

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/10/2026
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 12826 DAYLIGHT CIRCLE SAINT LOUIS, MO 63131			
(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
A2298	19 CSR 30-86.022(17) Oxygen Storage Requirements Oxygen storage shall be in accordance with NFPA 99, 1999 Edition. II/III This regulation is not met as evidenced by: Class III Based on observation and interview, the facility failed to ensure a resident's room was labeled with a sign indicating oxygen was stored in the room for one observed resident's room. The census was 48. Observation on 3/10/26 between 8:39 A.M. and 4:00 P.M., of resident room 226, showed a concentrator beside the apartment's door, propping the door open. No sign indicating oxygen or oxygen supplies were stored in the room. During an interview on 3/10/26 at 4:50 P.M., the Administrator said she did not know the resident's room did not have a sign. She said if the resident had oxygen and oxygen supplies in the room, there should be a sign on the door.	A2298			
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	A3235			

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Executive Director

(X6) DATE

4/10/26

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A3235	Continued From page 1 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 temperatures exceeded 120 degrees F. The census was 48. Review of the facility's water temperature log dated 1/2026, showed the following: -On 1/14/26, in resident room 106, unknown source, measured 114 degrees F; -On 1/14/26, in resident room 122, unknown source, measured 113 degrees F; -On 1/14/26, in resident room 217, unknown source, measured 113 degrees F; -On 1/14/26, in resident room 240, unknown source, measured 110 degrees F; -On 1/14/26, in the memory care unit laundry room, unknown source, measured 112 degrees F; -On 1/21/26, in resident room 116, unknown source, measured 110 degrees F; -On 1/21/26, in resident room 118, unknown source, measured 115 degrees F; -On 1/21/26, in resident room 202, unknown source, measured 111 degrees F; -On 1/21/26, in resident room 226, unknown source, measured 111 degrees F; -On 1/21/26, the kitchen sink, measured 114 degrees F; -On 1/28/26, in resident room 114, unknown source, measured 112 degrees F; -On 1/28/26, in resident room 126, unknown source, measured 112 degrees F;	A3235			

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A3235	Continued From page 2 -On 1/28/26, in the first floor laundry room, unknown source, measured 114 degrees F; -On 1/28/26, in resident room 214, unknown source, measured 116 degrees F; -On 1/28/26 in resident room 236, unknown source, measured 114 degrees F; -1/28/26 in the community laundry room, unknown source, measured 111 degrees F. 1. Observation on 3/10/26 at 3:18 P.M., of the memory care unit kitchenette, showed the sink's temperature measured 125.6 degrees F, when measured with a calibrated digital thermometer for two minutes. 2. Observation on 3/10/26 at 2:37 P.M., of the community room adjacent to the front lobby, showed the sink's temperature measured 125.1 degree F, when measured with a calibrated digital thermometer for two minutes. 3. Observation on 3/10/26 at 2:56 P.M., of resident room 112, in the bathroom, showed the sink's temperature measured 124.5 degrees F, when measured with a calibrated digital thermometer for two minutes. 4. Observation on 3/10/26 at 7:45 A.M., of the women's bathroom near the private dining room, showed the sink's temperature measured 124.2 degrees F, when measured with a calibrated digital thermometer for two minutes. 5. Observation on 3/10/26 at 3:54 P.M., of resident room 118, showed the sink's temperature measured 123.6 degrees F and the shower's temperature measured 124.8 degrees F, when measured with a calibrated digital thermometer for two minutes.	A3235		

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A3235	Continued From page 3 6. Observation on 3/10/26 at 4:15 P.M., of the water heaters showed the following: -Three tanks side by side; -The first tank on the left, had a digital screen showing the tank's temperature was 136 degrees F, with a set point of 136 degrees F; -The middle tank, had a digital screen showing the tank's temperature was 133 degrees F; -The last tank on the right, had a digital screen showing the tank's temperature was 133 degrees F; -The circulator to the right of the three tanks, had a temperature gauge which measured 132 degrees F. 7. During an interview on 3/10/26 at 4:24 P.M., the Maintenance person said he took temperatures monthly. He said he did not calibrate the thermometer before measuring the temperature. He said he bought a new thermometer every time he took a temperature. He said the water temperatures usually measured around 119 and 121 degrees F. He did not know the water temperature requirement. 8. During an interview on 3/10/26 at 5:05 P.M., the Administrator said she did not know the water temperature requirement and she did not know the water temperatures were measuring so hot.	A3235		
A4733	19 CSR 30-86.047(20)(I) Personnel Record-physician statement, employ The administrator shall maintain on the premises an individual personnel record on each facility employee, which shall include the following: (I) Written statement signed by a licensed physician or physician ' s designee indicating the person can work in a long-term care facility and	A4733		

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A4733	Continued From page 4 indicating any limitations; III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure all employees had a physician's statement in their personnel file which indicated the employee could work in long-term care, for three of four sampled employees. The census was 48. 1. Review of the Regional Chef's personnel record, showed the following: -Hire date unknown; -No Physician statement indicating the employee can work in long-term care. 2. Review of the Resident Aide B's personnel record, showed the following: -Hire date 11/25/25; -No Physician statement indicating the employee can work in long-term care. 3. Review of the Resident Care Manager's personnel record, showed the following: -Hire date 2/3/26; -No Physician statement indicating the employee can work in long-term care. 4. During an interview on 3/10/26 at 1:16 P.M., the Business Office Manager (BOM) said she did not know a Physician's statement indicating an employee could work in long-term care was required in every employee's personnel file. She said the physicals the employees are required to get only come back with "no job description" provided. 5. During an interview on 3/10/26 at 4:40 P.M., the Administrator said the BOM was responsible	A4733		

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A4733	Continued From page 5 for the personnel records. She said she did not know the employees required a Physician's statement indicating the person could work in long-term care.	A4733			
A4750	19 CSR 30-86.047(28)(F)(1)(B) Community Based Assessment - Semi-Annually 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: B. At least semiannually; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure semiannual community based assessments (CBA) were fully completed, for four of four sampled residents (Residents #4, #1, #2 and #3). The census was 48. 1. Review of Resident #4's medical record, showed the facility admitted the resident on 3/25/18, with diagnoses which included high blood pressure, high cholesterol, major depressive disorder, and dementia. Review of the resident's semiannual CBA dated 10/8/25, showed the following: -The prescription medication section was left blank; -The dosage section was left blank;	A4750			

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A4750	Continued From page 6 -The Physician/Pharmacy section was left blank; -The non-prescription medication section was left blank. 2. Review of Resident #1's medical record, showed the facility admitted the resident on 1/7/21, with diagnoses which included a fall risk, dementia, Alzheimer's disease and depression. Review of the resident's semiannual CBA dated 11/25/25, showed the following: -The prescription medication section was left blank; -The dosage section was left blank; -The Physician/Pharmacy section was left blank; -The non-prescription medication section was left blank. 3. Review of Resident #2's medical record, showed the facility admitted the resident on 11/27/23, with diagnosis which included Alzheimer's disease. Review of the resident's semiannual CBA dated 9/24/25, showed the following: -The prescription medication section was left blank; -The dosage section was left blank; -The Physician/Pharmacy section was left blank; -The non-prescription medication section was left blank; -The other health care provider section was left blank. 4. Review of Resident #3's medical record, showed the facility admitted the resident on 10/8/24, with diagnoses which included a chronic kidney disease, high blood pressure, and high cholesterol.	A4750		

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A4750	Continued From page 7 Review of the resident's semiannual CBA dated 10/8/25, showed the following: -The prescription medication section was left blank; -The dosage section was left blank; -The Physician/Pharmacy section was left blank; -The non-prescription medication section was left blank. 5. During an interview on 3/10/26 at 4:49 P.M., the Administrator said her and the Assistant Director of Nursing are responsible for the CBAs. She said the CBAs should be completed every six months. She said every section should be filled out and the resident's medication should be attached to the CBAs.	A4750		
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	A4751		

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A4751	Continued From page 8 resident who had multiple falls, sustained a head injury and required more assistance upon a return from the hospital, for one sampled resident (Resident #6). The census was 48. Review of Resident #6's medical record, showed the facility admitted the resident on 8/14/25, with diagnoses which included high blood pressure, disorientation and chronic heart failure. Review of the resident's progress notes, showed the following: -On 2/20/26 at 3:15 P.M., the resident returned to the community from the hospital. The resident was already on hospice and was not going to have any life saving procedures done. The resident was immediately moved to memory care from assisted living. The hospice team were to visit after the return; -On 2/21/26 at 3:15 A.M., the resident had been constantly moving around and "not trying to go to bed" for these past couple nights. The resident had been very anxious and medication that had been given was not working. The staff were to continue to monitor the resident; -On 2/22/26 at 8:45 P.M., the resident kept trying to get up and walk around. The resident was very disoriented and would not stay sitting or laying down; - On 2/22/26 at 10:45 P.M., the resident refused to lay down and said he/she did not want to, or he/she would start yelling saying he/she wanted to sit up. The resident sat in bed but kept trying to stand up and walk. The resident seemed really anxious to the point he/she kept moving to want to get out of bed. The staff member had been going into the resident's room every 30 minutes to an hour to make sure he/she did not fall. Review of the resident's medical record, showed	A4751		

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A4751	Continued From page 9 no change of condition CBA for the change of services noted for 2/20/26 and 2/22/26. During an interview on 3/10/26 at 4:51 P.M., the Administrator said she would classify hospice, fractures, or anything that required more assistance as a change of condition and any resident who had a change of condition should have an updated CBA. She said if the level of care changed, the resident should have an updated CBA. She said she did not have enough time to get the paperwork done because the resident returned on 2/20/26 and passed away on 2/24/26. MO00260853	A4751		
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 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, had falls and had no new interventions for each fall, no explanation of what kind of assistance the resident required, when a resident's spouse continuously assisted a	A4755		

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A4755	Continued From page 10 resident without calling for staff's assistance, when a resident was sleeping more, when a resident experienced increased confusion, and when a resident was verbally aggressive with other residents, were not documented in residents' ISPs, for four of four sampled residents and two additional reviewed residents (Residents #6, #7, #4, #3, #1 and #2). The census was 48. 1. Review of Resident #6's medical record, showed the facility admitted the resident on 8/14/26, with diagnoses which included high blood pressure, chronic heart failure, disorientation and weakness. Review of the resident's progress notes, showed the following: -On 1/7/26 at 8:00 A.M., the resident had a fall in his/her bathroom. The resident was observed sitting on the floor against the bathroom cabinet. The resident's spouse (also a resident) said the resident fell and he/she sat the resident up. The resident said he/she hit his/her head. The resident moved his/her arms and legs with no complaints of pain. The resident's walker was with him/her. The resident was not wearing socks or shoes. There was no spills or debris noted on the floor. There was a red area noted to the top left side of the resident's forehead. The Director of Nursing (DON) called 911 and the resident's family power of attorney. The resident went to the hospital for evaluation; -On 1/7/26 at 11:31 A.M., an incident report was created for the resident. The resident had an unwitnessed fall; -On 1/9/26 at 8:30 A.M., the resident's spouse got him/her up this morning. The resident seemed very happy this morning. There were no complaints at this time; -On 1/9/26 at 5:30 P.M., the resident had a quiet	A4755		

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A4755	Continued From page 11 day with some periods of confusion. The resident's spouse had to redirect him/her as usual. The resident had been up for all three meals; -On 1/31/26 at 2:45 P.M., the resident had been experiencing some periods of confusion. The resident's spouse had hollered at the resident trying to redirect the resident. The resident's family was aware; -On 2/16/26 at 6:45 P.M., at the beginning of the shift, the resident was roaming the halls, confused, looking for the boss loudly. The resident's spouse would enter the hall and begin yelling at the resident to come to bed, which further aggravated him/her. The staff member attempted to redirect both residents out of the hallway. The resident's spouse was successfully redirected to bed. The resident sat with the staff member for a while, received medication, and ate cookies before the staff was able to successfully redirect the resident back into the room and ready for bed. The attempts to redirect the resident required the staff to also redirect the resident's spouse because the spouse would yell at the resident for exiting the room which would "rile" up the resident. The staff redirected both residents back to bed where they remained for the rest of the night; -On 2/20/26 at 11:22 A.M., an incident report was created for the resident. The resident had a witnessed fall; -On 2/20/26 at 3:15 P.M., the resident returned from the hospital. The resident was already on Hospice and was not going to have any life saving procedures done. The resident was immediately moved from the assisted living side to the memory care unit; -On 2/21/26 at 3:11 A.M., an incident report was created for the resident. The resident had an unwitnessed fall;	A4755		

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A4755	Continued From page 12 -On 2/21/26 at 3:15 A.M., the resident was constantly moving around and not trying to go to bed for the past couple nights. The resident had been very anxious and medication that had been given, was not working; -On 2/21/26 at 11:26 P.M., an incident report was created for the resident. The resident had a witnessed fall; -On 2/22/26 at 8:45 P.M., the resident kept trying to get up and walk around. The resident was very disoriented and would not stay sitting or lying down; On 2/22/26 at 10:45 P.M., the resident refused to lay down. He/she said he/she did not want to, or he/she would start yelling saying he/she wanted to sit up. The resident sat up in bed, but he/she kept trying to stand up and walk. The resident seemed "real anxious" and kept moving to want to get out of bed. The staff had been going into his/her room every 30 minutes to an hour to make sure he/she did not fall; -On 2/23/26 at 2:10 A.M., an incident report was created for the resident. The resident had an unwitnessed fall; -On 2/23/26 at 11:46 A.M., an incident report was created for the resident. The resident had an unwitnessed fall; -On 2/23/26 at 10:29 P.M., an incident report was created for the resident. The resident had an unwitnessed fall. Review of the resident's ISP dated 2/24/26, showed the following: -Need: Bathing: The resident required "hands-on" assistance with transferring in and out of the shower. The resident required "hands-on" assistance with washing and drying. The Hospice shower aide assisted with showers two times/week. The facility staff assisted as needed; -Need: Dressing: The resident required	A4755		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CEDARHURST OF DES PERES

**12826 DAYLIGHT CIRCLE
SAINT LOUIS, MO 63131**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4755	Continued From page 13 "hands-on" assistance with dressing on a daily basis; -Need: Use of bathroom: The resident wore briefs. The resident required assistance with transferring on and off the toilet. The resident required assistance with changing and cleaning up as needed throughout the day and night; -Need: Escorting: The resident was able to ambulate around the community with his/her walker independently. The resident required a wheelchair when he/she felt weak. The resident required assistance with escorting when he/she was in his/her wheelchair; -Need: Transfers: The resident was able to ambulate around the community with his/her walker independently when he/she was feeling strong. The resident required a wheelchair when he/she was feeling weak and assistance with transferring when he/she was feeling weak; -Need: Problematic expressions: If the staff noticed any changes in his/her mood or behavior, the staff were to look for reason that may have caused the change and notify the Nurse. The resident had a history of becoming agitated and would yell out in a different language when he/she was upset; -Need: Redirection: The resident would like to have reminders when he/she was forgetful. The resident was new to the community. The staff were to orient him/her to his/her home by showing him/her where his/her apartment and dining room are located; -Need: Fall Risk: The resident had a fall risk. On 1/7/26, the resident had a fall in the bathroom, walking without shoes/socks. The resident's spouse was reminded to press the pendant for assistance. On 2/20/26, the resident fell in the bathroom and hit his/her head. The resident did not call for assistance. On 2/21/26 at 3:00 A.M., the resident fell in the theater leaning down to	A4755		

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A4755	Continued From page 14 pick something up. The area was checked for debris/clutter, none noted. The staff were to encourage the resident to sit back in his/her chair. On 2/21/26 at 11:00 P.M., the resident fell out of bed. The bed was moved to the wall. On 2/23/26 at 2:00 A.M., the resident fell out of bed, the bed was against the wall and in lowest position. The staff requested a floor mat from Hospice. On 2/23/26 at 11:00 A.M., the resident fell out of bed. The bed was moved to the wall and a floor mat was placed along side of the bed. Bolsters and a wider hospital bed was requested from hospice. On 2/23/26 at 10:00 P.M., the resident fell out of bed. The bed was against the wall and in the lowest position. As needed medication was administered by the Hospice Nurse. A medication review was required. New orders were given on 2/24/26; -Need: Safety Checks: The resident required two hour safety checks. During an interview on 3/10/26 at 3:32 P.M., the resident's spouse said the resident required a lot of assistance with getting dressed. The resident's spouse said he/she would dress the resident him/herself and would not call the staff for assistance. The resident's spouse said he/she would take the resident to the restroom, transfer him/her to and from the toilet, and assist the resident with the after care without calling for assistance from staff. The resident's spouse said he/she would escort the resident down the hall to the dining room him/herself. The resident's spouse said the resident was declining quickly because he/she required more reminders and assistance with all of his/her activities of daily living. The resident's spouse said he/she did not call for staff to assist because "it was better to do it him/herself than wait more than 20 minutes for the staff to respond." The resident's spouse said	A4755		

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A4755	Continued From page 15 the resident's memory was failing quickly. Review of the resident's ISP dated 2/24/26, showed the following: -The ISP did not indicate what kind of assistance the resident required with bathing and dressing; -The ISP did not address the resident's spouse refusing to call for staff's assistance; -The ISP did not address the resident's spouse continuous effort of assisting the resident him/herself; -The ISP did not address the resident's required assistance with transferring and escorting; -The ISP did not address the resident's increased confusion and memory loss and what the staff should do when the resident experienced this; -The ISP did not address the staff's additional check ins with the resident. 2. Review of Resident #7's medical record, showed the facility admitted the resident on 1/12/23, with diagnoses which included anxiety disorder, history of falling and high blood pressure. Review of the resident's ISP dated 5/2/25, showed the following: -Need: Bathing: The resident required assistance with bathing. The required assistance with getting in and out of the shower and ensuring the resident was clean. The Hospice team assisted with showers and the facility staff assisted as needed; -Need: Dressing: The resident required assistance with picking out new clothes and cueing to change his/her clothes. The resident could complete his/her own dressing with cueing/prompting. If the resident refused or became agitated, the staff were to reapproach or ask a different staff member to attempt;	A4755		

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A4755	Continued From page 16 -Need: Use of bathroom: The resident was incontinent of bladder. The staff were required to remind the resident to use the bathroom every four hours during waking hours; -Need: Transfers: The resident required stand by assistance when transferring on an as needed basis; -Need: Problematic expressions: The resident did not like anyone assisting him/her with anything. The resident would become angry and may yell at anyone attempting to assist him/her. The staff were to encourage him/her to take a shower, shave, brush his/her hair and ensure he/she was changing clothes. If the resident became angry and refused any of the above care or refused his/her room to be cleaned, the staff were to document. The resident liked to sit in his/her room with his/her clothes off. The staff were to remind/assist the resident getting dressed before leaving his/her room; -Need: Redirection/Reminders: The resident required reminders when he/she was forgetful. The staff were required to redirect the resident to where he/she needed to go when he/she became confused or turned around; -Need: Fall risk - High: The resident was a high fall risk. The resident had a history of falling and needed monitoring. The resident had periods of confusion and impaired judgement and required help finding his/her way around the community. On 5/2/25, the resident was observed kneeling in his/her room. The resident said he/she lowered him/herself to the knee. There were no injuries. The staff were required to encourage the resident to ask for assistance. The staff were to perform safety checks every two hours. Review of the resident's progress notes, showed the following: -On 12/25/25 at 12:00 P.M., the resident fell in	A4755		

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A4755	Continued From page 17 the hallway. He/she walked with his/her walker. The resident's "better half" said he/she did not know how the resident fell. The Hospice Nurse was already in the building and assessed the resident. The resident had a red area on both of his/her knees; -On 1/4/26 at 7:30 A.M., the resident roamed the halls, searching and waiting for his/her friend. The resident would attempt to sit on his/her walker but was continuously redirected by the staff to other chairs once observing returning to his/her room was not an option. The resident would return back to sitting on his/her walker. The staff redirected to a safer seating until the resident finally retired to his/her room at 4:00 A.M.; On 1/21/26 at 9:45 P.M., the resident's partner came and got assistance with the resident because he/she said the resident was on the floor. When staff walked in, the resident was sitting up in bed. The staff member asked the resident if he/she had a fall, and the resident said no. The staff noticed the resident had a medium size red bruise on the left side of his/her head. The staff called for the Nurse to come check the resident over. After the Nurse came to see the resident, he/she notified the staff member to call paramedics and notify the resident's power of attorney. The power of attorney refused to send the resident out. The power of attorney came to the community to sign a refusal form to send the resident out; -On 2/27/26 at 9:45 A.M., the Hospice Nurse made a visit with the resident on 2/26/26. The resident was sleeping in his/her apartment. The resident had been sleeping more. The resident had pitting edema to his/her bilateral lower extremities. The resident's vitals were stable, and he/she was not in any pain. Review of the resident's ISP dated 5/2/25,	A4755			

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A4755	Continued From page 18 showed the following: -The ISP did not address the resident's most recent falls with new/specific interventions to prevent future falls; -The ISP did not address the resident's roaming of the halls; -The ISP did not address the resident's head injury; -The ISP did not address the resident's increased sleeping. 3. Review of Resident #4's medical record, showed the facility admitted the resident on 3/25/18, with diagnoses which included high blood pressure, high cholesterol, major depressive disorder, and dementia. Review of the resident's ISP dated 3/10/26, showed the following: -Need: Dressing - staff was to assist with clothing selection. The resident needed hands on assistance with dressing on a daily basis. The resident needed assistance with clothing selection and hands on assistance with dressing; -The ISP did not address specifics on what was included with "hands on" assistance for staff to know what to do to assist the resident with dressing. 4. Review of Resident #3's medical record, showed the facility admitted the resident on 10/8/24, with diagnoses which included chronic kidney disease, high blood pressure and high cholesterol. Review of the resident's ISP dated 3/10/26, showed the following: -Need: Elopement risk: Staff were to monitor the resident for changes in mood or behavior and notify the nurse and physician. Staff were to	A4755		

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A4755	Continued From page 19 orient the resident to his/her "new home" by showing him/her where his/her apartment, the dining room, etc. were located when he/she got turned around. The resident had been assessed as low risk for elopement; -Need: Redirection-reminders (Behavior Patterns/Wandering Risk): The resident was "new" to the community. Staff were to assist to orient him/her to his/her "new home" by showing him/her where his/her apartment, the dining room, etc. were located when he/she got turned around; -The ISP did not address updated information for resident's status of elopement or wandering after living in the facility for two years. 5. Review of Resident #1's medical record, showed the facility admitted the resident on 11/7/21, with diagnoses which included depression, dementia and high blood pressure. Review of the resident's ISP dated 4/12/25, showed the following: -Need: Dressing: The resident required assistance with dressing on a daily basis; -Need: Problematic expressions: The resident required staff to approach him/her in a calm and gentle manner, using positive body language and facial expressions. The staff were to encourage the resident to participate in activities and programs that may interest him/her. The staff were to offer the resident a choice whenever possible. The staff were to give the resident praise and encouragement. The resident may become anxious or tearful and often felt forgotten about, or alone when he/she was not engaged by staff or others. Review of the resident's progress notes dated 1/5/26 at 10:45 A.M., showed the resident was	A4755			

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A4755	Continued From page 20 rolling around the facility in his/her wheelchair. The resident stopped and talked to some other residents. The resident got upset with the resident and cursed them out. The other resident kicked his/her wheelchair. The resident was okay, and the Nurse came and checked on the resident. Review of the resident's ISP dated 4/12/25, showed the ISP did not reflect the resident's verbal aggression with another resident or staff interventions for future events. 6. Review of Resident #2's medical record, showed the facility admitted the resident on 11/27/23, with a diagnosis which included Alzheimer's disease. Review of the resident's ISP dated 1/15/25, showed the resident required assistance with dressing. The resident currently had a cast on his/her left wrist. Observation on 3/10/26 at 10:00 A.M., showed the resident no longer had a cast on his/her wrist. Review of the resident's ISP dated 1/25/25, showed the ISP did not reflect the resident's healed wrist. 7. During an interview on 3/10/26 at 4:47 P.M., the Administrator said her and the Assistant Director of Nursing are responsible for completing the residents' ISPs. She said the ISP should show all the resident's activities of daily living (ADLs), who helps them with the ADLs and how much assistance they need with the ADLs. She said the ISPs should be as detailed as possible to care for the residents. She said all falls should be documented with specific interventions.	A4755		

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A4755	Continued From page 21 Behaviors and increased confusion or wandering should be documented on the ISP.	A4755		
A4756	19 CSR 30-86.047(28)(I) Individual Service Plan - Signatures 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: (I) Includes the signatures of an authorized representative of the facility and the resident or the resident ' s legal representative in the individualized service plan to acknowledge that the service plan has been reviewed and understood by the resident or legal representative; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure all resident individualized service plans were signed by a facility representative and the resident or the resident's responsible party upon the annual or change of condition review of the resident's ISP, for four of four sampled residents (Residents #4, #1, #2, and #3). The census was 48. 1. Review of Resident #4's medical record, showed the facility admitted the resident on 11/27/23, with diagnoses which included high blood pressure, high cholesterol, major depressive disorder and dementia. Review of the resident's ISP dated 3/10/26, showed no facility representative's signature or resident and/or resident's representative's signature.	A4756		

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A4756	Continued From page 22 2. Review of Resident #1's medical record, showed the facility admitted the resident on 11/7/21, with diagnoses which included depression, dementia and high blood pressure. Review of the resident's ISP dated 4/12/25, showed no facility representative's signature or resident and/or resident's representative's signature. 3. Review of Resident #2's medical record, showed the facility admitted the resident on 11/27/23, with a diagnosis of Alzheimer's disease. Review of the resident's ISP dated 1/15/25, showed no facility representative's signature or resident and/or resident's representative's signature. 4. Review of Resident #3's medical record, showed the facility admitted the resident on 10/8/24, with diagnoses which included chronic kidney disease, high blood pressure and high cholesterol. Review of the resident's ISP dated 3/10/26, showed no facility representative's signature or resident and/or resident's representative's signature. 5. During an interview on 3/10/26 at 4:57 P.M., the Administrator said the family should sign the ISP and she did not know the ISPs were missing this signature.	A4756		
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four	A4776		

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A4776	Continued From page 23 (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to provide protective oversight when the resident use kitchenette, equipped with a working gas stove/oven, was accessible to residents. This had the potential to affect all residents. The census was 48. Observation on 3/10/26 between 8:26 A.M. and 4:30 P.M., of the memory care unit's kitchenette with the red oven, showed the following: -The kitchenette had an open concept with no gate or closing mechanism; -An unlocked cabinet door at the bottom, on the left side of the oven, with a switch inside which activated the oven; -The stove top and oven were operable; -Between 3:00 P.M. and 3:21 P.M., five residents sat at a dining table adjacent to the kitchenette without staff supervision. During an interview on 3/10/26 at 4:56 P.M., the Administrator said the cabinet which held the kill switch to the oven should have been locked so the oven could not have been turned on.	A4776		
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System	A4797		

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A4797	Continued From page 24 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 Level One Medication Aide (LIMA) completed a safe and effective medication pass when he/she did not press and hold the insulin pen in a resident's stomach after injecting insulin for at least five to ten seconds, during the morning medication pass, for one observed resident (Resident #5). The census was 48.	A4797		

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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
A4797	Continued From page 25 Review of Resident #5's medical record, showed the facility admitted the resident on 11/6/24, with diagnoses which included diabetes and high blood pressure. Review of the resident's Physician's orders sheet dated 3/2026, showed the following: -Insulin, sliding scale. Inject 0-12 units subcutaneously three times daily with meals. A blood sugar of 301-350 required 8 units; -Lantus, inject 25 units by subcutaneous injection daily with breakfast. Increase Lantus by 2 units a day for morning blood sugar over 180. Observation on 3/10/26 at 8:13 A.M., showed the resident's blood sugar was 301. LIMA C prepped the resident's insulin, and the resident lifted his/her shirt to expose his/her stomach. The LIMA administered eight units into the resident's stomach and immediately removed the needle from the resident's stomach. Afterwards, the LIMA administered Lantus into the resident's stomach on the other side and immediately removed the needle from the resident's stomach. The LIMA did not press and hold the needle in the resident's stomach for at least five to ten seconds for either administration. During an interview on 3/10/26 at 4:57 P.M., the Administrator said when injecting insulin, the staff should be holding the needle in the resident's stomach for five to ten seconds.	A4797		
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:	A4836		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/10/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CEDARHURST OF DES PERES

**12826 DAYLIGHT CIRCLE
SAINT LOUIS, MO 63131**

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A4836	Continued From page 26 (A) Admission information including the resident 's name; admission date; confidentiality number; previous address; birth date; sex; marital status; Social Security number; Medicare and Medicaid numbers (if applicable); name, address and telephone number of the resident 's physician and alternate; diagnosis, name, address and telephone number of the resident 's legally authorized representative or designee to be notified in case of emergency; and preferred dentist, pharmacist and funeral director; III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to maintain a record for each resident that included contact information of the resident's preferred funeral director, for two of four sampled residents (Residents #1 and #2). The census was 48. 1. Review of Resident #1's medical record, showed the following: -Admit date 1/7/21; -Diagnoses included a fall risk, dementia, Alzheimer's disease and depression; -No documentation of preferred funeral home. 2. Review of Resident #2's medical record, showed the following: -Admit date 11/27/23; -Diagnoses included Alzheimer's disease; -No documentation of preferred funeral home. 3. During an interview on 3/10/26 at 4:59 P.M., the Administrator said the resident's preferred funeral director should be put in the resident's medical record and usually the staff put the information in the file when the resident provides the information. She said she did not know this was a requirement to have.	A4836		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER CEDARHURST OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 12826 DAYLIGHT CIRCLE SAINT LOUIS, MO 63131			
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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 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 III 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 two of two sampled direct care employee. The census was 48. 1. Review of Level One Medication Aide C's personnel file, showed the following: -Hire date 2/3/26; -A one hour training titled "Behavioral Health for	A4856			

Missouri Department of Health and Senior Services

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A4856	Continued From page 28 the Older Adult", and a one hour training titled "Alzheimer's disease and related disorders: The Disease Process"; -No third hour of Alzheimer's disease and/or dementia training. 2. Review of Resident Aide B's personnel file, showed the following: -Hire date 11/25/25; -A one hour training titled "Behavioral Health for the Older Adult", and a one hour training titled "Alzheimer's disease and related disorders: The Disease Process"; -No third hour of Alzheimer's disease and/or dementia training. 3. During an interview on 3/10/26 at 5:03 P.M., the Business Office Manager said there was a video the staff members watch but there was no documentation of how long the video was. She did not know the direct staff required three hours of training. 4. During an interview on 3/10/26 at 5:04 P.M., the Administrator said she knew the staff required a specific number of hours but did not know the requirement. She said all the employees get the same training.	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:	A4857		

Missouri Department of Health and Senior Services

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A4857	Continued From page 29 (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 III Based on interview and record review, the facility failed to ensure all employees providing non-direct care to residents had at least one hour of Alzheimer's disease and/or dementia training recorded in the employee's file, for one of two sampled non-direct care employees. The census was 48. Review of the Regional Chef's personnel file, showed the following: -Hire date unknown; -No documented Alzheimer's disease and/or dementia training. During an interview on 3/10/26 at 5:03 P.M., the Business Office Manager said there was a video the staff members watch but there was no documentation of how long the video was. She did not know the non-direct staff required one hour of training. During an interview on 3/10/26 at 5:04 P.M., the Administrator said she knew the staff required a specific number of hours but did not know the requirement. She said all the employees get the same training.	A4857		

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A7067	Continued From page 30	A7067		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure nonfood contact surfaces, were clean and free of dirt accumulation. The census was 48. 1. Observation on 3/10/26 between 8:34 A.M. and 4:30 P.M., of the memory care unit's red kitchenette, showed the following: -The cabinets were covered in brown, black, red and tan spots and streaks; -The cabinet handles were sticky to the touch; -The refrigerator freezer drawer was covered in a black and white dried substance in the crevice of the white seal; -The bottom of the freezer was covered with food crumbs; -The handle of the freezer and refrigerator were sticky to the touch; -Inside of the microwave covered in red, orange, tan and white spots and streaks on all sides, bottom and top. The microwave fan was covered in a sticky substance. 2. Observation on 3/10/26 between 8:40 A.M. and 3:38 P.M., of refrigerator #8 in the memory care kitchenette to the right side of the facility when entering the memory care neighborhood, showed the handle of the freezer and refrigerator was sticky to touch, and there was a black substance built up in the seal around the door to the freezer.	A7067		

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A7067	Continued From page 31 3. During an interview on 3/10/26 at 4:52 P.M., the Administrator said she looked at the kitchenette areas last week and did not notice the appliance's conditions. She said the Dining Service Director should be checking the kitchenette area to ensure cleanliness. MO00260853 MO00260760	A7067		
A8004	19 CSR 30-88.010(4) Resident Rights-Admission/Annual Review Each resident admitted to the facility, or his or her next of kin, legally authorized representative or designee, shall be fully informed of the individual's rights and responsibilities as a resident. These rights shall be reviewed annually with each resident, and/or his or her next of kin, legally authorized representative or designee, either in a group session or individually. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to review resident rights with residents or their representative upon admission and annually, for four of four sampled residents. (Residents #4, #1, #2 and #3). The census was 48. 1. Review of Resident #4's medical record, showed the following: -Admit date 3/25/18; -Diagnoses included high blood pressure, high cholesterol, major depressive disorder, and dementia; -No documentation of an initial resident rights review or annual reviews since admission.	A8004		

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A8004	Continued From page 32 2. Review of Resident #1's medical record, showed the following: -Admit date 1/7/21; -Diagnoses included a fall risk, dementia, Alzheimer's disease and depression; -No documentation of an initial resident rights review or annual reviews since admission. 3. Review of Resident #2's medical record, showed the following: -Admit date 11/27/23; -Diagnoses included Alzheimer's disease; -An initial resident rights review dated 11/25/23; -No documentation of an annual review since admission. 4. Review of Resident #3's medical record, showed the following: -Admit date 10/8/24; -Diagnoses included chronic kidney disease, high blood pressure, and high cholesterol; -An initial resident rights review dated 9/30/24; -No documentation of an annual review since admission. 5. During an interview on 3/10/26 at 4:43 P.M., the Administrator said the resident rights were on an initial assessment with the resident. She said typically the resident should sign the form and the form is reviewed with the resident or resident's representative annually. She said the resident reviews were completed with the resident but did not know how to show the resident had the rights reviewed with them if there was no signature on the form. She said she knew the residents required an annual review of their rights. *The higher the classification merited due to the extent of the violation.	A8004		

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A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to review resident's advanced directives with residents or their representative upon admission and annually, for four of four sampled residents (Residents #4, #1, #2 and #3). The	A8010		

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A8010	Continued From page 34 census was 48. 1. Review of Resident #4's medical record, showed the following: -Admit date 3/25/18; -Diagnoses included high blood pressure, high cholesterol, major depressive disorder, and dementia; -No documentation of an initial review of advanced directives and no annual review since admission. 2. Review of Resident #1's medical record, showed the following: -Admit date 1/7/21; -Diagnoses included a fall risk, dementia, Alzheimer's disease and depression; -No documentation of an annual review for 1/2024 or 1/2025. 3. Review of Resident #2's medical record, showed the following: -Admit date 11/27/23; -Diagnoses included Alzheimer's disease; -An initial advanced directives review dated 11/27/23; -No documentation of an annual review since admission. 4. Review of Resident #3's medical record, showed the following: -Admit date 10/4/24; -Diagnoses included chronic kidney disease, high blood pressure and high cholesterol; -An initial advanced directives review dated 9/30/24; -No documentation of an annual review since admission. 5. During an interview on 3/10/26 at 4:43 P.M.,	A8010		

Missouri Department of Health and Senior Services

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A8010	Continued From page 35 the Administrator said the advanced directives for residents were on an initial assessment with the resident. She said typically the resident should sign the form and the form is reviewed with the resident or resident's representative annually. She said the advanced directives were completed with the resident on this form, but the form was not signed by a resident or resident's representative and she did not know how to show it was completed without those signatures. *The higher the classification merited due to the extent of the violation.	A8010			

PLAN OF CORRECTION

Provider/Supplier Name:	Cedarhurst of Des Peres	
Street Address, City, Zip:	12826 Daylight Circle, St. Louis, MO 63131	
Date of Survey:	March 10, 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
A2298	19 CSR 30-86.022(17) Oxygen Storage Requirements Oxygen storage shall be in accordance with NFPA 99, 1999 Edition. II/III “Oxygen in Use” laminated signs in medication rooms for staff to hang outside of the resident door for residents with oxygen orders “Oxygen in Use” sign placed outside of room 226 O2 orders reviewed to confirm O2 signage is in place All staff in-serviced on where signs are located, how to hang the sign and when a sign is required DON or Nursing Designee to audit “Oxygen in Use” sign compliance weekly x 4 weeks and 1 x monthly for 3 months	4/8/26 3/10/26 4/10/26 5/10/26 4/9/26 On going
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 1. Memory Care kitchenette water temperature taken with a calibrated thermometer measured 118	4/6/26

	2. Community Room water temperature taken with a calibrated thermometer measured 119 3. Resident room 112 water temperature taken with a calibrated thermometer measured 114 4. Women's bathroom near PDR taken with a calibrated thermometer measured 115 5. Resident room 118 sink measured 116 and shower measured 117 Maintenance Director in-serviced on hot water temperature range of 105°F and 120°F, how to properly calibrate a thermometer and the procedure to take the water temperatures with an analog thermometer. The 3 water heaters set to 128°F to ensure water temperatures will be between 105°F and 120°F Documentation of calibration of the thermometer has been added to the weekly water temperature log ED or Designee to audit weekly water temperature logs 1 x weekly for 4 weeks	4/3/26 3/10/26 4/9/26 4/17/26 On-going
A4733	19 CSR 30-86.047(20)(I) Personnel Record-physician statement, employ The administrator shall maintain on the premises an individual personnel record on each facility employee, which shall include the following: (I) Written statement signed by a licensed physician or physician ' s designee indicating the person can work in a long-term care facility and indicating any limitations; III (Exhibit G, H, I) 1. Regional chef physician form signed by physician or physician designee 2. Resident Aide B is no longer employed by Cedarhurst 3. Resident Care Manager is no longer employed by Cedarhurst Business Office Manager (BOM) In-serviced on the need for Physician's statement to state, "Can work in long-term care." Physician or Physician's Designee form created with statement "Can work in long-term care" to be signed by the physician prior to start date.	5/10/26 4/13/26 4/9/26

	ED or Designee will audit personnel files of all new hires 1x monthly for 3 months	4/30/26 On-going
A4750	19 CSR 30-86.047(28)(F)(1)(B) Community Based Assessment - Semi-Annually 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: B. At least semiannually; II Resident #1, #2, #3 & #4 Community Based-Assessments updated with required information and no sections left blank Audit of all resident Community Based-Assessment forms to ensure no sections are left blank and updated as needed DON/ADON in-serviced on proper completion of semi-annual community-based assessment ED or nursing Designee to audit CBAs once monthly x 3 months	4/17/26 5/10/26 On-going 4/15/26 4/30/26 On-going
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 residents' condition, which may require a change in services. II Resident #6 has passed	5/10/26

	Audit of all Community Based Assessments to ensure change of condition has been documented. DON/ADON in-serviced on CBA change in condition documentation ED/DON or designee to audit CBA's for updates when a change of condition occurs 1 x monthly x 3 months (Exhibit K)	4/14/26 4/30/26 On-going
1001A4755	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 services; II Residents #7, #4, #3, #1 and #2 (#6 has passed) Individual Service Plans updated to include: • Interventions match current orders and care needs • Changes in Conditions are reflected in the ISP • Documentation, progress notes and incident reports match the ISP Audit all current ISPs to ensure the below: • Interventions match current orders and care needs • Changes in Conditions are reflected in the ISP • Documentation, progress notes and incident reports match the ISP Nurses and Department Leaders in-serviced on ISP policy and procedures including updating with changes in condition, revisions after falls and incidents complete with interventions ED/DON or Designee will audit 5 ISPs weekly X 4 weeks	4/17/26 5/10/26 4/24/26 4/14/26 On-going
A4756	19 CSR 30-86.047(28)(I) Individual Service Plan - Signatures 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: (I) Includes the signatures of an authorized representative of the facility and the resident or the resident 's legal representative in the individualized service plan to acknowledge that the service plan has been reviewed and understood by the resident or legal representative; II Residents #1, #2, #3 & #4 ISPs have been signed by a facility representative and the resident or the resident's responsible party. ADON In-serviced on ensuring all ISPs are signed by a facility representative and the resident or the resident's responsible party ED/DON or Designee will audit 5 ISPs weekly X 4 weeks for signatures	4/17/26 4/17/26 4/17/26 On-going
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident 's guardian of the resident 's departure, of the resident 's estimated length of absence from the facility, and of the resident 's whereabouts while on voluntary leave. I/II Staff immediately secured the door to the cabinet that houses the oven off/on switch with a locking mechanism. All staff in-serviced on protective oversight which requires the kill switch to the stove be behind lock and key Maintenance Director or Designee will complete daily audit to ensure cabinet remains locked x 1 month	3/10/26 5/10/26 4/13/26 On-going
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident 's condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the	

	original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II All nursing staff in-serviced on proper administration of insulin DON or Designee to observe insulin injection administration of all CMTs and LIMAs to ensure the 5-10 second hold is completed DON or Designee to audit insulin injections 1x per week for 3 weeks and then 1 X monthly x 2 months	5/10/26 5/10/26 4/12/26 On-going
A4836	19 CSR 30-86.047(58)(A) Resident Record Admission Info The facility shall maintain a record in the facility for each resident, which shall include the following: (A) Admission information including the resident ' s name; admission date; confidentiality number; previous address; birth date; sex; marital status; Social Security number; Medicare and Medicaid numbers (if applicable); name, address and telephone number of the resident ' s physician and alternate; diagnosis, name, address and telephone number of the resident ' s legally authorized representative or designee to be notified in case of emergency; and preferred dentist, pharmacist and funeral director; III Residents #1 and #2 have been updated with preferred funeral home All staff in-serviced on the Admission Information required upon admission including the funeral home ED or designee will audit Admission Information of all new residents monthly X 3 months (Exhibit W)	3/10/26 5/10/26 4/17/26 On-going
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 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: A4856 Class III 1. Level One Medication Aide C and Resident Aide B no longer work for Cedarhurst Alz/Dementia Training for Direct Care staff will be documented on an in-service sheet stating "3 hours" and signed by all new staff members	4/13/26
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 Regional Chef complete 1-hour of Alzheimer's training Dementia Training-Non-Direct Care staff will be documented on an in-service sheet stating "1 hour" and signed by all new staff members	4/17/26 4/13/25
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 Memory care kitchenettes deep cleaned to include all areas noted in the SOD. Cleaning checklists created for daily tasks to ensure cleanliness of nonfood contact surfaces and staff in-serviced Dining Services Director or Designee to audit the cleaning checklist completion daily x2 week, then monthly X 3 months	4/10/26 4/10/26 4/17/26 On-going
A8004	19 CSR 30-88.010(4) Resident Rights-Admission/Annual Review Each resident admitted to the facility, or his or her next of kin, legally authorized representative or designee, shall be fully informed of the individual's rights and responsibilities as a resident. These rights shall be reviewed annually with each resident, and/or his or her next of kin, legally authorized representative or designee, either in a group session or individually. II/III Residents #1, #2, #3 & #4 resident rights reviewed with resident or resident representative Resident Handbook & Residents Rights Acknowledgement form to be signed upon admission EHR has been updated to have Resident Rights acknowledgement added to the careplan acknowledgement form for annual review DON/ADON or designee to audit new move ins x 3months to ensure resident rights signed upon admission	4/17/26 4/13/26 On-going 4/17/26 4/30/26 On-going
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance	

	directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III Residents #1, #2 & #3 advanced directives updated Resident Handbook & Residents Rights Acknowledgement form to be signed upon admission which includes advanced directives EHR has been updated to have Advanced Directives acknowledgement added to the careplan acknowledgement form for annual review DON/ADON or designee to audit new move ins x 3months to ensure advanced directives reviewed upon admission (Exhibit DD)	4/17/26 4/17/24 4/10/26 4/30/26 On-going

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.