Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05047A	A. BUILDING: _____ B. WING _____	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARI DE VILLA RETIREMENT CENTER, INC	13900 CLAYTON ROAD TOWN AND COUNTRY, MO 63017

(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
A2026	19 CSR 30-85.022(10)(I) Smoke Detectors-Interconnected to FA System Complete Fire Alarm Systems. (I) All facilities shall have smoke detectors inter-connected to the complete fire alarm system in all corridors and spaces open to corridors. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure all spaces open to corridors were equipped with smoke detectors inter-connected to the facility's complete fire alarm system. This deficiency had the potential to affect residents and staff in two smoke compartments in the West building. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. 1. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the employee dining room, showed the space was open to the corridor. A cased opening/doorless passageway connected the employee dining room to the main corridor of the facility. The frame of the opening featured a latch cup, strike plate and holes from previously installed hinges but no door was installed in the opening to separate the employee dining room from the corridor. No smoke detection was installed in the employee dining room. During an interview on 5/11/26 at 12:50 P.M., Maintenance Technician R said there used to be a door installed in the cased opening between the employee dining room and the corridor. He/She	A2026	See attached plan of correction	

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A2026	19 CSR 30-85.022(10)(I) Smoke Detectors-Interconnected to FA System Complete Fire Alarm Systems. (I) All facilities shall have smoke detectors inter-connected to the complete fire alarm system in all corridors and spaces open to corridors. Smoke detectors shall be no more than thirty feet (30') apart with no point on the ceiling more than twenty-one feet (21') from a smoke detector. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure all spaces open to corridors were equipped with smoke detectors inter-connected to the facility's complete fire alarm system. This deficiency had the potential to affect residents and staff in two smoke compartments in the West building. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. 1. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the employee dining room, showed the space was open to the corridor. A cased opening/doorless passageway connected the employee dining room to the main corridor of the facility. The frame of the opening featured a latch cup, strike plate and holes from previously installed hinges but no door was installed in the opening to separate the employee dining room from the corridor. No smoke detection was installed in the employee dining room. During an interview on 5/11/26 at 12:50 P.M., Maintenance Technician R said there used to be a door installed in the cased opening between the employee dining room and the corridor. He/She	A2026		

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A2026	Continued From page 1 was not sure when the door was removed or why it was removed. He/She did not realize the employee dining room did not have a smoke detector. 2. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the sitting area across the hall from resident room 7 in the West building, showed the space was open to the corridor, through a cased opening/doorless passageway. Large non-porous, moisture resistant wall panels were installed on the lower half of the walls of the space and a call light was installed on a wall. During an interview on 5/11/26 at 12:15 P.M., Maintenance Technician R said the sitting room used to be an enclosed bathroom with a door. The door was removed from the room when it was converted to use as a sitting area. He/She was not aware a smoke detector was not installed in the space. 3. During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said he was aware areas open to the corridor needed to feature smoke detection. There did used to be doors on both the employee dining room and the converted sitting area in the West building. He was not sure when the doors were removed. The need to install smoke detectors in those spaces when the doors were removed was overlooked.	A2026		
A2032	19 CSR 30-85.022(11)(B) No Complete Sprinkler System Prior to 8/28/07 Sprinkler System. (B) All facilities licensed prior to August 28, 2007, that were not required to have a complete	A2032		

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A2032	Continued From page 2 sprinkler system in accordance with NFPA 13 shall have until December 31, 2012, to comply with NFPA 13, 1999 edition. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure the building was fully equiped with a complete sprinkler system in accordance with NFPA 13. This deficiency had the potential to affect residents and staff in one smoke compartment in the East building. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the laundry/soiled utility room in the East building, showed a closet approximately 18 square feet in size towards the back corner of the room. The closet was separated and enclosed from the rest of the room by walls and a door. The main area in the room featured sprinklers, but no sprinkler was installed inside the closet area. During an interview on 5/11/26 at 10:38 A.M., Maintenance Technician R said he/she was not aware the closet didn't have a sprinkler in it, and he was not sure why one was not installed. During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said he was not aware the closet in the laundry/soiled utility room in the East building did not have a sprinkler. The building should be fully sprinklered, and he was not sure why that area was not.	A2032		

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A2034	Continued From page 3	A2034		
A2034	19 CSR 30-85.022(11)(C) Sprinkler System-Test/Maintain Sprinkler System. (C) Facilities that have a sprinkler system installed prior to August 28, 2007, shall inspect, maintain, and test these systems in accordance with the requirements in effect for such facilities on August 27, 2007. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 (Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems). Staff failed to maintain sprinkler heads free of debris and ensure sprinklers were unobstructed. This deficient practice had the potential to affect all building occupants in five smoke compartments. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. 1. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., showed the following: -In the linen closet next to room 07 in the West building, a white substance on the sprinkler head; -In the elevator control room adjacent to the nurse's station near room 27 in the West building, a white substance on the sprinkler head; -In the bathroom behind the nurse's station near room 27 in the West building, a white substance on the sprinkler escutcheon; -In the laundry room, near the dryers above the clothes finisher and near the door to the boiler room, the sprinklers all loaded with dust.	A2034		

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A2034	Continued From page 4 During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said maintenance was responsible to ensure sprinklers were maintained. They should carefully clean the sprinklers if they are dusty or have foreign materials on them. 2. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the bathroom behind the nurse's station near room 40 in the West building, showed a light fixture in the room, installed directly next to the sprinkler head on the ceiling. There was less than 1/2 inche of space between the sprinkler deflector and the cover on the light fixture. 3. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the linen closet near the rear secured entrance/exit door, adjacent to the East nurse's station, showed clean linen supplies stacked on the top shelf in the closet, only 10 inches below the sprinkler head in the closet. 4. During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said sprinkler heads should be maintained free of obstructions. He was not aware of the two sprinkler heads that were obstructed. NFPA 25 (2011) 5.2.1.2* The minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. NFPA 13 (2010) 8.5.5.2.1 Continuous or noncontinuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall	A2034		

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A2034	Continued From page 5 comply with 8.5.5.2. NFPA 25 (2011) 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). NFPA 25 (2011) 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.	A2034		
A2041	19 CSR 30-85.022(16) Door Locks Door locks shall be of a type that can be opened from the inside by turning the knob or operating a simple device that will release the lock, or shall meet the requirements of Section 19.2 of NFPA 101, 2000 edition. Only one (1) lock will be permitted on any one (1) door. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure all exit doors were free of impediments to full instant use in the case of a fire or other emergency when the delayed-egress exit doors leading outside from the end of the	A2041		

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A2041	Continued From page 6 Waterford hall in the West building did not unlock and release to open when the fire alarm was activated. This deficiency had the potential to affect residents, staff and other occupants in one smoke compartment in the West building. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., showed a set of double delayed-egress exit doors led outside from the end of the Waterford hall in the West building. Both doors featured signage indicating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." When pressure was applied to the door, a countdown sequence initiated, the locking devices disengaged, and the doors released to open after 15 seconds. Observations during the fire alarm test on 5/11/26, between 2:45 P.M. and 3:00 P.M., showed the facility's fire alarm system was activate twice by means of a manual pull station device. Both times the fire alarm was activated, the double delayed-egress exit doors at the end of the Waterford hall in the West building remained locked. The locking devices installed on each door did not release to allow building occupants to rapidly exit while the fire alarm was active. The doors only released when pressure was applied and a 15 second countdown sequence was completed. During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said the delayed-egress exit doors leading outside at the end of the Waterford hall in the West building should have unlocked and released so occupants	A2041		

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A2041	Continued From page 7 could freely egress through them when the fire alarm was activated. He was not sure why the doors remained locked and did not open during the fire alarm test. All exit doors should be checked during fire drills, when the fire alarm is tested, to ensure they unlock and open. He was not aware of any issues reported with those doors not unlocking during fire drills. He was not aware of any work recently competed on the doors that would have impacted their programming.	A2041		
A2061	19 CSR 30-85.022(33)(D) Fire Drill Requirements, Evacuation (D) A minimum of twelve (12) fire drills shall be conducted annually with at least one (1) every three (3) months on each shift. At least four (4) of the required fire drills must be unannounced to residents and staff, excluding staff who are assigned to evaluate staff and resident response to the fire drill. The fire drills shall include a simulated resident evacuation that involves the local fire department or emergency service at least once a year. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure fire drills were conducted on each shift, quarterly, for three of four quarters reviewed. This deficiency had the potential to affect all residents and staff of the facility. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. Review of the facility's fire drill records on 5/11/26, showed the following:	A2061		

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A2061	Continued From page 8 -In the second quarter of 2025 (April-June), only one fire drill completed on 6/24/25 at 9:45 A.M., during the day shift. No fire drills completed on the evening shift or night shift during the second quarter of 2025; -In the third quarter of 2025 (July-September), a fire drill completed on 7/15/25 at 2:00 P.M. during the evening shift and a fire drill completed on 8/26/25 at 1:30 P.M., during the day shift. No fire drills completed on the night shift during the third quarter of 2025; -In the fourth quarter of 2025 (October-December), a fire drill completed on 10/18/25 at 1:00 P.M., during the day shift and on 12/15/25 at 3:15 P.M., during the evening shift. No fire drills completed on the night shift during the fourth quarter of 2025. During an interview on 5/11/26 at 5:00 P.M., the President of the facility/Administrator B said he was aware fire drills were supposed to be conducted on each shift, at least once quarterly. The person who was previously responsible for conducting the fire drills resigned from the facility some time ago. Both he and the Director of Nursing were now responsible for conducting fire drills, along with the assistance of maintenance staff. He was aware some of the fire drills were not completed last year while the former employee was still responsible for the task. *The higher classification merited due to the extent of the violation.	A2061		
A3030	19 CSR 30-85.032(31)(A) Electrical Wiring & Equipment Maintained Electrical Wiring Requirements. (A) Electrical wiring and equipment shall be	A3030		

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A3030	Continued From page 9 installed and maintained in accordance with the NFPA 70, 1999 edition. Facilities that were complying prior to the effective date of this rule with prior editions of the NFPA 70 referenced in this rule shall be permitted to continue to comply with the earlier editions, as long as there is not an imminent danger to the health, safety, or welfare of any resident or a substantial probability that death or serious physical harm would result as determined by the department. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all electrical wiring and equipment was maintained in accordance with NFPA 70 requirements. This deficiency had the potential to affect residents and staff in 10 smoke compartments. The facility has a capacity of 224 and had a census of 81 residents at the time of the licensure inspection. 1. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., showed the following: -In the East building salon, an outlet on the wall approximately 4 feet from the outside edge of the hair washing sink. The outlet did not feature ground fault circuit interrupter (GFCI) protection; -In the West building janitor's closet near room 51, an outlet on the wall approximately 4 feet from the outside edge of the mop sink. The outlet did not feature GFCI protection; -In the West building janitor's closet near room 17, an outlet on the wall approximately 3 feet from the outside edge of the mop sink. The outlet did not feature GFCI protection; -In the West building utility closet near the first floor nurse's station, an outlet serving a clothes	A3030		

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A3030	Continued From page 10	A3030		

washing machine. The outlet did not feature GFCI protection;
-In the laundry room in the West building, multiple outlets serving the laundry area, near washing machines and sinks. None of the outlets were GFCI protected.

2. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., showed the following:
-In a utility closet near rooms 61/62 in the East building, an electrical panel with items stored in front of/underneath it;
-In the West building janitor's closet near room 17, an electrical panel with items stored in front of/underneath it;
-In the boiler room attached to the laundry room in the West building, multiple pieces of electrical equipment with various items stored in front of/underneath them.

3. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., showed the following:
-In the bathroom across the hall from room 07 East, a light fixture with a missing cover;
-In the closet labeled "RPSI" in the East building, the light fixture was loose, unsecured and hanging slightly downward from the ceiling.

4. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the electrical panels in the stairwell across the hall from the Waterford dining/sitting room, showed one of two panels with a key in the lock on the panel enclosure door. Both panels in the stairwell were unlocked and accessible to the public.

5. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M.,

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A3030	Continued From page 11 showed a junction box missing a cover and with exposed wires, above the ceiling near room 27 in the West Building. 6. Observations during the fire safety tour on 5/11/26, between 8:30 A.M. and 5:00 P.M., of the employee dining room, showed exposed wires on the ceiling where a fixture had been removed. 7. During an interview on 5/11/26 at 5:30 P.M., the President of the facility/Administrator B said all electrical equipment should be maintained. He was aware outlets within 6 ft of the outside edges of sinks needed to be GFCI protected. He was not sure why some of them had not bee upgraded. He was aware a clear working space needed to be maintained around electrical equipment and staff should not be storing items too close to electrical equipment. The exposed wires on the ceiling in the dining room and above the ceiling in the West building should be properly covered. NFPA 70 (2011) 110.31 Enclosure for Electrical Installations. (D) Enclosed Equipment Accessible to Unqualified Persons. Ventilating or similar openings in equipment shall be designed such that foreign objects inserted through these openings are deflected from energized parts. Where exposed to physical damage from vehicular traffic, suitable guards shall be provided. Nonmetallic or metal-enclosed equipment located outdoors and accessible to the general public shall be designed such that exposed nuts or bolts cannot be readily removed, permitting access to live parts. Where nonmetallic or metal-enclosed equipment is accessible to the general public and the bottom of the enclosure is less than 2.5 m (8 ft) above the floor or grade level, the enclosure door or hinged	A3030		

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A3030	Continued From page 12	A3030		

cover shall be kept locked. Doors and covers of enclosures used solely as pull boxes, splice boxes, or junction boxes shall be locked, bolted, or screwed on. Underground box covers that weigh over 45.4 kg (100 lb) shall be considered as meeting this requirement.

NFPA 70 (2011) 110.32 Work Space About Equipment. Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (6 1/2 ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 110.34(A). In all cases, the work space shall permit at least a 90 degree opening of doors or hinged panels.

NFPA 70 (2011) 210.8 (B) Other Than Dwelling Units. All 125-volt, singlephase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.
(1) Bathrooms
(2) Kitchens
(3) Rooftops
(4) Outdoors
Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel

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A3030	Continued From page 13 are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. *The higher classification merited due to the extent of the violation.	A3030		
A4017	19 CSR 30-85.042(17) Criminal Background Check Request Effective August 28, 1997, each facility shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony	A4017		

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A4017	Continued From page 14 violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant ' s criminal record shows that no such conviction occurred. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to check the Criminal Background Checks (CBC, criminal history check conducted in accordance with Missouri law) and the Employee Disqualification List (EDL, a registry maintained by the Missouri Department of Health and Senior Services identifying individuals prohibited from employment in long-term care facilities) prior to allowing the employees to work with residents. Eight employee files were reviewed, and issues were found with all eight files.(Employee# BB, #CC, #DD, #EE, #GG, #AA, #FF, and #HH) The census was 81. Review of the facility's CBC and EDL policy, undated, showed: -Policy statement: The facility shall conduct required criminal background checks and EDL screenings for all applicable individuals prior to employment and as required thereafter. Individuals listed on the Missouri EDL or otherwise prohibited by Missouri law shall not be employed or permitted to provide care to residents; -Pre-Employment Screening Requirements: Prior to allowing an individual to work independently or provide direct care, the facility shall complete an EDL screening and initiate a CBC. Individuals listed on the EDL shall not be hired or retained;	A4017		

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A4017	Continued From page 15 -Documentation of EDL checks and background screenings shall be maintained in personnel files and made available for survey review. 1. Review of Employee BB's employee file, showed: -Date of Hire was: 3/19/26; -Start date was: 4/25/26 -CBC was completed on: 5/11/26; -EDL was completed on: 5/11/26. 2 .Review of Employee CC's employee file, showed: -Date of Hire was: 4/15/26; -CBC was completed on: 5/11/26; -EDL was completed on: 5/11/26. 3. Review of Employee DD's employee file, showed: -Date of Hire was: 4/8/26; -CBC was completed on: 5/11/26; -EDL was completed on: 5/11/26. 4. Review of Employee EE's employee file showed: -Date of Hire was: 3/25/26; -CBC was completed on: 5/11/26; -EDL was completed on: 5/11/26. 5. Review of Employee GG's employee file, showed: -Date of Hire was: 2/19/26; -CBC check was completed on: 5/11/26; -EDL was completed on: 5/11/26. 6. Review of Employee AA's employee file, showed: -Date of Hire was: 2/24/26; -CBC was completed on: 5/11/26	A4017		

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A4017	Continued From page 16 7. Review of Employee FF's employee file, showed: -Date of Hire was: 3/26/26; -CBC check was completed on: 5/11/26. 8. Review of Employee HH's employee file, showed: -Date of Hire was: 3/11/26; -CBC was completed on: 5/11/26. During an interview on 5/11/26 at 5:13 P.M., Administrator A said he would expect for the CBC and EDL checks to be completed prior to the employee caring for the residents. *The higher classification merited due to the extent of the violation.	A4017		
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to administer the two step Tuberculin Skin Testing (TST, the standard method for screening for tuberculosis lung disease) series for new	A4031		

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A4031	Continued From page 17	A4031		

employees. Eight employee files were reviewed, and issues were found with four (Employee #CC, #FF, #HH and #AA). The census was 81.

Review of the facility's Tuberculosis (TB) Screening and Monitoring policy, undated, showed:
-New employees must provide proof of a negative TB test completed within the previous twelve months. If proof cannot be provided, the facility shall administer the first step of a two-step TB test
between the time of hire and the employee's first day of work (orientation period);
-The second step of the TB test shall be administered 14 days after the first step.

Review of 19 CSR 20-20.100 TB Long-Term Care Employees and Volunteers. All new long term care facility employees and volunteers who work ten 10 or more hours per week are required to obtain a Mantoux PPD two-step tuberculin test within one month prior to starting employment in the facility. If the initial test is zero to nine millimeters (0-9 mm), the second test should be given as soon as possible within three weeks after employment begins, unless documentation is provided indicating a Mantoux purified protein derivative (PPD, standard skin test used to screen for TB) test in the past and at least one subsequent annual test within the past two years. It is the responsibility of each facility to maintain documentation of each employee's and volunteer's TB status.

1. Review of Employee CC's employee file, showed:
-Date hired: 4/15/26;
-There was no documentation showing a TB test was administered or the employee had a TB test

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A4031	Continued From page 18 in the last year. 2. Review of Employee FF's employee file, showed: -Date hired: 3/26/26; -Received TB test on 3/26/26. The results were 0 mm; -There was no documentation showing the second step was administered. 3. Review of Employee HH's employee file, showed: -Date hired: 3/11/26; -Received TB test on 3/11/26. The results were 0 mm; -There was no documentation showing the second step was administered. 4. Review of Employee AA's employee file, showed: -Date hired: 2/24/26; -Received TB test on 2/24/26. The results were 0 mm; -There was no documentation showing the second step was administered. During an interview on 5/11/26 at 5:13 P.M., Administrator A said he would expect the two step TB test to be administered per protocol.	A4031		
A4059	19 CSR 30-85.042(50) Self-Administration of Medication Self-administration of medication is permitted only if approved in writing by the resident's physician, and it is in accordance with the facility's policy and procedures. II This regulation is not met as evidenced by:	A4059		

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A4059	Continued From page 19 Based on observation, interview and record review, the facility failed to ensure residents' right to self-administer medications had been determined as clinically appropriate for four residents, who had medications at their bedside (Resident #8, #10, #11 and #12). The census was 81. Review of the facility's Medication Administration policy, undated, showed: -Procedures: -Verify physician orders for all medications prior to administration; -Prepare medications in a clean, well-lit area; -Administer medications via the prescribed route and observe for adverse reactions; -Document administration immediately after giving the medication; -Staff responsibilities: ensure medications are administrated safely and accurately; -Documentation: -Record all administered medications in the residents Medication Administration Record (MAR); -Document refusals, omissions and resident responses. 1. Review of Resident #8's hard chart, located at the nurse's station, showed: -Admitted on 1/9/26; -Alert and orientated times three (person, place, time); -Diagnoses include hypotension (low blood pressure), diabetes, anxiety, depression, malignant neoplasm prostate (cancerous tumor), obstructive sleep apnea (OSA, breathing repeatedly stops and starts during sleep); -There was no assessment completed to show the resident could self-administer medications.	A4059		

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A4059	Continued From page 20 Observation on 5/11/26 at 9:35 A.M., showed on the over bed table there were three open Sinex nasal inhalers and a box with a fast-acting nasal inhaler. He/She said he/she used the nasal inhalers "sometimes" when his/her nose was "plugged". In the bathroom there was a package with three Sinex inhalers and a package with two boxes of Mucinex. Review of the progress notes, dated 1/9/26 through 5/11/26, showed no documentation the physician was aware the resident had medications at bedside and could self-administer. Review of the physician order sheet, dated 4/21/26 through 5/20/26, showed: -A physician order for Mucinex (over the counter (OTC) expectorant) 600 milligrams extended release (ER), take one tablet every 12 hours as needed for congestion. The order failed to show may keep at bedside and self-administer. -There was no physician order Sinex (OTC, medication to help relieve nasal stuffiness) or fast acting inhaler (OTC, medication used to help relieve nasal congestion) and there was no physician order he/she may keep medications at the bedside, Observation on 5/11/26 at 1:25 P.M., showed the medications remained on the over the bed table. During an interview on 5/11/26 at approximately 1:30 P.M., Registered Nurse (RN) Q said it was okay for the resident to have OTC nasal sprays in his/her room. The doctor was aware and it was okay. 2. Review of Resident #10's hard chart, located at the nurse's station, showed: -Alert and orientated times three;	A4059		

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A4059	Continued From page 21 -Diagnoses included prostatic hypotension (orthostatic hypotension (a drop in blood pressure upon standing), edema, hernia with repair and congestive heart failure (heart can't pump blood well enough to give the body a normal supply); -There was no assessment completed to show the resident could self-administer medications. Observation on 5/11/26 at 10:55 A.M., showed the resident sat in a chair in his/her room. On a table next to the chair were two albuterol inhalers (Bronchia dilator, "rescue inhaler") a bottle of Tylenol, a box with debrox ear drops (over the counter (OTC) used to soften wax) and a box with triamcinolone 0.1% cream (used for inflammation and itching). The resident said he/she used the inhaler daily and the Tylenol when needed. The last time he/she took Tylenol was three to five days ago for pain. The triamcinolone cream was used when he/she had shingles. Review of the progress notes, dated 2/20/26 through 5/11/26, showed, on 3/30/26 no time documented, resident self-administered Debrox ear wax drops five to 10 drops twice daily. Resident educated. Review of the physician order sheet, dated 4/21/26 through 5/20/26, showed: -A physician order, may not have OTC medications in room; -A physician order for Debrox 6.5% ear drops place four drops into ear, drop five to 10 drops in each ear for four days then irrigate and repeat as needed. The order did not show the medication could be left at bedside and self-administered; -A physician order for Acetaminophen (Tylenol) 325 mg every six hours as needed for mild pain. The order did not show the medication could be	A4059		

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left at bedside and self-administered;
-A physician order for Albuterol HFA 90 micrograms (mcg) inhale two puffs by mouth every six hours as needed. The order did not show the medication could be left at bedside and self-administered;
-There was no physician order for the triamcinolone cream.

Observation on 5/5/26 at 1:00 P.M., showed the medications remained in the same place on the table next to the chair.

During an interview on 5/11/26 at approximately 1:30 P.M., RN Q said the resident self-administered the triamcinolone cream when he/she had shingles. The inhalers were his/her rescue inhalers, and they could be kept at the bedside. Also, the debrox was okay to be left at the bedside.

3. Review of Resident #11's hard chart, located at the nurse's station, showed:
-Admitted 3/13/26;
-Diagnoses included right lower extremity (RLE) wound, right femur fracture (partial or complete break in thighbone), high blood pressure, high cholesterol, migraines, depression, anxiety and irritable bowel syndrome (IBS, chronic functional gastrointestinal disorder).
-There was no assessment completed to show the resident could self-administer medications.

Observation on 5/11/26 at 10:30 A.M., showed the resident lay in bed. On the overbed table was a cup with six pills in it. When asked about the pills, the resident said he/she did not feel well, and he/she would take the pills later.

Review of the physician order sheet dated

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A4059	Continued From page 23 4/21/26 through 5/20/26, showed: -A physician order for aspirin 81 mg take one tablet daily for cardiovascular disease (cvd); -A physician order for sertraline 50 mg take one tablet once daily for depression; -A physician order for vitamin D3 2000 units take one tablet once daily for supplement; -A physician order for Senex on-S 50-8.6 mg, take two tablets twice daily for constipation; -A physician order for multivitamin take one every day (supplement). Review of the MAR dated 4/21/26 through 5/20/26, showed: -A physician order for aspirin 81 mg take one tablet daily for cvd; -The medication was documented as administered on 5/11/26; -A physician order for sertraline 50 mg take one tablet once daily for depression; -The medication was documented as administered on 5/11/26; -A physician order for vitamin D3 2000 units take one tablet once daily for supplement; -The medication was documented as administered on 5/11/26;. -A physician order for Senex on-S 50-8.6 mg, take two tablets twice daily for constipation; -The medications were documented as administered on 5/11/26; -A physician order for multivitamin take one every day (supplement); -The medication was documented as administered on 5/11/26. Observation on 5/11/26 at 1:05 P.M., showed the medication cup with the six pills remained on the over the bed table. During an interview on 5/11/26 at approximately	A4059		

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A4059	Continued From page 24 1:30 P.M., RN Q said the resident requested to have his/her medications left at the bedside today. The six medications in the med cup were his/her morning medications. The resident was not having a good day today and he/she got upset when they tried to remove the medications from the room. RN Q said the pills have been thrown away. 4. Review of Resident #12's hard chart, located at the nurse station, showed: -Diagnoses included diabetes with stage three chronic kidney disease (high blood sugar has caused moderate long term kidney damage), high cholesterol, chronic systolic heart failure (heart failure); -There was no assessment completed to show the resident could self-administer medications. Observation on 5/11/26 at 11:00 A.M., showed the resident lay in bed. On the overbed table next to the bed was a medicine cup with three pills in it. Two white round pills and a small blueish-green tablet. The resident said the medication was Tylenol and he/she has not taken Tylenol in quite some time. There also was an Astepro nasal inhaler (OTC, antihistamine nasal spray). He/She said he/she used the inhaler when he/she was clogged up. Review of the physician order sheet dated 4/21/26 through 5/20/26, showed: -A physician order for may not have OTC medication in room; -A physician order for loperamide two mg, take one four times daily as needed for diarrhea; -A physician order for Acetaminophen 325 mg, takes two tablets three times daily as needed; -There was no physician order showing the medications could be left at bedside and the	A4059		

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resident could self-administer.

Observation on 5/11/26 at 1:00 P.M., showed the resident not in his/her room. The medications remained on the over the bed table.

During an interview on 5/11/26 at approximately 1:30 P.M., RN Q said the white pills in the medication cup were Tylenol and the green pill was loperamide. The resident took the medication when he/she needed it. It was okay for the resident to have the medications at his/her bedside.

5. During an interview on 5/11/26 at 1:25 P.M., Licensed Practical Nurse (LPN) O said when he/she administered medications, he/she documented on the MAR after the medications were administered. If a resident refused medication, he/she signed the MAR and circled his/her initials and documented on the back of the MAR the reason the medications were not administered. Medications could not be left in the room. If a resident did not take their medications, he/she would remove the medications and try again later. Residents needed a physician's order to self-administer their medications and to keep them at the bedside. If a resident could self-administer their medications, it would be documented in the progress notes.

6. During an interview on 5/11/26 at 3:55 P.M.,. the Director of Nursing (DON) said the facility did not have an assessment for residents to self-administer medications. A resident would need a physician order to self-administer medications and to be able keep medications at bedside. If a resident did not take their medications, staff should remove the medications from the room and retry later.

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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to follow acceptable nursing practices when staff did not follow physician orders to ensure a safe mechanical lift transfer, when staff left the resident unattended while in the lift (Resident #6). The facility staff failed to ensure wound care treatments were documented (Resident #11). The facility staff also failed to ensure a resident was provided with an ordered mechanical soft diet (Resident #1). The sample size was 13. The census was 81. Review of the facility's Sit-to-Stand policy, undated, showed: -Purpose: To establish procedures for the safe and effective use of sit-to stand-lifts in accordance of state regulations; -Procedures: -Assess resident's physical and cognitive ability to use the sit-to stand lift; -Verify physician or care plan authorization for use of the lift; -Inspect lift equipment for cleanliness and functionality before each use; -Explain the procedure to the resident and ensure comfort and cooperation; -Position the lift and sling according to manufacturers instructions; -Safely transfer the resident and monitor for	A4075		

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signs of discomfort or distress;
-Return equipment to designated storage and sanitize after each use;
-Staff responsibilities:
-Operate lift equipment safely and according to training;
-Report equipment malfunctions or safety concerns immediately;
-Maintain resident dignity and safety during transfers.

Review of the facility's undated Wound Care policy, showed:
-Staff responsibilities: ensure wound care is provided as ordered and documented timely.

Review of the facility's undated Medication Administration policy, showed:
Documentation: document administration immediately after giving the medication and document refusals, omissions, and resident responses.

Review of the undated physician order compliance policy, showed:
-Purpose: to ensure all physician, advanced practice nurse and physician assistant orders are accurately received, implemented, documented and followed in accordance with regulations;
-Scope: applied to all nursing staff, ancillary staff and medical records personnel;
-Implementation of orders: orders shall be implemented promptly, transcribed accurately into the medication administration record (MAR) and treatment administration record (TAR) and followed as written unless clarification is required;
-Inability to carry out orders: if an order cannot be implemented due to resident refusal, facility limitation, or resource unavailability, the physician and Director of Nursing (DON) shall be notified

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A4075	Continued From page 28 immediately and documentation completed. 1. Review of Resident #6's monthly summary and care plan, dated 5/6/26, showed: -Severe cognitive impairment; -Requires assistance of two staff members for transfers using a mechanical lift; -Diagnoses includes urinary tract infection (UTI), weakness, kidney injury, dementia and heart disease; -Uses a Broda chair (a specialized adjustable chair). Observation on 5/11/26 at 1:17 P.M., showed the resident sat in his/her room in his/her Broda chair. The resident was positioned approximately 15 feet away from the resident's bed. Certified Nursing Assistant (CNA) K and CNA L informed the resident that they were getting the resident cleaned up and place him/her into bed. CNA L and CNA K attached the sit to stand lift belts round the resident. The resident was raised by CNA L and was mechanically lifted out of his/her Broda chair. The resident was approximately 15 feet away from the bed. The resident was unable to stand straight up and his/her knees were bent during the transfer. CNA L stepped away from the mechanical lift and searched for a brief in the closet. CNA K went into the bathroom to wash his/her hands. The resident was left unattended while in the sit-to-stand lift and was positioned approximately 15 feet away from the bed. CNA L and CNA K removed the resident's pants and brief and provided perineum care (cleansing of the genitals and anal area). CNA L and CNA K redressed the resident. CNA L propelled the resident toward his/her bed as the resident was in the sit-to-stand lift and lowered the resident into his/her bed.	A4075		

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A4075	Continued From page 29 During an interview on 5/11/26 at 3:45 P.M., CNA M said the staff should have prepared everything prior to moving the resident. The resident should not have been left unattended while the staff were obtaining items or washing their hands. One staff member should always be next to the resident while the resident was in the upright position for safety reasons in case the resident's legs gave out or if the resident could not hold onto the sit-to-stand handles. The resident should be positioned next to the bed when using the sit-to-stand lift so if the lift malfunctions the staff did not have to move the resident across the room to place the resident in the bed. During an interview on 5/11/26 at 3:50 P.M., Registered Nurse (RN) N said sit-to-stand mechanical lift transfers required two staff members. One staff member should be at the resident's side the entire time, to prevent an accident and in case the resident needed to be lowered to the floor. The lift should be positioned next to the bed when transferring the resident in case the lift malfunctions. During an interview on 5/11/26 at 4:36 P.M., the Director of Nursing (DON) said she expected staff to have the supplies gathered prior to transferring the resident. Residents should not be unattended while in a mechanical lift device. The resident should be positioned next to the bed during the transfer and staff should ensure the resident's safety during the transfer. 2. Review of Resident #11's medical record, showed: -Admitted 3/13/26; -Diagnoses included right lower extremity (RLE) wound;	A4075		

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A4075	Continued From page 30 Review of the skin assessment, dated 3/13/26, showed: -RLE current staph infection. Bone and tendon exposed. Stage four wound (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). Size 8.5 centimeters (cm) X 5 cm X 1.8 cm. Review of the telephone order sheet, dated 3/13/26, showed a physician order to cleanse RLE wound with wound cleanser, apply Santyl (sterile enzymatic debriding ointment) to wound bed, cover with wet to dry dressing, secure with kerlix (gauze) daily. Review of the Treatment Administration Record (TAR) dated 3/21/26 through 4/20/26, showed: -A physician order: cleanse RLE with wound cleanser, apply Santyl to wound bed, secure with wet to dry dressing and kerlix every day, discontinued on 4/14/26; -Documentation showed: seven out of 24 opportunities were blank. Review of the Provider Orders/Instruction Sheet, dated 4/14/26, showed: -The treatment was changed to clean leg wound with soap/water every day. Pat dry. Apply hydrogel (a gel in which water is the dispersion medium for wound healing) to damp saline gauze, then place over wound bed and cover with Absorbent dressing (ABD, dressing used to keep wounds dry)/gauze. Change daily. Review of the monthly summary/care plan, dated 4/16/26, showed the resident's cognition was moderately impaired (decisions poor, reminders/cues and supervision given). Resident	A4075		

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was pleasant and cooperative. He/She did not resist care.

Review of the TAR, dated 3/21/26 through 4/20/26, showed:
-A physician order to cleanse RLE with soap and water. Pat dry. Apply hydrogel to damp saline gauze, place over wound bed and cover with ABD/gauze every day, start date was 4/14/26;
-Document showed: two out of seven opportunities were blank.

Review of the progress notes, dated 3/13/26 through 5/11/26, showed no documentation the resident refused his/her treatment or the physician was notified the treatment was not administered.

Review of the TAR, dated 4/21/26 through 5/20/26, showed:
-A physician order for cleanse RLE with soap and water. Pat dry. Apply hydrogel to damp saline gauze, place over wound bed and cover with ABD/gauze every day;
-Documentation showed: seven out of 21 opportunities were blank.

During an interview on 5/11/26 at 1:25 P.M., Licensed Practical Nurse (LPN) O said treatments should be documented on the TAR after wound care was provided. If a resident refused the treatment, it should be documented on the TAR. A blank on the TAR meant the nurse may have forgotten to sign it out.

During an interview on 5/11/26 at 4:40 P.M., the DON said a blank on the TAR meant the treatment was not administered. She would expect staff to follow physician's orders.

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3. Review of Resident #1's medical record, showed:
-Admitted: 1/22/26;
-Moderate cognitive impairment;
-Diagnoses included high blood pressure, dementia, difficulty swallowing, traumatic brain injury and diabetes.

Review of the admission diet order and communication form, dated 1/22/26, showed:
-Communication: new resident;
-Diet order: regular;
-Texture: mechanical soft;
-Include chocolate supplements.

Review of the POS, undated, showed an order, for: diet, may have alcohol.

Review of the care plan, dated 4/29/26, showed:
-Eats with assistance;
-Diet: mechanical soft and receives supplements

Observations on 5/11/26, showed:
-At 12:00 P.M., the resident slept in bed, head of the bed slightly elevated. The over the bed table, pushed up to the resident and contained a covered plate, covered fruit bowl, and unopened milk and juice;
-At 12:25 P.M., the resident lay in the bed. The lunch tray contained a scoop of egg salad, one piece of toast cut in half, a bowl of fruit cocktail, a carton of milk and a glass of chocolate supplement drink. The food noted to be a regular consistency. The resident noted to place his/her fingers into the egg salad and lick his/her fingers. The resident said "it was good". No staff observed to assist or encouraged the resident to eat his/her lunch meal.

During an interview on 5/11/26 at 12:45 P.M.,

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A4075	Continued From page 33 Licensed Practical Nurse (LPN) G said Resident #1 had a poor appetite and experienced a slow decline. The physician recommended hospice services and the family was considering hospice. The staff should provide meal set up and assistance to eat if a resident appeared not to be eating. LPN G said the resident's lunch meal tray was a regular consistency diet. During an interview on 5/11/26 at 2:30 P.M., the DON said when staff completed the diet order sheet, those forms also were delivered to dietary, and dietary staff should serve the appropriate order. The DON verified a mechanical soft diet order and egg salad, and piece of toast were not a mechanical soft diet. Resident #1 had a poor appetite and often refused various food items. The physician recently discussed hospice services and family was considering the hospice care. Staff should provide meal set up and assistance if a resident needed assistance.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II	A4086		

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A4086	Continued From page 34 Based on interview and record review, the facility failed to administer the two step Tuberculin Skin Testing (TST, the standard method for screening for tuberculosis lung disease) series following admission to the facility for seven out of 12 sampled residents (Residents #1, #6, #5, #3, #4, #8 and #11). The census was 81. Review of the facility's Tuberculosis (TB) Screening and Monitoring policy, undated, showed: -Admission: Residents shall be assessed for TB exposure, symptoms, and history upon admission. Testing or chest X-ray shall be completed as ordered by a physician. -Documentation: The facility shall maintain documentation of TB test results, chest X-ray reports, physician clearance, and annual screening in resident medical records. Review of 19 CSR 20-20.100 TB Testing for Residents in Long-Term Care Facilities, showed: -Long-term care residents, within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a Mantoux purified protein derivative (PPD, standard skin test used to screen for TB) two -step tuberculin test. If the initial test is negative, the second test, which can be given after admission, should be given one to three (1-3) weeks later. 1. Review of Resident #1's medical record, showed: -Admitted: 1/22/26; -Diagnoses included dysphagia (difficulty swallowing), sacral (tailbone) wound, diabetes, dementia, anemia (low red blood cells), and fall history.	A4086		

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A4086	Continued From page 35 Review of the resident's TB test form, showed: -Date administered: 1/22/28; -Location: right forearm; -Test results: -Result: 0 millimeters (mm); -Negative; -Date read: 1/25/26. -Section for the second step was blank and incomplete. 2. Review of Resident #6's medical record, showed: -Admission: 6/13/24; -Diagnoses included urinary tract infection (UTI), weakness, kidney injury, dementia and heart disease; -No documentation that a PPD test administered or documentation of PPD test results; -No TB screening assessment tool. 2. Review of Resident # 5's medical record, showed; -Admission date, 11/11/25; -Diagnoses includes Alzheimer's disease, incontinent of urine, and peripheral vascular disease (PVD, a narrowing of blood vessels in the legs causing a lack of blood flow); -No documentation that a PPD test administered or documentation of PPD test results; -No TB screening assessment tool. 3. Review of Resident #3's medical record, showed: -Diagnoses include dementia, anxiety, and depression; -Resident alert and oriented. Review on 5/11/26 at 4:21 P.M., of the resident's medical record binder at the nurse's station, showed no immunization record.	A4086		

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A4086	Continued From page 36 4. Review of Resident #4's medical record, showed: -Diagnoses included type two diabetes, depression, and diabetic neuropathy (abnormality of the nervous system); -Resident alert and oriented. Review on 5/11/26 at 3:00 P.M., of the residents' TB immunizations form, showed: -On 10/11/25 the resident received the step one TB test. The test results for step one and the second test were left blank. 5. Review of Resident #8's medical record, showed: -Admitted on 1/9/26; -Diagnoses include hypotension (low blood pressure), diabetes, anxiety, depression, malignant neoplasm prostate (cancerous tumor), obstructive sleep apnea (OSA, breathing repeatedly stops and starts during sleep). Review of the Resident's TB Test form, showed the first step was administered on 1/9/26 and read on 1/11/26. The results were negative. No second step was documented. 6. Review of Resident #11's medical record, showed: -Admitted 3/13/26; -Diagnoses included right lower extremity (RLE) wound, right femur fracture (partial or complete break in thighbone), high blood pressure, high cholesterol, migraines, depression, anxiety and irritable bowel syndrome (IBS, chronic functional gastrointestinal disorder). Review of the Resident's TB Test form, showed the first step was administered on 3/13/26 and	A4086		

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A4086	Continued From page 37 was read on 3/16/26. The results were negative. No second step was documented. 7. During an interview on 5/11/26 at 4:48 P.M., the Director of Nursing said the floor nurse was responsible for administering the TB test on admission. If the TB test was negative, a second step should be administered one to three weeks later but no later than 21 days. After the nurse administers the PPD, they wrote on the calendar when the second step was due. The DON said she believed the nurses were administering the TB tests but they were forgetting to go back and document it. The DON was unable to find documentation showing the residents received their TB test. She would expect staff to complete the TB forms. 8. During an interview on 5/11/26 at 5:13 P.M., Administrator A said he would have expected the residents to receive their TB test, and he expected staff to follow the facility's policies and procedures.	A4086		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III	A6012		

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	05047A	A. BUILDING: _____ B. WING _____	05/11/2026

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A6012	Continued From page 38 This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility had clean floors in the main kitchen. The census was 81. Review of the facility's kitchen cleaning and sanitation policy, undated, showed: -Purpose: To ensure the kitchen and food service areas are maintained in a clean, sanitary, and safe condition in accordance with Missouri Department of Health and Senior Services (DHSS) regulations, and safe food handling standards, thereby preventing foodborne illness, maintaining resident safety, and supporting regulatory compliance; -Cleaning frequency and procedures, daily items: tile floors. Sweep after each meal. Wet mop with approved sanitizer multiple times a day. 1. Observations on 5/11/26 at 9:41 A.M., and 1:02 P.M., showed the floor under the milk/coffee station in the main dining room had dirt and food debris. 2. Observations on 5/11/26 at 9:42 A.M. and 12:59 P.M., showed the floor around and behind the deep fryer had food debris and sticky built up dark substances. During an interview on 5/11/26 at 3:15 P.M., Cook I said he/she would expect the floors under appliances and stations to be clean and free from trash and food debris. During an interview on 5/11/26 at 3:24 P.M., the Food Service Director said she would expect the floors in the kitchen to be clean. She said all staff was responsible for sweeping and mopping the floors.	A6012		

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A6012	Continued From page 39 During an interview on 5/11/26 at 5:25 A.M., Administrator A said he would expect the floors in the kitchen to be clean per the facility's policy.	A6012		
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed and sanitized at intervals throughout the day on a schedule based on food temperature, type of food and amount of food particle accumulation. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the refrigerator and ovens were clean and free from food debris and crumbs. The census was 81. Review of the facility's kitchen cleaning and sanitation policy, undated, showed: -Purpose: To ensure the kitchen and food service areas are maintained in a clean, sanitary, and safe condition in accordance with Missouri Department of Health and Senior Services (DHSS) regulations, and safe food handling standards, thereby preventing foodborne illness, maintaining resident safety, and supporting regulatory compliance;-Cleaning frequency and procedures, daily items: tile floors. Sweep after each meal. Wet mop with approved sanitizer multiple times a day. -Cleaning frequency and procedures, daily items: deep fryer: skim food debris and clean exterior. -Weekly cleaning schedule: clean and sanitize fridges.	A7065		

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A7065	Continued From page 40 1. Observations on 5/11/26 at 9:46 A.M. and 1:00 P.M., showed the refrigerator located outside of the main kitchen door had food debris and crumbs under the food packages on all three shelves. 2. Observations on 5/11/26 at 8:50 A.M. and 1:46 P.M., showed the ovens in both the main kitchen and the memory care kitchen to have food debris on the outside and sides of the oven. During an interview on 5/11/26 at 3:15 P.M., Cook I said he/she would expect the kitchen appliances to be clean. He/She said the cooks were responsible for cleaning the oven and deep fryer. During an interview on 5/11/26 at 3:24 P.M., the Food Service Director said she would expect the kitchen appliances and refrigerators to be clean and free from food debris. During an interview on 5/11/26 at 5:25 A.M., Administrator A said he would expect the kitchen appliances to be cleaned per the facility's policy.	A7065		
A8007	19 CSR 30-88.010(7) Res Rights/Rules Posted, Alz Unit Info Information regarding resident rights and facility rules shall be posted in a conspicuous location in the facility and copies shall be provided to anyone requesting this information. Informational documents which contain, but are not limited to, updated information on selecting an Alzheimer's special care unit or program shall be given by a facility offering to provide or providing these services to any person seeking information about or placement in an Alzheimer's special care unit	A8007		

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A8007	Continued From page 41 or program. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the contact information for the State Survey Agency hotline was prominently posted in a form and manner that was accessible to all residents and resident representatives. The census was 81. Review of the facility's admission packet, dated 8/15/25, showed: -Complaints: If you believe your privacy rights have been violated, you may file a complaint with the facility. or with the Secretary of the United States Department of Health and Human Services. Observations on 5/11/26 at 8:35 A.M., and 5:00 P.M., showed no posted reporting information for the Department of Health and Senior Services elder abuse hotline in a location visible to residents and their families. During an interview on 5/11/26 at 4:50 P.M., the Director of Nursing (DON) said she was unaware if the hotline number was posted anywhere in the facility. She would expect the hotline number to be in a visible location for residents and their family members. During an interview on 5/11/26 at 5:25 P.M., Administrator A said he was unaware that there was a state regulation for the elder abuse hotline to be posted where residents and their families could see it.	A8007		
A8020	19 CSR 30-88.010(20) Exercise Rights/Voice Grievances	A8020		

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A8020	Continued From page 42 Each resident shall be encouraged and assisted, throughout his or her period of stay, to exercise his or her rights as a resident and as a citizen and to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his or her choice. A staff person shall be designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the facility. Residents shall be informed of and provided a viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to maintain an effective grievance process for residents and family members to voice grievances and prompt the facility to resolve grievances for one resident (Resident #8), who lost personal property. The sample size was 13. The census was 81. Review of the facility's admission packet, last revised 8/15/25, showed: -Grievance Procedure: -The Administration of the facility is the "designee" to receive complaints or grievances against the facility and its staff; -If any resident wishes to complain about treatment, conditions or violations of rights he/she shall write or cause to be written his/her grievance or shall state them orally to said designee no later that 14 days after the occurrence giving rise to the complaint or	A8020		

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A8020	Continued From page 43	A8020		

grievance; Said designee shall confer with the persons involved in the occurrence and with any other witnesses and , no later than three days after the written grievance is received, provide an explanation of findings and proposed remedies, if any, to the complainant, or to the aggrieved party, if someone other than the complainant;

-If the complainant or grievance is not resolved by the designee to the complainant's satisfaction, the complainant may file a complaint with the Missouri Department of Health and Senior Services (DHSS) for its review and action;

-A complainant may file a complaint directly with the Missouri DHSS in lieu of filing such complaint with the facility.

1. Review of Resident #8's hard chart located at the nurses station, showed:
-Admitted on 1/9/26;
-Alert and orientated times three (person, place, time);
-Diagnoses include hypotension (low blood pressure), diabetes, anxiety, depression, malignant neoplasm prostate (cancerous tumor), obstructive sleep apnea (OSA, breathing repeatedly stops and starts during sleep);
-There was no personal inventory sheet.

During an interview on 5/11/26 at 9:35 A.M., the resident said he/she had 10 shirts missing. He/She reported it to the Administrator. He/she got some of the shirts back, but no one had gotten back to him/her about the other shirts.

During an interview on 5/11/26 at 11:35 A.M., Licensed Practical Nurse (LPN) O said they did not use inventory sheets. Instead, they used an admission check sheet.

During interview on 5/11/26 at 4:22 P.M., Social

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A8020	Continued From page 44 Worker (SW) D said on admission and as needed, the resident's clothing were labeled with their name. The resident was missing some shirts, but the facility found them and they have been returned to the resident. During an interview on 5/11/26 at 4:40 P.M.,. the Director of Nursing (DON) said the facility did not use inventory sheets. If an item was missing, the facility replaced it. During an interview on 5/11/26 at approximately 5:30 P.M., Administrator A said they called the residents family, and the family said the resident did not have 10 shirts. 2. During an interview on 5/11/26 at 9:45 A.M., a resident's family member said he/she had no idea how to file a grievance. The family member said he/she had "given up" going to the Administration about issues that arise because things didn't really get resolved to his/her satisfaction. 3. During an interview on 5/11/26 at approximately 12:00 P.M. and at 4:21 P.M., SW D said the facility did not have a grievance procedure or any type of grievance log. The community was family, and the residents informed SW D or the Administrators about issues verbally and the facility resolved them immediately. Communication of a grievance being resolved was only given verbally. The SW D said everyone on the Administration team was a Grievance Officer. They currently did not have a way a resident or their family could anonymously file a grievance. 4. During an interview on 5/11/26 at 5:14 P.M., Administrator A said the phone at the desk was directly connected to the phone next to his/her	A8020		

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A8020	Continued From page 45 bed. There was an Administrator in the building seven days a week. The door was always open for residents and their families to inform them of any issues. They took all complaints and lost items very seriously. They currently did not have a way to have a resident or their family member file an anonymous complaint. *The higher classification merited due to the extent of the violation.	A8020		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class III Based on observation, interview and record review, the facility staff failed to treat residents with dignity while providing care to two residents (Resident #6 and Resident #7). The sample was 13. The census was 81. Review of the facility's Admission Packet, revised 8/15/25, showed: Statement of Resident's Rights: The resident is to be treated with consideration, respect, and full	A8030		

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A8030	Continued From page 46 recognition of his/her dignity including privacy in treated and in care of his/her personal needs. 1. Review of Resident #6's monthly summary/care plan, dated 5/6/26, showed: -Severe cognitive impairment; -Requires assistance of two staff members for transfers using a mechanical lift; -Dependent on staff for dressing and grooming; -Incontinent of bowel; -Uses a Broda chair (a specialized adjustable chair); -Diagnoses included urinary tract infection (UTI), weakness, kidney injury, dementia and heart disease. Observation on 5/11/26 at 1:17 P.M., showed the resident sat in his/her Broda chair in his/her room. The resident was positioned approximately 15 feet away from the his/her bed. Certified Nursing Assistant (CNA) K and CNA L informed the resident they were getting the resident cleaned up and place him/her into bed. CNA L and CNA K attached the sit-to-stand lift belts around the resident. The resident was raised up by CNA L and mechanically lifted out of his/her Broda chair. The resident's backside faced the window with the window blinds open. The window faced a shared patio and an open lawn area. CNA L stepped away from the mechanical lift and said, "let me get his/her diaper" and searched for a brief in the resident's closet. CNA L and CNA K removed the resident' s pants and brief and provided perineum care (cleansing of the genitals and anal area) while the resident bare buttocks faced the window with open blinds. CNA L and CNA K redressed the resident. CNA L propelled the resident toward his/her bed and lowered the resident into his/her bed.	A8030		

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A8030	Continued From page 47 2. Review of Resident #7's monthly summary/care plan, undated, showed: -Oriented times three: time, place, person; -Incontinent of both bladder and bowel; -Required two assists for incontinent care and transfer; -Diagnoses included spinal fusion, coronary artery disease, high cholesterol, obstructive sleep apnea (a chronic disorder where the upper airway repeatedly collapses during sleep), squamous cell carcinoma (skin cancer). During an observation on 5/11/26 at 1:38 P.M., the resident was transferred from chair to bed using a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility), by CNA T and Licensed Practical Nurse (LPN) U. The window blinds were left open. The resident wore short pants exposing both legs with multiple wound dressing on both sides. When in bed, the resident was turned side to side to remove the Hoyer pad, then his/her pants. The resident's brief was wet. CNA T left the room to obtain a clean brief. He/She left the door open, privacy curtain not pulled, exposing the resident uncovered. Both staff continued with perineal care and turned the resident to the side with no lower body clothes or covers on while the window blinds were open. 3. During an interview on 5/11/26 at 3:45 P.M., CNA M said the staff should have closed the blinds and not had the resident's bare buttocks facing the open window. All staff should have provided privacy when giving direct care. A resident's brief should not have been called a diaper. 4. During an interview on 5/11/26 at 3:50 P.M., Registered Nurse (RN) N said staff should treat	A8030		

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A8030	Continued From page 48 all residents with dignity and respect their privacy. The blinds in a resident's room should have been closed when providing care and a brief should not have been called a diaper. 5. During an interview on 5/11/26 at 4:36 P.M., the Director of Nursing (DON) said she would expect staff to provide privacy to all the residents and cover as much of the body as they could when providing care. She would have expected the window blinds to be closed when providing care. A brief should not be called a diaper. All residents were expected to be treated with dignity and respect.	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Mari de Villa Retirement Center
Street Address, City, Zip:	13900 Clayton Rd., Town & Country, MO 63017
Date of Survey:	May 11, 2026

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	044351

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A2026	Smoke Detector Tech Electronics has been engaged with an agreed contract to install a new smoke alarm in the employee dining room. We anticipate the work to be completed by June 30, 2026 We believe that all existing corridors are appropriately monitored with smoke alarms, however, if we make any adjustments in the future, we will add additional smoke alarms where necessary.	On or before June 30, 2026
A2032	The utility room at the end of the east hallway has a supply closet. The supply closet is absent a sprinkler head. Following a suggestion during our survey, we have removed the closet door which will allow the existing sprinkler heads in the utility closet to service that closet area should there be a need. Completed 6/1/2026 	On or before June 1, 2026
A2034	As of 6/1/2026 Mari de Villa Maintenance staff has cleaned all sprinkler heads that have dust and or lint. One of our maintenance employees walked from room to room to ensure all heads were clear of dust. Mari de Villa will check monitor sprinkler heads in general areas monthly and in laundry rooms on a weekly basis. Completed 6/1/2026	Beginning June 1, 2026 and ongoing

		
A2041	On June 1, 2026, Tech Electronics repaired the doors on the Waterford Hallway that did not open with the fire alarm. Following their work the alarm was tested, and the doors did open correctly. This set and all locked doors that are tied to the fire alarm will be checked during our fire alarm drills to ensure the doors are functioning properly when the alarm goes off. Completed on 6/1/2026	Completed on June 1, 2026
A2061	Mari de Villa will conduct a minimum of 12 fire drills annually. Mari de Villa will keep these records in the main office. Mari de Villa will ensure that three drills are performed each quarter (One on each shift, day/ evening/ night). Zhen Wu (NHA) will ensure that Fire Drills are completed. To ensure Fire Drills have been completed, Zhen Wu (NHA), will cross check with Jessica Hans (DON) quarterly to see that Fire Drills have been completed. Zhen Wu to sign off on Fire Drills with Jessica Hans. As indicated during our survey, we had already recognized this prior to the survey the missing from last year and began a process in 2026 to correct this problem moving forward.	On or before June 1, 2026
A3030	GFCI related 1. In the East building salon, an outlet on the wall approximately 4 feet from the outside edge of the hair washing sink. The outlet did not feature ground fault circuit interrupter (GFCI) protection. a. Following the survey walk through, our maintenance staff took the initiative to change the outlets to GFCI outlets the same day as the survey and was completed on 5/11/26	Completed by June 1, 2026



2. In the West building janitor's closet near room 51, an outlet on the wall approximately 4 feet from the outside edge of the mop sink. The outlet did not feature GFCI protection
    a. Following the survey walk through, our maintenance staff took the initiative to change the outlets to GFCI outlets the same day as the survey and was completed on 5/11/26



3. In the West building janitor's closet near room 17, an outlet on the wall approximately 3 feet from the outside edge of the mop sink. The outlet did not feature GFCI protection;
    a. Following the survey walk through, our maintenance staff took the initiative to change the outlets to GFCI outlets the same day as the survey and was completed on 5/11/26
4. “In the West building utility closet near the first floor nurse's station, an outlet serving a clothes washing machine. The outlet did not feature GFCI protection;”

a. We have replaced the existing outlet serving the washing machine with a GFCI outlet. Completed on 6/1/2026



5. "In the laundry room in the West building, multiple outlets serving the laundry area, near washing machines and sinks. None of the outlets were GFCI protected."
    a. We have replaced all outlets in the West Laundry that near sinks and washing machines with GFCI outlets. Completed on 6/1/2026





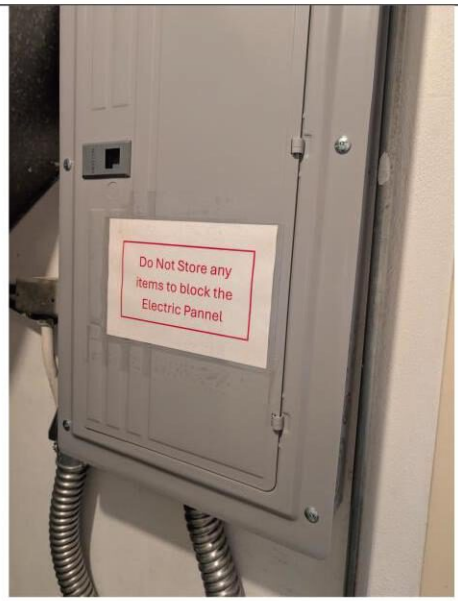
Items blocking the electrical panels

6. “In a utility closet near rooms 61/62 in the East building, an electrical panel with items stored in front of/underneath it;”
    a. There is not a room numbered 61 or 62 in the East building. There is not an electrical panel near 61/62 west either. We are not sure what location is being referenced in this deficiency. However, to ensure that we are compliant, we have reviewed all locations with electrical panels and electrical equipment, confirmed that they are accessible and free from all other equipment or items. We will train all staff to not store anything in front of these areas.
    b. A member of or maintenance department has reviewed and removed everything from in front of and below the electrical panels throughout the entire facility. We will in service all staff that the electrical panels should be clear and accessible. Examples of some the areas and panels that were addressed. Completed 6/1/2026









7. “In the West building janitor's closet near room 17, an electrical panel with items stored in front of/underneath it”
    a. A member of or maintenance department has reviewed and removed everything from in front of and below the electrical panels in the janitor’s closet near room 17 west. We will in service all staff that the electrical panels should be clear and accessible. Examples of some the areas and panels that were addressed.
    Completed 6/1/2026





8. “In the boiler room attached to the laundry room in the West building, multiple pieces of electrical equipment with various items stored in front of/underneath them.”
    a. We have removed anything from in front of electrical panels and equipment within the West Boiler Room. Our maintenance team has been instructed to only store anything necessary in

the boiler room, and if it must be in there, it needs to be out of the way of the electrical equipment. Completed 6/1/2026







Missing or loose light fixtures

9. “In the bathroom across the hall from room 07 East, a light fixture with a missing cover”
    a. The light fixture in the utility closet across from room 7 East has been replaced with a new light fixture. In the future we will monitor and replace any light fixtures that have a missing or broken cover. Completed 6/1/2026



10. “In the closet labeled "RPSI" in the East building, the light fixture was loose, unsecured and hanging slightly downward from the ceiling.”
    a. The ceiling light has been secured to the ceiling. In the future, we will monitor that all light fixtures are appropriately secured to the ceiling or wall. Completed 6/1/2026



Fire panels

11. “The electrical panels in the stairwell across the hall from the Waterford dining/sitting room, showed one of two panels with a key in the lock on the panel enclosure door. Both panels in the stairwell were unlocked and accessible to the public.”
    a. The electrical panels have been locked and the keys have been removed. Completed 6/1/2026

Missing cover plates

12. “showed a junction box missing a cover with exposed wires, above the ceiling near room 27 in the West building”

	a. The junction box in the ceiling outside of 27 West has had a plate cover installed. We will monitor that all junction boxes have appropriate coverings in the future. Completed 6/1/2026  Missing cover or fixture 13. "The employee dining room, showed exposed wires on the ceiling where a fixture had been removed" a. The ceiling fixture box and wires in the West Employee Breakroom have been removed all the back to the source. Completed 6/1/2026 	
A4017	Beginning 5/13/2026 Mari De Villa will ensure that Criminal Background checks and Employee Disqualification List are completed on every new hire prior start of first day on the floor. Mari De Villa implemented a new hire check list which includes; criminal background checks and Employee Disqualification List that will be kept in the employee's file. Employee BB, CC,DD,EE,GG,AA,FF and HH have current Criminal background checks and current Employee Disqualification List.	Beginning 5/13/2026 and ongoing

	Audit of Criminal background checks will be done weekly x 3 weeks then monthly x 3 months by Business office Manager of Designee.	
A4031	Beginning 5/20/2026 and ongoing, Mari De Villa will ensure that every new employee will obtain a two-step Tuberculin Skin Test per the facility's policy and the Missouri Department of Health regulations. An employee will have their first step Tuberculin skin test given and read prior to their first day working the floor. A new hire check list was implemented to Include two step Tuberculin skin test that will be kept in the employee's file. Audits will be performed weekly x 4 weeks then monthly x 3 months by the Director of Nursing or Designee.	Beginning 5/20/2026 and ongoing
A4059	Beginning 5/29/2020 and ongoing, Mari De Villa will ensure that no medications including over the counter medications are left at the bedside or in the guest rooms. Mari De Villa will educate nursing staff that medications are not to be left at the bedside for self-administration and that guest cannot have any over the counter medications stored in their room. In-Services will be conducted by Director of Nursing, to Nursing Staff on following the policy of medication storage and self-administration of medication, to be completed no later than 6/30/2026. Guest rooms will be randomly audited for medications weekly x 3 weeks and then monthly x 3 months by the DON or Designee.	Beginning 5/29/2026 and ongoing
A4075	Mari de Villa's DON will educate nursing staff pertaining to following physician orders to ensure safe mechanical lift transfer, ensure licensed nurses are documenting wound treatments and that residents are being provided with physician prescribed diet and will follow the steps below. Facility Dietician to review mechanical soft diets. 1) DON will educate staff to follow guest care plans for transfer. 2) DON will educate staff to ensure that all supplies are gathered prior to performing tasks and not to leave residents unattended in the lift at any time. 3) DON will educate staff on the facilities policy of mechanical lifts. 4) DON will educate all LPNs/RNs that all medications and treatments are to be done per the physician order and documented immediately. 5) DON will educate all LPN's/RNs on administering medications according to the 7 rights, emphasizing the right documentation following the administration of a medication or treatment. 6) DON or Designee will educate Dietary Cook and Nursing staff on following prescribed diets. 7) Dietary Manager will educate facility cooks on proper diet consistency. Audits will be conducted of nursing staff using Mechanical Lifts weekly x 3 weeks then Monthly x 3 months by DON or Designee.	On or before June 24, 2026

	Audits will be conducted of the MAR and TAR to ensure that all medications and treatments are being signed out according to the policy weekly x 3 weeks then monthly x 3 months by DON or Designee Audits of correct Diets will be conducted weekly x 3 weeks then monthly x 3 months by Dietary manager or Designee.	
A4086	Beginning 5/20/2026 and ongoing, Mari De Villa will ensure that every new admission will obtain a two-step Tuberculin Skin Test per the facility's policy and the Missouri Department of Health regulations. A Resident will have their first step Tuberculin skin test given day of admission and read according to the policy. In-Services will be conducted with nursing staff prior to 6/30/2026 on the proper procedure for performing new admission TB Testing. The Director of Nursing will oversee the procedure to ensure proper documentation has been performed, and TB testing was administered according to the Policy. Audits will be performed weekly x 4 weeks then monthly x 3 months by the Director of Nursing or Designee.	Beginning 5/20/2026 and ongoing
A6012	As of 5/25, Mari De Villa has implemented a weekly deep clean of the kitchen floors. Food Service Director and Dietitian will have an in-service for maintenance and dietary staff on the correct floor cleaning procedures. This will ensure effective daily cleaning and weekly deep cleaning. Food Service Director will inspect floors weekly and keep logs of inspections.	In servicing began on 5/25/26 – and ongoing Cleaning Logs began on 6/1/26 – and ongoing
A7065	Beginning 5/29/2026 Mari De Villa will implement a daily and weekly cleaning schedule for each dietary position. This will include daily cleaning of all kitchen appliances as well as a weekly deep clean for each appliance and surrounding areas. Food Service Director and Dietitian will have an in-service for maintenance and dietary staff on correct cleaning procedures and expectations. Each cleaning checklist will be signed and dated as the daily/weekly cleaning is completed. Logs of cleaning checklists will be kept by the Food Service Director.	In servicing began on 5/29/26 – and ongoing Cleaning Logs began on 6/1/26 – and ongoing
A8007	Mari de Villa will ensure that the Resident Rights are posted in both the West and East building where residents can view them. There will be a framed copy in the conference room of the East building and near the front entrance of the West building. Mari de Villa has consistently provided a copy of the resident's rights in the admission pack and will continue to ensure each resident is provided with a copy upon admission.	On or before June 24, 2026
A8020	Mari de Villa will ensure that residents, families, and staff have access to a formal grievance process for reporting concerns, complaints, or issues. In addition to ongoing access to facility management, Mari de Villa will install comment boxes at the front entrance of the West building and at the East building nurse's station to provide additional methods for submitting concerns. The Director of Social Services will serve as the designated Grievance Officer. Mari de Villa has implemented a grievance form and grievance binder, which will be maintained in the Social Services office. All grievances will be documented, reviewed, monitored, and responded to on a weekly basis.	On or before June 24, 2026

A8030	Mari de Villa will ensure that all guests be treated with consideration, respect and full recognition of his or her dignity, including privacy in treatment and care of his or her personal needs. In-services will be conducted by the Director of nursing to all nursing staff on or before 6/30/2026, to include ensuring that window blinds and shades are pulled prior to performing any type of personal care and to not refer to a depends as a diaper to protect the resident's dignity and privacy. Audits of Care will be performed weekly x 3 weeks then monthly x 3 months by DON or designee.	On or before June 24, 2026

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.