Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26178	A. BUILDING: _____ B. WING _____	C 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CREVE COEUR	ONE NEW BALLAS PLACE CREVE COEUR, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A2257	19 CSR 30-86.022(10)(B) Combustible Materials, Unnecessary Storage Of Protection from Hazards. (B) The storage of unnecessary combustible materials in any part of a building in which a licensed facility is located is prohibited. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure no unnecessary combustibles were stored in the facility. This had the potential to affect all residents. The census was 37. Observation on 8/21/25 between 10:55 P.M. and 3:00 P.M., of resident room 140, showed six tall oxygen tanks stored upright in a metal container, two tall portable oxygen tanks stored upright but not secured and a small portable oxygen tank on the floor, on its side, under the dining room table. During an interview on 8/28/25 at 10:14 A.M., the Administrator said the resident went through oxygen tanks rather quickly and when the tanks got delivered, the company put all the tanks in the resident's room. He said the tanks should be stored separately, upright and secured, in a closet in the kitchen. When the tanks aren't in use, they should be stored in that locked closet. The Administrator said the resident should not have had that many tanks in his/her room.	A2257	Plan of Correction: - On 8/28/25, all exces oxygen tanks were removed from room 140. - Resident now maintains only the in-use equpiment and spare cylinders are stored upright in approved holders in our community's designated oxygen storage area. - On 8/28/25, the Administrator and Health and Wellness Director jointly completed a 100% sweep of all apartments for residents with oxygen orders and all common areas to identify improper storage or excess quantities. - All assisted living associates will be re-inserviced on policies pertaining to proper oxygen use, handling, and storage to be completed by 10/3/25 and ongoing. - To ensure sustained compliance, regular rounds will be conducted by the nurse/designee on all residents with oxygen orders to verify proper limits and necessary storage.	
A3201	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed 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	A3201	Plan of Correction: On 8/25/25, the Administrator submitted work orders to address the condition of resident #7's room. On 9/11/25, the Administrator inspected and verified the following. (continued on next page)	

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A3201	Continued From page 1 This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all parts of the facility were maintained in good condition. The census was 37. 1. Observation on 8/21/285 between 10:35 A.M. and 3:00 P.M., of Resident #7's room, showed the following: -The doors of the closet adjacent to the bathroom, had chipped paint exposing the light colored wood underneath the white paint. The damaged area surrounded the entire bottom half of the doors; -The apartment door on either side, towards the bottom of the door, had large black scuff marks and chipped paint measuring the entire width of the door; -Every single wall in the apartment had various sizes and shapes of black scuff marks measuring the exact height of the resident's wheelchair; -Every single corner of the walls had chipped paint and pieces of drywall removed from being hit by the wheelchair; -The doorframe of the bathroom, the baseboards around the bathroom door, and the bottom half of the door, were all severely damaged, which exposed chipped paint and damaged drywall; -The bottom half of the bedroom door was completely covered with black scuff marks and several areas of chipped paint exposing drywall, in various sizes; -The wall entering the walk-in closet was covered in black scuff marks and chipped paint areas which exposed drywall in various sizes and shapes; -The baseboards around the entire apartment	A3201	- The doors of the closet adjacent to the bathroom were repaired and in good condition. - The apartment door was repaired and in good condition. - The walls inside the apartment were repaired and in good condition. - The corners of the walls inside the apartment were repaired and in good condition. - The doorframe and baseboards around the bathroom door were repaired and in good condition. - The bathroom door was repaired and in good condition. - The wall entering the walk-in closet was repaired and in good condition. - The baseboards throughout the apartment were repaired and in good condition. - The threshold of the shower was repaired and in good condition. On 8/25/25, the Administrator submitted work orders to address the condition of room 140. On 9/11/25, all work orders were closed and the Administrator inspected and verified the following: - The apartment door was repaired and in good condition. - The scuff mark by the resident's window was repaired and in good condition. On 9/25/25, the Administrator submitted work orders to address the condition of the north hall garbage room. Upon inspection, the Administrator determined that the numerous crescent moon shaped holes were likely caused by the use of a long metal pole used to push garbage down the chute when it becomes clogged. Executive Director and Maintenance (continued on next page)	

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A3201	Continued From page 2 were worn with pieces missing and chipped wood; -The threshold of the shower had exposed gray and white colored caulk and bare flooring. During an interview on 8/21/25 at 10:50 A.M., Resident #7 said the condition of his/her room did not bother him/her "anymore" because he/she had "gotten use to it." The resident said in the beginning, he/she was "embarrassed." The resident said he/she knew the condition of the room bothered his/her family and friends when they came to visit because "everyone comments on it." The resident said the damage had been like that for over a year. During an interview on 8/22/25 at 4:07 P.M., Care Aide (CA) H said he/she had not noticed the damage on the resident's walls but noticed the damage on the resident's doors. The damage was there because the resident is a "bad driver." CA H usually forgot about it when leaving the resident's room, so he/she never reported the damage to management. During an interview on 8/22/25 at 4:15 P.M., CA F said he/she was in the resident's room last Wednesday night and noticed the damage on the walls and doors. He/She said the bedroom doorway is a tight squeeze for the resident with his/her big wheelchair. CA F said the resident's room had "a lot of scuff marks" and he/she would be "disappointed" if the resident was his/her family member who lived there because he/she knew the families "spend a lot of money" to live at the facility. The damage should be fixed and he/she should have put a work order in, but had not yet. CA F said he/she never spoke to management about the damage.	A3201	Director informed of findings so that maintenance staff can be trained to prevent future damage. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 132. On 9/11/25, all work orders were closed and the Administrator inspected and verified the following: - The apartment door was repaired and in good condition. - The bedroom door and door frame was repaired and in good condition. - The closet door was repaired and in good condition. - The bathroom doorframe was repaired and in good condition. On 8/25/25, the Administrator submitted work orders to address the condition of room 125. The work order to address the black scuff marks on the bottom half of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 126. The work order to address the white gouge marks and black scuff marks on the bottom half of the apartment door and surrounding doorframe remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 113. The work order to address the thick line of black and white scuff marks on the bottom half of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25.	

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A3201	Continued From page 3 During an interview on 8/22/25 at 4:21 P.M., Level One Medication Aide (LIMA) G said the doorways were small enough to where the resident had to squeeze through and sometimes the resident would hit the wall. He/She said the resident's room would upset him/her if it was his/her family member residing in the room. During an interview on 8/22/25 at 3:53 P.M., LIMA H said he/she noticed the condition of the resident's room and all of the scuff marks on the walls. LIMA H noticed the damage on the resident's doors as well. Someone could say it was a "dignity thing" because of how bad the damage is and things should be "up to par" with how much the residents pay to the facility to live there. LIMA H said the residents who have the wide wheelchairs have the most damage in their rooms because of the doorways being too thin for them to get through. LIMA H said if he/she was the resident's family member, he/she would be like "Hey what's going on here" and it would concern him/her. During an interview on 8/22/25 at 3:12 P.M., CA J said the resident's walls are "pretty torn up" because the resident was a "bad driver" and his/her room looked like that for half of the year. During an interview on 8/28/25 at 10:16 A.M., the Administrator said he went to the resident's room and saw the damage from the wheelchair. He said the resident scraped the walls and hit the walls with his/her wheelchair. He said when he saw it, it did not look good. 2. Observation on 8/21/25 between 10:55 A.M. and 2:00 P.M., of resident room 140, showed the following: -On the outside of the apartment door, severe	A3201	On 8/25/25, the Administrator submitted work orders to address the condition of room 109. The work order to address the thick line of black and white scuff marks on the bottom half of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 102. The work order to address the white gouge marks on the bottom half of the apartment door and surrounding doorframe remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 103. The work order to address the black scuff marks on the bottom quarter of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 106. The work order to address the black scuff marks on the bottom quarter of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 107. The work order to address the black scuff marks on the bottom quarter of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25. On 8/25/25, the Administrator submitted work orders to address the condition of room 110. The work order to address the black scuff marks on the bottom quarter of the apartment door remains open as of 9/26/25. Projected completion date for all projects is 10/31/25.	

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A3201	Continued From page 4 damage on the bottom half of the door with several large black scuff marks and chipped tan paint, which exposed white paint. The entire half of the door had the damage; -On the inside of the apartment door, several long and wide black scuff marks on the bottom half of the door; -A scuff mark by the resident's window, approximately 3 inches long and 1 to 2 inches wide. 3. Observation on 8/21/25 between 11:00 A.M. and 3:00 P.M., of the garbage room, above the light switch, showed numerous crescent moon shaped holes, measuring approximately 3 inches in circumference, which covered the wall. 4. Observation on 8/21/25 between 11:05 A.M. and 2:50 P.M., of resident room 132, showed the following: -Several sizes of black scuff marks on the outside of the apartment door; -Inside the resident's room, on the bedroom door, chipped paint which exposed light colored wood covering the bottom half of the door; -The closet door had 9 chipped paint and scuffed areas on the door which exposed light colored wood; -The bathroom door frame and bedroom door frame had several areas of chipped wood. 5. Observation on 8/21/25 between 11:10 A.M. and 3:01 P.M., of resident room 125, showed the outside of the apartment door was covered in black scuff marks on the bottom half of the door. 6. Observation on 8/21/25 between 11:11 A.M. and 3:02 P.M., of resident room 126, showed the outside of the apartment door was covered in black scuff marks on the bottom half of the door.	A3201	The Administrator will conduct inspections of all apartments on an ongoing basis at least twice monthly to ensure good condition and will follow up with work orders to address concerns as needed.	

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A3201	Continued From page 5 7. Observation on 8/21/25 between 11:14 A.M. and 2:59 P.M., of resident room 113, showed the outside of the apartment door was covered in a thick line of black and white scuff marks on the bottom half of the door. 8. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 109, showed the outside of the apartment door had black scuff marks on the bottom half of the door. 9. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 102, showed the outside of the apartment door had white gouge marks at the base of the door and on the frame. 10. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 126, showed the outside of the apartment door had white gouge marks, and black scuff marks at the base of the door and on the frame. 11. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 103, showed the outside of the apartment door had black scuff marks on the bottom quarter of the door. 12. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 106, showed the outside of the apartment door had black scuff marks on the bottom quarter of the door. 13. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 107, showed the outside of the apartment door had black scuff marks on the bottom quarter of the door. 14. Observation on 8/21/25 between 12:08 P.M. and 2:42 P.M., of resident room 110, showed the	A3201		

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A3201	Continued From page 6 outside of the apartment door had black scuff marks on the bottom quarter of the door. 15. During an interview on 8/28/25 at 10:34 A.M., the Administrator said he was aware of the scuffs and marks on the resident room doors. He said he feels like they are always trying to address concerns with the building, and he is aware they have not kept up with all of it. *The higher classification is merited due to the extent of the violation.	A3201		
A3208	19 CSR 30-86.032(7) Handrails/Grab Bars in Toilet/Bath Areas Newly licensed facilities shall have handrails and grab bars affixed in all toilet and bathing areas. Existing licensed facilities shall have handrails and grab bars available in at least one (1) bath and toilet area. The foregoing requirements are applicable to residential care facilities. All assisted living facilities shall have handrails and grab bars affixed in all toilet and bathing areas. It This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure all resident use bathrooms had grab bars installed in each toileting area, when grab bars were not installed in two of three of the bathroom stalls, in the first floor women's locker room. The census was 37. Observation on 8/21/25 at 1:23 P.M., showed two stalls in the resident use, women's locker room, on first floor, with no grab bars installed. During an interview on 8/28/25 at 10:34 A.M., the	A3208	Plan of Correction: On 8/28/25, the Administrator submitted work orders to address the lack of grab bars in two bathroom stalls of the women's locker room. On 9/5/25, the Administrator and Maintenance Director inspected the women's locker room, identified the stalls requiring grab bars, and determined the best location for installing the grab bars. The grab bars were ordered and are scheduled to arrive on 9/29/25. Projected completion date is 9/30/25. The Administrator inspected all resident use restrooms throughout the facility on 9/5/25 and verified that grab bars were present by all other toilets.	

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A3208	Continued From page 7 Administrator said he was aware all stalls are required to have grab bars. He said he doesn't go into the women's locker room and was not aware there were not grab bars in those bathrooms.	A3208		
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 ensure all employees locked their medication carts when not in active use and followed the facility's policy entirely, when a Certified Medication Technician (CMT) failed to lock his/her cart and failed to park the medication cart correctly with the open drawers facing inward. The census was 37. Review of the facility's "Medication & Treatment - Administration/Assistance" dated 7/2024, showed during assistance of medications, the medication cart is kept closed and locked when out of sight of the medication Nurse or Aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. All outward sides should be inaccessible to residents or others passing by. 1. Observation on 8/21/25 between 8:17 A.M. and	A4782	Plan of Correction: The Administrator and Health and Wellness Director have sought to correct this error by the following methods: - Reinforcing the importance of keeping medication carts locked when not in use and/or when out of direct sight during shift change meetings with staff. - Conducting a re-inservice training with all staff during the September monthly staff meeting on 9/24/25 (see attached training sign-off sheet). - Conducting random lock checks on unattended carts whenever they are found and providing retraining in the moment if the cart is found to be unlocked. These lock checks will continue on an ongoing basis. - The Administrator met with a representative from OmniCare Pharmacy on 9/4/25 to examine the old carts and submit an order for replacement carts due to staff complaints that the locks were old and difficult to lock and unlock. The new carts have yet to be delivered as of 9/26/25.	

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A4782	Continued From page 8 8:25 A.M., on the first floor, during the morning medication pass, showed CMT A entered a resident's room and shut the door behind him/her. The medication cart was parked in front of the resident's door with the drawers facing the hallway. The medication cart was unlocked. The medication cart was out of sight and sound of CMT A. 2. Observation on 8/21/25 between 10:33 A.M. and 10:41 A.M., on the first floor, during the late morning medication pass, showed CMT A entered a resident's room and shut the door behind him/her. The medication cart was parked in front of the resident's door with the drawers facing the resident's door. The medication cart was unlocked. The medication cart was out of sight and sound of CMT A. 3. During an interview on 8/28/25 at 10:07 A.M., the Director of Nursing said the facility staff should never leave the medication cart unlocked even if they were in eye view of the medication cart. She said the medication cart can be unlocked only when in active use by the Medication Aides. She said the medication cart should have been parked with the drawers facing inward. 4. During an interview on 8/28/25 at 10:08 A.M., the Administrator said it was absolutely not okay to leave the medication cart unlocked and said the medication cart should have been parked with the drawer's facing inward. *The higher classification merited due to the extent of the violation.	A4782		

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A4797	Continued From page 9 19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure a safe and effective medication system when staff failed to administer medication appropriately when a Level One Medication Aide (LIMA) did not hold the inner canthus of a resident or instruct the resident to do so, after administering eye-drops, causing the	A4797	Plan of Correction: The Administrator and Health and Wellness Director have sought to correct this error by the following methods: - Reinforcing the importance of appropriately administering eye drops and inhaler medications, as well as going through the necessary steps for proper administration, during shift change meetings with staff. - Conducting a re-inservice training with all staff during the September monthly staff meeting on 9/24/25 (see attached training sign-off sheet). - Conducting random medication administration observations of medication technicians and providing in the moment retraining as needed. These random observations will continue on an ongoing basis.	

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A4797	Continued From page 10 medication to stream down the resident's cheek for one observed resident during the morning medication pass (Resident #6). Additionally, the facility failed to ensure a safe and effective medication system when a Certified Medication Technician (CMT) did not administer a resident's inhaler appropriately, causing the resident to not inhale all of the medication for one observed resident during the morning medication pass (Resident #7). The census was 37. 1. Review of Resident #6's medical record, showed the facility admitted the resident on 5/5/23, with diagnoses which included anxiety, abdominal pain, high blood pressure, insomnia and edema (water retention). Review of the resident's physician orders sheet, dated 8/1/25, showed the resident had an order for refresh tears ophthalmic solution, instill one drop into both eyes three times a day for dry eyes. Observation on 8/21/25 at 9:50 A.M., showed LIMA B greeted the resident and told the resident he/she had eye drops this morning. The resident leaned his/her head back and LIMA B squeezed one drop of the eye drop medication into each eye. LIMA B did not instruct the resident to hold the inner canthus and did hold the inner canthus him/herself. The eye drop medication rolled down the resident's cheek before he/she wiped the liquid away with a tissue. During an interview on 8/21/25 at 10:01 A.M., LIMA B said he/she did not know to hold the inner canthus after administering the eye drops but said "it made sense" to do so afterwards since the medication would stay in the eyeball had he/she held the inner canthus.	A4797		

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A4797	Continued From page 11 During an interview on 8/28/25 at 10:02 A.M., the Director of Nursing (DON) said when administering eye drops, the staff should wash their hands, put on gloves, ensure they have the right eye drops and let the resident know what they are about to do. The staff should pull the eye lid down, administer the eye drop and hold the inner canthus of the eye after administration. LIMA B should have held the resident's inner canthus or told the resident to do so. During an interview on 8/28/25 at 10:06 A.M., the Administrator said LIMA B should have held the inner canthus after administering the eye drops. 2. Review of Resident #7's medical record, showed the facility admitted the resident on 7/31/23, with diagnoses which included presence of a cardiac pacemaker, chronic obstructive pulmonary disease (COPD, a group of disease that obstruct airflow and cause difficulties breathing), vascular dementia, abnormalities of gait and mobility and repeated falls. Review of the resident's physician orders sheet, dated 8/1/25, showed the resident had an order for budesonide-formoterol fumarate inhalation aerosol (inhaler). Two puff inhale orally two times a day related to COPD. Rinse mouth with water after use. Do not swallow. Observation on 8/21/25 at 10:39 A.M., showed CMT A told the resident he/she had their inhaler, and the resident opened their mouth. CMT A sprayed the inhaler into the resident's mouth, twice. The resident did not breathe the inhaler spray in. The resident did not take a deep breath and did not hold his/her breath for 10 seconds after administration. The resident did not rinse	A4797		

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A4797	Continued From page 12 their mouth out after the inhaler administration. CMT A did not instruct the resident to hold their breath, count to 10 or rinse their mouth out. During an interview on 8/21/25 at 10:45 A.M., the resident said he/she tasted the inhaler "a lot" and "hoped" he/she had gotten what he/she needed out of the medication. During an interview on 8/28/25 at 10:02 A.M., the DON said the staff should have a resident shake the inhaler up, count to three and let the resident know to inhaler at three and hold it for 10 seconds. The staff should count out loud to the resident for 10 seconds and then let the resident know to breathe out. Also, the staff should have the resident rinse their mouth out. She said since this was not done, the resident may not have gotten all the medication they should have. She said the staff should have reported this to her so she could call the Physician and see if they could re-administer the inhaler. She said CMT A should have told the resident to inhale when he/she sprayed the inhaler in the resident's mouth. During an interview on 8/28/25 at 10:06 A.M., the Administrator said he knew the proper way to administer the inhaler, and the staff should have told the resident to take a deep breath, hold it for 10 seconds, and then rinse their mouth out. He said CMT A should have known better since he/she was a CMT.	A4797		
A4841	19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety Staffing Requirements. (A) The facility shall have an adequate number and type of personnel for the proper care of	A4841	Plan of Correction: The Administrator and Health and Wellness Director have sought to correct this error by the following methods: (continued on next page)	

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A4841	Continued From page 13 residents, the residents ' social well being, protective oversight of residents and upkeep of the facility. At a minimum, the staffing pattern for fire safety and care of residents shall be one (1) staff person for every fifteen (15) residents or major fraction of fifteen (15) during the day shift, one (1) person for every twenty (20) residents or major fraction of twenty (20) during the evening shift and one (1) person for every twenty-five (25) residents or major fraction of twenty-five (25) during the night shift. I/II Time Personnel Residents 7 a.m. to 3 p.m. (Day)* 1 3-15 3 p.m. to 9 p.m. (Evening)* 1 3-20 9 p.m. to 7 a.m. (Night)* 1 3-25 *If the shift hours vary from those indicated, the hours of the shifts shall show on the work schedules of the facility and shall not be less than six (6) hours. III This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to ensure a resident who had a fall received a Nurse's assessment prior to the facility staff lifting the resident off the floor. The resident went to the hospital and received a diagnosis of a broken tibia and fibula from the fall the resident had in the bathroom. Facility staff did not call the Nurse prior to lifting him/her off the floor and there was no Nurse in the building at the time of the fall (Resident #5). The census was 37. Review of the facility's "Falls Management Policy"	A4841	- Reviewing fall policy and procedure with staff during shift change meetings and reinforcing the need to contact nursing staff after every fall and before attempting to move the fallen resident. - Introducing new and more comprehensive fall packets with step-by-step instructions for staff. - Conducting a re-inservice training with all staff during the September monthly staff meeting on 9/24/25 (see attached training sign-off sheet). - The Administrator and Health and Wellness Director now review all fall packets and incident reports together to identify any deviations from procedure and follow up with staff to provide retraining.	

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A4841	Continued From page 14 dated 1/2025, showed the following: -When a fall occurs: -Assist the resident and provide first aid or call 911 as indicated and follow the directions of the 911 operator; -Notify the Health and Wellness director/Nurse/designee and Administrator; -Notify the resident's Physician/healthcare provider for evaluation, care and treatment if indicated and document in the resident's record; -Notify the resident's family/responsible party and document in the resident's record; -Document the resident fall/injuries resident response, and interventions taken in the progress notes; -Service plan is reviewed for potential fall interventions and updated as necessary; -Review the fall at the next stand up meeting; -Discuss resident falls at the next collaborative care review meeting. Review of Resident #5's medical record, showed the facility admitted the resident on 11/16/23, with diagnoses which included Parkinson's disease. Review of the resident's progress notes, showed the following: -On 5/14/25 at 5:51 P.M., the resident did not want to stand when staff assisted him/her to the bathroom. The staff asked him/her to help them assist him/her and it took a while for the staff to take him/her to the restroom, not trying to stand at all, barely trying to help; -On 5/14/25 at 6:00 P.M., the resident had a fall while staff attempted to take him/her to the bathroom. The resident was unable to assist staff, and the staff had to lower the resident to the floor; -On 5/17/25 at 4:30 A.M., the resident had a fall in the resident's bathroom near the toilet. The	A4841		

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A4841	Continued From page 15 details were first documented by the Medication Technician. The staff were assisting the resident in using the bathroom when his/her legs gave out and he/she fell to his/her knees; -On 5/17/25 at 8:51 P.M., the resident had a fall while being assisted to the bathroom by the facility staff.; -On 5/22/25 at 4:45 P.M., the resident's family member informed the facility the resident had two broken bones. During an interview on 8/21/25 at 12:32 P.M., Level One Medication Aide (LIMA) L said when he/she entered the room, there were two Care Aides (CA) in the bathroom with the resident on either side of the resident. LIMA L said the two staff were holding onto the gait belt, which was around the resident, but the resident was already in the process of falling while LIMA L was entering the room. LIMA A said the resident's knees were bent in front of him/her and the way they were bent, he/she could have broken a leg. LIMA L watched the staff lower the resident to the ground. LIMA L said the lowering was not too fast, but it looked like the staff could not hold the resident up anymore. When the resident got on the ground, he/she started to say his/her leg was hurting. LIMA L could not call the Nurse for a Nurse's assessment until the staff got the resident up and seated in the chair. LIMA L thought he/she reported this incident right away but then later said he/she put a note under the Nurse's office's door. LIMA L remembered talking to the Nurse a couple days after the incident and the Nurse said they would monitor the resident's leg. During an interview on 8/22/25 at 2:46 P.M., CA I said the resident had so many falls they were all running together but did not think anything out of	A4841		

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A4841	Continued From page 16 the ordinary happened. CA I could not remember the positioning of the resident's legs. CA I said he/she and another staff member got the resident off the floor multiple times. No one told him/her a Nurse had to assess a resident after a fall, prior to the staff lifting them off the floor. During an interview on 8/21/25 at 4:00 P.M., the Director of Nursing said she did not receive a call regarding the fall until the next day. She said when a resident falls, the staff are supposed to call her and also do range of motion. They are supposed to ask the resident if they have any pain and if they hit their head, the staff are required to automatically send them out. Staff should have called her immediately when the incident happened so she could have assessed the resident before the staff got him/her off the ground. She remembered coaching the staff regarding what to do when a resident falls but did not document the coaching. During an interview on 8/28/25 at 10:32 A.M., the Administrator said the staff should have contacted a Nurse prior to lifting the resident off the ground.	A4841		
A4861	19 CSR 30-86.047(65)(B) 1 hr transfer training, Annual-Licensed nurse Requirements for training related to safely transferring residents. (B) The facility shall ensure that a minimum of one (1) hour of transfer training is provided by a licensed nurse annually regarding safe transfer skills. II/III This regulation is not met as evidenced by: Class II*	A4861	Plan of Correction: The Administrator and Health and Wellness Director have sought to correct this error by the following methods: - Reinforcing the importance of using a gait belt for all transfers requiring physical assistance during shift change meetings with staff. - Providing personal gait belts to all staff members to be carried/worn as part of their uniform. - Conducting a re-inservice training with all staff during the September monthly staff meeting on 9/24/25 (see attached training sign-off sheet). (continued on next page)	

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A4861	Continued From page 17 Based on observation, interview and record review, the facility failed to ensure all staff properly transferred residents even after receiving transfer training when a Certified Medication Technician (CMT) transferred a resident without the use of a gait belt from the couch to the wheelchair for one reviewed resident (Resident #2). The census was 37. Review of the facility's "Safe Resident Handling Policy" dated 3/2020, showed the following: -Policy overview: This policy is intended to promote the safe handling of residents and help reduce the number and severity of work-related musculoskeletal disorders (lower back pain, neck or shoulder injuries) to associates in the community. This policy must be followed whenever an associate provides assistance to residents with transferring and movement, including but not limited to resident transfers, transfers using assistive devices, and assisting residents with mobility; -Policy detail: The community Administrator is responsible for: -Delegating the safe resident handling training and checklist completion responsibility to a community trainer with appropriate knowledge and skills, or licensure if required per state regulation; -Evaluating trends in resident and associate injuries and facilitating a quality improvement approach to injury reduction during the community safety committee meetings; -The transfer and mobility status of a resident should be determined at the time of admission or move in to the community and documented in the resident's service plan; -A resident should be routinely monitored for any changes in his/her transfer and movement status;	A4861	- Conducting care observations of new and existing staff to ensure transfer protocols are being followed and that gait belts are always used.	

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A4861	Continued From page 18 -The use of assistive devices (gait belts, sit-to-stand lifts, whole body lifts) is based on resident need and as permitted per state regulation. Review of CMT A's personnel file, showed the following: -Hire date 7/18/25; -Safe resident handling and transferring training for 15 minutes with a grade of 100%. Review of Resident #2's medical record, showed the facility admitted the resident on 7/29/24, with diagnoses which included vascular dementia and anxiety. Observation on 8/21/25 at 9:00 A.M., showed CMT A approached the resident, who sat in his/her wheelchair. CMT A asked the resident if he/she wanted to sit on the couch and the resident nodded. CMT A positioned the resident's wheelchair in front of the couch and locked the wheels. CMT A helped the resident stand up by putting his/her hands around the resident's waist and lifting upward. With CMT A's hands still around the resident's waist, he/she helped the resident pivot and sit on the couch. The resident's legs were never straight, and the resident took extremely tiny steps as he/she pivoted to sit on the couch. CMT A failed to use a gait belt during this process. At 9:10 A.M., CMT A came back to the resident and smiled at him/her. The resident said he/she had to use the restroom and CMT A said okay and positioned the resident's wheelchair in front of and to the left of the resident. CMT A bent down face to face to the resident and put his/her hands around the resident's waist. CMT A immediately stopped and said, "Oh I should have done this the first time." CMT A left the living room for approximately 10	A4861		

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A4861	Continued From page 19 minutes. When CMT A came back into the living room, he/she had a gait belt hanging over his/her shoulder. CMT A transferred the resident with the gait belt and wheeled the resident towards the bathroom. During an interview on 8/28/25 at 10.09 A.M., the Director of Nursing (DON) said the staff should always use a gait belt when transferring a resident. If a resident has a weak side, the chair should be closer to the weak side. She said it was never okay to transfer a resident without the use of a gait-belt. The DON said the gait belts are readily available in the stock room and CMT A should have known where the gait belts were kept. During an interview on 8/28/25 at 10:10 A.M., the Administrator said it was never okay to transfer a resident without the use of a gait belt. He said the staff should have used a gait belt when transferring the resident and CMT A should have known where to look for the gait belts. *The higher the classification merited due to the extent of the violation.	A4861		
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	A6005	Plan of Correction: The Administrator has sought to address these concerns by the following methods: - The Administrator conducted a search of resident rooms on 9/23/25 and removed all unapproved chemicals. - The Administrator contacted families of residents from whom restricted chemicals were taken to explain the policy and arrange for the chemicals to be picked up. - The Administrator will conduct room inspections on an ongoing basis at least twice monthly to ensure rooms are free of restricted chemicals.	

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A6005	Continued From page 20 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. The census was 37. Review of the facility's "Storage of Chemical/Toxic Materials for Resident Living Area" dated 8/2022, showed the following: -Policy overview: Chemicals, toxic or poisonous materials shall be stored in locked or secured areas not accessible to residents. These materials shall be monitored when in use, kept within sight of associates during use, transported safely, and locked in a secure area when not in use. These materials may include items used in personal care, cleansing agents, insecticides, rodenticides disinfectants, sanitizers, caustics, acids, polishes or other related cleaning or drying agents/chemicals. It is encouraged for residents to continue use of favorite personal care and cleaning items but to do so in a safe manner; -Policy detail: -Poisonous or toxic materials shall be stored in locked cabinets or in a similarly physically separate place used for no other purpose which is not accessible to residents; -Large quantities of liquid care products or cleansing agents used in common tub/shower areas shall be stored in a locked cabinet. 1. Review of Resident #7's medical record, showed the facility admitted the resident on 7/31/23, with diagnoses which included presence of a cardiac pacemaker, chronic obstructive pulmonary disease (COPD, a group of disease	A6005		

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A6005	Continued From page 21 that obstruct airflow and cause difficulties breathing), vascular dementia, abnormalities of gait and mobility and repeated falls. Review of the resident's Physician's orders sheet dated 8/1/25, showed no Physician order allowing the resident to have access to chemicals. Observation on 8/21/25 at 10:45 A.M., in the resident's room, showed the following: -In the closet: -A full 32 ounce (oz) spray bottle of Spray N' Wash. The precautionary statement read, "Eye and skin irritant. Avoid contact with eyes and skin. Avoid inhaling spray. Do not directly inhale the spray, as it may be harmful. Do not treat while wearing. Never apply the product to garments of fabrics while they are being worn. Do not mix with bleach. Keep out of reach of children."; -One 1/4 full gallon of Clorox bleach. The precautionary statement read, "Danger. Corrosive. May cause irritation or damage to the eyes. Harmful if swallowed. Protect eyes when handling. For prolonged use wear gloves. Wash hands after contact. Avoid breathing vapors. Use in well-ventilated areas. Keep out of reach of children."; -A full 32 oz spray bottle of 24 hour Microban cleaner. The precautionary statement read, "Contents under pressure. Compressed gas. May explode if heated. Do not pierce or burn, even after use. Keep away from heat/sparks/open flames/hot surfaces. No smoking. Do not spray on an open flame or other ignition source. Protect from sunlight. Store in a well-ventilated place. Keep out of reach of children."; -A Full 80 count container of Lysol lemon scent wipes; -A full 14 oz container of Spot Shot carpet cleaner. The precautionary statement read,	A6005		

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A6005	Continued From page 22 "Exposure of containers to extreme heat and flames can cause them to rupture, often with violent force and subsequent fire. Caution: contents under pressure. Avoid heat. May cause eye, skin and respiratory tract irritation. Harmful if intentionally inhaled. Harmful if absorbed through skin. May affect liver, kidneys, blood and nervous system. First aid emergency procedures: Call Physician immediately! Keep out of reach of children."; -In the bathroom: -A Half full container of 80 count Clorox wipes on a metal cabinet by the toilet. 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 8/21/25 between 11:00 A.M. and 2:00 P.M., of resident room 148, showed a full container of 80 count Lysol wipes on the kitchen counter by the sink. 3. During an interview on 8/28/25 at 10:12 A.M., the Director of Nursing (DON) said chemicals should be kept secured and locked away. She said no chemicals should be in resident apartments. 4. During an interview on 8/28/25 at 10:13 A.M., the Administrator said chemicals should be stored in the Nurse's station or in the medical room and both are to remain locked. He said there is also a locked closet in the DON's office which the staff can use to store chemicals. He said it was never okay to have chemicals in a resident's room without a Physician's order allowing the chemicals.	A6005		

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	26178	A. BUILDING: _____ B. WING _____	C 08/28/2025

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A6010	Continued From page 23	A6010		
A6010	19 CSR 30-87.020(10) Odors, Vapors, Fumes Vented to Outside In new or extensively remodeled facilities, all rooms from which obnoxious odors, vapors or fumes originate shall be mechanically vented to the outside. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to eliminate odors at the source using prompt cleaning when a dried, urine soaked, orange couch held a strong urine odor which caused gnats to form around the cushions of the couch. The census was 37. Observation on 8/21/25 between 8:12 A.M. and 2:00 P.M., of the common area living room, showed an orange couch pushed against the wall. The middle and right cushions were dried and hardened on the edges of the cushion. Gnats flew out of the middle cushion when it was pressed down. An extremely strong urine odor was present and permeated throughout the living room. Observation on 8/21/25 at 9:00 A.M., showed an unknown resident sat between the middle and right cushion of the orange couch. When the resident sat down, gnats flew out of the couch. Observation on 8/21/25 at 9:14 A.M., showed Cook J entered the doorway to the living room, from the dining room. Cook J put their hands on their hips and looked around. After a few seconds, Cook J put both their hands up to their face, covering their nose and mouth, and said "Whew, smells." Cook J immediately exited the living room.	A6010	Plan of Correction: The leadership team has sought to address these concerns by the following methods: - New couches were purchased for the Assisted Living living room by the Executive Director on 9/19/25 with an expected delivery date of 9/26/25, at which point the old couches will be disposed of. - The new couches were chosen specifically to be non-absorbant and to facilitate easy cleaning. - Pest control devices have been purchased and will be installed in the Assisted Living trash rooms and elsewhere in the facility to help mitigate insect issues.	

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A6010	Continued From page 24 During an interview on 8/28/25 at 10:18 A.M., the Administrator said he cleaned the couch several times with an upholstery cleaner. He believed he cleaned it himself the day before the State arrived. The Administrator said he had tried to mitigate the odors as best as he could. He didn't know the odor was as strong as it was.	A6010		
A6013	19 CSR 30-87.020(13) Carpeting Carpeting, if used as a floor covering, shall be of closely woven construction, properly installed, easily cleanable and maintained in good repair. Carpeting is prohibited in food-preparation, equipment-washing and utensil-washing areas where it would be exposed to large amounts of grease and water, in food-storage areas and toilet room areas where urinals or toilet fixtures are located. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the carpet was clean and in good repair in the common area living room and in the hallway outside room 116. The census was 37. 1. Observation on 8/21/25 between 8:10 A.M. and 2:45 P.M., of the common area living room, showed the following: -By the associate area, in front of the door, a dark colored stain in front of the blue chair approximately 26 inches in circumference; -In front of the blue chair, a dark colored stain approximately 2 feet long and 2 feet wide; -Under the television, multiple stains of various sizes that were dark in color; -A big dark stain to the right side of the middle couch.	A6013	Plan of Correction: Stanley Steemer was brought into the facility on 9/11/25 to do a thorough and intensive cleaning of all carpeting throughout Assisted Living. They have also come in since for spot treatments and will continue to be used as needed for any significant staining and to maintain the cleanliness of carpets. The Executive Director has also engaged a contractor to assess areas of damaged carpet and obtain quotes for repairs and capital improvement request submitted for replacement.	

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A6013	Continued From page 25 2 Observation on 8/21/25 between 12:10 P.M. and 2:42 P.M., of the hallway outside room 116, showed approximately six inches of raised red carpeting at the transition of the green carpeting. The carpet was lifted about 1/4" at the seam in the center of the hallway. 3. During an interview on 8/28/25 at 10:34 A.M., the Administrator said Housekeeping is responsible for cleaning the carpets. They clean it about every two weeks. He said he is aware of those carpets and their condition. He feels like he's chasing his tail when asking housekeeping to clean them and he's definitely aware of the situation.	A6013		
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 37. Observation on 8/21/25 at 9:26 A.M., in resident room 109, showed a camera sat on the top shelf	A9107	Plan of Correction: An electronic surveillance sign was posted on the door of the resident's room on 8/28/25. The Administrator will ensure that all rooms with electronic monitors will have appropriate signage and a signed waiver moving forward. The Executive Director purchased a decal for the front entrance alerting visitors to the use of electronic monitoring throughout the facility. The decal was placed on the front door on 9/23/25.	

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A9107	Continued From page 26 of the side table near the bed. There was no sign on or by the resident's apartment door upon entering the apartment. During an interview on 8/28/25 at 10:34 A.M., the Administrator said he is responsible for the process when a resident decides to install a camera. He knew they needed to have a signed form waiver, and a sign posted on the door. He said the family stopped using the camera in that room and must have removed the sign from the door.	A9107		
A9108	19 CSR 30-91.010 (9)(A)-(E) Installation-placement of EMD (9) The facility shall require an electronic monitoring device to be installed as follows: (A) In plain view; (B) Mounted in a fixed, stationary position; (C) Directed only on the resident who initiated the installation and use of AEM device; (D) Placed for maximum protection of the privacy and dignity of the resident and the roommate; and (E) In a manner that is safe for residents, employees, or visitors who may be moving about the room. II/III This STANDARD is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure electronic monitoring devices were mounted in a fixed, stationary position for two of two residents' rooms, which had an electronic device. The census was 37. 1. Observation on 8/21/25 at 9:25 A.M., in	A9108	Plan of Correction: The Administrator spoke with the Maintenance Director to see what would be the best way to mount any electronic monitors, and he recommended the use of command strips to secure any electronic monitors. The Administrator submitted work orders for the mounting of all monitors on 9/22/25 with a projected completion date of 10/3/25.	

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A9108	Continued From page 27 resident room 109, showed a camera sat on the top shelf of the side table near the bed. The camera was not stationary or mounted and was able to be moved by the Regulatory Auditor when she picked it up. 2. Observation on 8/21/25 at 12:16 P.M., in resident room 131, showed a camera set on an end table in the living room. The camera was not stationary or mounted and was able to be moved by the Regulatory Auditor when she picked it up. 3. During an interview on 8/28/25 at 10:34 A.M., the Administrator said he is responsible for the process when a resident wanted a camera installed in their room. He knew they needed to have a signed form and a sign posted on the door. He was not aware the camera needed to be mounted. *The higher classification is merited due to the extent of the violation.	A9108	Greg Dundulis 9/26/25 Greg Dundulis, Assisted Living Director	