

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/18/2026
NAME OF PROVIDER OR SUPPLIER SUNRISE OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 13460 MANCHESTER ROAD DES PERES, MO 63131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
A2010	19 CSR 30-85.022(6) Oxygen Storage Oxygen storage shall be in accordance with NFPA 99, 1999 edition. Facilities shall use permanent racks or fasteners to prevent accidental damage or dislocation of oxygen cylinders. Safety caps shall remain intact except where a cylinder is in actual use or where the regulator has been attached and the cylinder is ready for use. Individual oxygen cylinders in use or with an attached regulator shall be supported by cylinder collars or by stable cylinder carts. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure their oxygen storage was maintained in compliance with NFPA 99 (1999) requirements. This had the potential to affect all staff and residents in one of nine smoke compartments. The facility had a capacity of 102 with a census of 79 residents at the time of the licensure inspection. Observations during the fire safety tour on 5/18/26, between 10:00 A.M. and 5:00 P.M., of the oxygen storage area in the back of the Resident Care Coordinator's office, showed signs posted on the right side of the room indicated "full" and signs on the left side of the room indicated "empty." There was a line created using yellow tape placed on the floor, to visually divide it into two designated sides. Approximately two full and five partial/empty oxygen cylinders were stored in racks on the right side of the room designated for "full" tanks. Approximately eight full and eight partial/empty oxygen cylinders stored on the left side of the room designated for "empty" tanks. Empty and full oxygen cylinders were not segregated from each other and were	A2010		

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

TITLE

(X6) DATE

Andrew A. ...

Executive Director 6/18/2026

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A2010	Continued From page 1 not organized in any manner. Both empty/partial and full oxygen cylinders were stored mixed in with each other in various racks. During an interview on 5/18/26 at 4:30 P.M., the Director of Maintenance said he does not touch the oxygen storage at all. It is nursing's responsibility to ensure the oxygen cylinders were stored appropriately. A representative from a company delivered the oxygen cylinders to the facility on a regular basis, but he was not sure how often staff check the oxygen storage room for compliance. During an interview on 5/18/26 at 6:30 P.M., the Director of Nursing said nursing staff were responsible for maintenance of the oxygen storage room. Anyone who uses the oxygen storage rooms, stores empty tanks or pulls full ones to administer to residents, should be aware of how to properly store the oxygen cylinders. She would expect staff to follow storage guidelines. The empty and full oxygen cylinders should be stored segregated from each other. NFPA 99 (1999) 4-5.5.2.2 If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. *The higher classification merited due to the extent of the violation.	A2010		
A2016	19 CSR 30-85.022(8)(D) Fire Extinguisher UL/FM, Monthly Check	A2016		

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A2016	Continued From page 2 Fire Extinguishers. (D) All fire extinguishers shall bear the label of the UL or the FM Laboratories and shall be installed and maintained in accordance with NFPA 10, 1998 edition. This includes the documentation and dating of a monthly pressure check. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to maintain fire extinguishers in accordance with NFPA 10 (1998) standards. The facility failed to ensure fire extinguishers were not obstructed or obscured from view. This deficiency had the potential to affect residents and staff in five of nine smoke compartments. The facility had a capacity of 102 and a census of 79 residents at the time of the licensure inspection. Observations during the fire safety tour on 5/18/26, between 10:00 A.M. and 5:00 P.M., showed the following: -A fire extinguisher stored in a recessed cabinet in the wall next to the stairwell across from resident room 222, with a chair positioned in front of it; -A fire extinguisher in a recessed cabinet in the wall next to "Stair A" on the second floor, with a couch and an end table with a lamp positioned in front of it; -A fire extinguisher in a recessed cabinet in the wall next to "Stair A" on the third floor, with a baby doll cradle positioned in front of it; -A fire extinguisher in a recessed cabinet in the wall near the elevator on the third floor, with a small cabinet positioned in front of it; -A fire extinguisher in a recessed cabinet in the wall near "Stair C" on the third floor, with a	A2016		

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A2016	Continued From page 3 medical lift positioned in front of it; -A fire extinguisher hanging on a bracket installed on the laundry room wall, with boxes and bottles of chemicals stored in front of/on the floor around it. Observations during the fire safety tour on 5/18/26, between 10:00 A.M. and 5:00 P.M., of the laundry room, showed a spare fire extinguisher rested on the floor underneath where a fire extinguishers was mounted to the wall. The spare fire extinguisher was not secured from tipping by any means. During an interview on 5/18/26 at 4:30 P.M., the Director of Maintenance said he was aware items like furniture should not be stored in front of/around fire extinguishers, as they could create potential obstructions. He was constantly moving furniture around to ensure the fire extinguishers were not blocked. The residents on the third floor were confused and move items constantly. He was not aware there was an extra fire extinguisher in the laundry room. All fire extinguishers should be maintained secured from tipping. NFPA 10 (1998) 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferably, they shall be located along normal paths of travel, including exits from areas. 1-6.6*Fire extinguishers shall not be obstructed or obscured from view. *The higher classification merited due to the extent of the violation.	A2016		

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A2041	Continued From page 4	A2041		
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/I This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure door locks complied with NFPA 101 (2000), when two of two delayed egress stairwell exit doors did not unlock and release when the facility's fire alarm was activated. This deficiency had the potential to affect residents, staff and all other occupants on the third floor, in three of nine smoke compartments. The facility has a capacity of 102 residents and had a census of 79 at the time of the licensure inspection. Observations during the fire safety tour on 5/18/26, between 10:00 A.M. and 5:00 P.M., of the exit doors leading into the stairwells at either end of the third floor hall, showed the doors were equipped with delayed egress locking devices. The exit doors leading into the stairwells could be opened within 15 second by applying pressure to the door or by entering a code in a keypad on the wall near the door. Neither door featured signage instructing occupants on how to exit through the door. Observations during the fire alarm test on 5/18/26, between 2:30 P.M. and 2:45 P.M., of the exit doors leading into the stairwells at either end of the third floor hall, showed delayed egress locking devices installed on each door did not	A2041		

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A2041	Continued From page 5 release and unlock when the facility's fire alarm was activated by use of a pull station. The third floor stairwell exit doors could only be opened by entering a code on the keypad adjacent to each door or within 15 seconds of applying force to the door. During an interview on 5/18/26 at 2:45 P.M., the Area Facility Manager said the delayed egress exit doors should have released and unlocked when the fire alarm was activated. He was not sure why they did not, and he was not sure why those stairwell delayed-egress exit doors did not feature signage. During an interview on 5/18/26 at 2:45 P.M., the Director of Maintenance said he was aware the exit doors leading into the stairwells on the third floor were delayed egress. He was not aware they did not release and unlock when the fire alarm was activated. He was not aware the doors should have signage instructing occupants on how to exit through the door when it was locked. He was hesitant to add the required signage as some of the confused residents who reside on the secured unit for safety can still read and may use the instructions on the signs to elope from the third floor. NFPA 99 (1999) 7.2.1.6.1 Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria	A2041		

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A2041	Continued From page 6 are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke/width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	A2041		
A4007	19 CSR 30-85.042(7) Written Agreement for Outside Resources When outside resources are used to provide services to the resident, the facility shall enter into a written agreement with each resource. III	A4007		

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A4007	Continued From page 7 This regulation is not met as evidenced by: Based on interview and record review, the facility failed to keep record of written agreements with each outside resources used to provide services for five out of five residents sampled for hospice services. (Resident #4, # 5, #7, #10 and #11). This deficient practice had the potential to affect all residents who received services from an outside resource. The census was 79. Review of 19 CSR.30-85.042 (7) showed: when outside resources are used to provide services to the residents, the facility shall enter into a written agreement with each resource. 1. Review of Resident #4's medical record, showed: -Diagnoses included spinal stenosis (narrowing in the vertebrae), elevated blood pressure, macular degeneration (poor vision), and blood clots; -No documentation of written agreements with each outside resources used to provide services Review of the electronic physician order sheet (ePOS), last reviewed on 11/7/25 showed, a physician order dated 2/17/26, to admit to hospice with diagnosis of protein-calorie malnutrition (nutrition deficiency). 2. Review of Resident #5's medical record, showed: -Diagnoses include depression (mental illness), vertigo (felling dizzy), elevated blood pressure, Parkinsonism disease (trembles when walking, unsteady gait). No documentation of written agreements with each outside resources used to provide services.	A4007		

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A4007	Continued From page 8 Review of the ePOS, last reviewed on 11/10/25, showed a physician order dated 3/13/26, to admit to hospice with diagnosis of end stage Parkinson disease (severely impaired mobility). 3. Review of Resident #7's medical record, showed: -Diagnoses include hypothyroidism (the thyroid is not making enough thyroid hormone), hyperlipidemia (high cholesterol), dementia, anxiety disorder, Alzheimer disease (Dementia), heart disease, heart failure(chronic condition where the heart cannot pump enough blood to meet the body's needs), major depressive disorder, and acute kidney failure (renal failure associated with burns or other trauma or with acute infection or obstruction of the urinary tract). Review of the residents' electronic physician order sheet (ePOS), dated May 18, 2026, showed an order, dated 2/26/26 to admit to hospice with a diagnosis of end stage dementia. Further review of the resident's medical record, showed no documentation of a written agreement with an outside resource used to provide hospice services. 4. Review of Resident #10's face sheet, showed: -Diagnoses included: congestive heart failure, high cholesterol, Alzheimer's disease, depression, chronic kidney disease stage three (the kidneys are filtering waste and fluids less effectively than normal). Review of the service plan report, in use at the time of survey, showed: -Focus: Coordination of care, dated 8/13/25; -Goal: Will receive hospice services from desired	A4007		

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A4007	Continued From page 9 source and will have continued, uninterrupted support of service through the next review date; -Intervention included: Hospice care is provided by an outside source hospice. The nurse comes weekly and as needed. 5. Review of Resident #11's face sheet, showed: -Diagnoses included: diabetes, atrial fibrillation (a-fib, irregular heart rhythm), hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Review of the ePOS, in use at the time of survey, showed a physician order to admit to outside hospice company with diagnose of sequelae (aftereffect) of cerebral infarction, dated 10/17/25. 6. During an interview on 5/18/26 at 4:47 P.M., the Administrator said the facility did not have a contract with outside companies such as home health companies who provided therapy or home health care needs to the residents or with the hospice providers. All residents were private pay, and the resident/resident representative could choose any outside provider to provide hospice services. The facility would not have a contract with the providers because the contract would be between the resident/resident representative and the outside provider.	A4007			
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	A4017			

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A4017	Continued From page 10 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 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 III Based on interview and record review, the facility failed to ensure documentation was maintained verifying criminal background checks (CBC) were requested and received prior to outside contracted staff having resident contact. This deficient practice had the potential to affect all residents receiving services from outside providers. The census was 79. Review of the Resident Care Survey Intermediate Care Facility (ICF)/Skilled Nursing Facility (SNF) form, completed by the facility's staff, dated 5/18/26, showed the facility identified 11 residents on hospice or terminal care. During an interview on 5/18/26 at 4:47 P.M., the Administrator said all residents were private pay and if the resident or the resident representative	A4017		

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A4017	Continued From page 11 chose to hire an outside company, such as hospice to provide care they could. The CBC would be completed by the company who they worked for because no money was exchanged between the facility and the company. The facility recently called one of the outside companies to request the check and the company refused to give it to them.	A4017		
A4021	19 CSR 30-85.042(19) Employee/Volunteer Not on EDL No person who is listed on the employee disqualification list maintained by the division as required by section 198.070, RSMo shall work or volunteer in the facility in any capacity whether or not employed by the operator. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to complete/maintain records showing any person providing direct care to residents had an Employee Disqualification List (EDL, maintained by the Department of Health and Senior Services is a listing of individuals who have been determined to have: abused or neglected a resident, patient, client, or consumer; misappropriated funds or property belonging to a resident, patient, client, or consumer; or falsified documentation verifying delivery of services to an in-home services client or consumer) check completed prior to providing care from an outside contractor. This deficient practice had the potential to affect all residents who hired their own contracted company. The census was 79. Review of the Resident Care Survey Intermediate Care Facility (ICF)/Skilled Nursing Facility (SNF) form, completed by the facility's staff, dated	A4021		

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NAME OF PROVIDER OR SUPPLIER SUNRISE OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 13460 MANCHESTER ROAD DES PERES, MO 63131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4021	Continued From page 12 5/18/26, showed the facility identified 11 residents on hospice or terminal care. During an interview on 5/18/26 at 4:47 P.M., the Administrator said all residents were private pay, and if the resident or the resident representative chose to hire an outside company to provide care, such as hospice, they could. Their EDL check would be completed by the company they worked for because no money was exchanged between the facility and the company. The facility recently called one of the outside companies to request the check and the company refused to give it to them.	A4021		
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 interview and record review, the facility failed to ensure a bed rail assessment was completed and a physician order was obtained for the use of bed rails for one resident (Resident #7). The sample size was 11. The census was 79. Review of the facility's Bed Safety Program policy, revised February 2019, showed: -Overview and Background; --For years the Food and Drug Administration (FDA) has received reports where vulnerable residents have become entrapped in	A4075		

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A4075	Continued From page 13 hospital/medical bed systems while undergoing care and treatment in health care facilities; --Between 1985 and 2013 the FDA documented 901 incidents of life threatening bed entrapments in the US. Of those reports, 531 resulted in death. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards; -Definitions: --Assistive Device-Any device designed or adapted to help people with physical or emotional disorders to perform actions, tasks, and activities. For example-Halo ALC, deluxe assist handle (for Joerns beds), over the bed trapeze, a high/low bed, bathroom grab bars, etc.; --Entrapment-Describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, assistive devices, mattress, or hospital/medical bed frame; ---Entrapment is a risk when assistive devices are used on personal beds; --Hospital Bed-A hi/lo bed that may be crank or electrical and may elevate in height as well as various elevations for raising the head, also referred to as a medical bed. May be used as an assistive device to promote independence; ---Hospital Bed System-Encompasses the bed frame and its components, including the mattress, head and foot board, and any assistive devices added to the bed; --Restrictive/Mechanical Devices-Are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily or upon request, which restricts freedom of movement or normal access to one's body. For example-seat belt (if resident is unable to self-release), lap buddy, side rails	A4075		

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A4075	Continued From page 14 (full or half); -Section One: Assessment; --Assessing Risk; ---The Nurse assesses the resident, utilizing the Service Evaluation and Health Assessment (SEHA) located within the electronic health record; ----The SEHA includes a review of the resident's: -----Bed mobility; -----Cognition and safety awareness: -----Ability to transfer between positions, to and from bed or chair, to stand and toilet; -A resident should be assessed: --Prior to move in; --Determine if an assistive device is utilized at home: --The resident can demonstrate the use of the assistive device to assist with positioning and transfer; -Upon move-in: --Determine the need and type of assistive device is needed/if any; -A resident using an assistive device should be reevaluated, by the Nurse, to determine if the continued use of the device is necessary and appropriate: --Monthly Wellness Visit or SEHA assessment; --Six Month SEHA (unless frequency is otherwise required by state/province); --Significant Change of condition; --Change in the bed frame, mattress or device; --Application of a specialty mattress; --Change of bed, mattress or device by a care partner (Home Health, Hospice, etc. Review of Resident #7's medical record, showed; -Diagnoses included hypothyroidism (the thyroid is not making enough thyroid hormone), hyperlipidemia (high cholesterol), dementia, anxiety disorder, Alzheimer disease (Dementia),	A4075		

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A4075	Continued From page 15 heart disease, heart failure, major depressive disorder, and acute kidney failure (renal failure associated with burns or other trauma or with acute infection or obstruction of the urinary tract); -No physician order for the use of bed rails; -No bed rail assessment. Observation on 5/18/26 at 10:20 A.M., showed the resident lay in bed awake. One half-length sized bed rails were raised on both sides of the bed. During an interview on 5/18/26 at 4:55 P.M., the Administrator said the resident was not assessed for the use of bed rails prior to installation. The bed rails needed to come off. The bed rails needed to have an order whether the family wanted the side rails or not. The Director of Nursing (DON) completed bed rail assessments and Maintenance staff "rounded" on bed rails.	A4075		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to ensure kitchen staff members hair was properly and fully covered. This deficient practice had the potential to affect all residents who consumed food from the facility kitchen. The census was 79.	A7003		

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A7003	Continued From page 16 Review of the facility's Uniforms and Personal Hygiene for Food Service policy, reviewed 8/7/25, showed: -Responsible Parties: --Dining Services Coordinator/Director; --Neighborhood Coordinator; -Policy Statement: --Team members follow uniform and personal hygiene guidelines to present a professional appearance and promote a safe and sanitary dining services operation; -Scope: --This policy applies to US and Canadian communities. Communities must comply with applicable state/provincial laws and regulations; -Definitions: --Approved hair restraints are hair nets, facility logo baseball caps, solid black or white skull caps, or white toques; -Uniform requirements for Dining Services Coordinator/Director and cooks; --Action Steps: ---Uniform Requirements: ----Dining Services Coordinator/Director and Cooks: -----Approved hair restraint; -Uniform Requirements for Dishwashers: --Dish Washer: ---Approved hair restraint; -Hygiene: --Hair is neat and clean, and worn pulled away from the face. An approved hair restraint is worn at all times while preparing or plating food; --Facial hair is trimmed, neat and clean. A beard net is worn over facial hair at all times while preparing or plating food. Observations of the kitchen on 5/18/26 at 9:06 A.M., showed: -A staff person with a cap on his/her head and	A7003			

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A7003	Continued From page 17 his/her ponytail hung out the back from under his/her cap, not covered; -A staff person with a long ponytail down his/her back. A hair net covered the top (ball part) of his/her hair. The ponytail part of his/her hair was not covered. During an interview on 5/18/26 at approximately 3:58 P.M., the Dietary Manager (DM) said hair nets should always be worn in the kitchen. Anything that covered the head should be worn. The expectation was that hair was always covered, especially when dealing with or touching food.	A7003		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it	A7015		

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A7015	Continued From page 18 deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to label, date, and cover food and discard outdated Thickened Apple Juice. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 79. Review of the facility's Food Storage, Preparation and Service Policy, dated 8/7/25, showed: -Responsible Parties: --Dining Services Coordinator/Director; -Policy Statement: --Safe food handling practices are followed during the storage, preparation, and service of food; -Scope: --This policy applies to US and Canadian communities. Communities must comply with applicable state/provincial laws and regulations; -Highlights: --General Food Handling: -Definitions: --A food storage area includes walk-in and reach in refrigerators and freezers, under counter refrigeration and freezer units, bistro and common area refrigeration and freezer units, and any dry storage units; -Action Steps: --General Food Handling: ---Food storage areas are clean and orderly, and free from moisture, insects, rodents, and physical and chemical hazards; ---All food items are labeled, dated and rotated to maintain a system of First In First Out (FIFO);	A7015		

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A7015	Continued From page 19 ---Expired food is discarded; -Food Preparation: --Food is prepared on clean, sanitized surfaces with clean, sanitized equipment and tools. Appropriate precautions are taken to prevent cross-contamination during production; --Label and date the container(s); ---Left-over food must be properly cooled, covered, labeled, dated, refrigerated, reheated no more than one (1) time, and discarded if not used within three (3) days. 1. Observation of the Kitchen on 5/18/26 at 9:06 A.M., showed: -Walk in cooler: --A metal tub of ice with tongs in it, and not covered; --A half of a cucumber wrapped with plastic and without a date; --Two packages of shredded lettuce with a knot at the ends, without a date; --Eight slices of cake sat on a tray not covered; --A gallon of Cole slaw without a date; --A gallon of French dressing without a date; --A gallon of Ranch dressing without a date; --A bottle of Cattleman's barbeque sauce without a date; -Walk in freezer: --An opened box of cookie dough exposed to air; --An opened box of rustic crust exposed to air; --An opened box of churros exposed to air; --An opened box of cobbler crust exposed to air; --An opened box of breaded catfish fillets exposed to air; --A roll of hamburger patties in a bag without a date; --A package of carrots in a bag tied in a knot at the end without date; -Dry storage room: --A package of spaghetti wrapped in plastic and	A7015			

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A7015	Continued From page 20 without a date; --A package of cheese sauce wrapped in plastic and without a date; --An opened package of organic chocolate red berries, not wrapped in plastic and with a best by date of February 2026; --An opened package of macaroni noodles exposed to air; --A opened package of all-purpose flour, not wrapped in plastic and without a date; --Nine packages of Hidden Valley Ranch packets with an expiration date of 7/24/25; --An opened bottle of buffalo hot sauce without a date; --An bottle of soy sauce without a date; --A bottle of parsley flakes without a date; --A bottle of Bouget browning sauce without a date. 2. Observation of the kitchen's dry storage room on 5/18/26 at 9:06 A.M., showed three boxes of Thickened Apple Juice, with best if used by date of 3/19/25. 3. During an interview on 5/18/26 at approximately 3:58 P.M., the Dietary Manager (DM) said food items should be labeled, dated, and properly stored. Outdated and/or expired items should be discarded. He was responsible for ensuring items were properly labeled, dated, and stored. Opened on dates should be placed on food items when opened. Whoever opened the food item was responsible for placing the date on it. It was his expectation that expired thickened liquids should have been discarded.	A7015		
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning	A7056		

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A7056	Continued From page 21 Surfaces of equipment not intended for contact with food, but which are exposed to splash or food debris or which otherwise require frequent cleaning, shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections or crevices, and readily accessible for cleaning, and shall be of such material and in a repair as to be easily maintained in a clean and sanitary condition. III This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to ensure kitchen equipment was clean. This deficient practice had the potential to affect all residents who consumed food from the facility kitchen. The sample size was 11. The census was 79. Review of the facility's Food Storage, Preparation and Service Policy, dated 8/7/25, showed: -Responsible Parties: --Dining Services Coordinator/Director; -Policy Statement: --Safe food handling practices are followed during the storage, preparation, and service of food; -Scope: --This policy applies to US and Canadian communities. Communities must comply with applicable state/provincial laws and regulations; -Highlights: --General Food Handling: -Definitions: --A food storage area includes walk-in and reach in refrigerators and freezers, under counter refrigeration and freezer units, bistro and common area refrigeration and freezer units, and any dry storage units;	A7056		

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A7056	Continued From page 22 -Action Steps: --General Food Handling: ---Food storage areas are clean and orderly, and free from moisture, insects, rodents, and physical and chemical hazards; ---All food items are labeled, dated and rotated to maintain a system of First In First Out (FIFO); ---Expired food is discarded; -Food Preparation: --Food is prepared on clean, sanitized surfaces with clean, sanitized equipment and tools. Appropriate precautions are taken to prevent cross-contamination during production; --Label and date the container(s); --Left-over food must be properly cooled, covered, labeled, dated, refrigerated, reheated no more than one (1) time, and discarded if not used within three (3) days. 1. Observation of the Kitchen on 5/18/26 at 9:06 A.M., showed: -Stove: --Heavy charcoaled stains on the eyes and the top; --Stains along the front and side of the stove; --Dirty towel sat on floor visible from under the stove -Stand-alone oven: --Caked-on stains along the front inside doors; --Heavy charcoaled stains along the bottom of oven; --Caked stains along the inside walls of oven; 2. During an interview on 5/18/26 at approximately 3:58 P.M., the Dietary Manager (DM) said the expectation was that equipment and/or appliances should be cleaned. General cleaning was done daily, and deep cleaning was done once a week. Wipe downs were done once a day or as they went along. Degreasing was	A7056		

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A7056	Continued From page 23 done because they sanitized every day. They hadn't cleaned the stove or oven because they were short staffed. Both needed to be deep cleaned.	A7056		
A8004	19 CSR 30-88.010(4) Resident Rights-Admission/Annual Review Each resident admitted to the facility, or his or her next of kin, legally authorized representative or designee, shall be fully informed of the individual's rights and responsibilities as a resident. These rights shall be reviewed annually with each resident, and/or his or her next of kin, legally authorized representative or designee, either in a group session or individually. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to review Resident Rights with residents or their representative upon admission and annually for five of 11 sampled residents (Residents #2, #3, #4, #5, and #9). The census was 79. Review of the facility's Resident Rights policy, dated 8/28/25, showed: -Policy Statement: It is the policy of the community to inform the residents both orally and in writing, in a language that the resident understands, of their rights as a resident of the community; -Prior to or upon move-in, as required by state/provincial regulation, the Executive Director (ED)/designee shall inform the resident and/or the resident's representative of the resident's rights; -State/provincial specific resident rights are documented within the community's residency	A8004		

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A8004	Continued From page 24 agreement (RA); -The resident/resident representative will provide written acknowledgment of their rights as required by state/provincial regulations, prior to or at the time of occupancy; -A copy of the signed and dated acknowledgement shall be maintained as required by state/province regulations; -Resident rights will be reviewed at a frequency identified in the state/province regulations. 1. Review of Resident #2's medical record, showed: -Admitted 6/12/23; -Diagnoses included: history of malignant neoplasm (cancerous tumor) of the prostate, atrial fibrillation (A-fib, irregular heart rhythm), heart failure and chronic kidney disease stage three (impaired kidney function). -No documentation of an initial resident rights review or an annual review. 2. Review of Resident #3's medical record, showed: -Admitted 5/28/24; -Diagnoses included high blood pressure, anxiety, anemia (low red blood cell count), and major depressive disorder (serious mood disorder); -No documentation of an initial resident rights review or an annual review. 3. Review of Resident #4's medical record, showed: -Admitted 7/17; -Diagnoses included spinal stenosis (narrowing in the vertebrae), elevated blood pressure, macular degeneration (poor vision), blood clots; -No documentation of an initial resident rights review or an annual review.	A8004		

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NAME OF PROVIDER OR SUPPLIER SUNRISE OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 13460 MANCHESTER ROAD DES PERES, MO 63131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A8004	Continued From page 25 4. Review of Resident #5's medical record, showed: -Admitted 7/17; -Diagnoses include depression (mental illness), vertigo (felling dizzy), elevated blood pressure, Parkinsonism disease (trembles when walking, unsteady gait); -No documentation of an initial resident rights review or an annual review. 5. Review of the Resident #9's medical record, showed: -Admitted 9/7/23; -Diagnoses include diabetes mellitus (DM, metabolic disease), depression, sleep apnea, osteoarthritis (chronic degeneration of the joint cartilage), and scoliosis (abnormal lateral curvature of the spine), and peripheral vascular disease (PVD, poor circulation). -No documentation of an annual resident rights review. 6. During an interview on 3/20/26 at 4:47 P.M., the Administrator said the facility had not been reviewing resident's rights with the residents/resident representative annually. She was not aware it was a regulation for an Intermediate Care Facility (ICF).	A8004			
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws	A8010			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/18/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUNRISE OF DES PERES

**13460 MANCHESTER ROAD
DES PERES, MO 63131**

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A8010	Continued From page 26 related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to regularly review code statuses (indicates the specific medical intervention a person desires in a healthcare setting) for five (Resident #3, #4, #5, #10 and #9) of 11 sampled residents. The census was 79. Review of the facility's Advance Directive Planning policy, dated revised date 6/3/25, showed; -Policy statement: It is the community's policy to honor the advance directives and/or orders for life sustaining treatment of the residents or their legal representative according to state, provincial, and federal laws, guidelines, and regulations;	A8010		

Missouri Department of Health and Senior Services

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A8010	Continued From page 27 -Procedure: Upon move-in, the Executive Director (ED)/Director of Sales (DOS)/designee shall obtain the resident's or legally responsible party signature on the Residency Agreement (RA); -The RA includes explanations of the community's policies and procedures for implementing residents' rights including the resident's right to receive cardiopulmonary resuscitation (CPR, a lifesaving technique useful in which someone's breathing or heartbeat has stopped) or have a written advance directive refusing CPR and the state/province developed written description of advanced directives; -The ED/designee shall provide advance care planning training to appropriate team members during orientation and ongoing with content and frequency as required by state/province regulations; -Missouri law 19 CSR 30-88.010 (10) Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. 1. Review of Resident #3's medical record showed: -Admit date 5/28/24; -Diagnoses included high blood pressure, anxiety, anemia (low red blood cell count), and major depressive disorder (serious mood disorder); -There was no documentation showing the advanced directives were reviewed annually.	A8010		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/18/2026
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SUNRISE OF DES PERES

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DES PERES, MO 63131**

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A8010	Continued From page 28 Review of the electronic Physician Order Sheet (ePOS), showed a physician order, dated 5/29/24 for Do Not Resuscitate (DNR, instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. 2. Review of Resident #4's face sheet, showed; -Admission date of 7/17; -Diagnoses included spinal stenosis (narrowing in the vertebrae), elevated blood pressure, macular degeneration (poor vision), blood clots; -There was no documentation showing the advanced directives were reviewed annually. Review of the ePOS showed a physician order for DNR, revision date of 8/8/17. 3. Review of Resident #5's face sheet, showed; -Admission date of 7/17; -Diagnoses include depression (mental illness), vertigo (feeling dizzy), elevated blood pressure, Parkinsonism disease (trembles when walking, unsteady gait); -There was no documentation showing the advanced directives were reviewed annually. Review of the resident's ePOS, last reviewed 11/10/25, showed a physician order, dated 11/27/2023 for DNR. Review of the resident's service plan report, in use at the time of survey, last reviewed 2/26, did not show the residents' wish of DNR. 4. Review of Resident #10's face sheet, showed; -Admission date of 7/17; -Diagnoses include depression, Alzheimer's disease (cognition impairment), elevated blood pressure, Parkinsonism disease, Alcohol	A8010		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER SUNRISE OF DES PERES		STREET ADDRESS, CITY, STATE, ZIP CODE 13460 MANCHESTER ROAD DES PERES, MO 63131			
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A8010	Continued From page 29 dependence in remission; -There was no documentation showing the advanced directives were reviewed annually. Review of the resident's ePOS, last reviewed 5/15/25, showed, a physician order, dated 9/14/2022 for DNR. 5. Review of Resident #9's medical record, showed: -Admission date of 9/7/23; -Diagnoses include diabetes mellitus (DM, metabolic disease), depression, sleep apnea, osteoarthritis (chronic degeneration of the joint cartilage), and scoliosis (abnormal lateral curvature of the spine), and peripheral vascular disease (PVD, poor circulation)' -An out of hospital do not resuscitate (OHDNR) form, dated 9/8/23. Review of the residents' electronic ePOS, dated 5/18/26, showed an order, dated 9/8/23 for a DNR. Review of the resident's medical record, showed no further updated OHDNR and/or any documentation the resident's code status had been reviewed. 6. During an interview on 5/18/26 at 4:56 P.M., the Director of Nurse (DON) said they did not check codes statues yearly. They were only changed for significant concerns or at the request of the resident.	A8010			

PLAN OF CORRECTION

Provider/Supplier Name:	Sunrise of Des Peres	
Street Address, City, Zip:	13460 Manchester Road, Des Peres, MO 63131	
Date of Survey:	5/18/2026	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A2010	19 CSR 30-85.022(6) Oxygen Storage	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: On 5/18/2026, immediately upon identification of the deficient practice, the oxygen storage room was inspected and reorganized. All full oxygen cylinders were placed in the designated "FULL" storage area and all empty cylinders were placed in the designated "EMPTY" storage area. All oxygen cylinders were secured in approved storage racks. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Because oxygen cylinders are utilized throughout the facility and are accessible to multiple staff members and residents across all smoke compartments, all residents receiving oxygen therapy had the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: The facility reviewed its oxygen cylinder storage process to require: • Segregation of full and empty oxygen cylinders at all times. • Clear identification of empty cylinders. • Verification that all cylinders remain secured in approved racks or holders. • Routine monitoring of the oxygen storage room by nursing management. The Resident Care Director and/or designee to provide education to licensed nurses, certified nursing assistants, department managers, and any staff responsible for handling oxygen cylinders regarding:	

	• Proper segregation of full and empty cylinders. • Proper identification and storage of oxygen cylinders. • Staff responsibilities when removing or returning oxygen cylinders. Education has begun and will be complete 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Resident Care Director, or designee will complete weekly audits of oxygen storage areas for four (4) weeks and monthly audits thereafter for three (3) months. Audits will verify: • Full cylinders are stored only in designated full-cylinder storage areas. • Empty cylinders are stored only in designated empty-cylinder storage areas. • Oxygen cylinders remain secured in approved racks. • Storage room signage remains accurate and visible. Audit results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Any identified concerns will be corrected immediately, and additional education will be provided as necessary. 5. Completion Date: 7/8/2026	
A2016	19 CSR 30-85.022(8)(D) Fire Extinguisher UL/FM, Monthly Check 1. How corrective action will be accomplished for those found to be affected by the deficient practice: Upon identification of the deficient practice, all items obstructing access to or visibility of fire extinguishers were removed, including furniture, equipment, storage items, and resident belongings identified during the survey. The spare fire extinguisher located on the laundry room floor was removed from the floor and secured in an approved manner to prevent tipping. A facility-wide inspection of all fire extinguisher locations was completed to verify that fire extinguishers were readily accessible, visible, and free from obstruction. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Because all residents, visitors, and staff rely upon accessible fire extinguishers in the event of a fire emergency, all residents and staff had the potential to be affected by the deficient practice. The Maintenance Director completed a facility-wide audit of all fire extinguisher locations 5/20/2026 to verify: • Fire extinguishers were visible and unobstructed. • Access to fire extinguishers was not blocked by furniture,	7/8/2026

	equipment, decorations, or storage. • Fire extinguishers were properly mounted or secured. • Monthly inspection documentation was current. Any concerns identified during the audit were corrected immediately. 3.What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by Executive Director and/or designee to maintenance staff, nursing staff, housekeeping staff, department managers, and other applicable personnel has begun and will be complete regarding: • The prohibition of placing or storing furniture, equipment, resident belongings, or supplies in front of or in any way obstructing fire extinguishers. • Requirements for securing spare fire extinguishers. • Staff responsibility to immediately remove obstructions and report concerns. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Maintenance Director or designee will conduct weekly environmental safety audits of all fire extinguisher locations for four (4) weeks and monthly audits thereafter for three (3) months. Audits will verify: • Fire extinguishers remain visible and readily accessible. • No furniture, equipment, or stored items obstruct fire extinguishers. • Fire extinguishers are properly mounted or secured. • Monthly inspection tags and documentation are current. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months to review and follow-up. Any identified concerns will be corrected immediately, and additional staff education will be provided as warranted. 5. Completion Date: 7/8/2026	
A2041	SR 30-85.022(16) Door Locks	7/8/2026
	1.How corrective action will be accomplished for those found to be affected by the deficient practice: Immediately upon identification of the deficient practice the facility initiated corrective action regarding the two delayed-egress stairwell exit doors located on the third floor. The facility's contracted fire alarm/electronic security vendor was notified and evaluated the delayed-egress locking devices and associated fire alarm interface. Necessary repairs and programming corrections has begun and will be complete to ensure both delayed-egress locks automatically release upon activation of the facility fire alarm system and upon loss of power as required by NFPA 101.	

	Required delayed-egress signage was installed to exit door on the 3rd floor that leads into the stairwells. Following repairs, functional testing was performed to verify that both doors released immediately upon fire alarm activation and functioned in accordance with code requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents, staff, visitors, and occupants utilizing the third-floor smoke compartments had the potential to be affected by the deficient practice. The Maintenance Director completed a facility-wide review of all delayed-egress doors and electronically controlled locking devices 5.20.2026 to verify: • Release upon fire alarm activation. • Release upon loss of power. • Proper operation of delayed-egress functions. • Presence of required signage. Any deficiencies identified were corrected immediately. 3.What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education was provided by the Executive Director and/or designee to the Maintenance Director, housekeeping staff and coordinators has begun and will be complete regarding: • Delayed-egress requirements. • Required emergency release functions. • Required delayed-egress signage. • Documentation of routine testing and corrective action. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Maintenance Director or designee will conduct and document monthly inspections of all delayed-egress doors for three (3) months and quarterly thereafter through the facility's preventive maintenance program. Monitoring will include verification of: • Automatic unlocking upon fire alarm activation. • Unlocking upon power failure. • Proper delayed-egress operation. • Presence and readability of required signage. • Documentation of testing and repairs. Results of audits and testing will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process monthly for three (3) months. Any identified concerns will be corrected immediately and retraining provided as needed. 5. Completion Date: 7/8/2026	
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A4007	19 CSR 30-85.042(7) Written Agreement for Outside Resources	7/8/2026
	1.How corrective action will be accomplished for those found to be affected by the deficient practice: The facility reviewed the records of Residents #4, #5, #7, #10, and #11 and verified that hospice services were being provided by outside providers. The facility immediately contacted all hospice providers currently serving residents and obtained written agreements outlining the responsibilities of the facility and the outside. Copies of executed agreements were maintained in the facility's administrative records and made available for review. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility-wide audit was conducted of all residents receiving services from outside providers 6.15.2026 including but not limited to: • Hospice services • Home health services • Therapy services • Other contracted healthcare providers The audit verified the existence of written agreements between the facility and each outside resource providing resident services. Any missing agreements identified during the audit were obtained immediately. 3.What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by the Executive Director and/or designee to the Resident Care Director and Licensed Practical Nurses has begun and will be complete regarding regulatory requirements for outside resource agreements and record maintenance: • A written agreement be executed prior to or immediately upon initiation of services by an outside provider, if a contract is not established. • Administrative review and approval of all outside service providers. • Maintenance of a centralized log of all outside resources providing resident services. • Annual review of all provider agreements to ensure they remain current. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will maintain a current log of all outside providers serving residents. The Executive Director will conduct monthly audits for three (3) months and quarterly thereafter to verify: • Residents receiving outside services are identified. • A current written agreement is on file for each outside provider. • Agreements are maintained and updated as necessary.	

	Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for three months for review and follow-up. 5. Completion Date: 7/8/2026	
A4017	19 CSR 30-85.042(17) Criminal Background Check Request 1. How corrective action will be accomplished for those found to be affected by the deficient practice: Upon identification of the deficient practice, the facility conducted a review on 6.15.2026 of all outside agencies and providers whose employees have direct resident contact within the facility. The facility contacted all current outside providers serving residents, including hospice agencies and other contracted service providers, and obtained written agreements including verification that contracted personnel meet applicable background screening requirements (criminal background checks and Employee Disqualification List screening, as required). Executed agreements were reviewed for completeness, signed by authorized parties, and maintained in the facility's administrative records for ongoing compliance and surveyor review. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Because outside providers may provide services to any resident within the facility, all residents receiving services from outside agencies had the potential to be affected by the deficient practice. The Executive Director completed a facility-wide audit on 6.15.2026 of all outside providers currently serving residents to verify that a written agreement was in place with each provider and that the agreements included required provisions regarding verification of employee background screening (criminal background checks and Employee Disqualification List checks, as applicable). The audit also reviewed whether agreements were current, properly executed, and maintained in the facility's administrative records. Any missing, incomplete, or outdated documentation identified during the audit was immediately obtained, updated, and placed on file. The audit included: • Hospice providers • Home health agencies • Therapy providers Any other outside resource whose staff have resident contact Any missing documentation identified during the audit was obtained immediately.	7/8/2026

	3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by the Executive Director and/or designee to the Resident Care Director and Licensed Practical Nurses regarding regulatory requirements for outside provider agreements and record maintenance has begun and will be complete: The educations includes: • Written agreement with outside providers. • Maintenance of documentation in an administrative file of contracts. • Tracking of all outside agencies and personnel providing resident services. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will maintain a current log of all outside providers and verify written agreement is on file. Monthly audits will be conducted for three (3) months and quarterly thereafter to verify: • All outside providers are identified. • New providers have documentation prior to resident contact. • Required records remain current and accessible. Results of audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. Any identified deficiencies will be corrected immediately. 5. Completion Date: 7/8/2026	
A4021	19 CSR 30-85.042(19) Employee/Volunteer Not on EDL	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: Upon identification of the deficient practice, the facility conducted a review 6.15.2026 of all outside agencies and providers whose employees have direct resident contact within the facility. The facility contacted all current outside providers serving residents, including hospice agencies and other contracted service providers, and obtained written agreements including verification that contracted personnel meet applicable background screening requirements (criminal background checks and Employee Disqualification List screening, as required). Executed agreements were reviewed for completeness, signed by authorized parties, and maintained in the facility's administrative records for ongoing compliance and surveyor review has begun and will be complete 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Because outside providers may provide services to any resident within the facility, all residents receiving services from outside agencies had the potential to be affected by the deficient practice. The Executive Director completed a facility-wide audit 6.15.2026 of all outside providers currently serving residents to verify that a written	

	agreement was in place with each provider and that the agreements included required provisions regarding verification of employee background screening (criminal background checks and Employee Disqualification List checks, as applicable). The audit also reviewed whether agreements were current, properly executed, and maintained in the facility's administrative records. Any missing, incomplete, or outdated documentation identified during the audit was immediately obtained, updated, and placed on file. The audit included: • Hospice providers • Home health agencies • Therapy providers • Any other outside resource whose staff have resident contact Any missing documentation identified during the audit was obtained immediately. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by the Executive Director and/or designee has begun and will be complete to the Resident Care Director and Licensed Practical Nurses regarding regulatory requirements for outside provider agreements and record maintenance: The education includes: • Written agreement with outside providers. • Maintenance of documentation in an administrative file of contracts. • Tracking of all outside agencies and personnel providing resident services. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will maintain a current log of all outside providers and verify written agreement is on file. Monthly audits will be conducted for three (3) months and quarterly thereafter to verify: • All outside providers are identified. • New providers have documentation prior to resident contact. • Required records remain current and accessible. Results of audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. Any identified deficiencies will be corrected immediately. 5. Completion Date: 7/8/2026	
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: Upon identification of the deficient practice on 5/18/2026, Resident #7's bed rail use was immediately reviewed. The bed rails were removed pending completion of a nursing assessment and physician review. A comprehensive bed rail	

	assessment was completed in accordance with the facility's Bed Safety Program policy. If continued use of bed rails was determined to be clinically appropriate, a physician order has begun and will be complete and care plan interventions has begun and will be complete accordingly. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A facility-wide audit was conducted 6.18.2026 of all residents utilizing bed rails, assistive devices attached to beds, or other bed-related safety devices. The audit included verification of: • Physician orders for bed rail use. • Completion of bed rail assessments. • Evidence of resident or representative involvement when applicable. • Service plan interventions addressing bed rail use. • Evaluation of entrapment risk. Any identified deficiencies were corrected immediately. 3.What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Executive Director provided education has begun and will be complete to Resident Care Director and Licensed nursing staff regarding: • Bed rail regulations and resident safety requirements. • Bed entrapment risks. • Assessment requirements before bed rail installation. • Physician order requirements. • Documentation standards. • Care planning requirements for residents using bed rails. The Resident Care Director and/or designee will review and provide approval before any bed rail installation or continued use. A bed rail tracking log was established to ensure all residents with bed rails have current assessments, physician orders, and care plan documentation. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Resident Care Director and/or designee will conduct weekly audits of all residents utilizing bed rails for four (4) weeks and monthly audits thereafter for three (3) months. Audits will verify: • Physician orders are present. • Bed rail assessments are completed and current. • Entrapment risk evaluations are documented. • Service plans accurately reflect bed rail use. • Continued use remains clinically appropriate. Audit findings will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process monthly for three (3) months.	
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	Any identified concerns will be corrected immediately, and additional staff education will be provided as necessary. 5. Completion Date: 7/8/2026	
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: Immediately upon identification of the deficient practice, all dietary staff on duty were instructed to ensure full compliance with facility hair restraint policy. Staff observed with improper hair restraint use were immediately corrected, and proper hair restraints were applied to ensure all hair, including ponytails, was fully contained. A full inspection of all dietary staff working during the meal service was completed 5.20.2026 to verify compliance with hair restraint requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All food preparation, plating, dishwashing, and food distribution activities had the potential to be affected by the deficient practice. The Dining Service Coordinator completed a full audit of all kitchen staff present during operations 5.20.2026 to ensure: • Hair was fully contained using approved hair restraints. • No hair, including ponytails or loose strands, was exposed. • Staff were compliant with facility uniform and hygiene policy. Any noncompliant staff were immediately corrected and re-educated. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: The facility reinforced its Uniforms and Personal Hygiene for Food Service policy with all dietary staff. Education was provided Executive Director and/or designee to all kitchen personnel, including cooks, dietary aides, and dishwashers, regarding: • Proper use of approved hair restraints, including full containment of long hair and ponytails. • Requirement that hair restraints must fully cover all hair, not just partial coverage. • Infection control and food contamination prevention standards. • Responsibility of staff and supervisors to ensure compliance at all times. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Dining Service Coordinator or designee will conduct daily observations of kitchen staff for four (4) weeks and weekly audits thereafter for three (3) months. Monitoring will include verification that: • All hair, including long hair and ponytails, is fully contained. • Approved hair restraints are worn correctly at all times in the	

	kitchen. • Staff comply with uniform and hygiene policy during all food preparation and service. • Immediate correction occurs when deficiencies are identified. Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Any identified issues will be corrected immediately, with additional education provided as needed. 5. Completion Date: 7/8/2026	
A7015	19 CSR 30-87.030(13) Food-Protected, Temp,Need to Contact DHSS 1. How corrective action will be accomplished for those found to be affected by the deficient practice: Immediately upon identification of the deficient practice, all improperly stored, unlabeled, undated, uncovered, or expired food items identified during the survey were discarded. This included expired Thickened Apple Juice and all other items found without proper labeling, dating, or covering. All potentially hazardous foods were reviewed for safety and compliance with food storage standards. Items not in compliance with facility policy or expiration requirements were removed from service and discarded. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Dining Service Coordinator conducted a facility-wide audit 5.20.2026 of all food storage areas, including: • Walk-in refrigerator • Walk-in freezer • Dry storage areas • Preparation and service areas All food items were reviewed for: • Proper labeling and dating • Expiration dates and usability • Proper storage and covering • Evidence of cross-contamination risk • Any noncompliant items identified during the audit were immediately discarded or corrected. 3.What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Dining Service Coordinator and/or designee provided education has begun and will be complete to all dietary staff on food safety policies, including: • Labeling and dating of all food items immediately upon opening or preparation • Requirement that all stored food must be covered and protected from contamination • Discarding expired or outdated food products, including thickened liquids • Proper storage of opened and partially used food items	7/8/2026

	- Assigned responsibility for labeling remains with staff who open or prepare items, with supervisory verification 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Dining Service Coordinator or designee will conduct: - Daily kitchen and storage area audits for 4 weeks - Weekly audits thereafter for 3 months Monitoring will include verification that: - All food is labeled and dated appropriately - No expired or outdated items are present - All food is properly covered and stored - Thickened liquids are monitored for expiration and removed when expired Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Immediate corrective action and retraining will occur if deficiencies are identified. 5. Completion Date: 7/8/2026	
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: Immediately following identification of the deficient practice, All caked-on grease, carbon buildup, and food debris were removed from equipment surfaces. The surrounding kitchen area was also inspected and cleaned to ensure no additional contamination risks were present. Following cleaning, the equipment was inspected by the Dietary Manager 5.20.2026 to verify that surfaces were clean, smooth, and sanitary before being returned to service. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Dining Service Coordinator completed an audit 5.20.2026 of all kitchen food preparation and cooking equipment was completed, including: - Ovens - Stoves and burners - Fryers - Prep tables - Food contact and non-food contact surfaces - Ventilation areas adjacent to cooking equipment Any equipment found with grease buildup, food debris, or unclean surfaces was immediately cleaned, degreased, and sanitized before use. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur:	

	The Dining Service Coordinator and or/designee provided education has begun and will be complete for dietary staff including: • Daily cleaning of all cooking equipment (stoves, ovens, fryers) documented on cleaning logs • Weekly deep cleaning schedule with assigned responsibility and verification by Dining Service Coordinator. • Cleaning checklist for all kitchen equipment 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Dining Service Coordinator and/or designee will conduct: • Daily kitchen sanitation inspections for 4 weeks • Weekly deep-cleaning verification audits for 3 months Monitoring will include: • Verification that all cooking equipment is free of grease and debris • Completion of documented cleaning logs • Compliance with scheduled deep cleaning tasks • Immediate correction of any identified deficiencies Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Any noncompliance will result in immediate corrective action and staff retraining. 5. Completion Date: 7/8/2026	
A8004	19 CSR 30-88.010(4) Resident Rights-Admission/Annual Review	7/8/2026
	1. How corrective action will be accomplished for those found to be affected by the deficient practice: The facility immediately initiated Resident Rights reviews for Residents #2, #3, #4, #5, and #9, for whom documentation of initial and/or annual Resident Rights reviews missing. Each resident and/or their legally authorized representative was provided with a full review of Resident Rights verbally and in writing has begun and will be complete. Signed acknowledgements were obtained and placed in each resident's medical record by 7.8.2026 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Executive Director conducted a facility-wide audit for all current residents (census 79) to determine compliance with Resident Rights requirements, including: • Initial Resident Rights review upon admission • Annual Resident Rights review • Signed acknowledgment documentation Any missing or incomplete documentation was immediately corrected through completion of Resident Rights education and acknowledgment. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by Executive Director and/or designee has begun and will be complete to all administrative, nursing, and admissions staff regarding:	

	• Requirement for initial Resident Rights review upon admission • Requirement for annual Resident Rights review • Proper documentation and retention of signed acknowledgments 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will conduct monthly audits for three (3) months and quarterly thereafter to ensure compliance with Resident Rights requirements. Monitoring will include verification that: • All residents have documented initial Resident Rights review • Annual Resident Rights reviews are completed timely • Signed acknowledgments are present in each resident record • Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Any deficiencies identified will be corrected immediately, with additional staff education provided as needed. 5. Completion Date: 7/8/2026	
A8010	19 CSR 30-88.010(10) Advance Directive Requirements	7/8/2026
	1. Immediate Corrective Action for Affected Residents The facility immediately initiated Resident Rights reviews for Residents #3, #4, #5, #9, #10, for whom documentation of initial and/or annual Advance Directives reviews are missing. Each resident and/or their legally authorized representative was provided with a full review of Advance Directives verbally and in writing. Signed acknowledgments were obtained and placed in each resident's medical record by 7.8.2026. 2. Identification of Other Residents Potentially Affected The Executive Director conducted a facility-wide audit 6/15/2026 for all current residents (census 79) to determine compliance with Advance Directive requirements, including: • Initial Advance Directive review upon admission • Annual Advance Directive review • Signed acknowledgment documentation Any missing or incomplete documentation was immediately corrected through completion of Advance Directive education and acknowledgment. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur: Education provided by Executive Director and/or designee has begun and will be complete to all administrative, nursing, and admissions staff regarding: • Requirement for initial Advance Directive review upon admission • Requirement for annual Advance Directive review • Proper documentation and retention of signed acknowledgments	

	4. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will conduct monthly audits for three (3) months and quarterly thereafter to ensure compliance with Resident Rights requirements. Monitoring will include verification that: • All residents have documented initial Advance Directives review • Annual Advance Directives reviews are completed timely • Signed acknowledgments are present in each resident record • Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months. Any deficiencies identified will be corrected immediately, with additional staff education provided as needed. 5. Completion Date: 7/8/2026	

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.