STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13663D	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF TESSON HEIGHTS	12335 WEST BEND DRIVE SAINT LOUIS, MO 63128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4506	19 CSR 30-86.045(3)(A)(6)(A) Individual Evacuation Plan-Staff Requirements General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 6. At a minimum the evacuation plan shall include the following components: A. The responsibilities of specific staff positions in an emergency specific to the individual; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide the responsibilities of a single staff position who would be responsible for the resident in an emergency on the Individual Evacuation Plan (IEP), for one of six sampled residents (Residents #6). The census was 64. Review of Resident #6's medical record, showed the facility admitted the resident on 12/20/24, with diagnoses which included depression, diabetes, dementia, and high blood pressure. Review of the resident's IEP dated 6/16/25, showed the following: -The resident required staff from Douglas hall to assist him/her into his/her wheelchair, go to his/her apartment door, turn left out of the door and at area of refuge; -The IEP did not address which specific staff position was assigned to the resident in a total evacuation. During an interview on 7/23/25 at 12:05 P.M., the Director of Nursing said she was responsible for the residents' IEPs. She said she went over this	A4506		

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A4506	Continued From page 1 last year and said she wrote the IEPs how she was told to last year. She said there was a Medication Technician assigned to that floor along with a "floater" who floated to two different floors. She did not know to put the specific staff position. During an interview on 7/23/25 at 12:03 P.M., the Administrator said he was aware the IEPs had to have the specific staff position on the IEP but didn't know if two staff members were covering the hall. He said if there were two staff members on the resident's hall, the IEP had to break it down to one specific staff position.	A4506		
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; 1I This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop individualized service plans which included resident needs, services to be provided by staff and goals expected by the resident or the resident's legal representative for three of six sampled residents (Residents #3, #6, and #2). The census was 64.	A4754		

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A4754	Continued From page 2 1. Review of Resident #3's medical record, showed the facility admitted the resident on 12/9/24, with diagnoses which included family history of alcohol dependence, acid reflux, diabetes, anemia, absence of left great toe. Review of the resident's progress notes, showed the following: -On 1/6/25 at 9:30 A.M., the resident had a lot of neuropathy in his/her legs; -On 3/9/25 at 4:30 A.M., the resident slipped from the toilet onto the floor. There were no injuries or bruises from the fall; -On 4/3/25 at 5:15 P.M., the resident's feet needed to be checked, and the staff needed to help the resident with his/her feet in the shower because his/her feet smelled really bad; -On 5/22/25 at 9:30 P.M., the resident had a fall while transferring from the toilet to the wheelchair. Review of the resident's ISP dated 6/11/25, showed the following: -Fall risk: the resident had been assessed and he/she was a fall risk; -Skin breakdown: the resident had been assessed and was not currently at risk for skin breakdown. Review of the resident's progress notes, showed the following: -On 6/23/25 at 9:45 A.M., the resident said he/she felt like he/she was "almost better" but wanted to know if he/she needed more antibiotic therapy. The Director of Nursing (DON) talked to the resident's Nurse Practitioner (NP) who said no and to "keep an eye" on the resident; -On 7/7/25 at 3:45 P.M., the Nurse informed home health the resident had a weeping bilateral lower extremity (wound) with strong odor and	A4754		

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A4754	Continued From page 3 edema. The Nurse contacted the resident's Physician who prescribed new medication orders; -On 7/10/25 at 11:45 A.M., the resident had open sores on his/her right lower leg; -On 7/11/25 at 9:30 A.M., the resident had a cough; -On 7/11/25 at 3:30 P.M., the DON notified the resident's NP regarding the resident having a cough and continued to have edema in his/her legs but was better today due to laying down. The resident had hoarse; lung sounds diminished but had no congestion. The resident's oxygen was going down to 77% and went back up to 85% on room air. The resident denied shortness of breath. The resident was educated to wear his/her oxygen cannula and to keep his/her legs elevated. The resident's home health Nurse would see him/her due to the open areas of his/her legs; -On 7/14/25 at 6:00 P.M., the home health Nurse wrote the resident was responding well to treatment. The resident had no open wounds and the blisters were clearing up. For the left leg, the staff were to use a paste of petroleum jelly and zinc oxide (wound ointment), wrap with Kerlix (wound bandage) and ace wraps. For the right wounds, the staff were to use Xeroform and abdominal pads. For the non-wound areas, use a paste of petroleum jelly and zinc oxide, wrap with Kerlix and ace warps. The resident had a right shin distal wound measuring 3 x 5.5. The resident used a scrub mitt (loofa), and the wound opened more. The resident was advised to no longer use the scrub mitt and to only use his/her hands to wash his/her legs. The resident had a right shin proximal wound measuring 2 x 3 centimeters (cm) and a right ankle wound measuring 1 cm x 1 cm; -On 7/15/25 at 12:45 P.M., the resident said he/she did not feel good. The DON took the	A4754		

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A4754	Continued From page 4 resident's vitals. The resident's lung sound was diminished, and she did not hear any movement. The resident's oxygen with two liters per minute went from 80 to 86%. The resident's blood pressure was 130/78. The NP said to send the resident to the emergency room; -On 7/20/25 at 12:45 P.M., the resident had a large amount of liquor and beer in his/her room. The staff was instructed by the Administrator and DON to remove the liquor and beer. The resident had 1/2 of an 18 pack box and 1/2 bottle of whiskey in the resident's refrigerator. The resident had an empty liter bottle of whiskey under his/her kitchenette sink along with an empty 18 pack box of beer. Observation on 7/22/25 at 2:45 P.M., showed the resident in his/her room seated on his/her bed. The resident had a concentrator in his/her room that had an oxygen cannula attached that the resident wore. The resident had a covered wound on his/her right shin. Review of the resident's ISP dated 6/11/25, showed the following: -The ISP did not address the resident's most recent falls or new interventions for each fall; -The ISP did not address the resident's skin issues and wounds on his/her leg; -The ISP did not address the resident's use of oxygen; -The ISP did not address the resident's liquor/beer use; -The ISP did not address the resident's need of home health care for the wounds; -The ISP did not address who would complete the wound care. 2. Review of Resident #6's medical record, showed the facility admitted the resident on	A4754		

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A4754	Continued From page 5 12/20/24, with diagnoses which included depression, diabetes, dementia, and high blood pressure. Review of the resident's progress notes, showed the following: -On 5/6/25 at 3:15 P.M., the staff were to monitor the resident's blood sugar at night because his/her blood sugar had dropped to 28 at 2:00 A.M. and Sunday, it was 88 at 2:00 A.M. On Monday, it was 44 at 2:00 A.M.; -On 5/7/25 at 12:30 P.M., the DON spoke with the resident's NP regarding the resident's blood sugar going low in the middle of the night. The NP changed the resident's orders, and the NP was to see the resident the next day. The DON called the resident's family member to let them know; -On 5/10/25 at 2:45 P.M., staff found the resident face forward on the floor, with his/her right arm twisted behind his/her back. The resident said he/she was attempting to place a covering over some boxes that were located on the floor in his/her room. The resident said he/she hit his/her head. There were three abrasions including his/her forehead, scalp and left knee. The area was cleaned with gauze, and normal saline. The resident said he/she did not want to go to the hospital. The paramedics were contacted to evaluate the resident, and they arrived at 2:09 P.M., the staff contacted the resident's family members regarding the fall, and they agreed he/she did not need to go to the hospital. Staff called the resident's Physician regarding the fall. The facility Nurse assessed the resident and vitals were taken. The resident said he/she did not have any pain currently. The resident was educated on call light use. He/she was currently upright in his/her wheelchair. The staff were to monitor the resident every hour for safety;	A4754		

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A4754	Continued From page 6 -On 5/10/25 at 11:15 P.M., the resident fell earlier on the shift and hit his/her face and head. The resident had visible injury to his/her forehead. The resident requested an as needed pain pill but did not have any orders to be given anything. The resident was asked if he/she wanted to go to the hospital to be assessed but he/she still refused to go. The resident said he/she just wanted something to make his/her headache stop; -On 5/22/25 at 4:45 P.M., the resident was restless the entire night and kept requesting Melatonin (helps regulate circadian rhythms, which are the body's natural sleep-wake cycles). The staff explained to the resident that he/she did not have orders to give that. The staff passed the information to the Nurse on call; -On 5/24/25 at 3:45 P.M., the resident told the Medication Technician, "one of these days I'm going to commit suicide." The Medication Technician instantly reported the statement to the Assistant Director of Nursing (ADON); -On 5/24/25 at 4:45 P.M., the ADON went into the resident's room where the resident was just assisted with incontinence care. The ADON said he/she needed to have a conversation with the resident and the resident told the ADON "No! I am trying to go to dinner, and everyone keeps bothering me." The ADON said he/she needed to ask him/her questions due to the fact he/she told one of the Nursing Staff he/she was going to commit suicide. The resident backed his/her wheelchair out of the bathroom and agreed to talk to the ADON. The resident was very frustrated with having to have been assisted with incontinence care. He/she then went on to tell the ADON it is all due to his/her diabetes. He/she was not properly diagnosed as a child, and the fact his/her place of employment made him/her travel all over the country, which affected his/her diabetes making it terminal and for that is the	A4754		

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A4754	Continued From page 7 reason he/she cannot control his/her bladder or bowels. The resident also discussed some resentments with his/her parents and thought they "did not want" him/her. When the ADON asked him/her why he/she told the staff he/she wanted to kill him/herself, the resident said, "Well my life is over. I cannot control any of my body anymore. The only thing that gives me any comfort is my belief that God must have me here still for a reason, maybe to help people and fix problems." The ADON allowed the resident to explain his/her exact faith beliefs and they discussed how much he/she helped people in the community. The ADON explained to him/her that when anyone under the facility's care makes threats, such as "I want to die or kill myself." Anything along those lines, the facility takes it very seriously. The resident said he/she did not want to be taken to the hospital, that he/she did not want to die but was having a frustrating day realizing more things he/she cannot do for him/herself. He/she said it was more venting than threatening and he/she had no plan to commit suicide. The ADON informed the resident if he/she was having a frustrating or hard day, to please reach out to her or other Nursing Staff, they were all there to listen and help him/her. The ADON informed him/her if there was any further threat, or even talk about taking his/her life, he/she would be sent to the hospital. The resident agreed and said he/she would "use a better choice of words." The Nursing Staff were made aware of the current action plan with the resident if anything were to occur or come up in conversation; -On 6/6/25 at 7:00 A.M., the resident had a red area on his/her bottom that was getting worse. The staff member put more barrier cream in his/her room for the staff to use while changing and encouraged the resident to lay in different	A4754		

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A4754	Continued From page 8 positions while in bed. Review of the resident's progress notes dated 6/27/25 at 6:20 P.M., showed the resident had an unwitnessed fall. Review of the resident's ISP dated 7/18/25, showed the following: -Fall risk: the resident was at risk for falls; -Safety check: the resident required safety checks at 10:00 A.M., 6:00 P.M., and 2:00 A.M.; -The ISP did not address the resident's recent falls and new interventions for each fall; -The ISP did not address the resident's suicidal ideation; -The ISP did not instruct the staff on how to monitor for the resident's suicidal ideation; -The ISP did not address the resident's red area on his/her buttock; -The ISP did not instruct the staff on how and when to monitor the resident's red area on his/her buttock. 3. Review of Resident #2's medical record, showed the facility admitted the resident on 4/6/23, with diagnoses which included major depressive disorder, degenerative disease of the nervous system, high blood pressure, unspecified fall and heart disease. Review of the resident's progress notes dated 1/15/25 at 2:03 P.M., showed the resident had an unwitnessed fall. Review of the resident's ISP dated 5/29/25, showed the following: -Fall risk: The resident had been assessed and was at risk for falling. "Please make sure that the resident was weak and having difficulty ambulating. Please encourage the resident to use	A4754		

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A4754	Continued From page 9 his/her walker."; -The ISP did not address the fall on 1/15/25 and a new intervention for the fall. 4. During an interview on 7/23/25 at 12:10 P.M., the DON said she was responsible for the resident ISPs. She said she needed staff to know how to take care of the resident, so everything the resident needs assistance with should be addressed on the ISP. She said if a resident is suicidal, it should be listed on the ISP, so the staff know how to monitor the resident's feelings. She said if a resident has a drinking habit, it should be on the resident's ISP. She said all wound details should be addressed on the resident's ISP. She said who is treating the wounds, how to treat the wounds, all of those details should be addressed on the ISP. She knew falls and interventions should be listed on the ISPs and thought she had updated most ISPs. 5. During an interview on 7/23/25 at 12:24 P.M., the Administrator said the resident's ISPs should have more detail and list every behavior, wound details, and falls on the ISP.	A4754		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/II This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility	A4798		

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A4798	Continued From page 10 failed to follow physician's orders when staff failed to administer medications and also administer medications within the two-hour window of the physician's ordered administration time for one reviewed resident (Resident #3). The census was 64. Review of Resident #3's medical record, showed the facility admitted the resident on 12/9/24, with diagnoses which included family history of alcohol dependence, acid reflux, diabetes, anemia, absence of left great toe. Review of the resident's physician's orders dated 1/2025, showed the following: -Acetaminophen (used to treat pain), 325 milligrams (mg). Take two tablets by mouth every eight hours at 6:00 A.M., 2:00 P.M., and 10:00 P.M.; -Vitamin B-12, 500 micrograms (mcg). Take two tablets by mouth daily at 8:00 A.M.; -Folic acid (used to treat vitamin deficiency), 1 mg. Take one tablet by mouth daily at 8:00 A.M.; -Furosemide (used to treat high blood pressure), 20 mg. Take one tablet by mouth daily at 8:00 A.M.; -Gabapentin (used to treat nerve pain), 400 mg. Take two capsules by mouth three times daily at 6:00 A.M., 2:00 P.M., and 10:00 P.M.; -Glimepiride (used to treat diabetes), 4 mg. Take one capsule by mouth every eight hours at 7:00 A.M.;; -Incruse (inhaler, used for asthma). Inhale one puff by inhalation route one time daily at 8:00 A.M.; -Metformin (used to treat diabetes), 1000 mg. Take one tablet by mouth twice daily at 8:00 A.M. and 4:00 P.M.; -Primidone (used to treat seizures), 50 mg. Take one tablet by mouth at bedtime at 8:00 P.M.;	A4798		

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A4798	Continued From page 11 -Pantoprazole (used to treat high blood pressure), 40 mg. Take one tablet by mouth daily at 8:00 A.M.; -Rosuvastatin (used to treat high cholesterol), 5 mg. Take one tablet by mouth one time daily at 8:00 P.M.; -Tramadol (used to treat pain), 50 mg. Take one tablet by mouth every eight hours at 6:00 A.M., 2:00 P.M., and 10:00 P.M.; -Amitriptyline (used to treat depression), 50 mg. Take one tablet by mouth at bedtime at 8:00 P.M.; -Duloxetine (used to treat depression), 30 mg. Take one capsule by mouth one time daily at 8:00 A.M.; -Pregabalin (used to treat nerve pain), 150 mg. Take one capsule by mouth twice daily at 8:00 A.M. and 4:00 P.M. Review of the resident's medication administration record (MAR) dated 1/2025, showed the following: -On 1/1/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:12 A.M., 12 minutes late; -On 1/2/25, the 4:00 P.M., dose of Metformin was given at 6:43 P.M., one hour and 43 minutes late; -On 1/6/25, amitriptyline, was not administered to the resident with no documentation as to why; -On 1/7/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:19 A.M., 19 minutes late; -On 1/10/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:23 A.M., 23 minutes late; -On 1/11/25, Rosuvastatin and amitriptyline was given at 9:38 A.M., 38 minutes late; -On 1/16/25, Rosuvastatin and amitriptyline was given at 9:21 A.M., 21 minutes late; -On 1/18/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:12	A4798		

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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
A4798	Continued From page 12 A.M., 12 minutes late; -On 1/20/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:33 A.M., 33 minutes late; -On 1/25/25, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 10:01 A.M., 61 minutes late; -On 1/29, vitamin B-12, furosemide, Incruse, Metformin and pantoprazole were given at 9:38 A.M., 38 minutes late; -On 1/30/25, the 8:00 A.M. and 4:00 P.M., doses of Pregabalin were not administered to the resident with no documentation as to why. Review of the resident's physician's orders dated 7/2025, showed the following: -Vitamin B-12, 500 mcg. Take two tablets by mouth daily at 8:00 A.M.; -Folic acid, 1 mg. Take one tablet by mouth daily at 8:00 A.M.; -Furosemide, 20 mg. Take one tablet by mouth daily at 8:00 A.M.; -Incruse. Inhale one puff by inhalation route one time daily at 8:00 A.M.; -Metformin, 1000 mg. Take one tablet by mouth twice daily at 8:00 A.M. and 4:00 P.M.; -Primidone, 50 mg. Take one tablet by mouth at bedtime at 8:00 P.M.; -Pantoprazole, 40 mg. Take one tablet by mouth daily at 8:00 A.M.; -Rosuvastatin, 5 mg. Take one tablet by mouth one time daily at 8:00 P.M.; -Duloxetine, 30 mg. Take one capsule by mouth one time daily at 8:00 A.M.; -Pregabalin, 150 mg. Take one capsule by mouth twice daily at 8:00 A.M. and 4:00 P.M.; -Spironolactone (used to treat heart failure), 25 mg. Take two tablets by mouth one time daily at 8:00 A.M.; -Torsemide, 20 mg. Take two tablets by mouth at	A4798		

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	13663D	A. BUILDING: _____ B. WING _____	C 07/23/2025

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A4798	Continued From page 13 8:00 A.M. Review of the resident's MAR dated 7/2025, showed the following: -On 7/1/25, folic acid, furosemide, Incurse, Metformin, Pregabalin, B-12 and duloxetine were given at 9:41 A.M., 41 minutes late; -On 7/3/25, folic acid, furosemide, Incurse, Metformin, Pregabalin, B-12 and duloxetine were given at 6:30 P.M., 10 hours and 30 minutes late; -On 7/10/25, folic acid, Incruse, Metformin, Pregabalin, duloxetine, Spironolactone, and torsemide were given at 12:16 P.M., four hours and 16 minutes late; -On 7/12/25, folic acid, Incruse, Metformin, Pregabalin, duloxetine, Spironolactone, and torsemide were given at 10:01 A.M., two hours and one minute late; -On 7/13/25, folic acid, Incruse, Metformin, Pregabalin, duloxetine, Spironolactone, and torsemide were given at 9:02 A.M., two minutes late; -On 7/14/25, folic acid, Incruse, Metformin, Pregabalin, duloxetine, Spironolactone, and torsemide were given at 9:44 A.M., 44 minutes late; -On 7/15/25, folic acid, Incruse, Metformin, Pregabalin, duloxetine, Spironolactone, and torsemide were given at 9:36 A.M., 36 minutes late. During an interview on 7/23/25 at 11:50 A.M., the Director of Nursing said if there is a blank in the MAR, it might be correct that the resident did not get the medication. She said there was no other way to prove the medication was given unless they counted the medication, but it came in individual packets. She said if the staff did not chart a "no pass" and didn't put anything in the blank, she wouldn't know if the medication was	A4798		

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A4798	Continued From page 14 given or not. She said some staff members said they have trouble with the internet, and they couldn't chart the medication in real time. She said the staff should be charting the medication in real time. She said after the staff give the medication to the resident, they need to go back to the medication cart and chart it right then. She said she realized this was an issue when she recently started auditing the MARs. She said the medication should be administered within one hour before or one hour after the prescribed time. During an interview on 7/23/25 at 11:56 A.M., the Administrator said he expected staff to chart the medication in real time and they should not be waiting until the end of their shift or the end of the day to chart the medication. *The higher the classification merited due to the extent of the violation.	A4798		
A8037	19 CSR 30-88.010(36) Personal Clothing/Possessions Each resident shall be permitted to retain and use personal clothing and possessions as space permits. Personal possessions may include furniture and decorations in accordance with the facility's policies and shall not create a fire hazard. The facility shall maintain a record of any personal items accompanying the resident upon admission to the facility, or which are brought to the resident during his or her stay in the facility, which are to be returned to the resident or responsible party upon discharge, transfer, or death. II/III This regulation is not met as evidenced by: Class III	A8037		

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A8037	Continued From page 15 Based on interview and record review, the facility failed to ensure personal inventory lists were completed, for six of six sampled residents (Residents #1, #4, #5, #3, #6, and #2). The census was 64. 1. Review of Resident #1's medical record, showed the following: -Admit date 3/31/18; -No documented inventory sheet. 2. Review of Resident #4's medical record, showed the following: -Admit date 2/2/24; -No documented inventory sheet. 3. Review of Resident #5's medical record, showed the following: -Admit date 2/21/24; -No documented inventory sheet. 4. Review of Resident #3's medical record, showed the following: -Admit date 12/9/24; -No documented inventory sheet. During an interview on 7/22/25 at 4:00 P.M., the Administrator said he had the inventory sheet for the resident, but did not have access to it because it was kept in the resident's business file, and he did not have access to that file because the Business Office Manager was out of the office. 5. Review of Resident #6's medical record, showed the following: -Admit date 12/20/24; -No documented inventory sheet.	A8037		

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A8037	Continued From page 16 6. Review of Resident #2's medical record, showed the following: -Admit date 4/6/23; -No documented inventory sheet. 7. During an interview on 7/22/25 at 4:00 P.M., the Administrator said he was aware all residents required an inventory sheet in their medical record.	A8037		

PLAN OF CORRECTION

Provider/Supplier Name:	Cedarhurst of Tesson Heights
Street Address, City, Zip:	12335 W Bend Drive Saint Louis, MO 63128
Date of Survey:	07/23/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	The Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Correction does not constitute an admission on the part of Cedarhurst of Tesson Heights as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of the Plan of Correction does not constitute an admission that the findings constitute a deficiency or the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the conceptus employed in Rule 407 of the Federal Rules of Evidence and any corresponding State rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in civil or criminal action against the Community or any employee.	
A4506	If the community admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the community, the community shall: 6. At a minimum the evacuation plan shall include the following components: A. The responsibilities of specific staff positions in an emergency specific to the individual.	
	1. IEPs for each resident will be updated to reflect the specific staff positions assigned to assist in an emergency specific to the individual.	8/31/2025
	2. At least seven different IEPs will be audited by the ED (or their appointee) and reviewed with the DON (or their appointee) each month for the next 90-day period.	10/7/2025
A4754	The community 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 the rule, and only if the community: (G) Develops an individualized service plan (ISP), which mean the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and goals expected by the resident or the resident's legal representative in partnership with the facility.	

Thomas D. Hornstein

	1. ISPs for each resident will be reviewed (updated as needed) to show all current interventions for most recent falls; wound details, who is treating the wounds, and how they are being treated; as well as any behaviors of concern for the residents' well-being (SI) and drinking.	10/7/2025
	2. At least seven different ISPs will be audited by the ED (or their appointee) and reviewed with the DON (or their appointee) each month for the next 90-day period following the completion of the ISP review.	10/7/2025
A4798	Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed.	
	1. All nursing staff licensed/certified to administer medication will be in-serviced by the Director of Nursing (or their appointee) on proper medication administration within the window of time according to the hour designated by the orders; including real time charting.	8/31/2025
A8037	Each resident shall be permitted to retain and use personal clothing and possessions as space permits. Personal possessions may include furniture and decorations in accordance with the facility's policies and shall not create a fire hazard. The facility shall maintain a record of any personal items accompanying the resident upon admission to the facility, or which are brought to the resident during his or her stay in the facility, which are to be returned to the resident or responsible party upon discharge, transfer, or death.	
	1. Inventory forms for all current residents will be reviewed for completion and ensure they are in their proper files by the ED (or their appointee).	8/31/2025
	2. All new resident files will be checked by the ED (or their appointee) for completed inventory forms to be in their proper files over the next 90-day period	10/7/2025

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.

Missouri Department of Health and Senior Services

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{A4754}	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 7/23/25. Based on interview and record review, the facility failed to develop individualized service plans (ISP) which included resident needs and services to be provided by staff, for seven of seven sampled residents (Residents #6, #11, #7, #3, #12, #10, and #9). The census was 59. 1. Review of Resident #6's medical record, showed the facility admitted the resident on 12/20/24, with diagnoses which included depression, dementia, high blood pressure, and diabetes. Review of the resident's observation notes, showed the following: -On 9/3/25 at 3:50 P.M., bathing needs - full assistance. No "pass": refused by resident. The resident said he/she did not want a shower and just wanted help wiping him/herself off; -On 9/5/25 at 6:45 A.M., when toileting and	{A4754}		

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{A4754}	Continued From page 1 standing at the bar across from the toilet, the resident threw him/herself back, flopping down very hard on the toilet creating redness on his/her bottom from the hard impact. Even with the assistance of staff guiding him/her to the toilet, the toilet sits so low, the resident drops down. The resident could benefit from having a toilet booster with arms; -On 9/6/25 at 12:56 A.M., the resident pressed his/her pendant and said he/she had the chills, and his/her body ached. The resident did not want medical attention at this time. The staff tried to encourage him/her to possibly get checked out at the hospital, but the resident refused; -On 9/6/25 at 4:00 A.M., the resident's beside commode arrived. The commode was put together and was in his/her room were he/she preferred it to be, next to the recliner where he/she had been sleeping; -On 9/20/25 at 5:13 P.M., bathing needs - full assistance. No pass: refused by resident. The resident said he/she did not want to get wet; -On 9/21/25 at 6:15 P.M., the resident was very confused. He/she pressed his/her light because he/she could not remember if he/she had dinner and he/she misplaced his/her keys. The resident said he/she was confused and did not know what was going on; -On 9/23/25 at 6:15 P.M., the resident was agitated throughout the majority of the night making comments about dying. The resident said he/she wished he/she would "just die already" and "everyone would be better off if he/she died but they just wanted to take his/her money" and the resident felt as though he/she was dying. The resident had a large, loose/runny bowel movement which caused the resident to become more irritated because he/she had to get in bed to be properly cleaned due to him/her not being	{A4754}		

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{A4754}	Continued From page 2 able to bear weight long enough for the staff to clean him/her while standing; -On 9/24/25 at 11:30 P.M., the resident refused to get in his/her bed and had staff put him/her in his/her recliner instead. The resident had an area on his/her bottom that he/she should be letting staff treat and it was easier to treat while he/she laid down. The resident instead wanted to be changed standing with his/her walker in front of the recliner, but he/she was unable to bear weight long enough to clean him/her properly. The resident had feces everywhere from the result of not being able to clean him/her correctly. The resident refused to lay down to be cleaned. The resident said he/she was not getting in the bed and to just "let him/her die." The staff had no issue cleaning the resident, but the resident made it very difficult to do proper care on him/her. The resident was partially clean due to his/her refusal and not cooperating and he/she cannot stand long enough to be cleaned with the very large bowel movement he/she had; -On 9/24/25 at 2:45 A.M., the resident was acting very confused tonight. The resident's call light was answered numerous times. The resident was dry and comfortable in his/her bed. The resident asked the staff member why they reached for his/her pendant every time they entered his/her room. The staff explained to him/her the pendant is what he/she or anyone who needed assistance used to notify staff help is needed. The resident said do not touch it and he/she started ranting about dying over and over. The staff asked him/her was there anything else he/she needed assistance with after trying to give words of encouragement to uplift him/her. The resident said no. Two different staff members asked the resident if they could reset the pendent and the resident refused;	{A4754}		

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{A4754}	Continued From page 3 -On 9/24/25 at 3:30 A.M., staff checked on the resident and he/she had no need for any type of assistance but refused to allow his/her pendant to be reset. The resident was confused and said he/she did not know what was going on. The staff explained to the resident what time it was and that mostly everyone was in their apartment in bed. The staff asked him/her if he/she was ready to get up and he/she said no this place is just crazy. The staff member had this experience with him/her before and will communicate the issue with the Director of Nursing; -On 9/27/25 at 9:45 P.M., the resident had low blood sugar readings. Staff checked his/her blood sugar and it was 84. The resident did not want any juice or snacks to help bring it up; -On 10/8/25 at 1:45 P.M., the resident yelled and said he/she hated being at the facility and no one knew what they were doing. The resident would be going to rehab when he/she was stable to move. Review of the resident's ISP dated 10/9/25, showed the following: -Bathing needs - full assistance. The resident required assistance with all aspects of bathing. The staff were required to assist the resident with his/her showers every Wednesday and Saturday; -Personal hygiene - reminders: the resident required reminding to take care of his/her personal hygiene and completion of the tasks. The staff were required to ensure the resident was brushing his/her teeth and assist him/her with shaving; -Use of bathroom - assistance. The resident required someone to assist him/her with all aspects of using the bathroom. The resident was incontinent of urine and required assistance with cleaning him/herself;	{A4754}		

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{A4754}	Continued From page 4 -Safety check - the resident required safety checks at 10:00 A.M., 6:00 P.M., 2:00 A.M., and as needed; -Skin breakdown risk - the resident had wounds on his/her lower legs. The resident was incontinent of urine and at a risk for skin breakdown. The staff were required to report changes of the wounds to the community nurse. The resident had wounds on his/her left foot, right toe and second toe; -The ISP did not address the resident's behavior of refusing bathroom assistance; -The ISP did not address the resident's inability to bare all of his/her weight while standing/cleaning the resident after bathroom use; -The ISP did not address the resident's suicidal comments/behaviors and did not provide interventions or phrases the staff members could use to encourage the resident to stay in good spirits. During an interview on 10/9/25 at 2:00 P.M., Resident Aide (RA) H said the resident made passive suicidal comments a lot like "let me die." RA H said the resident would refuse to go to the hospital if he/she needed to and also refused care at times. RA H said the resident was very depressed. RA H said no one in management provided additional support or educated him/her on different interventions he/she could use to care for the resident and these negative thoughts/comments. RA H said the resident had a wound on his/her bottom because the resident would refuse peri-care assistance. The resident also had to get a toilet cushion for his/her toilet. Also, the resident cursed towards the staff members quite a bit.	{A4754}		

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{A4754}	Continued From page 5 During an interview on 10/9/25 at 2:15 P.M., Certified Medication Technician (CMT) G said the resident said he/she wanted to kill him/herself once to him/her. CMT G said the resident said he/she would be better off dead. 2. Review of Resident #11's medical record, showed the facility admitted the resident on 2/17/25, with diagnoses which included high blood pressure, pre-diabetes, and heart disease. Review of the resident's observation notes, showed the following: -On 8/1/25 at 9:22 A.M., dressing - reminders/some assistance. No pass: refused by the resident. The resident refused assistance with changing his/her clothes and kept the same outfit on as yesterday; -On 8/27/25 at 2:15 P.M., the staff member went into the resident's room and saw the resident was soaking wet. The staff member asked the resident if he/she could give him/her a shower and the resident refused and said he/she would wait until after dinner. The staff member proceeded to call other staff members to talk to the resident to get him/her to shower right now and the resident said he/she did not care if he/she lost his/her privilege to go down to the dining room because of his/her smell. The resident said he/she had the right to refuse and did not care how anyone else felt about it. The staff member will try again after dinner; -On 8/27/25 at 4:00 P.M., the staff member called and spoke with the resident's family member regarding the resident having behaviors of refusing and becoming aggressive with staff as well as peeing on the floor. The resident was not changing him/herself correctly and had been smelling like urine. The resident did not want staff	{A4754}		

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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
{A4754}	Continued From page 6 to assist him/her with changing his/her depends or his/her clothes. Also, the staff member had power tools in his/her room; -On 8/29/25 at 9:30 A.M., the resident had a urine odor coming from his/her room. The staff member gathered all of the trash and while doing so, the staff found briefs in a bag on the side of the resident's bed. He/she also found an open brown bag full of trash under the bed. The staff member went to the resident's bathroom and found a large bag of briefs in the bathroom located in the shower. The staff member removed all of the trash out of the resident's room; -On 9/17/25 at 5:46 P.M., bathing needs - full assistance. No pass: refused by the resident. The resident had no clean towels. The staff washed them and will be giving him/her shower on Friday; -On 9/18/25 at 8:30 P.M., dressing - reminders/some assistance. No pass: refused by the resident. The resident refused to change his/her shirt; -On 9/20/25 at 5:53 P.M., bathing needs - full assistance. No pass: refused by the resident. He/she did not want to; -On 9/26/25 at 11:45 A.M., the resident had a strong smell of urine coming from his/her room. The staff changed the resident's bed linens and emptied the trash in the room. The staff noted the mattress still had an odor of urine after the linens were changed; -On 9/24/25 at 6:38 P.M., bathing needs - full assistance. No pass: refused by the resident. The resident said he/she wanted to do it Saturday; -On 9/30/25 at 9:50 A.M., dressing - reminders/some assistance. The resident refused to change his/her outfit this morning;	{A4754}		

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	13663D	A. BUILDING: _____ B. WING _____	R-C 10/09/2025

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{A4754}	Continued From page 7 -On 9/30/25 at 2:00 P.M., the resident refused care with toileting and changing his/her briefs him/herself only when staff informs him/her he/she smells of urine. The resident is now complaining of a sore on his/her bottom; -On 10/3/25 at 8:16 A.M., dressing - reminders/some assistance. No pass: refused by the resident. The resident wanted it tomorrow instead; -On 10/4/25 at 7:15 P.M., bathing needs - full assistance. No pass: refused by the resident. The resident wanted it tomorrow instead. Review of the resident's ISP dated 10/9/25, showed the following: -Bathing needs - full assistance. The resident required someone to assist him/her with all aspects of bathing. The resident required assistance with getting in and out of the shower and washing what the resident was unable to wash. The staff were required to ensure the resident's private areas are washed. The resident required one person assistance on Wednesday and Saturday; -Dressing - reminders/some assistance. The resident required to be reminded to dress and have assistance with clothes selection and completion of task. The staff were required to ensure the resident had clean clothes on daily; -Personal hygiene - independent. The resident did not require assistance with personal hygiene; -Use of bathroom - assistance. The resident required assistance with all aspects of using the bathroom. The resident was unable to clean him/herself properly. The staff were required to assist him/her with getting to the restroom, getting on the toilet, and the resident required assistance with cleaning his/her private area. The staff were required to ensure the resident had a	{A4754}		

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{A4754}	Continued From page 8 clean brief on; -Housekeeping - weekly. The resident required weekly housekeeping; -Laundry service - community. The resident required assistance with laundry tasks. The staff were required to change his/her sheets, wash the resident's bed linens, personal laundry and remake his/her bed every Saturday; -Linens - one time/week. The staff were required to change the resident's bed linens every Saturday; -The ISP did not address the resident's refusal of care; -The ISP did not address the resident's behavior of urinating on the floor; -The ISP did not address the resident's wound on his/her coccyx; -The ISP did not address the resident's toilet cushion; -The ISP did not address the resident's need for additional housekeeping; -The ISP did not address the resident's urine odor; -The ISP did not address the resident's frequent need of linen changes. 3. Review of Resident #7's medical record, showed the facility admitted the resident on 10/9/23, with diagnoses which included acid reflux, macular degeneration, and abnormal brain scan. Review of the resident's observation notes, showed the following: -On 8/2/25 at 9:14 P.M., bathing needs - full assistance. No pass: refused by resident. The resident's spouse helped him/her; -On 8/9/25 at 5:04 P.M., bathing needs - full assistance. No pass: refused by resident. The	{A4754}		

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{A4754}	Continued From page 9 resident said he/she did not want to today; -On 8/15/25 at 3:25 A.M., incident report fall (fall - unwitnessed) created for the resident; -On 8/20/25 at 5:34 P.M., bathing needs - full assistance. No pass: refused by resident. The resident refused and said his/her spouse will help him/her "wipe down."; -On 8/27/25 at 4:14 P.M., bathing needs - full assistance. Refused by resident. The resident's spouses will give him/her a "wipe down."; -On 8/29/25 at 8:45 A.M., the resident pushed his/her call light. The resident sat on his/her butt at the end of his/her bed. The resident was laughing as he/she said he/she got weak and sat on the floor but could not get up. The staff assisted the resident to his/her feet and the resident took off with his/her wife to breakfast. The resident said he/she was not hurt when asked if he/she needed a nurse or to go to the hospital. The resident restated "he/she did not fall and did not need to go to the hospital"; -On 8/30/25 at 3:10 P.M., bathing needs - full assistance. No pass: refused by resident. He/she said no; -On 10/5/25 at 7:13 P.M., incident report fall (fall - witnessed) created for the resident; -On 10/5/25 at 11:50 P.M., follow up - fall. No pass: refused by resident. See observation for follow up; -On 10/7/25 at 5:49 A.M., the resident was on observation for a fall. The resident was checked on throughout the night and he/she denied all pain or discomfort at this time. The staff will continue to monitor the resident for any change of condition; -On 10/7/25 at 6:17 A.M., follow up - fall. No pass: refused by resident. See observation notes.	{A4754}		

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{A4754}	Continued From page 10 Review of the resident's ISP dated 10/9/25, showed the following: -Bathing needs - full assist. Directions: the resident required assistance with all aspects of bathing. The resident required someone to assist him/her with his/her bathing on Wednesday and Saturday. The resident required assistance with all aspects of bathing. The resident required assistance with his/her bathing on Monday and Thursday; -Problematic expressions: Needs/preferences and Individualized service: None at this time. The staff were required to report any mood or behavior to the Nurse; -Fall risk - high: The resident was assessed and was at a high risk for falls. On 5/31, the resident lost his/her balance in the bathroom - educated resident to ask for assistance when needed and to take his/her time. On 8/20/24, the resident fell when attempting to get up from chair - educated the resident to make sure he/she was in front of his/her walker and feet are correct prior to getting up. On 8/21/24 - the resident bent down to pick something up and slid off his/her bed - educated the resident to ask staff for assistance when getting something off the floor; -The ISP did not address resident's spouse helping the resident with his/her bathing; -The ISP did not address the resident's refusal for bathing assistance from staff; -The ISP did not address the resident's most recent falls with specific/new interventions for each fall to help the staff prevent future falls. 4. Review of Resident #3's medical record, showed the facility admitted the resident on 12/9/24, with diagnoses which included anemia, diabetes, essential tremor, acid reflux, and arthritis.	{A4754}		

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{A4754}	Continued From page 11 Review of the resident's observation notes, showed the following: -On 9/8/25 at 7:45 A.M., throughout the night, the resident was in his/her room arguing with another resident from independent living; -On 9/8/25 at 7:47 A.M., incident report (fall - unwitnessed) created for the resident; -On 9/24/25 at 2:30 A.M., the resident had a visitor from independent living in his/her room around 1:00 A.M. Conversation began to be really loud, and the staff were able to hear the conversation while sitting at the nursing area. The staff asked the visitor to go back to his/her apartment, as he/she was disturbing the other residents on the hall. The visitor said he/she would stop yelling and the staff agreed he/she could stay. The smell of alcohol was present in the room; -On 9/27/25 at 1:27 P.M., incident report (fall - unwitnessed) created for the resident; -On 9/27/25 at 1:30 P.M., the resident was found on the floor with no injury. The resident was not able to support him/herself to get off the floor. The resident may have been drinking last night because it seemed that he/she went to sleep after he/she slid or fell out of the bed and did not push the help button; -On 9/29/25 at 2:00 A.M., the resident was on observation for a fall. The resident did not have complaints of pain or discomfort. The resident sat up in his/her wheelchair and said he/she did not need help to bed; -On 10/4/25 at 6:58 A.M., incident report (fall - unwitnessed) created for the resident. Review of the resident's ISP dated 10/9/25, showed the following: -Dining - independent. The resident required no	{A4754}		

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{A4754}	Continued From page 12 assistance with his/her dining needs; -Fall risk - the resident had been assessed and was a fall risk. The staff were required to remind the resident to wear and use his/her pendant whenever the resident needed assistance. The staff were required to answer the resident's call light or page from the resident's pendant promptly; -The ISP did not address the resident's alcohol consumption and possible fall due to consumption; -The ISP did not address the resident's visitor and disruptive behavior; -The ISP did not address the resident's most recent fall and new interventions for each fall. 5. Review of Resident #12's medical record, showed the facility admitted the resident on 8/6/24, with a diagnoses which included anemia, restless leg syndrome, high blood pressure, acid reflux, and acid reflux. Review of the resident's observation notes, showed the following: -On 9/17/25 at 5:58 A.M., incident report (fall - unwitnessed) created for the resident; -On 9/29/25 at 9:06 P.M., bathing needs - full assistance. No pass: not needed. Given by hospice; -On 10/2/25 at 2:00 P.M., hospice had a visit with the resident on 10/1/25. The resident had stable vitals at this time. The resident was sleeping more than in the prior two weeks. The resident's consumption of foods are decreased. The resident was spending majority of his/her time in the bed; -On 10/6/25 at 9:52 P.M., bathing needs - full assistance. Hospice assistance.	{A4754}		

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{A4754}	Continued From page 13 Review of the resident's ISP dated 10/9/25, showed the following: -Bathing needs - full assistance. The resident required someone to assist with all aspects of bathing. The staff were required to assist the resident with getting in and out of the shower. The staff were required to assist with washing anything the resident was unable to and washing his/her hair; -The ISP did not address the resident's need for hospice, and it did not clarify who (facility staff or hospice) was required to assist the resident with bathing. 6. Review of Resident #10's medical record, showed the facility admitted the resident on 3/28/25, with diagnoses which included diabetes, anxiety, heart failure, high blood pressure, and cognitive impairment of uncertain or unknown etiology. Review of the resident's observation notes, showed the following: -On 10/2/25 at 6:45 P.M., home health Nurse came to visit the resident, and the resident was admitted to home health and will have nursing visits for four weeks to provide disease management education. The resident was doing well, but he/she had some chaffing to his/her coccyx. The resident was instructed to apply barrier cream to the area at least daily and as needed with each bowel movement; -On 10/8/25 at 3:15 P.M., home health Nurse came to visit the resident and applied barrier cream to his/her coccyx. Review of the resident's ISP dated 10/9/25, showed the following: -Use of bathroom - assistance. The resident was	{A4754}		

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{A4754}	Continued From page 14 incontinent and used Depends. The resident required assistance with transferring on and off the toilet and pulling his/her pants and Depends up; -Safety check - the resident required daily safety checks at 10:00 A.M., 6:00 P.M., and 2:00 A.M., and as needed; -The ISP did not address the resident's chaffing on his/her coccyx; -The ISP did not address the resident's need for home health. 7. Review of Resident #9's medical record, showed the facility admitted the resident on 5/15/24, with diagnoses which included high blood pressure, heart failure, and mixed hyperlipidemia (too many lipids in the blood). Review of the resident's observations notes, showed the following: -On 10/2/25 at 6:45 P.M., late entry for 9/26/25, the resident was admitted to home health services and will have Nurse visits for a total of three weeks to provide disease management education; -On 10/4/25 at 2:21 P.M., monthly vitals/weights. No pass: refused by resident; -On 10/7/25 at 9:45 A.M., hospice visited the resident and educated him/her on chronic heart failure and the importance of daily weights. Review of the resident's ISP dated 10/9/25, showed no documentation of the resident's need for home health. 8. During an interview on 10/9/25 at 4:05 P.M., the Regional Nurse Specialist said the ISPs should have falls and interventions for each fall as well as behaviors of each resident, especially	{A4754}		

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{A4754}	Continued From page 15 with suicidal ideation/comments. She said skin tears, wounds and home health services should be indicated on the resident's ISP. She did not know the ISPs were lacking these details. During an interview on 10/9/25 at 4:07 P.M., the Administrator said he knew the previous nurse did not update the ISPs to his expectations. He said the behaviors of each resident and ways to manage the behaviors, falls and interventions to prevent future falls, hospice and home health, as well as wounds and skin tears, should all be on the resident's ISPs. He said each ISP should be specific to the resident it's referencing. MO00258342	{A4754}		
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: I added ISP information. Please move to 19 CSR 30-86.047(36) Class II Class II Based on observation and interview, the facility failed to provide proper care to one resident with bathing, dressing, personal hygiene, and housekeeping needs. The facility failed to implement interventions related to the resident's refusal for care and services to be provided. These failures resulted in the resident having an extremely strong urine odor inside his/her room and in the hallway leading to the room. The resident was observed with clothing that was	A4777		

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A4777	Continued From page 16 covered in dark spots, a brown crusty substance, and food crumbs. Other residents complained about the smell, which was noted in the hallway and the elevator. The census was 59. 1. Review of the resident's ISP dated 10/9/25, showed the following: -Bathing needs - full assistance. The resident required someone to assist him/her with all aspects of bathing. The resident required assistance with getting in and out of the shower and washing what the resident was unable to wash. The staff were required to ensure the resident's private areas are washed. The resident required one person assistance on Wednesday and Saturday; -Dressing - reminders/some assistance. The resident required to be reminded to dress and have assistance with clothes selection and completion of task. The staff were required to ensure the resident had clean clothes on daily; -Personal hygiene - independent. The resident did not require assistance with personal hygiene; -Use of bathroom - assistance. The resident required assistance with all aspects of using the bathroom. The resident was unable to clean him/herself properly. The staff were required to assist him/her with getting to the restroom, getting on the toilet, and the resident required assistance with cleaning his/her private area. The staff were required to ensure the resident had a clean brief on; -Housekeeping - weekly. The resident required weekly housekeeping; -Laundry service - community. The resident required assistance with laundry tasks. The staff were required to change his/her sheets, wash the resident's bed linens, personal laundry and remake his/her bed every Saturday;	A4777		

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A4777	Continued From page 17 -Linens - one time/week. The staff were required to change the resident's bed linens every Saturday. Review of the resident's ISP dated 10/9/25, showed the following: -The ISP did not address the resident's refusal of care; -The ISP did not address the resident's behavior of urinating on the floor; -The ISP did not address the resident's need for additional housekeeping; -The ISP did not address the resident's urine odor; -The ISP did not address the resident's frequent need of linen changes. Observation on 10/9/25 between 8:57 A.M. and 3:00 P.M., on the second floor, throughout the hallway near Resident #11's room, showed the following: -An extremely strong urine odor which started before Resident #11's room and the odor increased closer to the room; -Resident #11 lay in his/her bed and the strong urine odor permeated the resident's bedroom; -The resident's TED (compression stockings designed to prevent blood clots and leg swelling) hose had a white and clear substance on them. The resident's shorts were covered in dark spots, a brown crusty substance and food crumbs. During an interview on 10/9/25 at 9:50 A.M., Resident #11 said the staff helped him/her shower and he/she refused showers at times. The resident said "there is a difference in definition" because if the staff say they are supposed to be at his/her room at 6:00 A.M. and the staff come at 7:00 A.M., he/she will not shower that day. The resident said the staff	A4777		

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A4777	Continued From page 18 usually helped him/her toilet but did not know how many times a day that happened. The resident said he/she did not wait until he/she was saturated before calling the staff for assistance. The resident said he/she urinated often but there was a "definition", and the Caregivers say he/she was wet, but he/she knew he/she was not wet per this "definition." During an observation and interview on 10/9/25 at 10:08 A.M., Resident #13 propelled his/her wheelchair past the resident's room. The resident said he/she had to wheel past Resident #11's room several times a day and the hallway always "stunk." The resident said it was "disgusting." He/she said Resident #11 was a "nice person", but he/she needed to shower more. The resident said the odor "really bothered" him/her. He/she said Resident #11 invited him/her into his/her room once and Resident #13 "about gagged", because the odor was so horrible. During an interview on 10/9/25 at 10:30 A.M., Resident #14 said he/she smelled urine, and it was "terrible in the hallway." He/she said the odor came from a person up the hall from him/her. He/she said the odor "really bothered" him/her. Resident #14 said Resident #11 always had his/her door open and when a person walked past the room, "it's really bad" (speaking of the odor). Resident #14 said he/she had been at the facility for about a year and had noticed the odor the entire time. During an interview on 10/9/25 at 2:30 P.M., Certified Medication Technician (CMT) F said Resident #11 refused showers often. He/she said the resident required assistance with toileting and was on a toileting schedule. CMT F said it was	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13663D	A. BUILDING: _____ B. WING _____	R-C 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF TESSON HEIGHTS	12335 WEST BEND DRIVE SAINT LOUIS, MO 63128

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A4777	Continued From page 19 not okay to have other residents and family members "roll through the funk." He/she thought the Housekeepers should go into the resident's room daily and change the resident's bed. During an interview on 10/9/25 at 2:43 P.M., CMT G said Resident #11 refused assistance "a lot." He/she said the odor had been there since he/she started, three months ago. CMT G said the resident required assistance with changing his/her clothes, toileting and showering. CMT G said he/she did not want to change his/her clothes for the staff. CMT G said the resident would wet the bed a lot and Housekeepers would go into his/her room daily, but the odor was still present. CMT G said the resident would refuse a shower often and there would be urine on the floor and the resident would refuse staff to clean the urine up. CMT G said even when he/she would see the wetness on the floor, the resident would still reject assistance. CMT G said the resident was "very rejectful" of the assistance. CMT G said all of the residents complain about the odor. Observation on 10/9/25 between 9:50 A.M. and 10:45 A.M., showed a heavy urine odor inside the elevator. During an interview on 10/9/25 at 4:03 P.M., the Regional Nurse Specialist said she was not aware of the odors coming from Resident #11's room. During an interview on 10/9/25 at 4:03 P.M., the Administrator said he was aware of the resident's odors. He met with the family about the odor and how the resident was urinating on the floor. The Administrator said the resident told him he/she	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13663D	A. BUILDING: _____ B. WING _____	R-C 10/09/2025

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A4777	Continued From page 20 wanted the staff to tell him/her when he/she smells but then would refuse assistance to be changed. The Administrator said he had a care plan meeting with the family and the resident, and the resident said he/she did not need help. He had not issued a discharge letter to the resident yet but thought about it. The Administrator said he was aware other residents were complaining of the odor. MO00258342	A4777		

PLAN OF CORRECTION

Provider/Supplier Name:	Cedarhurst of Tesson Heights
Street Address, City, Zip:	12335 W Bend Drive Saint Louis, MO 63128
Date of Survey:	10/09/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	The Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Correction does not constitute an admission on the part of Cedarhurst of Tesson Heights as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of the Plan of Correction does not constitute an admission that the findings constitute a deficiency or the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the conceptus employed in Rule 407 of the Federal Rules of Evidence and any corresponding State rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in civil or criminal action against the Community or any employee.	
A4754	The community 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 the rule, and only if the community: (G) Develops an individualized service plan (ISP), which mean the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and goals expected by the resident or the resident's legal representative in partnership with the facility.	
	1. ISPs for each resident will be reviewed (updated as needed) to show all current interventions for most recent falls; wound details, who is treating the wounds, and how they are being treated; as well as any behaviors of concern for the residents' well-being (SI) and drinking. This will be completed by the Regional Nurse Specialist or appointee and audited for a 90 day period after the revisit.	11/26/2025
A4777	Residents shall receive proper care as defined in the individualized service plan.	11/26/2025
	1. Discuss with the resident and POA the conversation had with DHSS surveyors regarding the resident needing a	

	higher level of care based on constant refusal of care that is imposing on other residents.	
	2. Provide an involuntary discharge letter to the resident for needing a higher level of care based on constant refusal of care.	
	3. Ensuring any further incidents with residents of refusing care does not impose on the rights of other residents, to be ongoing by the Regional Nurse Specialist & Executive Director (or appointees).	

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.