STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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) COMPLETION DATE
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to follow its policy to have an Administrator who planned, directed and monitored compliance with State and Federal government regulatory agencies by not having an active Administrator on-site on a full time basis. The facility census was 123. Review of the facility's (undated) job description for the Administrator, showed: -Job Title: Administrator; -Reports To: Chief Operating Officer; -Status: Exempt; -Positions Summary: -Provides leadership, oversight and administration to all long-term care operations. Responsible for ensuring maximum operating efficiency, overall cost-effectiveness, and strict compliance with all applicable State and Federal rules and regulations; -Develops, monitors and improves facility quality standards; -Essential Duties and Responsibilities: -Develops and ensures the implementation	F 835		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/9/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	**322 OLD STATE ROAD ELLISVILLE, MO 63021**

(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) COMPLETION DATE
F 835	Continued From page 1	F 835		

of the facility's short and long-term goals and objectives;

-Establishes, supports and continually assesses the facility structure for maximum realization of objectives;

-Assures that facility maintains standards at the highest possible level and is responsible for results of survey by the Department of Health;

-Develops, implements and assesses facility policies and procedures to ensure compliance with applicable State and Federal rules, regulations, and accreditation standards;

-Oversees and directs the department heads in direct line of responsibility. Conducts regular department head meetings to promote a constant flow of information, open discussions, knowledge sharing and to keep department heads well-informed;

-Oversees, evaluates and ensures the ongoing delivery of care and services. Provides routine analysis of the quality of care based on observation, customer service surveys and feedback;

-Plans, directs and monitors compliance with State and Federal government regulatory agencies;

-Ensures the implementation and continued maintenance of facility standards in compliance with the organization's values, goals and objectives;

-Participates actively in census development and public relations process to provide input and management;

-Maintains contacts with peers and professional colleagues among other local health care facilities, vendors, service providers, and other potential referral sources;

-Serves as a mentor, leader, and role model, representing the corporation in a manner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	**322 OLD STATE ROAD ELLISVILLE, MO 63021**

(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) COMPLETION DATE
F 835	Continued From page 2	F 835		

that conveys professionalism, confidentiality, courtesy, honesty and fairness;
-Promotes excellent community relations;
-Performs all tasks and duties in an efficient and safe manner;
-Performs other related duties as assigned or as necessary;
-Remains flexible and adaptable in work schedules and work assignments as defined by departmental and facility needs;
-Represents the corporation in a manner that conveys professionalism, confidentiality, courtesy, fairness, personal integrity, and respect for the fundamental rights, dignity, personal comfort and privacy of others;
-In the event that the corporation has an opening for an Administrator in any of its Missouri facilities, the current Administrator will be responsible for assigning a licensed Administrator to assume duties at Heisinger Bluffs. The Administrator will serve as the interim Administrator for the vacant facility until a permanent hire is made, or until the current administrator notifies the corporation that he/she is no longer able to accommodate the interim assignment;
-Signed by: Administrator M and Dated 1/20/2025;
-The job description did not include if the position was a full time position and/or a remote position.

Review of an email sent to the facility's Residents and Family members on 1/21/25 at 5:40 P.M. showed; Dear facility Residents and Family Members, I hope this message finds you well. At this facility, we value transparency and want to share some important updates regarding our leadership and medical services. As of today, Former Administrator L is no longer the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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) COMPLETION DATE
F 835	Continued From page 3	F 835		

Administrator of the facility. We are pleased to announce that Administrator M will be stepping in as Interim Administrator while we conduct a search for a permanent replacement. Many of you may remember, Administrator M's name, from her time as Interim Administrator last summer. In addition to her experience here, Administrator M , serves as the Executive Director of Heisinger Bluffs and Heisinger Bluffs West in Jefferson City. She is deeply committed to ensuring the care and well-being of your loved ones remains our top priority. If you have any questions or concerns Administrator M can be reached directly and her personal cell phone and/or her work email address.

1. During interviews on 3/28/25 at 6:53 A.M., 8:55 A.M., 10:30 A.M., and 3:00 P.M., the Director of Nursing (DON) said she was aware the facility had had multiple citations "one right after the other", including three Immediate Jeopardies (IJ). It seemed like there had been a different surveyor in the facility every week with multiple complaints. The facility couldn't get one thing fixed before there was something else. She had never seen anything like it. The facility had an interim Administrator. Administrator M would not be at the facility today because she had a survey team in her other building in Jefferson City, MO. Administrator M was an interim Administrator at the facility and split her time between the facility in St. Louis, MO and two other facilities in Jefferson City, MO. Administrator M usually worked two to three days in St. Louis and the remaining time at the other two facilities. It would benefit the facility to have a full time Administrator. Administrator M was available by phone or text but it was not the same as having that support in the facility. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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) COMPLETION DATE
F 835	Continued From page 4	F 835		

corporation does not have a local Regional Nurse Manager to assist with the day to day operations of the facility. She was only one person and could only handle so much. It had been overwhelming the past couple of months since former Administrator L left.

2. During an interview on 3/28/25, at 6:57 A.M., the Assistant Director of Nursing (ADON) said Administrator M was physically in the facility two to three times a week. Administrator M was over two additional facilities in Jefferson City, MO.

3. During interviews on 3/28/25 at 8:11 A.M., and 3/28/25 at 11:00 A.M., the Human Resource (HR) representative said Administrator M was an interim Administrator. Administrator M was onsite at the facility two to three days per week. She splits her time between the facility in St. Louis and two additional facilities in Jefferson City.

4. During an interview on 3/28/25, at 8:40 A.M., Administrator M said she was in the facility five days per week. She worked a 40 hour week. She would not be in the facility today because she was in Jefferson City. There is no way to track the time she actually spent working in the facility.

5. During an interview on 3/28/25, at 8:55 A.M., Staffing Coordinator (SC) A said he/she had worked at the facility for a little over a month. Administrator M was not physically in the facility five days a week. Administrator M was there maybe two to three days a week. She splits her time between St. Louis and Jefferson City.

6. During an interview on 3/28/25, at 9:13 A.M., Social Worker (SW) C said Administrator M did not typically work a five day week at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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) COMPLETION DATE
F 835	Continued From page 5	F 835		

Administrator M was there at the most three days a week. Administrator M was also the Administrator of two additional facilities in Jefferson City. Administrator M was there last week for five days, but that was the first time he/she could recall the Administrator M was in the facility for five consecutive days.

7. During an interview on 3/28/25, at 9:15 A.M., Registered Nurse (RN) D said Administrator M was there Monday through Friday last week. Other than that, Administrator M was usually there two to three days a week. She splits her time between one home in St. Louis and two homes in Jefferson City.

8. During an interview on 3/28/25, at 9:22 A.M., Admissions Coordinator (AC) E said Administrator M was onsite in the facility approximately three days a week. She had two additional facilities in Jefferson City she was responsible to oversee. Administrator M was the interim Administrator. AC E believed the facility had hired a new full time Administrator, but he/she didn't know when that person was supposed to start.

9. During an interview on 3/28/25, at 9:28 A.M., Medical Records (MR) F said the Administrator M was in the facility on a flexible schedule. Administrator M was usually in the building two to three days per week, but had worked up to five days in the past. Administrator M was also the Administrator at two facilities in Jefferson City. Administrator M was an interim Administrator and was only working until a full time Administrator could be hired for the facility.

10. During an interview on 3/28/25, at 9:30 A.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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) COMPLETION DATE
F 835	Continued From page 6	F 835		

Licensed Practical Nurse (LPN) G said Administrator M was physically in the facility about three days per week. Administrator M was not in the facility today because there was an ongoing survey at her other facility.

11. During an interview on 3/28/25, at 9:32 A.M., Business Manager (BOM) F said Administrator M averaged maybe two or three days physically in the facility. Administrator M was also the Administrator of two facilities in Jefferson City. Administrator M was available by phone if BOM F needed anything.

12. During an interview on 3/28/25, at 9:37 A.M., the Director of Rehabilitation (DOR) I said Administrator M was did not work five days a week in the facility. She worked remotely. Administrator M averaged about three days a week in the facility. Administrator M was also the Administrator of two additional facilities in Jefferson City.

13. During an interview on 3/28/25, Activity Director (AD) J said Administrator M was not physically in the facility five days a week. Administrator M was the interim Administrator. Administrator M split her time between the facility and two other facilities in Jefferson City.

14. During an interview on 3/28/25, at 10:15 A.M. Housekeeping and Laundry Supervisor (HLS) K said Administrator M did not work a 40 hour week in the facility. Administrator M worked two to three days a week because she was also the Administrator at two facilities in Jefferson City. When Administrator M was in the facility things seemed to be much calmer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. BUILDING _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	**322 OLD STATE ROAD ELLISVILLE, MO 63021**

(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) COMPLETION DATE
F 835	Continued From page 7 15. During an interview on 3/28/25, at 2:00 P.M. the Ombudsman for the facility said the facility had not had a full time Administrator since Administrator L left in January. Administrator M was splitting her time between St. Louis and Jefferson City, MO. The Ombudsman had heard complaints and concerns voiced by residents and residents' family members about the lack of a full time Administrator in the facility. He/She has been in contact with the Administrator M by email. He/She felt there should be a full time Administrator on site at least five days a week.	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15226A	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLISVILLE REHABILITATION AND NURSING	322 OLD STATE ROAD ELLISVILLE, MO 63021

(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
A4004	19 CSR 30-85.042(4) Administrator-Full Time, Multiple Facilities The administrator shall be employed in the facility and serve in that capacity on a full-time basis. An administrator cannot be listed or function as an administrator in more than one (1) licensed facility at the same time, except that one (1) administrator may serve as the administrator of more than one (1) licensed facility if all facilities are on the same premises. II/III This regulation is not met as evidenced by: *Class II See the deficiency cited at F835. *The higher classification merited due to the extent of the violation.	A4004		

PLAN OF CORRECTION

Provider/Supplier Name:	Ellisville Rehabilitation and Nursing
Street Address, City, Zip:	322 Old State Rd. Ellisville, MO 63021
Date of Survey:	03/28/2025

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
F835/A4004	• No residents were directly affected • All residents have the potential to be affected • Independent LTC consultant provided education to the administrator on the requirements of affective administration per regulation • A corporate office designee will monitor that training requirements are being met • Training will be provided to the newly hired administrator • Greentree contacted the independent LTC consulting company to assist with Ellisville on March 25, 2025 This consulting group is providing support, education and resources to managers and staff. • The consulting company was on site at Ellisville April 1-3 and April 7-8/2025. In addition there have been frequent remote assistance and support • On April 9, 2025 Ellisville established a bi-weekly call with the independent LTC consulting company and the corporate office to monitor plans of corrections and review any newly identified opportunities. In addition, the LTC consulting company is available for remote support as needed. A return on-site visit has been scheduled for April 21-23/2025	04/03/2025

	• Ellisville has a full-time administrator on-site effective 4/1/2025 • Administrator job description has been updated to reflect it is a full-time position • Administrator will clock in and out each day. Should a time punch be missed the Administrator will fill out a time punch card and turn into Human Resources and Regional Director of Operations • All time punches will be available upon request • Administrator hours will be reviewed in quarterly QAPI meetings with oversite from the independent LTC consultants and corporate representative.	

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.