STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22009C	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW GARDENS AT SCHUETZ ROAD	11210 SCHUETZ ROAD SAINT LOUIS, MO 63146

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22909C	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW GARDENS AT SCHUETZ ROAD	11210 SCHUETZ ROAD SAINT LOUIS, MO 63146

(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 1	A4797		

to residents. The census was 94.

1. Review of Resident #2's medical record, showed the facility admitted the resident on 7/23/22, with diagnoses which included dementia, high blood pressure, chronic kidney disease, and diabetes,.

Review of the resident's physician's order sheet (POS) dated 8/2025, showed the following:
-An order for Atorvastatin (helps prevent serious cardiovascular events like heart attack and stroke) 20 milligram (mg) tablet, give one tablet by mouth at bedtime;
-An order for Creon (used to treat people who cannot digest food normally because their pancreas does not make enough enzymes) 36,000 unit capsule, give two capsules by mouth three times daily with meals;
-An order for Donepezil (used to treat dementia) 5 mg tablet, give one tablet by mouth one time daily;
-An order for Memantine (used to treat moderate to severe Alzheimer's disease) 5 mg tablet, give one tablet by mouth two times daily;
-An order for Terbinafine (used to treat fungal skin infections) 1% creme, apply topically to nails two times daily.

Review of the resident's medication administration record (MAR) dated 8/2025, showed the following:
-On 8/1, 8/4, 8/5, 8/10, 8/12, 8/24, 8/26, 8/27, 8/28, and 8/29/25, Level One Medication Aide (L1MA) D administered Atorvastatin at bedtime, to the resident;
-On 8/1, 8/4, 8/5, 8/10, 8/12, 8/24, 8/26, 8/27, 8/28, and 8/29/25, L1MA D administered Creon during the evening timeframe, to the resident;
-On 8/1, 8/4, 8/5, 8/10, 8/12, 8/24, 8/26, 8/27,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22909C	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW GARDENS AT SCHUETZ ROAD	11210 SCHUETZ ROAD SAINT LOUIS, MO 63146

(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 2 8/28, and 8/29/25, L1MA D administered Donepezil during the evening timeframe, to the resident; -On 8/1, 8/4, 8/5, 8/10, 8/12, 8/24, 8/26, 8/27, 8/28, and 8/29/25, L1MA D administered Memantine during the evening timeframe, to the resident; -On 8/1, 8/4, 8/5, 8/10, 8/12, 8/24, 8/26, 8/27, 8/28, and 8/29/25, L1MA D administered Terbinafine during the evening timeframe, to the resident. 2. Review of L1MA D's employee file, showed the following: -Date of hire 10/1/24; -L1MA certificate expired on 10/28/24; -No documentation that a renewed state licensed certification of L1MA was obtained. 3. During an interview on 9/4/25 at 1:44 P.M., the Business Office Manager (BOM) said the Health Services Director (HSD) was responsible for the recertifications of the L1MAs and she was not aware that L1MA D's certification had expired. She said she was aware certification was required to pass medications. 4. During an interview on 9/4/25 at 1:35 P.M., the HSD said L1MA D had been working as a L1MA and passing medications. She said the BOM was responsible for checking the certifications. She was not aware L1MA D had a certification which had expired. She said she was aware certification was required to pass medications. 5. During an interview on 9/5/25 at 1:32 P.M., the Administrator both the BOM and the HSD are responsible for checking the recertifications' of the L1MAs. She said she was not aware L1MA D's certification had expired and she was aware a	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22909C	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW GARDENS AT SCHUETZ ROAD	11210 SCHUETZ ROAD SAINT LOUIS, MO 63146

(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 3 certification was needed to pass medications.	A4797		

PLAN OF CORRECTION

Provider/Supplier Name:	Autumn View Gardens Assisted Living Creve Coeur
Street Address, City, Zip:	11210 Schuetz Road Creve Coeur, MO 63146
Date of Survey:	September 4, 2025

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
	Please accept this Plan of Correction as our Credible Allegation of Compliance.	
	This Plan of Correction is submitted to meet requirements established by the state and federal law.	
A4797	19 CST 30-86.047 (46) Safe & Effective Medication System	
	The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents' medications are administered. All individuals who administer medication shall be trained in medication administration; a licensed nurse, certified medication technician, or level 1 medication aide.	
	All current staff have been verified that they are certified and scanned in the electronic medical record system to enable checking each month.	
	ED/ HSD/ Designee will ensure all are certified by auditing reports in electronic medical record system each month for expiration dates. As upcoming recertifications are needed, two options will be advised. 1. HSD is certified to do update classes for L1MA (or) 2. Utilize Guardian Pharmacy L1MA classes	
	Prior to employment, all new hires will be audited for current certification and added on electronic medical record system for monthly audits.	