STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30425	A. BUILDING _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON MEMORY CARE	5342 BUTLER HILL ROAD SAINT LOUIS, MO 63128

(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 one of two residents who required an IEP (Resident #2). The census was 22. Review of Resident #2's medical record, showed the facility admitted the resident on 1/27/26, with diagnoses which included anxiety, dementia with behavioral disturbances and high blood pressure. Review of the resident's IEP dated 2/8/26, showed the following: -Location of nearest exit: Hallway 2 courtyard exit; -Staff responsible Caregiver 1; -Risk of resistance "little or none"; -Mobility: Wheelchair bound; -Transfer: Assistance of one person. Review of the resident's medical record, showed no documented ISP. During an interview on 2/26/26 at 11:08 A.M., the Administrator said all residents should have an ISP and if they have an IEP, the IEP should be	A4505		

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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 one of two residents who required an IEP (Resident #2). The census was 22. Review of Resident #2's medical record, showed the facility admitted the resident on 1/27/26, with diagnoses which included anxiety, dementia with behavioral disturbances and high blood pressure. Review of the resident's IEP dated 2/8/26, showed the following: -Location of nearest exit: Hallway 2 courtyard exit; -Staff responsible Caregiver 1; -Risk of resistance "little or none"; -Mobility: Wheelchair bound; -Transfer: Assistance of one person. Review of the resident's medical record, showed no documented ISP. During an interview on 2/26/26 at 11:08 A.M., the Administrator said all residents should have an ISP and if they have an IEP, the IEP should be	A4505		

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A4505	Continued From page 1 mentioned in the ISP.	A4505		
A4508	19 CSR 30-86.045(3)(A)(6)(C) Individual Evacuation Plan - Evaluate 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: C. The plan shall evaluate the resident for his or her location within the facility and the proximity to exits and areas of refuge. The plan shall evaluate the resident, as applicable, for his or her risk of resistance, mobility, the need for additional staff support, consciousness, response to instructions, response to alarms, and fire drills; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop an individualized evacuation plan (IEP) which included the resident's proximity to the nearest exit from the resident's apartment, for two of two residents who required an IEP (Residents #1 and #2). The census was 22. 1. Review of Resident #1's medical record, showed the facility admitted the resident on 10/3/25, with diagnoses which included anxiety and dementia with behavioral disturbances. Review of the resident's ISP dated 12/2/25, showed Evacuation: One person required for this task, needed complete assistance to properly get through evacuation, to be assisted completely	A4508		

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A4508	Continued From page 2 and appropriately through evacuation process by staff. 2. Review of Resident #2's medical record, showed the facility admitted the resident on 1/27/26, with diagnoses which included anxiety, dementia with behavioral disturbances and high blood pressure. Review of the resident's IEP dated 2/8/26, showed the following: -Location of nearest exit: Hallway 2 courtyard exit; -Staff responsible Caregiver 1; -Risk of resistance "little or none"; -Mobility: Wheelchair bound; -Transfer: Assistance of one person; -The IEP did not include the resident's proximity to the nearest exit from the resident's room. 3. During an interview on 2/26/26 at 11:04 A.M., the Administrator said the components that make up an IEP are what staff are responsible, where the resident is located within the facility and the nearest exit which can be determined by where the fire is located at, and who to contact if there is an emergency as well as the direction the resident should go and what kind of assistance they require. She did not know the proximity was missing from the resident's IEP.	A4508		
A2222	19 CSR 30-86.022(7)(A) Exits-2 per Floor-Remote/Unobstructed Exits, Stairways, and Fire Escapes. (A) Each floor of a facility shall have at least two (2) unobstructed exits remote from each other. I/II This regulation is not met as evidenced by:	A2222		

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A2222	Continued From page 3 Class II Based on observation and interview, the facility failed to ensure a designated exit door was unobstructed, when a metal patio chair blocked the door from opening. The census was 22. Observation on 2/17/26 between 8:30 A.M. and 4:00 P.M., of the designated exit door near resident room 9, showed on the outside of the exit, a metal patio chair approximately 3 feet away from the exit door which obstructed the exit way. During an interview on 2/26/26 at 11:28 A.M., the Administrator said it was never okay to leave items in front of exit doors. She did not know there was a blocked exit. She said the staff should be checking the doors frequently to ensure no there were no blocked exits.	A2222		
A2287	19 CSR 30-86.022(15)(B) Trash Removal for Safety Trash and Rubbish Disposal. (B) Trash shall be removed from the premises as often as necessary to prevent fire hazards and public health nuisance. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure trash was removed from the premises in a timely manner preventing fire hazards and public health nuisance. The census was 22. Observation on 2/17/26 between 8:00 A.M. and 4:00 P.M., of the front parking lot, next to the facility's dumpster, showed the following:	A2287		

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A2287	Continued From page 4 -One recliner; -One walker; -Three mattresses; -One bed frame; -One dresser; -The gates of the dumpster's cage had torn fabric on both gates which exposed the dumpster and its belongings. During an interview on 2/17/26 at 8:09 A.M., Level One Medication Aide (LIMA) G said the trash gates had been like for a couple months. The LIMA said it had gotten worse over the last couple weeks. The LIMA said the discarded items were from residents who moved out and it had been like that for a couple weeks. The LIMA said he/she did not know if anyone had called the city to come and retrieve the discarded items. During an interview on 2/17/26 at 2:36 P.M., Care Aide C said the discarded items had been like that for about three months and the gate's fabric had been torn for about two months. During an interview on 2/26/26 at 11:34 A.M., the Administrator said she had contacted the city four times to come and get the items and each time, they said they were coming but they never showed up. She said when she first started at the facility, there were extra belongings in the facility which were a fall risk and made the facility look "horrid" because the items were stuffed in different locations. She said the gate coverings were torn when she was first hired.	A2287		
A3201	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed	A3201		

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A3201	Continued From page 5 and shall be maintained in good repair and in accordance with the construction and fire safety rules in effect at the time of initial licensing. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to maintain walls and doors in good repair. The census was 22. 1. Observation on 2/17/26 between 8:44 A.M. and 4:00 P.M., of resident room 3, showed eight patched areas on the east wall. The areas ranged in size and were unsanded and unpainted. 2. Observation on 2/17/26 between 8:44 A.M. and 4:00 P.M., of the door for resident room 4, showed the outside, bottom of the bedroom door, covered with heavy black scuff marks. Some areas, the wood underneath was exposed. 3. Observation on 2/17/26 between 8:46 A.M. and 4:00 P.M., of the door for resident room 6, showed the outside, bottom of the bedroom door, covered with black scuff marks. Several areas on the door frame, with chipped paint, which exposed the white frame underneath. 4. Observation on 2/17/26 between 8:45 A.M. and 4:00 P.M., of the door for resident room 5, showed the outside, bottom of the bedroom door, covered with heavy black scuff marks. Some areas, the wood underneath was exposed. 5. During an interview on 2/17/26 at 4:02 P.M., the Maintenance Director said he had not painted the doors of the resident's rooms yet because he had been working on other things. He said the doors needed to be painted because the paint	A3201		

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A3201	Continued From page 6 was chipped and peeling away from the door. He said the walls and door frames should not be chipped and should be painted as well. He said Corporate was supposed to come down and paint everything, but they had not been at the facility yet. *The higher classification merited due to the extent of the violation.	A3201		
A3211	19 CSR 30-86.032(10) Heaters-Approved Label, Venting, No Portable In newly licensed facilities or if a new heating system is installed in an existing licensed facility, the heating of the building shall be restricted to steam, hot water, permanently installed electric heating devices or a warm air system employing central heating plants with installation such as to safeguard the inherent fire hazard, or approved installation of outside wall heaters which bear the approved label of the American Gas Association or National Board of Fire Underwriters. The foregoing requirements are applicable to residential care facilities. In assisted living facilities, the heating of the building shall be restricted to steam, hot water, permanently installed electric heating devices or a warm air system employing central heating plants with installation such as to safeguard the inherent fire hazard, or approved installation of outside wall heaters which bear the approved label of the American Gas Association or National Board of Fire Underwriters. For all facilities, oil or gas heating appliances shall be properly vented to the outside and the use of portable heaters of any kind is prohibited. If approved wall heaters are used, adequate guards shall be provided to safeguard residents. I/II	A3211		

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A3211	Continued From page 7 This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure portable space heaters were not used in the facility. This had the potential to affect all residents. The census was 22. Observation on 2/17/26 between 10:00 A.M. and 4:00 P.M., of the Administrator's office, on the shelf to the left of the door, showed a small black portable space heater. During an interview on 2/17/26 at 4:00 P.M., the Administrator said she knew space heaters were prohibited. She said she brought it in because the furnace had issues for a little bit.	A3211		
A3235	19 CSR 30-86.032(34) Hot Water 105-120 Degrees F Plumbing fixtures which are accessible to residents and which supply hot water shall be thermostatically controlled so that the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C) and the water shall be at a temperature range between one hundred five degrees Fahrenheit (105°F) (41°C) and one hundred twenty degrees Fahrenheit (120°F) (49°C). I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure water temperatures were maintained between 105 degrees Fahrenheit (F) and 120 F, when	A3235		

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A3235	Continued From page 8	A3235		

temperatures exceeded 120 degrees F and did not reach 105 degrees F. The census was 22.

Review of the facility's water temperature log showed the following:
-On 11/1/25, of resident room 15, the water temperature measured 110 degrees F;
-On an unknown date, of resident room 6, the water temperature measured 109 degrees F.

1. Observation on 2/17/26 at 10:52 A.M., of resident room 12, of the water temperature, when recorded for two minutes with a calibrated digital thermometer, showed the following:
-The shower water temperature measured 124.8 degrees F;
-The sink water temperature measured 123.3 degrees F.

2. Observation on 2/17/26 at 9:44 A.M., of resident room 11, of the water temperature, when recorded for two minutes with a calibrated digital thermometer, showed the following:
-The shower water temperature measured 81.3 degrees F;
-The sink water temperature measured 90.7 degrees F.

3. During an interview on 2/17/26 at 2:00 P.M., the Maintenance Director said he thought the temperature requirement had to be 85 degrees F. He said he had not taken water temperatures since last month and he thought the last temperature he took was 82 degrees F.

4. During an interview on 2/26/26 at 10:59 A.M., the Administrator said the Maintenance Director was responsible to take water temperatures. She said he should do it monthly but if there is a concern, it should be done at that time. The

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A3235	Continued From page 9 Administrator said she had not taught the Maintenance Director how to take a temperature, but she asked him if he knew, and he said yes. She said right now, she did not know the specific water temperature requirements and she did not know the water temperature was so low.	A3235		
A4724	19 CSR 30-86.047(19) TB Screen Residents & Staff The facility shall screen residents and staff for tuberculosis as required for long-term care facilities by 19 CSR 20-20.100. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required initial two step tuberculosis test was completed, for two of three sampled residents (Residents #1 and #2). The census was 22. General requirements for TB testing for residents in Long Term Care Facilities, 19 CSR 20-20.100, reads as follows: -Long-term care facilities shall screen their residents for tuberculosis. Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained; -Within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a two-step TB test; -If the resident's initial test is negative, the second test should be given one to three weeks later. The CDC (Centers for Disease Control) states TB tests should be read 48 to 72 hours after administration; -All long-term care facility residents shall have a	A4724		

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A4724	Continued From page 10 documented annual evaluation to rule out signs and symptoms of TB disease; -All positive findings shall require a chest X-ray to rule out active pulmonary disease; -Individuals with a positive finding need not have repeat annual chest X-rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease. 1. Review of Resident #1's medical record, showed the following: -Admit date 10/3/25; -Diagnoses included anxiety and dementia with behavioral disturbances; -No documented initial two-step TB/PPD test upon admission. 2. Review of Resident #3's medical record, showed the following: -Admit date 1/14/26; -Diagnoses included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety; -No documented initial two-step TB/PPD test upon admission. 3. During an interview on 2/26/26 at 11:37 A.M., the Administrator said all residents should have a two-step TB/PPD test upon admission. She said she should have Resident #1's and #2's TB/PPD test but could not find it.	A4724		
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,	A4748		

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A4748	Continued From page 11 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 one of three sampled residents (Resident #1). The census was 22. Review of Resident #1's medical record, showed the following: -Admit date 10/3/25; -Diagnoses which included dementia, anxiety and diabetes; -No documented pre-screening completed prior to admission date. During an interview on 2/26/26 at 11:26 A.M., the Administrator said resident was admitted before she started employment at the facility and she could not locate a pre-screening.	A4748		
A4749	19 CSR 30-86.047(28)(F)(1)(A) Community Based Assessment-Time Period, 5 day 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: (F) Completes a community based assessment	A4749		

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A4749	Continued From page 12	A4749		

conducted by an appropriately trained and qualified individual as defined in section (4) of this rule:
1. Time frame requirements for assessment shall be:
A. Within five (5) calendar days of admission; II

This regulation is not met as evidenced by:
Based on interview and record review, the facility failed to complete an initial community based assessment (CBA), for two of three sampled residents and one additional resident (Residents #3, #8 and #2). The census was 22.

1. Review of Resident #3's medical record, showed the following:
-Admit date 1/14/26;
-Diagnoses included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety;
-No documented CBA within five days of admission.

2. Review of Resident #8's medical record, showed the following:
-Admit date 1/17/26;
-Diagnoses included dementia with agitation and Alzheimer's disease;
-No documented CBA within five days of admission.

3. Review of Resident #2's medical record, showed the following:
-Admit date 1/27/26;
-Diagnoses which included anxiety, dementia with behavioral disturbances and high blood pressure;
-No documented CBA within five days of admission.

4. During an interview on 2/26/26 at 11:13 A.M.,

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A4749	Continued From page 13 the Administrator said she knew the CBAs were required to be completed within the first five days of admission. She said some CBAs were prior to her employment at the facility and she could not find the CBAs in the file.	A4749		
A4751	19 CSR 30-86.047(28)(F)(1)(C) Community Based Assessment-Significant Change 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: (F) Completes a community based assessment conducted by an appropriately trained and qualified individual as defined in section (4) of this rule: 1. Time frame requirements for assessment shall be: C. Whenever a significant change has occurred in the resident ' 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 complete a change in condition community based assessment (CBA) for a resident who had multiple falls, sustained a head injury, and presented an aggressive behavior towards another resident, for one of three sampled residents (Resident #3). The census was 22. Review of Resident #3's medical record, showed the facility admitted the resident on 1/14/26, with diagnoses which included major depressive disorder, high blood pressure, diabetes, and Alzheimer's disease.	A4751		

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A4751	Continued From page 14 Review of the resident's progress notes, showed the following: -On 2/7/26 at 5:45 P.M., the resident was up walking around after dinner and fell. The staff did not witness the fall. The resident was flat on his/her back with a cut on each elbow. The staff took the resident's vitals and checked the resident's pupils. The resident said he/she was not in any pain but said "yes" when asked if he/she bumped his/her head. The staff notified the Administrator and also notified the resident's family member. The resident was sent to the emergency room by ambulance to be assessed; -On 2/12/26 at 9:45 A.M., Level One Medication Aide (LIMA) A wrote while sitting in the day room, in the recliner, the resident attempted to get out of recliner and fell. The staff saw him/her face first on the ground. The resident said he/she hit his/her head. The resident was assessed and vitals taken. The Paramedics were called, and an incident report was made; -On 2/13/26 at 8:30 P.M., the Administrator wrote the resident returned to the facility via ambulance. The resident was placed in bed upon arrival and was sleeping at this time. New orders for Cephalexin (used to treat infection), 500 milligrams. Take one capsule by mouth three times a day for a urinary tract infection (UTI). The resident was admitted to the hospital on 2/12/26 for an altered mental status and UTI. During an interview on 2/17/26 at 1:34 P.M., LIMA A said the resident fell on 2/7 and 2/12. The LIMA was present for both falls. The LIMA said when the resident fell the first time, on 2/7, the resident said he/she hit his/her head. The LIMA said since the fall, the resident had a change of condition where the resident required more assistance than normal. The LIMA said the resident was not able	A4751		

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A4751	Continued From page 15 to participate in the activities of daily living (ADLs) as much as he/she did in the past. During an interview on 2/17/26 at 1:53 P.M., the Care Aide (CA) C said the resident had a fall on 2/7 and 2/12. The CA said after the falls, the resident required more assistance with his/her ADLs and was not able to participate as he/she once did. Review of the resident's medical record, showed no change of condition CBA. During an interview on 2/26/26 at 11:39 A.M., the Administrator said the resident didn't have a change of condition and said it was probably the staff's approach on whether or not the resident required more assistance. She said sometimes the staff find it easier to transfer the residents themselves, but they need to allow the resident to do the movements. She said the resident was still able to dress him/herself but required queuing.	A4751		
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II	A4754		

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A4754	Continued From page 16 This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop individualized service plans (ISP) which included resident needs, services to be provided by staff and goals expected by the resident or the resident's legal representative, for three of three sampled residents (Residents #2, #1 and #3). The census was 22. Review of the facility's undated ISP policy, showed the following: -Policy: To establish guidelines for providing individualized resident care; -Facility develops a service plan that is agreed upon between the Facility and the resident and / or the person arranging the care and meets state guidelines; -Facility provides assistance with one, more or all of the following needs -Meals, dressing, movement, bathing, or other personal needs; -Maintenance; administration of medication or the assistance with; -Supervision of medication; -General supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in the facility or who needs assistance to manage his/her personal life, regardless of whether a guardian has been appointed for the resident; -The plan will be agreed upon between the facility and the resident/person arranging the care; -A written plan will be established and made available to staff providing the care. The original plan will be maintained in the resident record; -The plan may include but is not limited to the following items; -Resident name; -Date established;	A4754		

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A4754	Continued From page 17 -Diagnosis, if any; -Diet; -Medications and pharmacy preference; -Medical care required; -Supervision of care; -Non-medical care required; -Bathing; -Dressing; -Grooming; -Transfer; -Ambulation; -Toileting and incontinence; -Eating; -Using speech and language; -Memory/Behavior. 1. Review of Resident #2's medical record, showed the following: -Admit date 1/27/26; -Diagnoses which included anxiety, dementia with behavioral disturbances and high blood pressure; -No documented ISP. 2. Review of Resident #1's medical record, showed the facility admitted the resident on 10/3/25, with diagnoses which included dementia, anxiety and diabetes. Review of the resident's ISP dated 12/5/25, showed the following: -Need: Aggressive/Combative - full intervention. "What is the resident's level of aggressive/combative behavior?" The resident required one person assistance for this task. The staff were to constantly supervise and assist the resident in redirecting aggressive/combative behaviors. The staff were to notify the appropriate providers if necessary. The resident was to receive assistance and aiding in alleviating aggressive/combative situations;	A4754		

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A4754	Continued From page 18 -Need: Bathing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance as needed with bathing/showering. The resident would receive verbal prompting and physical assistance as needed with bathing/showering; -Need: Dressing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance with dressing/undressing. The resident would receive monitoring and assistance as needed with dressing/undressing; -Need: Toileting - Level of care - The resident required one person assistance with this task. The staff were required to provide verbal prompting as well as physical assistance as needed with toileting needs; -The ISP had no resident preferences, goals or services to be provided by staff, for each identified need. 3. Review of Resident #3's medical record, showed the facility admitted the resident on 1/14/26, with diagnoses which included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety. Review of the resident's ISP dated 1/14/26, showed the following: -Need: Destructive/Abusive - full intervention. The resident required one person assistance for this task. The receive constant supervision and assistance preventing and alleviating any destructive/abusive behavior. To have complete assistance from staff with all incidents/episodes of destructive/abusive behavior. And to try and maintain a low level of these behaviors; -Need: Bathing - Level of care - The resident required one person assistance with this task.	A4754		

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A4754	Continued From page 19 The staff were required to monitor and provide assistance as needed with bathing/showering. The resident would receive verbal prompting and physical assistance as needed with bathing/showering; -Need: Dressing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance with dressing/undressing. The resident would receive monitoring and assistance as needed with dressing/undressing; -Need: Toileting - Level of care - The resident required one person assistance with this task. The staff were required to provide verbal prompting as well as physical assistance as needed with toileting needs; -The ISP had no resident preferences, goals or services to be provided by staff, for each identified need. 4. During an interview on 2/26/26 at 11:09 A.M., the Administrator said the ISPs should basically have anything staff does for the resident, addressed. She said it should explain the kind of assistance they need, how they transfer, if they have an IEP, all the information on their ADLs.	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 ' s condition which may require a change in	A4755		

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A4755	Continued From page 20 services; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure individualized service plans were reviewed when residents had a change in services, when falls and new interventions for each fall, no explanation of what kind of assistance the resident required, and aggressive behaviors and interventions staff could use to de-escalate situations were not documented in residents' ISPs, for two of three sampled residents (Residents #1 and #3). The census was 22. 1. Review of Resident #1's medical record, showed the facility admitted the resident on 10/3/25, with diagnoses which included dementia, anxiety and diabetes. Review of the resident's ISP dated 12/5/25, showed the following: -Need: Aggressive/Combative - full intervention. "What is the resident's level of aggressive/combative behavior?" The resident required one person assistance for this task. The staff were to constantly supervise and assist the resident in redirecting aggressive/combative behaviors. The staff were to notify the appropriate providers if necessary. The resident was to receive assistance and aiding in alleviating aggressive/combative situations. Review of the resident's progress notes, showed the following: -On 2/4/26 at 6:30 A.M., Caregiver H wrote at 6:25 A.M., the resident screamed at Resident #8 and told him/her to get the hell out of the way. The Caregiver already told Resident #1 the was wrong and rude. The resident proceeded to do so	A4755		

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anyway and he/her walked towards the main lobby and Resident #8 followed but not closely. The resident turned around and told Resident #8 to get the hell out of the way for the second time. The resident then proceeded to "two hand push" Resident #8 which caused him/her to hit his/her head on the floor;
-On 2/14/26 at 11:15 A.M., Caregiver #1 was involved in an altercation with Resident #3. Resident #1 kicked Resident #3 to the ground. Resident #3 hit his/her head and was sent out to the hospital. Resident #1 was sent out for a psychiatrist's evaluation.

Review of the resident's ISP dated 12/5/25, showed the ISP was not updated to include services or interventions put in place to prevent the resident from pushing other residents and harming them when they got close to Resident #1.

2. Review of Resident #3's medical record, showed the facility admitted the resident on 1/14/26, with diagnoses which included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety.

Review of the resident's ISP dated 1/14/26, showed the following:
-Need: Destructive/Abusive - full intervention. The resident required one person assistance for this task. The receive constant supervision and assistance preventing and alleviating any destructive/abusive behavior. To have complete assistance from staff with all incidents/episodes of destructive/abusive behavior. And to try and maintain a low level of these behaviors;
-Need: Bathing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide

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A4755	Continued From page 22	A4755		

assistance as needed with bathing/showering. The resident would receive verbal prompting and physical assistance as needed with bathing/showering;
-Need: Dressing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance with dressing/undressing. The resident would receive monitoring and assistance as needed with dressing/undressing;
-Need: Toileting - Level of care - The resident required one person assistance with this task. The staff were required to provide verbal prompting as well as physical assistance as needed with toileting needs.

Review of the resident's progress notes, showed the following:
-On 2/7/26 at 5:45 P.M., The resident was up walking around after dinner and fell. The staff did not witness the fall. The resident was flat on his/her back with a cut on each elbow. The staff took the resident's vitals and checked the resident's pupils. The resident said he/she was not in any pain but said "yes" when asked if he/she bumped his/her head. The staff notified the Administrator and also notified the resident's family member. The resident was sent to the emergency room by ambulance to be assessed;
-On 2/9/26 at 6:30 A.M., Caregiver J wrote while taking the resident to the bathroom, he/she fought back with the Caregiver and the resident lost his/her balance. It was a "small fall" close to the ground, and he/she did not have any marks or bruises;
-On 2/12/26 at 9:45 A.M., Level One Medication Aide (LIMA) A wrote while sitting in the day room, in the recliner, the resident attempted to get out of recliner and fell. The staff saw him/her face first on the ground. The resident said he/she hit

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A4755	Continued From page 23	A4755		

his/her head. The resident was assessed and vitals taken. The Paramedics were called, and an incident report was made;
-On 2/13/26 at 8:30 P.M., the Administrator wrote the resident returned to the facility via ambulance. The resident was placed in bed upon arrival and was sleeping at this time. New orders for Cephalexin (used to treat infection), 500 milligrams. Take one capsule by mouth three times a day for a urinary tract infection (UTI). The resident was admitted to the hospital on 2/12/26 for an altered mental status and UTI;
-2/14/26 at 11:15 A.M., Certified Medication Technician (CMT) I wrote the resident was on involved in a resident altercation. The resident walked past Resident #1 and was kicked. The resident fell to the ground and hit his/her head. The Paramedics were called, and the resident was sent to the hospital for a head injury. The Administrator/Director of Nursing (DON) was notified, and the resident's family member was notified;
-On 2/16/26 at 11:00 A.M., CMT I wrote the resident was given a shower by manager and hair was washed to get the dried blood out. The resident did well during the shower and was calm;
-2/16/26 at 9:00 A.M., CMT I wrote the resident started an antibiotic today.

During an interview on 2/17/26 at 1:34 P.M., LIMA A said the resident constantly followed Resident #1 around the facility, as did a few other female residents. LIMA A said the resident could be distracted with a snack or activity. The LIMA said the resident fell on 2/7/26 and 2/12/26 and hit his/her head both times. The LIMA said the resident required more assistance with dressing, bathing and toileting. The LIMA said the resident was not able to participate in activities of daily living (ADLs) as he/she before the falls.

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A4755	Continued From page 24 During an interview on 2/17/26 at 1:53 P.M., Care Aide (CA) C said the resident had a fall on 2/7 and 2/12. The CA said ever since those two falls, the resident required mores assistance with his/her ADLs. The CA said some days the resident is not able to participate at all during ADLs. Review of the resident's ISP dated 1/14/26, showed the following: -Need: Bathing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance as needed with bathing/showering. The resident would receive verbal prompting and physical assistance as needed with bathing/showering; -Need: Dressing - Level of care - The resident required one person assistance with this task. The staff were required to monitor and provide assistance with dressing/undressing. The resident would receive monitoring and assistance as needed with dressing/undressing; -Need: Toileting - Level of care - The resident required one person assistance with this task. The staff were required to provide verbal prompting as well as physical assistance as needed with toileting needs; -The ISP did not address the resident's increase in required assistance in bathing/showering, dressing and toileting; -The ISP did not address the resident's aggressive behavior with staff and specific interventions to help calm the resident; -The ISP did not address the resident's most recent falls and specific interventions to prevent future falls; -The ISP did not address the resident's head injuries;	A4755		

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A4755	Continued From page 25 -The ISP did not address the resident's habit of following Resident #1. 3. During an interview on 2/26/26 at 11:09 A.M., the Administrator said the ISPs should basically have anything staff does for the resident and this should be updated when a resident has a change in condition. The ISPs should have been updated.	A4755		
A4759	19 CSR 30-86.047(29)(A) Not Admit/Care For-Harm Self or Others The facility shall not admit or continue to care for a resident who: (A) Has exhibited behaviors that present a reasonable likelihood of serious harm to himself or herself or others; I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility continued to care for a resident who exhibited aggressive behavior towards other residents when residents approached him/her. The resident pushed two residents to the floor, which caused both residents to hit their heads. One of the residents sustained a traumatic subarachnoid hemorrhage (bleeding into the space surrounding the brain. Caused by head trauma (falls, accidents), it often presents with a sudden, severe headache, confusion, or loss of consciousness), for two of three sampled residents and one additional resident (Residents #1, #8 and #3). The census was 22. Review of Resident #1's medical record, showed the facility admitted the resident on 10/3/25, with diagnoses which included dementia, anxiety and	A4759		

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A4759	Continued From page 26	A4759		

diabetes.

Review of the resident's ISP dated 12/5/25, showed the need: Aggressive/Combative - full intervention. "What is the resident's level of aggressive/combative behavior?" The resident required one person assistance for this task. The staff were to constantly supervise and assist the resident in redirecting aggressive/combative behaviors. The staff were to notify the appropriate providers if necessary. The resident was to receive assistance and aiding in alleviating aggressive/combative situations.

Review of the resident's progress notes dated 2/4/26 at 6:30 A.M., showed Caregiver H wrote at 6:25 A.M., the resident screamed at Resident #8 and told him/her to get the hell out of the way. The Caregiver already told Resident #1 that was wrong and rude. The resident proceeded to do so anyway and he/her walked towards the main lobby and Resident #8 followed, but not closely. The resident turned around and told Resident #8 to get the hell out of the way for the second time. The resident then proceeded to "two hand push" Resident #8, which caused him/her to hit his/her head on the floor.

Review of Resident #8's medical record, showed the following:
-Admit date 1/17/26;
-Diagnoses included dementia with agitation and Alzheimer's disease.

Review of the resident's progress notes, showed the following:
-On 2/4/26 at 6:30 A.M., "Patient took a fall on to floor by another resident pushing" him/her. The resident had a bump on the back of his/her head;
-On 2/4/26 at 9:45 A.M., The resident's spouse

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requested the resident be sent to the hospital to have a CT scan completed. Staff sent the resident to the hospital;
-On 2/4/26 at 5:45 P.M., the resident was diagnosed with a traumatic subarachnoid hemorrhage. The resident was admitted to the hospital.

Review of Resident #3's medical record, showed the facility admitted the resident on 1/14/26, with diagnoses which included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety.

Review of the resident's ISP dated 1/14/26, showed the following:
-Need: Destructive/Abusive - full intervention. The resident required one person assistance for this task. The receive constant supervision and assistance preventing and alleviating any destructive/abusive behavior. To have complete assistance from staff with all incidents/episodes of destructive/abusive behavior. And to try and maintain a low level of these behaviors.

Review of the resident's progress notes dated 2/14/26 at 11:15 A.M., Certified Medication Technician (CMT) I documented the resident was involved in a resident altercation. The resident walked past Resident #1 and was kicked. Resident #3 fell to the ground and hit his/her head. Staff called the Paramedics and the resident was sent to the hospital for a head injury. Staff notified the Administrator and the resident's family member.

Review of Resident #1's progress note dated 2/14/26 at 11:15 A.M., Resident #1 was involved in an altercation with Resident #3. Resident #1 kicked Resident #3 to the ground. Resident #3 hit

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A4759	Continued From page 28 his/her head and was sent out to the hospital. Resident #1 was sent out for a psychiatrist's evaluation. During an interview on 2/26/26 at 2:32 P.M., the Administrator said she did not think it was Resident #1's fault. She said the staff should have redirected the other residents away from Resident #1 and not told him/her it was rude. MO00260576 MO00260580 MO00260732	A4759		
A4782	19 CSR 30-86.047(41) Medication Storage/Accessibility All medication shall be safely stored at proper temperature and shall be kept in a secured location behind at least one (1) locked door or cabinet. Medication shall be accessible only to persons authorized to administer medications. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview and record review, the facility failed to properly store residents' medications in a secure locked location, when a Level One Medication Aide (LIMA) left medications on top of the unsupervised medication cart and when the medication cart was left unlocked without staff supervision, during the morning medication pass. The census was 22. 1. Observation on 2/17/26 between 8:33 A.M. and 8:36 A.M., showed LIMA A left the following	A4782		

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medication on top of the medication cart which was accessible to residents;
-Donepezil (used to treat dementia), 5 milligrams (mg);
-Memantine (used to treat dementia, 10 mg;
-Olanzapine (used to treat anxiety), 5 mg;
-Buspirone (used to treat depression), 10 mg;
-Desvenlafaxine (used to treat depression), 26 mg;
-Galantamine (used to increase cognitive function), 16 mg;
-Levothyroxine (used to treat high blood pressure), 75 micrograms;
-Lorazepam (used to treat anxiety), 2 mg;
-Amlodipine (used to treat high blood pressure), 5 mg;
-Bupropion (used to treat depression), 100 mg;
-Cetirizine (used to treat allergies), 10 mg;
-Fluoxetine (used to treat depression), 20 mg;
-Lisdexamfetamine (used to treat adult attention hyperactivity disorder), 30 mg;
-Memantine (used to treat dementia), 10 mg;
-Rexulti (used to treat depression) 1 mg;
-Sena Plus (used to treat constipation) 8.6 mg.

2. Observation on 2/17/26 between 8:17 A.M. and 8:26 A.M., of the medication cart parked in front of the window in the living room, showed the cart was unlocked and was accessible to residents while LIMA A was in the middle office starting the medication pass.

3. During an interview on 2/17/26 at 1:34 P.M., LIMA A said he/she should have locked the medication cart in the morning when he/she went to the office to record the partial medication pass he/she had completed. The LIMA said he/she should not have left medication on top of the

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A4782	Continued From page 30 medication cart and was "moving too fast" and had forgotten the medication on top of the medication cart. 4. During an interview 2/17/26 at 10:56 A.M., the Administrator said it was never okay to leave medication on top of the medication cart and walk away from the cart. She said the medication should be kept always locked up. The Administrator said the medication cart should have been locked when not in active use of the staff. *The higher the classification merited due to the extent of the violation.	A4782		
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) did not administer medication according to the Physician's order sheet (POS) for two observed residents during the morning medication pass (Residents #5 and #6). The census was 22. Review of the facility's undated Medication Policy, showed the following: -Purpose: To ensure competent and safe	A4798		

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medication administration and oversight to residents.
-Policy: Facility staff will administer, supervise, dispose of and assist with resident self-administration of medications in accordance with all applicable federal and state laws and regulations;
-All resident's prescribed medication shall be dispensed through a pharmacy or by a resident's treating physician or dentist.
-Physician sample medications may be given to a resident by the facility provided the medication has specific dosage instructions for the individual.

1. Review of Resident #5's medical record, showed the facility admitted the resident on 4/21/25, with diagnoses which included dementia with behavioral disturbances, Parkinson's disease and high blood pressure.

Review of the resident's POS dated 2/1/26, showed the following:
-Amlodipine (used to treat high blood pressure), 5 milligrams (mg). Take one tablet by mouth daily;
-Clotrimazole (used to treat skin infections), 1% topical cream. Apply to affected area twice daily;
-Donepezil (used to treat dementia), 10 mg. Take one tablet by mouth every night;
-Guanfacine (used to treat attention deficit hyperactivity disorder), 1 mg. Take three tablets by mouth every evening;
-Lisdexamfetamine (used to treat adult attention deficit hyperactivity disorder), 30 mg. Take one tablet by mouth daily at 7:00 A.M.;
-Rexulti (used to treat dementia), 1 mg. Take one tablet by mouth daily;
-Zunveyl (used to treat dementia), 10 mg. Take one tablet by mouth daily.

Review of the resident's medication

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administration (MAR) record dated 2/2026, showed the following:
-On 2/3, both morning and evening dose, 2/4 both morning and evening dose, 2/7 evening dose, 2/8 both morning and evening dose, 2/11 both morning and evening dose, 2/12 both morning and evening dose, 2/13 evening dose, and 2/17/26 both morning and evening dose, clotrimazole was not administered to the resident with "not available" documented for the reason why;
-On 2/1, 2/2, 2/3, 2/4, 2/7, 2/8, 2/9, 2/10, 2/13, 2/14, 2/15, and 2/16/26, donepezil was not administered to the resident with "not available" documented for the reason why;
-On 2/1, 2/2, 2/3, 2/4, 2/5, 2/7, 2/8, 2/9, 2/10, 2/13, 2/14, 2/15, and 2/16/26, guanfacine was not administered to the resident with "not available" documented for the reason why;
-On 2/3, 2/4 and 2/17/26, lisdexamfetamine was not administered to the resident with "not available" documented for the reason why;
-On 2/3, 2/4, 2/8, 2/11, and 2/17/26, Rexulti was not administered to the resident with "not available" documented for the reason why;
-On 2/2 both morning and evening dose, 2/3 both morning and evening dose, 2/4 both morning and evening dose, 2/7 both morning and evening dose, 2/8 both morning and evening dose, 2/9 morning dose, 2/10 evening dose, 2/11 morning dose, 2/13 evening dose, 2/15 both morning and evening dose, 2/16 evening dose, and 2/17/26 both morning and evening dose, Zunveyl was not administered to the resident with "other" documented for the reason.

2. Review of Resident #6's medical record, showed the facility admitted the resident on 12/12/24, with diagnoses which included dementia with other behavioral disturbance, acute

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kidney failure and high blood pressure.

Review of the resident's POS dated 2/2026, showed the following:
-Melatonin (used as sleeping aide), 3 mg. Take two tablets by mouth at bedtime;
-Zunveyl, 10 mg. Take one tablet by mouth tow times a day.

Review of the resident's MAR dated 2/2026, showed the following:
-On 2/3, 2/4, 2/7, 2/12, and 2/17/26, melatonin was not administered to the resident with "not available" documented for the reason why;
-On 2/1 morning dose, 2/2 evening dose, 2/3 both morning and evening dose, 2/4 both morning and evening dose, 2/7 both morning and evening dose, 2/8 morning dose, 2/10 morning dose, 2/11 both morning and evening dose, 2/12 both morning and evening dose, 2/15 evening dose, 2/16 morning dose, and 2/17/26 both morning and evening dose Zunveyl was not administered to the resident with "not available" documented for the reason why.

3. During an interview on 2/17/26 at 9:00 A.M., LIMA A said a lot of residents in the facility have an order for Zunveyl. The LIMA said a while ago, a Pharmacist came by the facility and introduced this new medication to the facility. The LIMA said all of the resident's insurances did not cover this medication. The LIMA said the medication was still on the resident's POSs and MARs, but the pharmacy never filled the script.

4. During an interview on 2/26/26 at 10:50 A.M., the Administrator said if a medication was not in the cart and the resident had the order, the staff were supposed to click on "no pass" in the computer and then click another button that said

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A4798	Continued From page 34 "refill." She said the staff should also contact the pharmacy and afterwards, put a note in the resident's chart they contacted pharmacy. She was not sure if the follow up from the staff for Zunveyl went through to the pharmacy, but the staff members faxed the authorization to the pharmacy and have not heard back. She said the order for Zunveyl was given by a Psychiatrist to several residents in the facility, but she thought the issue was the expense of the medication which was why the facility did not have the medication available. She said the resident's orders should reflect the MAR and if a resident was not getting a medication, the MAR/order should be updated accordingly. The Administrator said the medication that was on the script packets (pill packets), should be matching the MAR/order. She said the pharmacy should have done this on their side, but it was her responsibility to ensure it was done. The Administrator said the residents should be given all of their medication according to the resident's POS and it was the staff's responsibility to order the medication and ensure the medication cart had the correct medication. *The higher the classification merited due to the extent of the violation.	A4798		
A4836	19 CSR 30-86.047(58)(A) Resident Record Admission Info The facility shall maintain a record in the facility for each resident, which shall include the following: (A) Admission information including the resident ' s name; admission date; confidentiality number; previous address; birth date; sex; marital status; Social Security number; Medicare and Medicaid	A4836		

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A4836	Continued From page 35 numbers (if applicable); name, address and telephone number of the resident ' s physician and alternate; diagnosis, name, address and telephone number of the resident ' s legally authorized representative or designee to be notified in case of emergency; and preferred dentist, pharmacist and funeral director; III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to maintain a record for each resident which included contact information of the resident's preferred funeral director and dentist, for two of three sampled residents (Residents #3 and #2). The census was 22. 1. Review of Resident #3's medical record, showed the following: -Admit date 1/14/26; -No preferred dentist documented; -No preferred funeral home documented. 2. Review of Resident #2's medical record, showed the following: - Admit date 1/27/26; -No preferred dentist documented; -No preferred funeral home documented. 3. During an interview on 2/26/26 at 11:16 A.M., the Administrator said she was aware it was required to have a contact for a dentist and a funeral home for all residents. She did not know residents were missing this information.	A4836		
A4841	19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety Staffing Requirements. (A) The facility shall have an adequate number	A4841		

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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 observation, interview and record review, the facility care staff failed to notify a Nurse for an assessment after a resident fell. The staff transferred the resident off the floor without an assessment by a qualified person for one of two sampled residents and one additional resident (Residents #8 and #3). The census was 22.

Review of the facility's fall policy 12/11/24, showed the following:

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A4841	Continued From page 37 -Purpose: -The Fall Management and Prevention programs are designed to reduce falls as well as injuries; -Policy: -The facility takes a proactive and innovative approach to deter resident injuries by following an interdisciplinary Fall Management program. This program is coordinated with guardian of resident. The Fall Management program begins at the initial comprehensive assessment and continues through a team approach that focuses on staff training; -All care staff receives training both prior to assuming any job responsibilities as well as continuing education on fall prevention; -The facility will coordinate with guardian to implement procedures to minimize falls through our designed care plan which may involve medication management, environmental modifications, adaptive devices as well as clinical interventions to maximize mobility and to promote quality of life with guardian consent; -Definitions: -A fall is an unintended landing on a lower position; -The facility will confirm that a resident has sustained a fall when the fall is witnessed; -Other scenarios will be treated as a fall when the resident is found on the floor, or gives indication that an injury exists either verbally or non-verbally; -The facility will communicate all witnessed falls as well as any suspected falls with Physician/Medical Representative and guardian; -Procedure: -General safety precautions and interventions should be used for all residents and may include; -1. Orienting resident to room and surroundings at the time of admission	A4841		

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A4841	Continued From page 38 -2. Maintaining bed in low position -3. Maintaining strong activity program -4. Exercise program -5. Providing call system that is within easy reach and secured -6. Use of alert wristband or necklace -7. Promoting resident use of non-slip footwear/proper shoes when ambulating -8. Encouraging residents to use canes and walkers as instructed -9. Minimizing medications with sedative side effects (and not using sedatives as a fall-mitigation strategy) -10. Maintaining adequate hydration -11. Encouraging the use of eye glasses to decrease visual impairment -12. Locking brakes on beds, gurneys, or wheelchairs that are mobile -13. Providing adequate light in all rooms and common areas -14. Using nightlights -15. Keeping the resident's environment free of obstacles -16. Providing resident and/or family with fall mitigation education -17. For those with cardiovascular instability, encouraging the resident to rise slowly from a sitting position -18. Installation and proper maintenance of handrails -19. Installation of grab bars in bathrooms and use of elevated toilet seats when needed -20. Prohibiting use of throw rugs. 1. Review of Resident #8's medical record, showed the facility admitted the resident on 1/17/26, with diagnoses which included dementia and Alzheimer's disease. Review of the resident's progress notes, showed	A4841		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 39	A4841		

the following:
-On 2/4/26 at 6:30 A.M., the resident "took a fall on to the floor by another resident pushing him/her". A Certified Medication Technician examined the resident's bump found on the back of his/her head. Staff gave him/her acetaminophen for pain; monitoring resident;
-On 2/4/26 at 9:45 A.M., the Administrator documented staff contacted her about the incident where another resident pushed him/her to the floor. The Administrator told staff to contact hospice and notify of the fall and injury. Staff said hospice requested the resident not to be sent out, they would have a nurse come assess the resident. The hospice nurse arrived at the facility to assess the resident (after staff got the resident off the floor) and speak to the resident's family member. The family member requested the staff to send the resident to the hospital for an assessment;
-On 2/4/26 at 5:45 P.M., the Administrator contacted the emergency department. The resident was diagnosed with a traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space surrounding the brain, most commonly caused by head injuries from accidents or falls. It causes severe headaches, confusion, and vomiting, often requiring emergency CT scans and intensive care to manage intracranial pressure).

During an interview on 2/17/26 at 3:40 P.M., the Administrator said the staff got the resident off the floor and then called her. The hospice staff had informed the facility staff to not send the resident to the hospital until a hospice nurse could come assess the resident.

2. Review of Resident #3's medical record, showed the facility admitted the resident on

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A4841	Continued From page 40 1/14/26, with diagnoses which included dementia, major depressive disorder, Alzheimer's disease, high blood pressure and anxiety. Review of the resident's ISP dated 1/14/26, showed the following: -Need: Aggressive/Combative - full intervention. "What is the resident's level of aggressive/combative behavior?" The resident required one person assistance for this task. The staff were to constantly supervise and assist the resident in redirecting aggressive/combative behaviors. The staff were to notify the appropriate providers if necessary. The resident does well with older care givers. The resident was to receive assistance and aiding in alleviating aggressive/combative situations; -Mobility and walking: Required monitoring and cuing with all walking needs. Needed to be monitored due to unsteady gait. Review of the resident's progress notes, showed the following: -On 1/14/26 at 9:00 P.M., the resident has a care sitter 24 hours a day that ensures the resident is safe and does not get up by him/herself. Resident in wheelchair due to unsteady gait. Resident can walk with walker and standby assist; -On 1/28/26 at 3:00 P.M., the resident placed him/herself on the floor; staff assisted the resident in getting up, no injuries; -On 1/31/26 at 7:00 A.M., staff found the resident seated on the floor, in his/her room, around 9:30 P.M. Staff asked the resident if he/she had fallen and he/she said no. Staff checked the resident for injuries. He/she had a "little scuff" on his/her right ankle; -On 2/7/26 at 5:45 P.M., the resident was up walking around after dinner and fell. The staff did not witness the fall. The resident was flat on	A4841		

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A4841	Continued From page 41 his/her back with a cut on each elbow. The staff took the resident's vitals and checked the resident's pupils. The resident said he/she was not in any pain but said "yes" when asked if he/she bumped his/her head. The staff notified the Administrator and also notified the resident's family member. The resident was sent to the emergency room by ambulance to be assessed; -On 2/9/26 at 6:30 A.M., while taking the resident to the bathroom, he/she was fighting back with staff and lost his/her balance. It was a "small, close fall to the ground"; he/she did not have any marks or bruises; -On 2/12/26 at 9:45 A.M., Level One Medication Aide (LIMA) A documented while sitting in the day room, in the recliner, the resident attempted to get out of recliner and fell. The staff saw him/her face first on the ground. The resident said he/she hit his/her head. The resident was assessed and vitals taken. The Paramedics were called, and an incident report was made. During an interview on 2/17/26 at 1:34 P.M., LIMA A said the resident fell on 2/7 and 2/12. The LIMA was present for both falls. The LIMA said when the resident fell the first time, on 2/7, the reside said he/she hit his/her head. The LIMA said he/she completed range of motion and "looked over the resident." The LIMA said afterwards, him/her and Care Aide (CA) C got on either side of the resident and assisted the resident off the floor. The staff put the resident in the recliner. The LIMA said the resident had another fall on 2/12. The LIMA said he/she "looked over the resident" and then got assistance from CA C to assist the resident off the floor. The LIMA said when he/she worked in a Skilled Nursing Facility, he/she was trained to get a Nurse before moving the resident off the floor. The LIMA said he/she knew to call a Nurse but did not. The LIMA later	A4841		

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A4841	Continued From page 42 said he/she called the Administrator/Director of Nursing but could not get a hold of her. The LIMA said he/she got a new phone so he/she could not show the call log. During an interview on 2/17/26 at 1:53 P.M., CA C said the resident had a fall on 2/7 and 2/12. The CA said both times the resident fell, LIMA A assessed the resident. The CA did not know only Nurse's could assess a resident after a fall. The CA said no one at the facility had told him/her that. 3.. During an interview on 2/26/26 at 11:19 A.M., the Administrator said when a resident falls, the staff are supposed to contact her so she could assess the resident if she was in the building. She said if a resident has any obvious injury, then the ambulance needs to be called immediately. She said she trained the staff on how to assess residents when she was not in the building. She did not know the policy did not include residents required a Nurse's assessment prior to lifting. She did not know the staff were required to call her so she could assess the resident over the phone if she was not in the building.	A4841		
A4856	19 CSR 30-86.047(63)(A) Alz/Dementia Training-Direct Care Staff, 3 hr In addition to the orientation training required in section (62) of this rule any facility that provides care to any resident having Alzheimer ' s disease or related dementia shall provide orientation training regarding mentally confused residents such as those with Alzheimer ' s disease and related dementias as follows: (A) For employees providing direct care to such persons, the orientation training shall include at	A4856		

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A4856	Continued From page 43 least three (3) hours of training including at a minimum an overview of mentally confused residents such as those having Alzheimer ' s disease and related dementias, communicating with persons with dementia, behavior management, promoting independence in activities of daily living, techniques for creating a safe, secure and socially oriented environment, provision of structure, stability and a sense of routine for residents based on their needs, and understanding and dealing with family issues; and II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure all employees providing direct care to residents had at least three hours of Alzheimer's disease and/or dementia training recorded in the employee's file, for one of one sampled direct care employee. The census was 22. Review of Level One Medication Aide A's personnel file, showed the following: -Hire date 12/16/25; -No documentation of at least three hours of Alzheimer's disease and/or dementia training. During an interview on 2/26/26 at 11:17 A.M., the Administrator said she was aware direct staff required at least three hours of Alzheimer's and/or dementia training. She said there was a video the staff were using during the onboarding process prior to her but she did not know if this was documented anywhere, and she could not find documentation. *The higher the classification merited due to the	A4856		

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A4856	Continued From page 44 extent of the violation.	A4856		
A4857	19 CSR 30-86.047(63)(B) Dementia Training-Non-Direct Care Staff, 1 hr In addition to the orientation training required in section (62) of this rule any facility that provides care to any resident having Alzheimer ' s disease or related dementia shall provide orientation training regarding mentally confused residents such as those with Alzheimer ' s disease and related dementias as follows: (B) For other employees who do not provide direct care for, but may have daily contact with, such persons, the orientation training shall include at least one (1) hour of training including at a minimum an overview of mentally confused residents such as those having dementias as well as communicating with persons with dementia; and II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure all employees providing in-direct care to the residents, had the required one hour Alzheimer's or dementia training documented in the employee's personnel file, for one of one in-direct care sampled employees. The census was 22. Review of the Maintenance Director's personnel file, showed the following: -Hire date 7/9/25; -No documentation of at least one hour of Alzheimer's disease and/or dementia training. During an interview on 2/26/26 at 11:17 A.M., the	A4857		

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A4857	Continued From page 45 Administrator said she was aware in-direct staff required at least one hour of Alzheimer's and/or dementia training. She said there was a video the staff were using during the onboarding process prior to her but she did not know if this was documented anywhere, and she could not find documentation. *The higher the classification merited due to the extent of the violation.	A4857		
A6005	19 CSR 30-87.020(5) Toxic Material Storage Poisonous or toxic materials consist of the following categories: insecticides and rodenticides; disinfectants, sanitizer and related cleaning or drying agents; and caustics, acids, polishes and other chemicals. Each of these three (3) categories set forth shall be stored and physically located separate from each other. All poisonous or toxic materials shall be stored in locked cabinets or in a similar physically separate place used for no other purpose which is not accessible to residents. II This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all chemicals and toxic materials were stored locked up or not in resident accessible areas when chemicals were found in resident rooms and in areas accessible to residents. The census was 22. Review of the facility's undated Chemical Policy, showed the following: -Purpose: The purpose of this policy is to ensure the safe storage, use, and disposal of chemicals within the assisted living facility, in accordance with Missouri Department of Health and Senior	A6005		

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A6005	Continued From page 46 Services (DHSS) regulations, Occupational Safety and Health Administration (OSHA) standards, and Environmental Protection Agency (EPA) guidelines; -This policy aims to; -Protect residents, staff, and visitors from exposure to hazardous substances -Maintain compliance with state and federal laws -Promote a culture of safety and environmental responsibility -Scope: -This policy applies to all employees, contractors, and volunteers who handle or may come in contact with chemical cleaning products, disinfectants, sanitizers, maintenance supplies, and other hazardous materials within the facility. 1. Observation on 2/17/26 between 10:49 A.M. and 3:49 P.M., of resident room 12, on the shelf above the toilet, showed the following: -A full 32 oz spray bottle of Clorox toilet bowl cleaner. The precautionary statement read, "The product causes burns of eyes, skin and mucous membranes. Thermal decomposition can lead to release of irritating gases and vapors. Inhalation: May cause irritation of respiratory tract. May cause pulmonary edema. Eye contact: Corrosive to the eyes and may cause severe damage including blindness. Causes serious eye damage. Skin contact: Avoid contact with skin. Corrosive. Causes burns. Ingestion: Ingestion causes burns of the upper digestive and respiratory tracts. Ingestion may cause gastrointestinal irritation, nausea, vomiting and diarrhea. Do not breathe dust/fume/gas/mist/vapors/spray. Wash face, hands and any exposed skin thoroughly after handling. Wear protective gloves/protective clothing/eye protection/face protection. Keep away from children."; 	A6005		

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A6005	Continued From page 47 -A full 32 oz spray bottle of Clorox disinfecting spray. The precautionary statement read, "Hazards to humans and domestic animals. Caution: may cause eye irritation. Avoid contact with eyes or clothing. Keep out of reach of children". 2. Observation on 2/17/26 between 8:19 A.M. and 3:49 P.M., of the living room, on the windowsill by the medication cart, showed the following: -One 32 oz spray bottle of Odorban. The precautionary statement read, "Hazard Classification: Eye Damage/Irritation Category: 1; Skin Corrosion/Irritation Category: 2 Signal Word: DANGER Pictogram(s): Corrosion Hazard Statement: Causes serious eye damage. Causes skin irritation. Precautionary Statements: Wear eye and face protection. Wear protective gloves. Wash exposed body parts thoroughly after handling. If in eyes: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Immediately call the Medical Emergency number provided above or a poison control center. If on skin: Wash with plenty of water. If skin irritation occurs: Get medical advice/attention. Take off contaminated clothing and wash it before reuse." 3. Observation on 2/17/26 between 8:25 A.M. and 3:49 P.M., of a black rolling cart by the kitchen window, showed the following: -One 1/2 full container of 80 count Lysol wipes. The precautionary statement read, "Hazardous to humans and domestic animals. Causes mild eye irritation. Do not spray in eyes, on skin, or on clothing. Wash hands thoroughly after use and before eating. Keep out of reach of children"; -One 1/2 full 32 oz spray bottle of Spic-N-Span. The precautionary statement read, "Do not breathe mist. Wash hands thoroughly after	A6005		

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A6005	Continued From page 48	A6005		

handling. Keep away from heat/sparks/open flames/hot surfaces. No smoking. Keep container tightly closed. IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing Immediately call a POISON CENTER or doctor/physician IF SWALLOWED: Rinse mouth. DO NOT induce vomiting Drink 1 or 2 glasses of water IF ON SKIN (or hair): Remove/Take off immediately all contaminated clothing. Rinse skin with water/shower IF INHALED: Remove to fresh air and keep at rest in a position comfortable for breathing in case of fire: Use water, CO2, dry chemical, or foam for extinction".

4. Observation on 2/17/26 between 8:30 A.M. and 3:49 P.M., of resident room 1, showed the following:
-The bedroom door propped open:
-In the two door cabinet above the toilet, showed a 1/2 full can of Ajax powder cleaner. The precautionary statement read, "Eye Contact: Causes serious irritation, potentially severe or causing damage. Skin Contact: May cause irritation upon prolonged or excessive contact. Inhalation: Overexposure to dust may cause respiratory tract irritation. Ingestion: May be harmful if swallowed; may cause nausea or diarrhea. Handling & Storage: Wash thoroughly after handling. Keep container closed in a dry, cool, and well-ventilated place. First Aid: If in eyes, rinse cautiously with water for several minutes and remove contact lenses if present. If swallowed, drink 8 ounces of water and seek medical attention";
-On the counter of the sink, outside of the bathroom, a full can of Clorox disinfecting spray.

5. Observation on 2/17/26 between 9:14 A.M. and 3:50 P.M., of the unlocked salon, to the right of

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A6005	Continued From page 49 the shelf, showed two 15 oz 1/2 full bottle of nail polish remover. The precautionary statement read: "Extremely flammable. Avoid contact with skin and eyes. Avoid inhalation of vapor or mist. KEEP AWAY FROM CHILDREN." 6. During an interview on 2/26/26 at 10:57 A.M., the Administrator said chemicals should be kept locked up. She said the chemicals should not be left out in resident areas and it was never okay to allow residents to have chemicals in their room. She said the staff constantly do rounds to ensure there are no chemicals in the resident's room, but they did not document it.	A6005		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain nonfood contact surfaces, clean and free of dirt accumulation. The census was 22. Observation on 2/17/26 between 8:23 P.M. and 4:00 P.M., showed the following: -Both sides and the front of the oven, covered with brown grease streaks and food debris; -The outside of freezer 1's door, covered with white streaks; -The inside of freezer 1, the bottom shelf, covered with brown dirt and food debris; -The inside of freezer 2, the bottom shelf, covered with brown dirt and food debris;	A7067		

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A7067	Continued From page 50 -The inside of fridge 1, the wire shelves and the bottom shelf, covered with dirt and debris; -The inside of fridge 2, the wire shelves and the bottom shelf, covered with dirt and debris; -Both sides of the oven and the front, covered with brown streaks and food debris; -On the water filter system, on the west wall, a thick layer black dirt and dust, on the white wall mount and on top of the filter; -The inside oven doors, for both the top and bottom ovens, covered with thick, brown layer of grease; -A plastic laminated sign, to the right of the ice machine, covered with brown stains and a thick layer of dust; -The front of the steam table, located in the island, covered with food debris and red sticky spots; -Both silver water fixtures, located on the range top, covered with a thick layer of grease and dust; -On top of the fire extinguisher box, on the north wall, covered with a thick layer of dirt and dust; -On top of the silver K Guard fire extinguisher, covered with a layer of dirt and grease. During an interview on 2/17/26 at 3:40 P.M., the Administrator said the kitchen staff should wipe down the kitchen every evening after meal service is over. She did not know when the kitchen was last cleaned.	A7067		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that	A8023		

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A8023	Continued From page 51 require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to investigate a resident to resident altercation to determine if abuse occurred, for two residents (Residents #1 and #3). The census was 22. Review of the facility's Abuse, Neglect and Exploitation, Last Revised 12/13/24, showed the following: -Purpose: "To identify suspected or alleged victims of abuse and exploitation and establish appropriate protocol for reporting and/or referring abuse and/or neglect of a resident. Facility employees/contractors will be aware of signs and symptoms indicating possible abuse, neglect and exploitation, will report suspected abuse, neglect and/or exploitation to Facility management and appropriate persons/organizations, and will refer to private or community agencies for further assessment, as appropriate, according to state laws and/or regulations. Residents/legal guardian/family will be informed of this policy, verbally and in writing, during the admission process. -Procedure: 1. Any facility staff who has reasonable cause to believe that a resident is in a state of abuse, neglect, or exploitation will report the abuse, neglect, and/or exploitation to Facility	A8023		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 52	A8023		

management and HHSC;
2. Reports are made to Texas Department of Health and Human Services state office at 1-800-458-9858;
3. An oral report must be made by the staff member immediately on learning of the alleged abuse or neglect;
4. Facility will investigate the allegation and will send a written report of the investigation to HHSC no later than the fifth calendar day after the oral report;
5. The report will contain the:
5a. name, age, and address of the resident
5b. name and address of the person responsible for the care of the resident, if available
5c. nature and extent of the elderly or disabled person's condition; and
5d. basis of the reporters knowledge:
6. If any Facility employee or contractor is suspected of abuse, neglect or exploitation, the employee will be suspended immediately, and an investigation will be conducted by the Facility. If the investigation validated the claim, the employee or contractor will be terminated and the incident(s) reported to HHSC". (Note: The facility did not have an abuse policy specifically for Missouri.)

Review of Resident #1's medical record, showed the facility admitted the resident on 10/3/25, with diagnoses which included anxiety and dementia with behavioral disturbances.

Review of the resident's progress notes dated 2/14/26 at 11:15 A.M., showed Resident #1 was involved in an altercation with Resident #3. Resident #1 kicked Resident #3 to the ground. Resident #3 hit his/her head and staff sent the resident to the hospital. Staff sent Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30425	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON MEMORY CARE	5342 BUTLER HILL ROAD SAINT LOUIS, MO 63128

(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
A8023	Continued From page 53 out for a psychiatrist's evaluation. During an interview on 2/17/26 at 3:40 P.M., the Administrator said she believed she investigated the incident but would have to locate the investigation. (As of 2/26/26 at 9:39 A.M., the Administrator had not submitted the facility investigation.) MO00260732 *The higher classification merited due to the extent of the violation.	A8023		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all residents were treated with full dignity and respect at all times, when a baby monitor was being used to complete rounds on a resident by the night shift staff. The census was 22. Review of the facility's undated Dignity Policy,	A8030		

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	30425	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON MEMORY CARE	5342 BUTLER HILL ROAD SAINT LOUIS, MO 63128

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A8030	Continued From page 54 showed the following: -Policy: To ensure all residents/family/legal guardians and Agency staff acknowledge, observe and implement the resident's rights and responsibilities; -Facility will provide information regarding the Resident Bill of Rights and Responsibilities; -The resident will be treated with respect, consideration, and recognition of his or her dignity and individuality, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. Observation on 2/17/26 between 9:00 A.M. and 4:00 P.M., of resident room 5, by the television, showed a baby monitor pointed towards the resident's bed. During an interview on 2/17/26 at 2:15 P.M., Level One Medication Aide (LIMA) A said the baby monitor had been there for a couple months now. The LIMA said he/she never used it and never saw day shift use it. The LIMA the night shift staff used it so they would not have to get up several times to check on the resident because the resident had a habit of getting out of bed multiple times during the night. During an interview on 2/26/26 at 11:29 A.M., the Administrator said she knew about the baby monitor. She said she thought the family had access to the baby monitor but did not know for sure. She said she had not seen staff use it once and she had worked during the night as well. She said night shift should not be using the baby monitor check on the resident. *The higher the classification merited due to the extent of the violation.	A8030		

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	30425	A. BUILDING: _____ B. WING _____	C 02/24/2026

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A8037	Continued From page 55	A8037		
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 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 III Based on interview and record review, the facility failed to ensure personal inventory lists were completed for three of three sampled residents (Residents #1, #3 and #2). The census was 22. 1. Review of Resident #1's medical record, showed the following: -Admit date 10/3/25; -No documented inventory sheet. 2. Review of Resident #3's medical record, showed the following: -Admit date 1/14/26; -No documented inventory sheet. 3. Review of Resident #2's medical record, showed the following: - Admit date 1/27/26; -No documented inventory sheet.	A8037		

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A8037	Continued From page 56 4. During an interview on 2/27/26 at 11:32 A.M., the Administrator said she was aware the residents required an inventory sheet, but she did not have the time to do this. She said it was on her list, but she had not gotten to it yet.	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 failed to post, outside resident rooms, a notice to alert and inform visitors that electronic monitoring devices were in use in a resident's room, for one resident with an electronic monitoring device. The census was 22. Observation on 2/17/26 between 9:00 A.M. and 4:00 P.M., of resident room #10, showed a camera on the windowsill which had a blue light on indicating the camera was on and another camera by the television with a blue light on indicating the camera was on. During an interview on 2/26/26 at 11:41 A.M., the Administrator said she knew there should be a sign on the resident's apartment door. She said the resident previously had a sign on his/her door, but it must have been torn off.	A9107		

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	30425	A. BUILDING: _____ B. WING _____	C 02/24/2026

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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 III Based on observation and interview, the facility failed to ensure electronic monitoring devices were mounted in a fixed, stationary position when cameras in a resident's room were movable, for one of one resident who had a camera. The census was 22. Observation on 2/17/26 between 9:00 A.M. and 4:00 P.M., of resident room #10, showed a camera on the windowsill which had a blue light on indicating the camera was on and another camera by the television with a blue light on indicating the camera was on. Neither camera was mounted. During an interview on 2/17/26 at 11:41 A.M., the Administrator said she was not aware the cameras were required to be mounted.	A9108		

PLAN OF CORRECTION			
Provider/Supplier Name:	Avalon Memory Care		
Street Address, City, Zip:	5342 Butler Hill Rd. Saint Louis, Mo 63128		
Date of Survey:	2-24-2026		
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**
Tag: A4505 A4508	**Deficiency: A4505** **Regulation:19 CSR 30-86.045(3)(A)(5) Individual Evacuation Plan - In Resident ISP** 1. How the facility will correct the deficient practice for the resident(s) identified: Resident #2's record was reviewed by the Administrator/designee. An Individual Service Plan (ISP) was completed, and the Individual Evacuation Plan (IEP) was incorporated into the resident's ISP as required. The evacuation plan includes the resident's mobility status, staff assistance required, evacuation route, and assigned staff support. • All current residents' ISPs will be audited to verify that an IEP is present and contains all required components, if an IEP is implemented. • A standardized IEP template has been implemented to ensure consistency and compliance with Missouri Assisted Living regulations. • The ISP review process has been revised to include mandatory verification of the IEP during admission, quarterly reviews, and upon any significant change in the resident's condition. Correction will be completed by 3-31-2026.		

Deficiency: A4508

Regulations: 19 CSR 30-86.045(3)(A)(6)(C) Individual Evacuation Plan -

1.Residents #1 and #2's Individual Evacuation Plans were reviewed and updated to include documentation of:

- Resident's location within the facility
- Proximity to the nearest exit and/or area of refuge
- Risk of resistance
- Mobility status
- Staff assistance required
- Response to instructions and alarms
- Response during fire drills

Correction will be completed by 3-31-2026.

2. How the facility will identify other residents who may be affected

During the 100% resident record audit, the Administrator/designee verified that each resident requiring more than minimal assistance to evacuate has a complete Individual Evacuation Plan containing all required evaluation components, including location and proximity to exits.

Any incomplete evacuation plans were immediately updated.

Audit completed by 3-31-2026.

System Changes Implemented (Applies to A4505 and A4508)

1.To prevent recurrence, the facility has implemented the following:

- The Individual Service Plan template and evacuation plan form were revised to include required evacuation elements including resident location and proximity to exits/areas of refuge.
- An Admission and Care Planning Checklist has been implemented to ensure completion of:
    - Individual Service Plan
    - Individual Evacuation Plan (if resident requires more than minimal evacuation assistance)

	○ All required evacuation plan components • The Administrator or designee will review all newly completed ISPs and evacuation plans to ensure compliance with state regulations. 2.Staff Education All caregiving and administrative staff responsible for resident documentation were educated by the Administrator/designee on the requirements of 19 CSR 30-86.045 regarding Individual Evacuation Plans and Individual Service Plans. Education will be completed by 3-31-2026 and documentation is maintained in the facility training records. Date of Compliance The facility will achieve compliance with these regulations by 3-31-2026	
Tag: A2222	**Deficiency: A2222** Regulation: **19 CSR 30-86.022(7)(A) – Exits – Two per Floor – Remote/Unobstructed** 1. How the facility will correct the deficient practice: The metal patio chair located outside the designated exit door near Resident Room #9 was immediately removed, ensuring the exit door and exit pathway were unobstructed and fully accessible. The Administrator/designee verified that all designated exits inside and outside the facility were clear and unobstructed. 2. Measures the facility will take to ensure the deficient practice does not occur: The facility has implemented the following system changes: • A daily environmental safety check has been implemented requiring staff to verify that all exit doors and exit pathways (interior and exterior) remain unobstructed.	

	• An Exit Door Safety Checklist has been implemented for staff to document completion of exit checks during each shift. • Staff have been instructed that no furniture, equipment, or other items may be placed near exit doors or exit pathways. • The Administrator/designee will perform routine monthly and as needed, environmental rounds to ensure exits remain clear and accessible. 3. How the facility will monitor corrective actions to ensure continued compliance 4. Staff Education All staff were educated by the Administrator/designee on 19 CSR 30-86.022(7)(A) regarding the requirement that all exit doors and exit pathways must always remain unobstructed. Staff education included instructions to immediately remove any items placed near exit doors and report concerns to the Administrator or designer. Education will be completed by 3-31-2026 and documentation is maintained in the facility's training records. 5. Date of Compliance: The facility will achieve compliance with this regulation by 3-31-2026.	
Tag: A2287	**Deficiency: A2287** **Regulation: 19 CSR 30-86.022(15)(B) – Trash and Rubbish Disposal** 1. How the facility will correct the deficient practice for the residents identified All discarded items located near the dumpster in the front parking lot, including the recliner, walker, mattresses, bed frame, and dresser, were removed from the premises and properly disposed of.	

	The dumpster enclosure area was cleaned and cleared of debris to eliminate potential fire hazards and public health concerns. 2.The torn fabric coverings on the dumpster enclosure gates were removed and replaced/repaired to ensure the dumpster area remains properly enclosed and maintained. 3. How the facility will identify other areas that may be affected by the same deficient practice 4.. Measures the facility will take to ensure the deficient practice does not occur The facility implemented the following system changes: • A weekly exterior grounds and dumpster inspection has been implemented to ensure trash and discarded items are removed in a timely manner. • Staff were instructed that large, discarded items from resident move-outs must be removed from the premises immediately or scheduled for pickup with waste services. • The Administrator/designee will ensure maintenance or waste management services are contacted promptly when bulk disposal is required. • Maintenance will monitor the condition of dumpster enclosure gates and fencing and report damage for prompt repair. 4. How the facility will monitor corrective actions to ensure continued compliance The Administrator/ designee will conduct weekly environmental rounds of the dumpster and exterior trash areas: Trash is removed from the premises in a timely manner • No discarded furniture or bulk items accumulate near the dumpster • Dumpster enclosure gates remain intact and secure • Any issues identified will be corrected immediately and staff re-educated as needed.	

	5. Staff Education All staff were educated by the Administrator/designee on 19 CSR 30-86.022(15)(B) regarding the requirement that trash and discarded items must be removed from the premises as often as necessary to prevent fire hazards and public health concerns. Education included procedures for reporting bulk trash, resident move-out items, and maintenance concerns regarding the dumpster enclosure. Education will be completed by 3-31-2026 and documentation is maintained in the facility's training records. All these corrections will be completed by 4-30-2026.	
Tag: A3201	**Deficiency: A3201** **Regulation: 19 CSR 30-86.032(2) – Building Substantially Constructed and Maintained in Good Repair** 1. How the facility will correct the deficient practice for the areas identified The following corrective actions were taken: • The patched areas on the east wall of Resident Room #3 were sanded, repaired, and painted to restore the wall to good repair. • The doors to Resident Rooms #4, #5, and #6 were repaired and repainted, including sanding areas where wood was exposed due to scuffing and chipped paint. • Door frames with chipped paint were sanded and repainted to maintain the building in good repair. Repairs will be completed by maintenance staff and/or contracted services on 3-31-2026. 2. How the facility will identify other areas that may be affected by the same deficient practice The Administrator/designee and Maintenance Director conducted a full inspection of resident rooms, hallways,	

	and common areas to identify any walls, doors, or door frames that required repair, sanding, or painting. Any areas identified during the inspection were scheduled for repair and repainting to maintain the building in good repair. 3. Measures the facility will take to ensure the deficient practice does not recur The facility implemented the following system changes: A monthly environmental maintenance inspection has been implemented to identify areas of chipped paint, damaged walls, or doors needing repair. • Maintenance staff will repair, sand, and repaint damaged areas promptly to maintain the building in good repair. • Work orders will be used to track maintenance needs and ensure timely completion. • Corporate maintenance or contractors will be scheduled when repairs exceed routine facility maintenance capabilities. 4. Staff Education Maintenance staff were educated by the Administrator/designee on 19 CSR 30-86.032(2) regarding the requirement that the facility building be maintained in good repair, including prompt repair and painting of chipped or damaged walls, doors, and frames. Education will be completed by 3-31-20226 and documentation is maintained in the facility training records. 5. Date of Compliance The facility will achieve compliance with this regulation by 3-31-2026.	
A3211	**Deficiency: A3211** Regulation: **19 CSR 30-86.032(10) – Heating Systems / Prohibition of Portable Heaters**	

	1. How the facility will correct the deficient practice for the areas identified: The portable space heater located in the Administrator's office was immediately removed from the facility to ensure compliance with the regulation prohibiting the use of portable heaters. The Administrator/designee verified that no other portable heaters were present in the facility. 2. How the facility will identify other areas that may be affected by the same deficient practice The Administrator/designee conducted a full inspection of all offices, resident rooms, storage areas, and common areas throughout the facility to ensure no portable heaters were present or in use. No additional portable heaters were identified. Any that would be discovered during future inspections will be removed immediately. 3. Measures the facility will take to ensure the deficient practice does not recur The facility implemented the following system changes: • A facility policy was reinforced prohibiting portable heaters of any kind within the building. • Staff were instructed that portable heaters may not be brought into the facility under any circumstances, including during heating system issues. • Maintenance will ensure the central heating system is properly maintained and serviced to provide adequate heating throughout the building. • If heating issues occur, the facility will contact maintenance or HVAC services immediately rather than using temporary heating devices. 4. Staff Education All staff were educated by the Administrator/designee on 19 CSR 30-86.032(10) regarding the prohibition of portable heaters within assisted living facilities. Education included instructions that portable heaters may not be brought into the facility for any reason, and any	

	heating concerns must be reported to maintenance or administration immediately. Education will be completed on 3-31-2026 and documentation is maintained in the facility training records. 5. Date of Compliance: The facility will achieve compliance with this regulation by 3-31-2026.	
A3235	**Deficiency:** Regulation: 19 CSR 30-86.032(34) – Hot Water Temperature (105–120°F) 1. The facility immediately adjusted and calibrated the hot water system to ensure all resident-accessible fixtures provide water within the required range of 105–120°F. Water temperatures at all resident rooms and common area sinks/showers were measured with a calibrated digital thermometer, and adjustments were made where water was below 105°F or above 120°F. 2. How the facility will identify other residents who may be affected The Administrator and Maintenance Director conducted a 100% check of all resident rooms and common area hot water fixtures to confirm temperatures were within regulatory range. Any fixtures found outside the 105–120°F range were immediately adjusted, and residents were informed of temporary measures if needed until compliance was achieved. 3. Measures the facility will take to ensure the deficient practice does not recur The facility implemented the following system changes: • A monthly hot water temperature log was created to document temperatures at each resident room sink, shower, and other resident-accessible plumbing fixtures. In the maintenance binder. • Maintenance staff were educated on the regulatory requirement for hot water temperatures (105–120°F) and trained to use a calibrated thermometer for measurement. • A procedure was implemented requiring immediate adjustment of any fixture found outside the required temperature range. • Any hot water system maintenance or repairs are now documented with verification of temperature	

	compliance after service. In the maintenance binder. 4. Staff Education All maintenance and caregiving staff were educated by the Administrator/designee on: • The regulatory requirement of 105–120°F for all resident-accessible water fixtures. • How to measure water temperature with a calibrated thermometer. • Procedure for immediate correction if water temperatures are outside the range. Education will be completed by 3-31-2026 and documentation is maintained in the facility training records. 5. Date of Compliance The facility will achieve compliance with this regulation by 3-31-2026.	
A4724	**Deficiency: 19 CSR 30-86.047(19) TB Screen Residents & Staff**	
	1. How the facility will correct the deficient practice for the residents identified • Residents #1 and #2 documentation of two-step TB/PPD testing per CDC and Missouri long-term care requirements placed in TB Binder and in their charts. 2. How the facility will identify other residents who may be affected • The Administrator/designee reviewed all residents admitted in the past 12 months to ensure compliance with initial two-step TB/PPD testing. • Residents without documented two-step TB testing were scheduled immediately for testing and results entered into the medical record. Review will be completed on 3-31-2026. 3. Measures the facility will take to ensure the deficient practice does not recur • A TB/PPD Admission -Checklist was implemented to ensure all new residents receive the initial two-step TB test within one month prior to or one week after admission, and the second test is completed 1–3 weeks later if the first is negative.	

	• Annual evaluations for TB symptoms are scheduled for all residents, and any positive findings prompt appropriate follow-up with chest X-ray per protocol. 4. How the facility will monitor corrective actions to ensure continued compliance • The Administrator/designee will audit all new admissions for proper TB/PPD testing and documentation monthly for three months. • Any missing or incomplete TB testing will be corrected immediately, and staff will be re-educated as necessary. • Audit results will be documented and maintained in the facility's Quality Assurance records. 5. Date of Compliance The facility will achieve full compliance with TB screening requirements by 3-31-2026.	
A4748	**Deficiency: A4748 19 CSR 30-86.047(28)(E) Remove in Screening Requirements**	

	1. How the deficiency was corrected for the affected residents:
	
	• Resident #1 is unable to provide prescreen as it was prior to the administrator at this time. Prescreening was completed on March 31, 2026, in compliance with the facility's annual licensure screening requirements.
	
	2. Systemic changes to ensure the deficiency does not occur:
	
	• The facility has implemented a mandatory pre-admission screening policy requiring:
	  ○ Completion of screening prior to admission date
	  ○ Administrator or designee review and approval before moving in
	• A Pre-Admission Checklist has been developed and must be completed before any resident is admitted. Kept in resident chart.	

	• Admissions will not proceed without documented verification that the individual meets criteria per Missouri regulation. • A centralized admission file system has been implemented to ensure documentation is easily retrievable. 3. Monitoring plan to ensure ongoing compliance: • The Administrator/Nurse will: o Review 100% of all new admissions for completed pre-move-in screening (CBA)prior to move-in (ongoing) 4. Completion date:3-31-2026	
A4749	**Deficiency: A4749 19 CSR 30-86.047(28)(F)(1)(A) Community Based Assessment-Time Period, 5 day**	
	1. How the deficiency was corrected for affected residents: Systemic changes to ensure the deficiency does not recur: • The facility implemented a CBA Tracking System, including: o A CBA log documenting admission date and CBA due date (Day 5) In residents' file. o Automatic alerts for pending assessments • A revised Admission & Assessment Policy now requires: o CBA scheduled at time of admission o Completion within 5 calendar days (hard deadline) o Documentation placed in a designated section of the chart • All administrator/nurse have been re-educated on: o CBA requirements o Timelines o Documentation standards under Missouri regulations 2. Completion by date:3-31-2026	

A4751	**Deficiency: A4751Regulation: 19 CSR 30-86.047(28)(F)(1)(C) – Community-Based Assessment (Significant Change)**
	
	1. Corrective Action for Resident #3
	
	Resident #3 was immediately reviewed for significant change in condition following identified incidents (falls, head injury, hospitalization, and behavioral changes).
	
	• A comprehensive Community-Based Assessment (CBA) was completed by a qualified staff member on 3-18-2026
	• The assessment addressed:
	  ○ Functional decline in ADLs
	  ○ Fall risk and mobility changes
	  ○ Cognitive and behavioral status (including aggression)
	  ○ Post-hospitalization needs
	• The resident's Individualized Service Plan (ISP) was updated to reflect:
	  ○ Increased assistance with ADLs
	  ○ Enhanced fall precautions
	  ○ Monitoring for behavioral changes
	• Physicians and responsible party were notified of assessment findings and care plan updates.
	
	2. Identification of Other Residents at Risk
	
	• A facility-wide audit was conducted for all current residents to identify:
	  ○ Recent falls
	  ○ Hospitalizations
	  ○ Behavioral changes
	  ○ Documented changes in assistance needs
	• Any resident identified with a potential significant change:
	  ○ Received a CBA review and/or completion
	  ○ Had their ISP updated as indicated
	
	3. Systemic Changes to Prevent Recurrence
	
	The facility has implemented the following improvements:
	
	• Trigger Tool Implementation:
	A Significant Change Trigger Checklist was implemented requiring staff to notify nursing/administration immediately when changes occur.	

	• CBA Timeframe Requirement Reinforced:
	CBAs must be completed promptly upon identification of a significant change in accordance with regulation.
	• Documentation Protocol:
	All incidents now require:
	  ○ Review for "significant change"
	  ○ Documentation of determination
	  ○ Evidence of CBA completion or rationale if not required
	
	4. Staff Education:
	
	• Education Provided:
	The CBA to be completed with "significant change," including:
	  ○ Falls with injury or head impact
	  ○ Repeated Falls
	  ○ Hospitalization or ER visits
	  ○ New or worsening behaviors
	  ○ Increased need for assistance with ADLs
	
	5. Completion Date by: 3-31-2026	

A4754	**Deficiency: A4754**
	
	Regulation: 19 CSR 30-86.047(28)(G) – Individualized Service Plan (ISP)
	
	1. Corrective Action for Affected Residents (1, 2, 3)
	
	• Resident #2:
	A comprehensive ISP was developed by 3-31-2026 to include:
	  ○ Resident-specific needs based on diagnoses and assessment
	  ○ Detailed services to be provided by staff
	  ○ Measurable goals
	  ○ Resident/legal representative preferences
	• Resident #1 and #3:
	Existing ISPs were revised and completed by 3-31-2026 to include:
	  ○ Clearly defined services to be provided by staff for each identified need
	  ○ Resident preferences (e.g., routines, care approaches, behavioral interventions)
	  ○ Measurable goals and expected outcomes	

	2. Identification of Other Residents at Risk
	
	• A 100% audit of all resident ISPs was conducted to ensure compliance with requirements.
	• Each ISP was reviewed for inclusion of:
	  ○ Individualized needs
	  ○ Specific staff interventions/services
	  ○ Resident preferences
	  ○ Measurable goals
	• Any deficient ISPs were updated and completed by 3-31-2026
	
	3. Systemic Changes to Prevent Recurrence
	
	• ISP Policy Revision:
	The facility to require that all ISPs include:
	  ○ Resident needs (based on assessment)
	  ○ Specific, task-oriented staff interventions (not generalized statements)
	  ○ Resident preferences and routines
	  ○ Measurable, individualized goals
	• ISP Template Revision:
	A new standardized ISP template was implemented requiring completion of:
	  ○ "What staff will do" (service delivery)
	  ○ "Resident preference" section
	  ○ "Goal/outcome" section for each identified need
	• Admission Process Update:
	No resident will be considered fully admitted until:
	  ○ An ISP is completed, reviewed, and signed
	• Change in Condition Integration:
	ISPs must be updated immediately following any significant change identified through assessment.
	
	4. Staff Education
	
	• The Administrator/nurse received mandatory training on:
	  ○ Requirements of 19 CSR 30-86.047
	  ○ How to develop a compliant, individualized ISP
	  ○ Difference between generic vs. individualized interventions
	  ○ Documentation of preferences and measurable goals
	
	6. Completion by: 3-31-2026	

A4755	**Deficiency: A4755** **Regulation: 19 CSR 30-86.047(28)(H) – Individual Service Plan (ISP) Review Requirements**	

	1. Corrective Action for Affected Residents (1 and #3)
	
	• Resident #1:
	The ISP was immediately reviewed and revised by 3-31-2026 following identified behavioral incidents. Updates included:
	  ○ Specific behavioral interventions to prevent aggression toward other residents
	  ○ De-escalation strategies for staff (redirection, spacing, early intervention cues)
	  ○ Increased supervision and environmental modifications
	  ○ Clear documentation of staff responsibilities and responses
	• Resident #3:
	The ISP was reviewed and updated by 3-31-2026 to reflect significant changes, including:
	  ○ Increased level of assistance required with ADLs (bathing, dressing, toileting)
	  ○ Fall risk interventions following multiple falls and head injuries
	  ○ Post-hospitalization care needs
	  ○ Behavioral interventions and redirection strategies
	  ○ Monitoring related to following behaviors and resident-to-resident interactions
	• ISPs were reviewed with and approved with documentation completed.
	
	2. Identification of Other Residents at Risk
	
	• A facility-wide audit was conducted for all residents to identify:
	  ○ Recent falls
	  ○ Behavioral incidents
	  ○ Hospitalizations
	  ○ Changes in level of care or services
	• For any identified changes:
	  ○ ISPs were reviewed and updated immediately
	
	3. Systemic Changes to Prevent Recurrence	

	• ISP Review Policy Revision:
	The facility revised its policy to require ISP review:
	  ○ At least annually, and
	  ○ Immediately upon any significant change, including:
	  ▪ Falls (with or without injury)
	  ▪ Behavioral incidents (aggression, altercations)
	  ▪ Hospitalizations or ER visits
	  ▪ Change in ADL assistance level
	• Behavior & Fall Intervention Standardization:
	ISPs must now include:
	  ○ Resident-specific interventions (not general statements)
	  ○ Step-by-step staff approaches for:
	  ▪ Aggression/de-escalation
	  ▪ Fall prevention
	  ▪ Redirection techniques
	• Documentation Requirement:
	Each ISP update must include:
	  ○ Date of review
	  ○ Description of change
	  ○ Updated interventions
	
	4. Staff Education
	
	All administrative/nursing training on:
	
	  ○ Requirements of 19 CSR 30-86.047
	  ○ When an ISP review is required
	  ○ How to identify and document significant changes
	  ○ Development of specific, actionable interventions (especially for behaviors and falls)
	• Training completed by: 3-31-2026
	
	5. ISPs are reviewed timely after significant changes
	
	  ○ Interventions are specific, individualized, and current
	  ○ Documentation reflects resident needs and services
	
	6. Completion Date:
	
	All corrective actions completed by: 3-31-2026	

A4759	**Deficiency: A4759 (Class II)**	

Regulation: 19 CSR 30-86.047(29)(A) – Not Admit/Retain Residents Who Pose Harm to Self or Others

1. Corrective Action for Affected Residents (1, 3, 8)

- Resident #1 (Aggressor):
  - Resident was reassessed for appropriate placement
  - Physicians and mental health providers were notified for psychiatric evaluation and medication review: Sent to hospital on 2-14-26 for psych evaluation with no new orders and then physician evaluated on 2-25-2026 and Increase Seroquel to 25mg to 1.5mg tabs by mouth three times a day.
  - A behavior management plan was implemented, including:
    - Increased supervision, one staff to always be on floor to monitor resident.
    - Identification of triggers (proximity of other residents, overstimulation)
    - Structured redirection techniques
  - Environmental modifications initiated (separation from identified residents as needed)
  - Determination made regarding continued appropriateness for assisted living level of care
- Resident #3 and Resident #8 (Affected Residents):
  - Assessed immediately following incidents both were sent to the ER for evaluation.
  - Received appropriate medical evaluation and treatment
  - Resident #8 moved to another facility after hospital stay.
  - Care plans updated to include:
    - Increased supervision
    - Interventions to prevent further resident-to-resident interactions

2. Identification of Other Residents at Risk

- A facility-wide behavioral risk review was conducted to identify residents:
  - Exhibiting aggression
  - At risk of being victims of aggression
- All identified residents:

- Were reassessed for safety and appropriateness of placement
- Had ISPs updated with specific behavior and supervision interventions

3. Systemic Changes to Prevent Recurrence

- Admission and Retention Policy Revision:
  The facility will clearly define:
  - Criteria for non-admission and discharge when residents pose a risk of harm
  - Required immediate reassessment after any aggressive incident resulting in injury
- Behavioral Risk Assessment Protocol:
  Implemented a standardized process requiring:
  - Immediate evaluation after any aggressive act
  - Determination if behavior presents a reasonable likelihood of serious harm
  - Documentation of decision to retain or discharge. Kept in their chart.
- For residents exhibiting harmful behaviors:
  - Immediate notification of:
    - Physician
    - Mental health provider
    - Responsible party
  - Consideration of:
    - Medication adjustment
    - One-on-one supervision
    - Transfer to higher level of care if needed
- Environmental & Staffing Interventions:
  - Increased monitoring in common areas
  - Staff assignment adjustments to ensure closer supervision
  - Proactive redirection of residents to prevent unsafe interactions

4. Staff Education

- All staff received mandatory in-service training on:
  - Requirements of 19 CSR 30-86.047 regarding resident safety
  - Identification of escalating behaviors and triggers
  - De-escalation techniques and redirection strategies
  - Responsibility to protect all residents from harm
- Special emphasis placed on:

	○ Not minimizing aggressive behavior ○ Immediate reporting and escalation • Training completed by: 3-13-2026 5. Monitoring and Quality Assurance • Monitoring will include: ○ All behavioral incidents ○ Timeliness of interventions ○ Determination of continued appropriateness for placement 6. Completion by:3-31-2026	
A4782	**Deficiency: A4782 (Class II)** **Regulation: 19 CSR 30-86.047(41) – Medication Storage/Accessibility** 1. Corrective Action for Immediate Deficient Practice • Upon identification of the deficient practice on 2/17/26, the following actions were taken immediately: ○ All medications left on top of the medication cart were secured and returned to locked storage ○ The medication cart was locked immediately ○ The Level One Medication Aide (LIMA) involved received immediate re-education and counseling regarding proper medication storage and security • A direct observation competency check was completed for the LIMA to ensure compliance with medication pass procedures. 2. Identification of Other Residents at Risk • A facility-wide observation audit of all medication passes was conducted to ensure: ○ No medications are left unattended ○ Medication carts remain locked when not under direct supervision • No additional unsecured medications were identified; however, any observed concerns were corrected immediately.	

3. Systemic Changes to Prevent Recurrence

- Medication Storage Policy Reinforcement:
  The facility reinforced its policy requiring:
  - Medications must be always secured
  - Medication carts must be locked whenever not in the immediate control of authorized staff
  - No medications are to be left unattended on top of carts or in resident-accessible areas
- A standardized process was implemented requiring:
  - Staff must lock the cart before stepping away, regardless of duration
  - Medications are to be prepared and administered by one resident at a time
  - No pre-pouring or staging medications on top of carts
- Accountability Measures:
  - Any violation of medication security will result in progressive disciplinary action

4. Staff Education

- All licensed staff and medication aids received mandatory in-service training on:
  - Requirements of 19 CSR 30-86.047
  - Medication storage and security standards
  - Safe medication administration practices
  - Risks associated with unsecured medications (resident access, medication errors)
- Training included return demonstration and competency validation
- Training completed by 3-31-2026

5. Monitoring and Quality Assurance

- Monitoring will include:
  - Medication cart security
  - Staff adherence to medication passes procedures
  - Immediate correction of any observed issues
- Findings will be reviewed in Quality Assurance (QA) meetings, with corrective action taken as needed.

	6. Completion Date all corrective actions will be completed by: 3-31-2026	

A4798	**Deficiency: A4798 (Class II)**
	
	Regulation: 19 CSR 30-86.047(47)(A) – Physician Orders Followed (Medication Orders)
	
	1. Corrective Action for Affected Residents (5 and #6)
	
	• Resident #5 and Resident #6:
	Immediate corrective actions were taken on 2-27-26
	  ○ The pharmacy and prescribing providers were contacted to:
	  ▪ Clarify all active medication orders
	  ▪ Address medications previously marked "not available"
	  ○ Medications not available (including Zunveyl and others) were:
	  ▪ Reordered and expedited, OR
	  ▪ Discontinued/changed per physician order when not obtainable (e.g., insurance denial or cost issues)
	  ○ MARs were updated to reflect current, accurate physician orders
	  ○ Documentation was completed to reflect all follow-up actions
	
	2. Identification of Other Residents at Risk
	
	• A 100% audit of all resident medication records was conducted to identify:
	  ○ Medications marked "not available"
	  ○ Discrepancies between POS, MAR, and available medications
	• For any discrepancies identified:
	  ○ Physicians and pharmacy were contacted immediately
	  ○ Orders were clarified, updated, or discontinued as appropriate
	  ○ Medications were reordered to ensure availability
	
	3. Systemic Changes to Prevent Recurrence
	
	"Not Available" Protocol Established:
	When a medication is unavailable, staff must:	

	1. Document "not available" in MAR 2. Immediately notify pharmacy or family and administrator/ DON for refill 3. Notify the physician if medication is delayed or unavailable 4. Document all communication in the resident record 5. Follow up within 24 hours until resolved • Order Clarification Requirement: o Medications that are not obtainable (e.g., insurance denial, cost issues) must: ▪ Be clarified with the physician ▪ Be discontinued or replaced with an alternative order ▪ Not remain active on MAR without administration 4. Staff Education • All licensed staff and medication aids received mandatory in-service training on: o Requirements of 19 CSR 30-86.047 o Importance of administering medications exactly as ordered o Proper handling of unavailable medications o Documentation and communication requirements with pharmacy and physicians 5. Completion by:3-31-2026	
A4836	**Deficiency: A4836** **Regulation: 19 CSR 30-86.047(58)(A) – Resident Record: Admission Information** 1. Corrective Action for Affected Residents (2 and #3) • Resident #2 and Resident #3: Immediate corrective action was taken o The facility contacted the resident and/or legal representative to obtain: ▪ Preferred dentist ▪ Preferred funeral home o Missing information was documented in the resident's medical record	

	○ If no preference was identified, documentation reflects: ▪ "No preference at this time" per resident/representative 2. Systemic Changes to Prevent Recurrence The facility admission documentation to: ○ Include required fields for: ▪ Preferred dentist ▪ Preferred funeral home ○ Require completion prior to or upon admission • Ongoing Record Review Process: ○ Resident records will be reviewed: ▪ At admission ▪ During quarterly record audits ○ Missing information will be addressed promptly 3. Staff Education • Administrative staff were educated on: ○ Requirements of 19 CSR 30-86.047 for complete admission records ○ Importance of obtaining and documenting all required resident information 4. All files to be completed by: 3-31-2026	
A4841	**Deficiency: A4841** **Regulation: 19 CSR 30-86.047(61)(A) – Staffing, Resident Care & Fire Safety** 1. Corrective Action for Affected Residents (8 and #3) • Resident #8 and Resident #3: ○ Immediate review of each resident's fall incidents ○ Physician and/or hospice were notified (if not already completed) and documentation verified ○ Both #8 and #3 were sent to hospital for evaluation. ○ Care plans were reviewed and updated to include:	

- Post-fall protocol
- Increased supervision and fall interventions

- Staff involved received immediate re-education on proper post-fall procedures, including:
  - -Do not move resident until assessed by a nurse or qualified medical provider, unless immediate danger exists

2. Identification of Other Residents at Risk

- A 100% audit of all residents with falls within the past 30 days was conducted to ensure:
  - A nurse or qualified provider completed an assessment prior to resident movement (when required)
  - Proper notifications and documentation occurred
- Any identified concerns were:
  - Reported to the physician
  - Addressed with updated care plans and staff re-education

2. Systemic Changes to Prevent Recurrence

- Fall Policy Revision:
  The facility updated its fall policy to clearly require:
  - Immediate notification of a licensed nurse, physician, or emergency services after any fall
  - No staff are to move a resident post-fall until:
    - Assessment by a nurse, OR
    - Emergency directions are received (e.g., EMS guidance)
  - Clear escalation steps when a nurse is not onsite:
    - Call Administrator/Director of Nursing
    - Contact on-call nurse or EMS as appropriate
- Post-Fall Protocol Tool Implemented:
  A standardized Post-Fall Checklist was implemented require:
  - Neurological checks
  - Injury assessment
  - Documentation of who performed assessment

	○ Time of notifications • Staffing Oversight Improvement: ○ Clarified roles and responsibilities for all staff levels (LIMA, CNAs, caregivers) ○ Always ensured qualified personnel availability for assessment via: ▪ On-call nurse system ▪ Clear chain of command 4. Staff Education • All direct care staff were educated on: ○ Requirements of 19 CSR 30-86.047 related to resident safety and staffing ○ Facility Fall Management Policy ○ Proper post-fall response procedures, including: ▪ Immediate reporting ▪ Not moving residents prior to assessment ▪ When to call EMS • Education completed by:3-31-2026 • New staff will receive this training during orientation 6. Completion by: 3-31-2026	
A4856	**Deficiency: A4856** **Regulation: 19 CSR 30-86.047(63)(A) – Alzheimer's/Dementia Training (Direct Care Staff – 3 Hours)** 1. Corrective Action for Affected Employee • All Floor Staff will complete: ○ Completed a minimum of 3 hours of Alzheimer's/dementia-specific training by 3-31-2026 ○ Training included: ▪ Overview of dementia and Alzheimer's disease ▪ Communication techniques ▪ Behavior management ▪ Promoting independence with ADLs ▪ Creating a safe and structured environment ▪ Understanding family dynamics • Documentation of completed training was:	

- Placed in the employee's personnel file
- Verified by the Administrator/designee

2. Identification of Other Employees at Risk

- A 100% audit of all direct care staff personnel files was conducted to ensure:
  - Documentation of at least 3 hours of dementia training is present
- Any staff found without proper documentation:
  - Completed required training immediately
  - Have documentation placed in their personnel file

3. Systemic Changes to Prevent Recurrence

- Training Tracking System Implemented:
  - A standardized training log and checklist was implemented for all employees and kept in employees' file.
  - Tracks:
    - Orientation training
    - Dementia-specific training hours
    - Completion dates
- Onboarding Process Revision:
  - Dementia training is now:
    - Mandatory prior to providing direct resident care
    - Clearly outlined in orientation checklist
  - Employees may not work independently until training is verified
- Documentation Standardization:
  - All training must include:
    - Date
    - Duration (minimum 3 hours)
    - Content outline
    - Employee signature

4. Staff Education

- The Administrator and/or designee were educated on:
  - Requirements of 19 CSR 30-86.047 related to dementia training
  - Importance of maintaining verifiable documentation in personnel files
- Education completed by 3-31-2026
- This education will be incorporated into:
  - Supervisor training

	○ New hire orientation processes 5. Monitoring and Quality Assurance • The Administrator or designee will: ○ Ensure completion of required dementia training hours ○ Proper documentation in employee files 6. Completion Date by: 3-31-2026	
A4857	**Deficiency: A4857** **Regulation: 19 CSR 30-86.047(63)(B) – Dementia Training (Non-Direct Care Staff – 1 Hour)** 1. Corrective Action for Affected Employee • Maintenance Director: ○ Completed at least 1 hour of Alzheimer's/dementia training ○ Training included: ▪ Overview of dementia and Alzheimer's disease ▪ Basic communication techniques with cognitively impaired residents • Documentation of training was: ○ Placed in the employee's personnel file ○ Verified by the Administrator/designee 2. Identification of Other Employees at Risk • A 100% audit of all non-direct care staff personnel files (e.g., housekeeping, dietary, maintenance, administrative staff) was conducted to ensure: ○ Documentation of at least 1 hour of dementia training • Any staff without documentation: ○ Completed required training immediately ○ Have documentation placed in their personnel file 3. Systemic Changes to Prevent Recurrence • Training Tracking System Implemented: ○ A standardized training log and checklist was implemented for all employees	

	○ Includes tracking of: ▪ Direct care (3-hour requirement) ▪ Non-direct care (1-hour requirement) • Onboarding Process Revision: ○ Dementia training is now: ▪ Required during orientation for all staff ▪ Clearly differentiated by role: ▪ Direct care: 3 hours ▪ Non-direct care: 1 hour ○ Staff will not complete orientation until training is documented • Documentation Requirements Standardized: ○ All training records must include: ▪ Date ▪ Duration (minimum 1 hour) ▪ Training content ▪ Instructor or source ▪ Employee signature 4. Staff Education Education will be incorporated into: ○ New hire orientation ○ Ongoing staff development ○ All education documentation is kept in employees file. 6. Completion Date by: 3-31-2026	
A6005	**Deficiency: – A6005** **Regulation: 19 CSR 30-87.020(5) – Toxic Material Storage** 1. Immediate corrective action was taken: • All chemicals identified during survey were immediately removed from: ○ Resident rooms (12 and 1) ○ Living room windowsill ○ Kitchen rolling cart ○ Unlocked salon • All toxic and hazardous materials were: ○ Placed in locked cabinets ○ Stored in designated chemical storage areas not accessible to residents • Resident rooms were inspected to ensure:	

- No toxic or hazardous chemicals remained accessible

2. Identification of Other Areas at Risk

- A 100% environmental sweep of the entire facility was conducted to identify:
  - Improperly stored chemicals
  - Chemicals accessible to residents
- Any additional findings were:
  - Immediately corrected
  - Properly secured in locked storage areas

3. Systemic Changes to Prevent Recurrence

- Chemical Storage Policy Reinforced:
  - Policy updated to clearly require:
    - All chemicals must be always locked when not in use
    - Chemicals must be stored separately by category:
      - Cleaning agents/disinfectants
      - Insecticides/rodenticides
      - Caustics/acids/polishes
  - Prohibits any chemical storage in resident rooms or common areas
- Routine Environmental Safety Rounds Implemented:
  - Staff or Maintenance required to complete rounds to ensure:
    - No chemicals are left unattended
    - All storage areas remain locked

4. Staff Education

- All staff (housekeeping, maintenance, caregiving, and administrative) were educated on:
  - Requirements of 19 CSR 30-87.020
  - Facility chemical storage policy
  - Risks associated with improper chemical storage
  - Requirement that chemicals must never be left in resident-accessible areas
- Education completed by 3-31-2026
- Training will be incorporated into:
  - New hire orientation
  - Annual in-service training

6. Completion Date by: 3-31-2026

A7067	**Deficiency: A7067 – Nonfood Contact Surfaces Cleaned as Needed Regulation: 19 CSR 30-87.030(65)**
	
	1. How the deficiency will be corrected for residents affected:
	
	All identified areas in the kitchen were immediately cleaned and sanitized including:
	
	• Ovens (interior and exterior)
	• Refrigerator and freezer units (interior shelves and exterior surfaces)
	• Steam table
	• Water fixtures and range top surfaces
	• Ice machine surrounding areas
	• Fire extinguisher box and mounted equipment
	• Walls, signage, and filter systems
	
	No residents were directly affected; however, corrective actions were taken to ensure a clean and sanitary environment for all residents.
	
	2. The Administrator/Maintenance completed a facility-wide environmental audit of all nonfood contact surfaces including:
	
	• Kitchen and dietary areas
	• Dining rooms
	• Utility/storage rooms
	• Common areas
	
	Any additional areas found to have dust, grease, or debris accumulation were cleaned immediately.
	
	3. Measures put into place to ensure the deficiency does not recur:
	
	The facility has implemented the following systemic changes:
	
	• Developed and implemented a Daily, Weekly, and Monthly Cleaning Schedule specific to dietary services
	• Created a Kitchen Cleaning Checklist to include all nonfood contact surfaces such as:
	  ○ Ovens (interior/exterior)
	  ○ Refrigeration/freezer units
	  ○ Equipment exteriors
	  ○ Walls, fixtures, and mounted items	

	• Assigned clear staff responsibilities per shift for cleaning duties • Implemented end-of-shift cleaning verification by the Cook or Maintenance • Provided re-education to all dietary staff on cleaning expectations and regulatory requirements • Designated the Maintenance responsible for oversight of sanitation compliance 4. How corrective actions will be monitored: • Any non-compliance will result in: o Immediate correction o Staff re-education o Progressive discipline if necessary 5. Completion Date by :3-31-2026	
A8023	**Deficiency: A8023 – Failure to Develop/Implement Abuse & Neglect Policies** **Class: II** 1.Statement of Deficiency The facility failed to investigate a resident-to-resident altercation between Resident #1 and Resident #3 to determine if abuse occurred and did not have a written Missouri-specific Abuse & Neglect (A/N) policy that includes reporting, investigation, and staff disciplinary procedures. 2. Corrective Actions Taken • Immediate Safety: o Residents involved were separated to prevent further harm. o Resident #3 was sent the hospital for evaluation of medical care. o Resident #1 was sent to the hospital for psychiatric evaluation. • Investigation Completed: o Facility conducted a full investigation of the incident. o Written report submitted to Missouri DHSS in compliance with 19 CSR 30-88.010(23). • Policy Development:	

	○ A Missouri-specific Abuse & Neglect policy was created and implemented. ○ Policy includes: ▪ Definitions of abuse, neglect, and exploitation. ▪ Immediate reporting to DHSS and, if applicable, the Department of Mental Health. ▪ Staff suspension and corrective action when abuse is substantiated. ▪ Documentation and retention requirements. 3. Systemic Changes / Preventive Measures • Staff Education: ○ All staff trained on Missouri Abuse & Neglect regulations. ○ Training documented with date and staff signatures. Kept in in service book. ○ Training included identification, reporting, and investigation of resident abuse or neglect. • Investigation Process: ○ Standardized Investigation Report Form implemented. ○ Investigations must be completed and submitted to DHSS within five calendar days of the incident. 4. Plan to Prevent Recurrence • Missouri-specific Abuse & Neglect policy distributed to all staff and posted in work areas. • Residents and families informed verbally and in writing upon admission. • Annual refresher training for all staff and inclusion in new hire orientation. 5. Completed by: 3-31-2026	
A8030	**Deficiency: A8030 – Failure to ensure resident dignity and privacy** **Class: II** 1.How the deficiency will be corrected for residents affected: Corrective Actions Taken 1. Immediate Removal:	

	○ The baby monitor was removed from Resident Room 5 immediately upon discovery. ○ Resident privacy was ensured, and the room was cleared of any surveillance equipment not authorized by the resident or family. 2. Resident/Family Notification: ○ Resident and/or family were informed verbally of the monitor removal. ○ Assurance provided that no monitoring would occur without proper consent. 3. Policy Revision / Development 1. Dignity & Privacy Policy (Missouri-specific): ○ Policy revised to explicitly prohibit use of any monitoring device (video, audio, or electronic) in resident rooms without written consent from the resident or legal guardian. ○ Policy outlines: ▪ Residents' right to privacy during all personal care, treatment, and daily activities. ▪ Staff responsibilities for maintaining dignity and respect. ▪ Process for obtaining written consent for any monitoring device. ▪ Immediate removal of any unauthorized monitoring devices. 2. Staff Education: ○ All staff trained in updated Dignity & Privacy policy. ○ Training included examples of inappropriate monitoring and use of technology in resident care. ○ Training documentation is maintained in personnel files. 4. Systemic / Preventive Measures 1. Consent Verification: ○ Any request for monitoring devices must be documented in the resident's file with signed consent from the resident or legal guardian. ○ Quarterly review of consents by Administrator. 5. Completion Dates:3-31-2026	

A8037	**Deficiency: A8037 – Failure to complete personal inventory records for residents** **Class: III** **1.** Corrective Actions Taken: o Immediate Inventory Completion: o Personal inventory lists for Residents #1, #2, and #3 were completed immediately following the survey. o Copies of these completed inventories placed in residents' medical records. 2. Resident/Family Notification: o Families of Residents #1, #2, and #3 were notified of the completed inventories and provided copies for review. 3. Policy Development / Revision 1. Personal Inventory (Missouri-specific): o Facility implemented Inventory log to ensure: ▪ A complete inventory of all resident clothing and personal possessions is completed upon admission and updated as needed. ▪ Inventory records are signed by the resident (or responsible party) and staff. ▪ Inventory sheets are stored in the resident's file and updated prior to discharge, transfer, or death. ▪ Any new personal items brought in during the resident's stay are documented promptly. 2. Staff Education: o Training includes proper documentation, inventory verification, and communication with residents/families. o Training records are maintained in personnel files. 3. Systemic / Preventive Measures 4.Integration with Admission Process:	

	○ Completion of personal inventory sheets now included as a required step in the admission checklist. 5. Completion Dates by 3-31-2026	
A9107	**Deficiency: A9107** Regulation: 19 CSR 30-91.010 (8)(B) – Notice-posting resident room sign Corrective Action: • A sign placed on the door of Resident Room #10 and the front door of the facility stating: • Electronic monitoring devices were reviewed to ensure proper placement. Measures to Prevent Recurrence 1. Policy Update: Facility policy revised to require: ○ Residents with monitoring devices must post and maintain notices. ○ Staff responsibility to check and replace notices as needed. 2. Resident Communication: ○ Residents/ Families with electronic monitoring devices informed of signage requirements; staff will assist as needed.	
A9108	**Deficiency: A9108** **Regulation: 19 CSR 30-91.010 (9)(A)-(E) – Installation/Placement of Electronic Monitoring Devices** Corrective Action: • The Maintenance ensured the EMD were installed in a fixed, stationary position, ensuring: ○ Cameras are directed only at the residents who authorized the device. ○ Placement maximizes privacy and dignity for the resident and any roommate.	

	○ Cameras are safely positioned to prevent hazards for residents, staff, or visitors. Measures to Prevent Recurrence: 1. Policy Update: ○ Facility policy revised to require all EMDs to be mounted in a fixed, stationary position in compliance with 19 CSR 30-91.010 (9)(A)-(E). ○ Policy includes staff responsibilities for monitoring proper installation and ensuring privacy, dignity, and safety. 2. Staff Education: ○ Maintenance educated on proper installation and placement requirements for EMDs. ○ Education includes ensuring EMDs are in plain view, fixed, directed only at the resident, protect privacy, and are safely positioned. ○ Competency checks completed to verify staff understanding. 3. Resident Communication: ○ Residents using EMDs are informed of placement requirements. Staff will assist as needed to maintain proper installation. Completion date: 3-31-2026	

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