are in the kitchen or serving food. She expected them to change their hair net if they leave the kitchen for anything other than serving to the residents and put a new one on when they come back. She said all hair should be contained inside the hair net and beard guards worn if needed.	A7003		
A8037	19 CSR 30-88.010(36) Personal Clothing/Possessions Each resident shall be permitted to retain and use personal clothing and possessions as space permits. Personal possessions may include furniture and decorations in accordance with the facility's policies and shall not create a fire hazard. The facility shall maintain a record of any personal items accompanying the resident upon admission to the facility, or which are brought to	A8037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A8037	Continued From page 41 the resident during his or her stay in the facility, which are to be returned to the resident or responsible party upon discharge, transfer, or death. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure personal inventory lists were completed for eight of eight sampled residents (Residents #8, #6, #4, #7, #3, #2, #1 and #5). The census was 79. 1. Review of Resident #8's medical record, showed the following: -Admit date 10/6/23; -No documented inventory sheet. 2. Review of Resident #6's medical record, showed the following: -Admit 3/24/24; -No documented inventory sheet. 3. Review of Resident #4's medical record, showed the following: -Admit date 6/13/24; -No documented inventory sheet. 4. Review of Resident #7's medical record, showed the following: -Admit date 5/12/25; -No documented inventory sheet. 5. Review of Resident #3's medical record, showed the following: -Admit date 9/17/25; -No documented inventory sheet. 6. Review of Resident #2's medical record,	A8037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A8037	Continued From page 42 showed the following: -Admit date 11/13/25; -No documented inventory sheet. 7. Review of Resident #1's medical record, showed the following: -Admit date 11/30/25; -No documented inventory sheet. 8. Review of Resident #5's medical record, showed the following: -Admit date 1/7/26; -No documented inventory sheet. 9. During an interview on 2/3/25 at approximately 10:08 A.M., the Administrator said she was not aware the facility was not keeping inventory sheets for each resident. The Administrator said the facility should make sure all residents have a list of personal property in their files. *The higher classification merited due to the extent of the violation.	A8037		
A9107	19 CSR 30-91.010 (8)(B) Notice-posting resident room sign (8) If a resident installs and uses an electronic monitoring device, a notice to alert and inform visitors shall be posted at the entrance of the facility and resident's room. (B) The facility shall require the resident to post and maintain a conspicuous notice at the entrance of the resident's room stating: "This room is being monitored by an electronic monitoring device." III This STANDARD is not met as evidenced by: Based on observation and interview, the facility	A9107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A9107	Continued From page 43 failed to post, at the entrance of each resident room which had an electronic monitoring device which stated, "this room is being monitored by an electronic monitoring device". The census was 79. 1. Observation on 2/2/26 between 9:31 A.M. and 4:35 P.M., of resident room 203, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 2. Observation on 2/2/26 between 9:34 A.M. and 4:35 P.M., of resident room 214, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 3. Observation on 2/2/26 between 9:39 A.M. and 4:35 P.M., of resident room 224, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 4. Observation on 2/2/26 between 9:44 A.M. and 4:35 P.M., of resident room 304, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 5. Observation on 2/2/26 between 9:47 A.M. and 4:35 P.M., of resident room 304, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 6. Observation on 2/2/26 between 9:52 A.M. and 4:35 P.M., of resident room 304, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 7. Observation on 2/2/26 between 9:55 A.M. and 4:35 P.M., of resident room 304, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!".	A9107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A9107	Continued From page 44 8. Observation on 2/2/26 between 10:02 A.M. and 4:35 P.M., of resident room 304, showed a camera placed on his/her windowsill and a sign which stated, "Video Camera in Use!". 9. During an interview on 2/3/26 at 10:36 A.M., the Administrator said she was aware a sign needed to be posted but was not aware there was a specific wording that needed to be used on the sign.	A9107		
A9108	19 CSR 30-91.010 (9)(A)-(E) Installation-placement of EMD (9) The facility shall require an electronic monitoring device to be installed as follows: (A) In plain view; (B) Mounted in a fixed, stationary position; (C) Directed only on the resident who initiated the installation and use of AEM device; (D) Placed for maximum protection of the privacy and dignity of the resident and the roommate; and (E) In a manner that is safe for residents, employees, or visitors who may be moving about the room. II/III This STANDARD is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure electronic monitoring devices were mounted in a fixed, stationary position when cameras in resident rooms were movable. The census was 79. 1. Observation on 2/2/26 between 9:31 A.M. and 4:35 P.M., of resident room 203, showed a	A9108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A9108	Continued From page 45 camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 2. Observation on 2/2/26 between 9:34 A.M. and 4:35 P.M., of resident room 214, showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 3. Observation on 2/2/26 between 9:39 A.M. and 4:35 P.M., of resident room 224, showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 4. Observation on 2/2/26 between 9:44 A.M. and 4:35 P.M., of resident room 304 showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 5. Observation on 2/2/26 between 9:47 A.M. and 4:35 P.M., of resident room 304 showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 6. Observation on 2/2/26 between 9:52 A.M. and 4:35 P.M., of resident room 304, showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable.	A9108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31049	A. BUILDING: _____ B. WING _____	C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE WILDWOOD VILLAGE	251 PLAZA DRIVE WILDWOOD, MO 63040

(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
A9108	Continued From page 46 7. Observation on 2/2/26 between 9:55 A.M. and 4:35 P.M., of resident room 304, showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 8. Observation on 2/2/26 between 10:02 A.M. and 4:35 P.M., of resident room 304, showed a camera on the windowsill in the bedroom which was plugged into the wall and appeared to be active. The camera was not secured and was moveable. 9. During an interview on 2/3/26 at 10:36 A.M., the Administrator said she was not aware the cameras needed to be secured so they were not able to be moved. *The higher the classification merited due to the extent of the violation.	A9108		

PLAN OF CORRECTION

Provider/Supplier Name:	American House at Wildwood Village
Street Address, City, Zip:	251 Plaza Dr Wildwood Mo 63040
Date of Survey:	2/2/2026

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4505	**19 CSR 30-86.045(3)(A)(5) Individual Evacuation Plan- In resident ISP** **Immediate: The** Wellness Director (WD) will update the Individual Service Plans (ISPs) to include each resident's Individual Evacuation Plan (IEP) elements (assistance level, device, route/area of refuge). **Audit:** The WD audited all residents requiring more than minimal evacuation assistance to ensure IEP content is reflected within the ISP; any missing actions were corrected the same day. **Systemic: Staff** have been educated that the IEP section is a required field within the ISP workflow and on the move-in and change-in-condition checklists; ISPs cannot finalize without IEP completion when evacuation assistance exceeds minimal. **Monitoring**: WD will audit 100% of new admissions and all change-in-condition updates for 60 days, then monthly for 6 months, and report to Executive Director and Regional Nurse. **Responsible Persons**: Wellness Director (designee); Assistant Director of Nursing (designee).	02/25/2026 2/25/2026 2/24/2025 and ongoing 2/24/2026 and ongoing
A4506	**19 CSR 30-86.045(3)(A)(6)(A) Individual Evacuation Plan- staff requirements**	2/25/2026

	Immediate: The WD reviewed the IEP form for each current resident with an IEP to specify the responsible staff position(s) during evacuation (e.g., Care Partner/Medication Aide/LPN/RN). **Audit**: The WD audited all active IEPs and ensured a responsible position is listed; updates completed same day. **Systemic**: The revised IEP is now required in the ISP workflow and tied to posted hallway/zones and evacuation clipboards. **Monitoring: Monthly** fire/evacuation drills will include IEP spot checks; WD reviews 10 IEPs/month for 6 months, then quarterly. **Responsible Persons**: Wellness Director (designee); Assistant Director of Nursing (designee).	2/13/2026 2/27/2026 and ongoing 2/26/2026 and ongoing
A2257	**19 CSR 30-86.022(10)(B) Combustible Materials, Unnecessary Storage Of** **Immediate**: Nursing and maintenance removed excess oxygen cylinders from rooms, secured remaining cylinders upright in approved racks, and verified concentrators had required clearance. Rooms 210 and 224 corrected; vendor pickup arranged. **Audit:** Same-day inspection verified room/common-area par levels (≤2 spare cylinders unless clinically justified) and securing; all discrepancies corrected. **Systemic**: Implemented an Oxygen Management SOP(par levels; delivery/return log; monthly reconciliation; concentrator clearance; prohibition of unnecessary combustibles). **Monitoring**: Weekly environmental rounds for 8 weeks, then monthly with oxygen checklist. **Responsible Persons**: Wellness Director (designee); Assistant Director of Nursing (designee).	02/6/2026 2/10/2026 and ongoing 2/10/2026 and ongoing 2/10/2026 and ongoing

A4748	**19 CSR 30-86.047(28)(E) Pre-Move In Screening Requirements** **Immediate**: Available pre–move-in screenings completed prior to admission were scanned/uploaded. Where paper forms were not located, late entries were completed with supporting documentation and provider/representative attestations confirming eligibility at admission. **Audit:** Admissions for the last 12 months were audited to verify completion prior to admission; missing documentation completed with reasoning. **Systemic**: Pre-admission workflow is completed and approved before move-in scheduling; checklist updated. **Monitoring**: WD will review 100% of move-ins for 90 days; then conduct monthly spot audits of 5 charts and report results to Executive Director and Regional nurse. **Responsible Persons: Wellness** Director (designee); Assistant Director of Nursing (designee).	2/15/2026 2/16/2026 2/10/2026 and ongoing 2/15/2026
A4754	**19 CSR 30-86.047(28)(G) Individual Service Plan - Develop** **Immediate:** ISPs for all cited residents will be reviewed and updated to reflect current needs, including hospice services, fall history, mobility changes, behavioral concerns, medication refusals, wandering behaviors, and required ADL assistance. **Audit:** All resident records will be reviewed to ensure ISP review documentation is present **Systemic:** A procedure will be implemented requiring ISP review at admission, annually, and upon significant change in condition, with documented signatures. Staff were educated on this requirement.	2/11/2026 2/26/2026 2/26/2026

	Monitoring: The Wellness Director or designee will audit ISP reviews monthly for compliance **Responsible Persons**: Wellness Director (designee); Assistant Director of Nursing (designee).	2/20/2026 and ongoing
A4755	**19 CSR 30-86.047(28)(H) Individual Service Plan-Review Requirements** **Immediate:** ISPs for all cited residents will be reviewed with the residents and/or legal representatives, and signatures were obtained to document participation. **Audit:** All resident records will be reviewed to ensure ISP review documentation is present. **Systemic:** A procedure will be implemented requiring ISP review at admission, annually, and upon significant change in condition, with documented signatures. Staff were educated on this requirement. **Monitoring:** The Wellness Director or (designee) will audit IP reviews monthly for signature compliance **Responsible Persons:** Wellness Director (designee); Assistant Director of Nursing (designee).	2/25/2026 2/26/2026 2/27/2026 and ongoing 2/27/2026 and ongoing
A4797	**19 CSR 30-86.047(46) Safe & Effective Medication System** **Immediate:** All medication staff completed return-demonstration on: (1) eye-drop technique including nasolacrimal occlusion for 1–2 minutes; (2) observing ingestion; (3) not leaving meds unattended. **Audit**: Skills/competency checks completed for all LIMAs/CMTs. **Systemic**: Policy requires observed swallow unless a	02/27/2026 2/28/2026 2/15/2026 and ongoing

	provider authorized self-administration; eye-drop checklist added to competencies. **Monitoring: DON**/designee conducts at least 2 med-pass observations weekly for 8 weeks, then monthly for 6 months. New hires will have an observed med pass biweekly for the first three months. **Responsible Person**: Director of Nursing (designee); Assistant Director of Nursing (designee).	2/24/2026 and ongoing for 6 months
A4798	**19 CSR 30-86.047(47)(A) Physician Orders Followed** **Immediate**: Stopped crushing meds without orders. obtained order parameters or reverted to staff administration of drops. . **Audit**: MARs reviewed to identify any crushed meds without orders, self-admin meds without orders, or recurring late-dose risks; corrected and orders obtained as needed. **Systemic**: "Crush" requires active provider order; "self-admin" requires order and competency; out-of-window doses require documentation and nurse/provider notification. **Monitoring**: Weekly MAR exception reports and med-pass audits for 8 weeks; then monthly. **Responsible Persons**: Director of Nursing (designee); Assistant Director of Nursing (designee).	2/21/2026 2/27/2026 2/15/2026 and ongoing 2/20/2026 and ongoing
A4799	**19 CSR 30-86.047(47)(B) Physicians Orders requirements** **Immediate**: The DON will pull all unsigned physicians orders to fax and call to attain signatures. **Audit:** All residents' POS cycles reviewed to ensure signatures at least every 90 days; any missing signatures will be requested.	02/26/2026 2/27/2026 2/10/2026 and ongoing 2/13/2026

	Systemic: Physician orders will be signed upon admission or within 5 days on all current residents. **Monitoring**: Monthly audit of physician orders to monitor for compliance. **Responsible Persons**; Director of Nursing (designee); Assistant Director of Nursing (designee).	and ongoing
A4837	**19 CSR 30-86.047(58)(B) Resident Condition/Medication Review** **Immediate: Late-**entry clinical notes for any missed incident completed. **Audit: Incident** logs/behavior reports (past 60 days) cross-checked against charts to ensure each event has a clinical note and, when indicated, an ISP update. **Systemic:** Established Incident-to-Chart reconciliation: every incident form needs a required chart note and ISP review task. Wellness staff educated that every incident requires an ISP task. In service education done at orientation and monthly for 6 months then quarterly. **Monitoring:** Weekly reconciliation for 8 weeks; then monthly; **Responsible Persons**: Director of Nursing (designee); Assistant Director of Nursing (designee).	02/27/2026 3/15/2026 2/28/2026 and ongoing 2/28/2026
A4841	**19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety.** **Immediate: Re-**trained all care staff on post-fall protocol: do not move a resident until a nurse assessment is completed unless immediate danger exists; complete vitals/head-to-toe assessment, document, and notify provider/family. **Audit:** Past-60-day falls reviewed to confirm nurse assessments; gaps corrected with late entries and coaching.	02/10/2026 2/13/2026 2/20/2026

	Systemic; Caregivers/CMTs must contact the nurse **before** lift assist. Education on this will be upon hire and quarterly. **Monitoring**: DON audits 100% of falls for 60 days; then monthly, with reeducation for any variance. **Responsible Persons:** Director of Nursing (designee); Assistant Director of Nursing (designee).	2/23/2026
A7002	**19 CSR 30-87.030 (2) Wash Hands/Arms & Clean Fingernails** **Immediate:** (Kitchen) Eliminated bare-hand contact with RTE foods; glove changes and handwashing required between tasks. (Wellness) Educated on proper handwashing and sanitizing during med pass. **Audit:** Competency observations for all culinary and medication staff completed by Culinary and Wellness Director **Systemic**: Educated staff about hand hygiene & glove Use policy; added sanitizer stations; supervisors conduct pre-meal line checks. **Monitoring: Daily** culinary line checks; observations for 8 weeks, then monthly; noncompliance managed per progressive discipline. Wellness observation med pass for 6 weeks and managed per progressive discipline. **Responsible Persons**: Director of Culinary(designee); Director of Wellness(designee), Executive Director(designee)	02/8/2026 2/10/2026 2/10/2026 and ongoing
A7003	**19 CSR 30-87.030 (3) Clean Clothing, Hair restraints** **Immediate:** Enforced full hair containment (including bangs) and beard guards when applicable for all production/serving staff; immediate corrections made when observed out of compliance. **Audit**: Daily pre-shift appearance/PPE checks at the	02/10/2026 2/10/2026 2/10/2026

	kitchen entry done by Director of Culinary or Sous Chef. **Systemic**: Policy clarified 02/10/2026; signage posted at kitchen entry; hair restraints required whenever preparing or serving food. **Monitoring :** Supervisors document compliance each shift; trends reviewed weekly for 8 weeks, then monthly. **Responsible Persons**: Director of Culinary (designee), Sous Chef(designee), Executive Director (designee)	2/13/2026
A8037	**19 CSR 30-88.010 (36) Personal Clothing/ Possessions** **Immediate**: Completed personal property inventory forms for all current residents from Jan 1 with resident/representative input; filed in charts and provided copies on request. Plan to give inventory sheets to update at every care plan to ensure each current resident has an inventory sheet. **Audit**: All current residents reviewed to ensure a completed inventory is on file; missing forms will be completed back to Jan 1, 2026, and all current residents prior to Jan 1 will get new inventory sheets at next care plan. **Systemic**: Inventory form added to admission and quarterly review checklists for Sales/ Wellness to review. **Monitoring**: Monthly audit of 10 charts for 6 months by nursing leadership. **Responsible Persons**: Director of Nursing (designee); Assistant Director of Nursing (designee), Community Relations Director(designee), Executive Director(designee)	02/25/2026 2/25/2026 2/25/2026 and ongoing 3/2/2026 and ongoing
A9107	**19 CSR 30-91.010(8)(B) Notice Posting Resident Room Sign** **Immediate:** Replaced all EMD notices with the required wording: "This room is being monitored by an electronic monitoring device." Posted at the facility entrance and the	02/6/2026 2/6/2026

	entrance of each monitored room. **Audit**: Facility-wide rounds confirmed signage at all EMD rooms. **Systemic**: Standardized signage packet added to admission materials for residents choosing EMDs; maintenance posts and documents in the EMD log. **Monitoring**: Weekly rounds for 8 weeks; then monthly. **Responsible Persons**: Director of Plant Operations(designee), Community Relations Director(designee), Executive Director(designee)	2/7/2026 2/10/2026
A9108	**19 CSR 30-91.010(9)(A)-(E) Installation- Placement of EMD** **Immediate Installed**: fixed, stationary mounts for EMDs; removed movable cameras from windowsills; ensured direction only to the consenting resident; secured cords to eliminate tripping hazards. **Audit**: Verified all active EMD installations meet placement requirements (plain view; fixed; resident-directed; privacy/dignity; safe). **Systemic**: Sales and Marketing will assure paperwork is completed and signed for any resident using an EMD upon admission. Sales will keep binder and a copy of the paperwork in each resident's chart. **Monitoring**: Monthly verification of all EMD rooms for compliance for 6 months the quarterly. All new incoming residents with EMD assured on move in that EMD is in compliance. **Responsible Persons**: Director of Maintenance (Designee), Director of Community Relations(designee), Executive Director (Designee)	02/28/2026 2/28/2026 3/10/2026

Kathleen Nadler 3/2/26