

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27826	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/01/2025
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NAME OF PROVIDER OR SUPPLIER FIELDS OF FLORISSANT	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GARDEN PLAZA DRIVE FLORISSANT, MO 63033
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A4754	<p>19 CSR 30-86.047(28)(G) Individual Service Plan - Develop</p> <p>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:</p> <p>(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</p> <p>This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop an individualized service plan (ISP) related to Resident #1's behavioral needs and strategies for staff to use when providing personal care to ensure resident and staff safety. This effected one of one sampled resident. The census was 65.</p> <p>Review of Resident #1's medical record, showed the facility admitted the resident on 9/12/24, with a diagnosis which included unspecified dementia with anxiety.</p> <p>Review of the resident's individualized service plan (ISP) dated 1/17/25, showed the following: -Need: Behaviors. The resident had non-active, but history of behavioral issues; -Need: Dressing and Grooming. The resident required standby assist/set up with dressing and/or grooming; -Need: Transfer Assistance. The resident required staff to standby with all transfers.</p> <p>During an interview on 7/21/25 at 9:15 A.M., the</p>	A4754		
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Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Kevin Leng #16908</i>	Administrator (outgoing)	8/28/2025
<i>Rachel Marie Orsog #1327</i>	Administrator (incoming)	8/28/2025

STATE FORM 5899 7LSG11 If continuation sheet 1 of 10

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A4754	<p>Continued From page 1</p> <p>Executive Director said on 7/20/25 at around 5:30 A.M., Resident Care Assistant (RCA) A and RCA B were getting the resident changed and dressed for the day. The resident started to resist care and stiffen his/her body up which is something he/she is known to do. When this happens, the staff are to back away from the resident and reapproach at a later time. The staff did not back away from the resident. RCAA was behind the resident and had the resident's arm crossed over his/her chest. When the resident tried to pull away from RCAA, he/she pushed the resident onto the bed and immediately started punching him/her.</p> <p>During an interview on 7/25/25 at 2:44 P.M., RCA A said the resident is always "fiesty" during care. He/She knows the resident's going to be fiesty and it's nothing they can avoid. From working with the resident he/she knew the resident needed to be "restrained" in order to provide care.</p> <p>During an interview on 7/25/25 at 3:01 P.M., the Resident Care Director (RCD) said the Clinical Support Coordinator (CSC) told her that she knows the resident would "beat on" staff and the staff knows the resident is combative.</p> <p>During an interview on 7/29/25 at 3:19 P.M., the CSC said all the staff know the resident is aggressive during care. The resident was known to get combative with the female caregivers when they tried to change him/her.</p> <p>During an interview on 7/30/25 at 1:11 P.M., the RCD said she learned she's responsible for writing the ISPs. She said she had training to walk her through how to do it. Behavior-wise, if they are not aggressive it should not be included in their ISP. It should be included if they are</p>	A4754		

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A4754	Continued From page 2 having behaviors. She did not think it should be included on the resident's ISP, because he/she does not have behaviors if you are not aggressive with him/her. During an interview on 7/30/25 at 2:10 P.M., the Administrator said the RCD is responsible for doing the ISPs. She said they were in the process of changing systems and the old ISPs did not have the behaviors, but it should have.	A4754		
A8022	19 CSR 30-88.010(22) Free From Abuse Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion. I This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when Resident Care Assistant (RCA) A restrained and struck the resident in the face. Additionally, immediate steps were not taken to ensure residents were protected from further potential abuse, resulting in RCA A continuing to provide direct care to residents for an additional 2 hours. The census was 65. Review of the facility's Abuse Neglect and Exploitation policy (revised 2/19/25), showed the following: -Any Community staff member or volunteer who has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Resident Care Director, and Executive Director.	A8022		

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A8022	<p>Continued From page 3</p> <p>In all cases the Executive Director will be informed as soon as possible;</p> <p>-Staff must take seriously any resident comments about potential abuse or unusual physical/mental signs/conditions that may indicate possible abuse;</p> <p>-Upon the notice of reported, observed, suspected, or at imminent risk of any form of abuse, immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted. The alleged perpetrator will have NO CONTACT with any residents during the investigation.</p> <p>Review of Resident #1's medical record showed the facility admitted the resident on 9/12/24, with a diagnosis of unspecified dementia with anxiety.</p> <p>Review of the resident's individualized service plan dated 1/17/25, showed the following:</p> <p>-Need: Behaviors. The resident had non-active, but history of behavioral issues;</p> <p>-Need: Dressing and Grooming. The resident required standby assist/set up with dressing and/or grooming;</p> <p>-Need: Transfer Assistance. The resident required staff to standby with all transfers.</p> <p>During an interview on 7/25/25 at 3:41 P.M., RCA B said on 7/20/25 around 5:30 A.M., he/she was doing rounds and the resident was one of his/her "morning get ups." While he/she was starting to assist the resident, he/she became combative. RCA A came in the room to give the resident his/her medications and help with getting him/her up for the day. When the resident became combative, RCA A put both arms on the resident trying to hold him/her down. The resident bit RCA A and he/she started punching the resident like</p>	A8022		

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A8022	<p>Continued From page 4</p> <p>he/she was "fighting someone on the street." RCA B said RCA A told him/her to hold down the resident's legs and he/she told him/her no. He/she said he/she then tried to call the RCD, but did not get an answer at first. He/she said the resident's nose and mouth were bleeding and his/her hands were bruised up. RCA B said RCA A told him/her to "do this yourself" and walked out of the room. RCA B said RCA A should not have hit the resident.</p> <p>During an interview on 7/25/25 at 2:44 P.M., RCA A said he/she was assisting the resident to take his/her medications. He/she went into the room to give the medications and assist RCA B to get the resident up for the day. He/She told the resident it was time to get up for the day. He/she said the resident started "throwing fists" at him/her. He/she took the resident's wrists and tried to hold them together and told him/her to stop fighting. He/she did not grab the resident, was "just restraining" him/her. He/she said the resident is always "feisty" and the situation was nothing he/she could have avoided. He/she said the resident's wheelchair was too close to the wall so when he/she transferred the resident into the wheelchair, he/she hit his/her arm on the wall, causing the skin tear. RCA A said he/she went to get a towel to stop the bleeding and wrap the arm up. He/she then let RCA B finish getting him/her up. He/she said the resident hit him/herself in the face when he/she was fighting RCA A and when he/she was restraining the resident. He/she did not get a chance to write a statement about the incident, because he/she was getting off work and later the RCD called and told him/her he/she was suspended.</p> <p>During an interview on 7/21/25 at 9:15 A.M., the Executive Director (ED) said on 7/20/25 at around</p>	A8022		

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A8022	<p>Continued From page 5</p> <p>5:30 A.M., Resident Care Assistant (RCA) A and RCA B provided care to the resident. The two workers were getting the resident changed and dressed for the day. The resident started to resist care and stiffen his/her body up, which is something he/she is known to do. When this happens, the staff are to back away from the resident and reapproach at a later time. The staff did not back away from the resident. RCA A was behind the resident and had the resident's arm crossed over his/her chest. When the resident tried to pull away from RCA A, he/she pushed the resident onto the bed and immediately started punching him/her. RCA A punched the resident five or six times and scratched his/her face with his/her long nails in the process. RCA B kept saying "stop, what are you doing, stop it." RCA B got the resident dressed and placed in his/her wheelchair. RCA A tried to pull the wheelchair out of the room, but the resident tried stopping him/her and RCA A pulled harder which caused a skin tear to the resident's elbow from the door frame. After the resident was out of the room, RCA B immediately called the Resident Care Director (RCD). The RCD was out of town and not at the facility. RCA B and RCA A were both on the phone with the RCD on speaker and the two were arguing back and forth. RCA A kept saying he/she did not put his/her hands on the resident, but RCA B kept saying, "yes you did." They were raising their voice at each other. The ED said he did not get a call from the RCD, but at 4:52 P.M., he was at the facility and saw the resident in the dining room, eating ice cream and that is when he saw the laceration and bruising on the resident's face. The ED called the resident's physician who said to send him/her to the hospital and get a CT scan.</p> <p>Review of the resident's hospital emergency</p>	A8022		

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A8022	<p>Continued From page 6</p> <p>department notes dated 7/20/25, showed the following:</p> <ul style="list-style-type: none"> -Resident had a history of dementia. Per emergency medical services (EMS), EMS was called to the facility because a staff member assaulted the resident. The staff wanted the resident evaluated to make sure he/she had no acute injuries. Per EMS, he/she was complaining of left wrist and arm pain and had some superficial abrasions on his/her face; -Linear superficial abrasions lower face and right lateral neck. No active bleeding; -Assault victim; -Assault, left arm pain. No acute fractured seen of wrist and elbow x-ray. <p>During an interview on 7/25/25 at 10:22 A.M., Resident #1 said he/she did not remember how his/her injuries happened. He/she does not have a good memory anymore. He/she thought it happened "one night." He/she did not know what it was all about, but remembered going to the hospital</p> <p>During an interview on 7/25/25 at 3:01 P.M., the RCD said she was informed by RCA B around 5:30 A.M. on 7/20/25, that RCA A was hitting the resident while they were trying to get him/her up for the day. She called the Clinical Support Coordinator (CSC). She said the CSC told her that she knows the resident would "beat on" staff and the staff know the resident is combative. She said later in the day, around 1:30 P.M., RCA B sent her pictures of the scratches and bruises on the resident. She then called the Executive Director to inform him of the incident. She said the Executive Director was already in the facility and he contacted the resident's physician and the resident was sent out to the hospital.</p>	A8022		

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A8022	<p>Continued From page 7</p> <p>During an interview on 7/29/25 at 3:19 P.M., the CSC said on 7/20/25 at 5:58 A.M., the RCD called her and said a worker needed help with getting the resident up for the day. She said the RCD told her RCAA went to help and he/she blacked the resident's eye. She said when she got to work the next day, there was no black on the resident's eye and nothing purple. She did not go into the facility on 7/20/25. She said everyone knew the resident was aggressive.</p> <p>During an interview on 7/30/25 at 1:11 P.M., the RCD said the resident is only combative when people are aggressive with him/her. You have to talk to the residents nicely. She had been trained on what to do when a resident is combative. When they get like that, you just stop and come back. You give them time. Ask them if there's something hurting them, ask them questions, see if they're trying to communicate something, and then just give them time and come back. Some of the staff told her a couple of the staff on nights were too aggressive, too rude and we "nipped it in the bud." Those staff weren't nice to the resident. That's why he/she would have behaviors. She has not seen a lot of the behaviors since RCAA is no longer there. At the time, she thought she was supposed to call the Executive Director. She said later, she figured out she should have called the Administrator and not the Executive Director. She said RCAA probably left the facility on 7/20/25 at 7:30 A.M., because he/she kept calling. We watched the camera, at the facility, for the whole shift and all we saw RCAA do after she left the resident's room was go get other residents up and pass pills. At most, he/she would have gone into ten other resident rooms. She said RCAA could absolutely have had an incident with the other residents after the incident with Resident #1. When she called the CSC, the CSC said</p>	A8022		

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A8022	<p>Continued From page 8</p> <p>there was no way possible that incident would have happened. She said she told her there was no need to go in and assess the resident. She wanted to suspend RCAA right then, but she wasn't sure what to do. She said the CSC told her there was no need to suspend him/her. The RCD said she should have suspended him/her immediately. She said she was new to her position and was not fully sure what was going on. She said she was out of town and could not come into the facility and felt the CSC should have gone in to assess the resident and not wait until Monday morning.</p> <p>During an interview on 7/30/25 at 2:10 P.M., the Administrator said she was not notified until 5:09 P.M. on 7/20/25 of the incident. She said the RCD should have called her at the time of the incident. It was not an acceptable time frame to report the incident. She said the instructions the staff had originally said to report to the Executive Director and if they could not get a hold of him, then they could call her. She said there were no other concerns from other residents about RCAA and she was not sure how many residents she would have seen after the incident. She said she had assumed because of the incident, RCAA would have immediately left the building, because when they looked at his/her time sheet he/she had not clocked in or out for the shift. She did not know RCAA stayed in the building and continued to work with residents until 7:30 A.M. No one had shared that information with her.</p> <p>MO00257425</p> <p>NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the</p>	A8022		

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A8022	<p>Continued From page 9</p> <p>onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the imminent danger was removed.</p>	A8022		

PLAN OF CORRECTION

Provider/Supplier Name:	Fields of Florissant	
Street Address, City, Zip:	1101 Garden Plaza Drive, Florissant, MO 63033	
Date of Survey:	8/01/2025	
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A4754	<p><i>19 CSR 30-86.047 (28)(G) Individual Service Plan</i></p> <p><i>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, only if the facility:</i></p> <p><i>(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 resident's legal representative in partnership with the facility; II</i></p> <p>All residents will have their Individual Service Plans written to ensure their needs and preferences, services to be provided and expected goals.</p> <p>Service Plans are initiated upon admission, with significant change, with re-admission and at least annually. This will be done by the Resident Care Director. It will be monitored for compliance by the Executive Director/Administrator, ongoing.</p> <p>Resident #1's Individual Service Plan has been updated to reflect behavioral issues when assisting residents with dressing/grooming and during transfers.</p>	<p>Ongoing</p> <p>Ongoing</p> <p>7/31/2025</p>

	<p>All Individual Service Plans will be audited to ensure that they are updated to include resident behaviors.</p>	<p>9/15/2025</p>
<p>A8022</p>	<p>19 CSR 30-88.010 (22) Free From Abuse</p> <p><i>Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion.</i></p> <p>In-Services on Abuse, Neglect & Exploitation were conducted with all employees to immediately address the issues of failing to meet this regulation.</p> <p>All employees will receive Abuse, Neglect & Exploitation Training upon hire during their initial orientation. This will be done by the Business Office Director. The Executive Director/Administrator will monitor for compliance.</p> <p>This training will be reviewed semi-annually so that all employees understand that they are mandated reporters and that all residents shall be free from abuse. This will be done by the Business Office Director & Resident Care Director. The Executive Director/Administrator will monitor for compliance.</p> <p>The training courses will include reporting procedures per state as well as the Willow Ridge Policy & Procedures for Abuse, Neglect and Exploitation. Employees will understand the importance of documenting, investigating and immediately reporting to the Resident Care Director and the Executive Director/Administrator. The Resident Care Director will ensure this standard is met. The Executive Director/Administrator will monitor for compliance.</p> <p>All employees will receive training upon hire on reporting incidents and understanding the chain of command. This will be done by the Business Office Director. The Executive Director/Administrator will monitor for compliance.</p>	<p>7/21/2025</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

	<p>In-Services were completed on reporting incidents to the administrator and understanding the chain of command procedures.</p> <p>The Resident Care Director and the Business Office Director will ensure that in the future the alleged perpetrator is immediately suspended pending further investigation and removed from the community so that they do not have any contact with residents. The Executive Director/Administrator will monitor for compliance.</p> <p>In-Services on Resident Behaviors were conducted with all employees to help employees understand residents' behaviors, those that may be resistant to care and when to walk away and reapproach later.</p> <p>The Resident Care Director will conduct in-services on Resident Behaviors if there is an immediate change in the condition of a resident and their behaviors that was not previously noted. The Executive Director/Administrator will monitor for compliance.</p> <p>The Resident Care Director will monitor residents' mental and emotional well-being to ensure their residents feel safe and secure. The Executive Director/Administrator will monitor for compliance.</p> <p>The Business Office Director will ensure all employees receive and review resident rights upon hire during the orientation process. The Executive Director/Administrator will monitor for compliance.</p> <p>The Business Office Director will ensure that Resident Rights will be reviewed with employees semi-annually. The Executive Director/Administrator will monitor for compliance.</p> <p>In-Services on Resident Rights were conducted so that all employees understand residents have rights.</p>	<p>07/31/2025</p> <p>Ongoing</p> <p>7/31/2025</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>9/05/2025</p>
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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.