

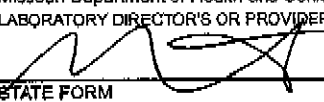
Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04078C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/19/2024
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NAME OF PROVIDER OR SUPPLIER SMILEY MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5415 THEKLA AVE SAINT LOUIS, MO 63120
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A3210	<p>19 CSR 30-86.032(9) Temperatures In Resident Areas</p> <p>Each room or ward in which residents are housed or to which residents have reasonable access shall be capable of being heated to not less than eighty degrees Fahrenheit (80°F) under all weather conditions. Temperature shall not be lower than sixty-eight degrees Fahrenheit (68°F) and the reasonable comfort needs of individual residents shall be met. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation, interview and record review, the facility failed to provide a comfortable environment, heated to no less than 68 degrees Fahrenheit (F) for two of two days of observation. The census was 18.</p> <p>1. Review of Resident #8's medical record, showed the facility admitted the resident on 12/19/19, with diagnoses which included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), dementia and alcohol dependence.</p> <p>During an interview and observation on 1/8/24 at 12:03 P.M., the resident said it was "real cold" in the facility. The resident said he/she wore coats to keep warm. The resident said he/she was cold right now. The resident said it was cold in the small television room. The resident wore a leather coat. The resident's hands were cold. The temperature of the room measured 67.3 degrees F.</p> <p>2. Observation on 1/11/24 at 9:05 A.M., of resident room 17, showed the temperature measured at 62.4 degrees F.</p>	A3210		

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


2/14/24
TITLE
(X6) DATE

Valarrie Smith, Manager

STATE FORM 6889 YFZG11 If continuation sheet 1 of 16

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A3210	<p>Continued From page 1</p> <p>Observation on 1/11/24 at 9:06 A.M., showed the resident lay on his/her bed under two thin blankets.</p> <p>During an interview on 1/11/24 at 9:07 A.M., the resident said he/she had a small black heater on the floor at the head of the bed but someone took it out yesterday. Staff installed a new furnace yesterday. It felt a little bit warmer but it can definitely be warmer than what it is. It's really cold at night. The extremely low temperatures for next week are a concern for him/her. The resident does not know how he/she is going to survive.</p> <p>3. Review of Resident #7's medical record, showed the facility admitted the resident on 7/21/14, with diagnoses which included schizophrenia and seizure.</p> <p>During an observation and interview on 1/8/24 at 12:10 P.M., the resident said he/she wore a trench coat to keep warm. The resident said it was cold in the facility on both floors of the facility. The resident wore a brown trench coat and it was buttoned up.</p> <p>4. Observation on 1/8/24 at 11:10 A.M., of resident room 17, showed the temperature measured at 60.8 degrees F.</p> <p>During an interview on 1/8/24 at 11:13 A.M., Resident #8 said he/she was cold. He/She had been cold all week and he/she sleeps with his/her jacket on. The resident said his/her room has been cold since the start of winter and he/she would like his/her room to be warmer.</p> <p>5. Observation on 1/8/24 at 9:48 A.M., of resident room 2, showed the temperature measured at</p>	A3210		

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A3210	<p>Continued From page 2</p> <p>65.1 degrees F.</p> <p>During an interview on 1/8/24 at 9:50 A.M., Resident #5 said he/she sleeps in his/her jacket and wants his/her room to be warmer.</p> <p>6. Observation on 1/8/24 at 11:55 A.M., of the game room on the first floor, showed the temperature of the room measured 54.1 degrees F.</p> <p>7. Observation on 1/8/24 at 2:31 P.M., of the first floor, in the dining room, showed the temperature of the room measured 57.7 degrees F.</p> <p>8. Observation on 1/8/24 at 9:43 A.M., of resident room 15, showed the temperature measured at 59.7 degrees F.</p> <p>9. Observation on 1/8/24 at 9:35 A.M., of resident room 2, showed the temperature measured at 60.4 degrees F.</p> <p>10. Observation on 1/8/24 at 9:38 A.M., of resident room 13, showed the temperature measured at 60.4 degrees F.</p> <p>11. Observation on 1/11/24 at 9:29 A.M., of living room near the dining room, showed the temperature measured at 60.8 degrees F.</p> <p>12. Observation on 1/11/24 at 8:51 A.M., of resident room 14, showed the temperature measured at 65.1 degrees F.</p> <p>13. Observation on 1/11/24 at 8:55 A.M., of resident room 16, showed the temperature measured at 65.1 degrees F.</p> <p>14. Observation on 1/11/24 at 9:10 A.M., of</p>	A3210		

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A3210	<p>Continued From page 3</p> <p>resident room 2, showed the temperature measured at 66.9 degrees F.</p> <p>15. Observation on 1/11/24 at 9:15 A.M., of resident room 1, showed the temperature measured at 66.9 degrees F.</p> <p>16. Observation on 1/8/24 at 11:17 A.M., of the second floor, in the hallway, showed the current temperature of the facility was 67.0 degrees F and the set point on the thermometer was 80.0 degrees F.</p> <p>17. During an interview on 1/8/24 at 9:49 A.M., the Manager said they were in the process of getting a furnace installed because the electrical heating unit was not producing enough heat to get to the resident rooms on one side of the building. The heating company was supposed to come out and replace it 1/6/24 but something "came up" on their end. They now have rescheduled to 1/9/24. The Manager said a few residents have complained to him they were cold.</p> <p>18. During an interview on 1/16/22 at 4:22 P.M., the Administrator said she was unaware the resident rooms were cold. She said some residents are "cold-natured". Some residents have jackets on during the summer time. She never asked residents if they were cold.</p>	A3210		
A3224	<p>19 CSR 30-86.032(23) Rooms Neat, Orderly, Cleaned Daily</p> <p>Rooms shall be neat, orderly and cleaned daily. II/III</p> <p>This regulation is not met as evidenced by: Class II</p>	A3224		

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A3224	<p>Continued From page 4</p> <p>Based on observation and interview, the facility failed to ensure resident rooms were neat, clean and orderly for two of two days of observation. The census was 18.</p> <p>1. Observation on 1/8/24 at 9:46 A.M., of room 2, showed the following: -The perimeter of the room's floor, covered with pieces of plaster from the wall; -From the inside of the room, the bottom of the wooden door, covered with water damage; -A mop bucket sat under the sink. When the faucet was turned on, water shot out of the pipes underneath the sink into the mop bucket.</p> <p>During an interview on 1/8/24 at 9:49 A.M., the resident said his/her sink had been leaking since he/she moved in which was eight days ago. He/She said he/she wants it fixed.</p> <p>2. Observation on 1/8/24 at 9:29 A.M., of room 14, showed the following: -The perimeter of the room, covered in a thick layer of dirt, debris and dust; -Multiple cans of soda and paper cups were on top of the dresser; -Six empty 2-liter bottles of soda under the resident's bed.</p> <p>During an interview on 1/8/24 at 9:33 A.M., Resident #3 said it was his/her responsibility to clean his/her room. He/She was told that when he/she moved into the facility. He/She has been at the facility for eight or nine years.</p> <p>Observation on 1/11/24 at 9:39 A.M., of room 14, showed Resident #3 mopping his/her floor with a large pile of dirt and dust under his/her bed.</p>	A3224		

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A3224	<p>Continued From page 5</p> <p>3. Observation on 1/8/24 at 9:35 A.M., of room 13, showed the following: -Multiple bags of clothing, dirt and debris under the resident's bed; -Multiple magazines spread over the top of the dresser and the cabinet; -Two empty 2-liter soda bottles by the resident's bed; -A mattress with no sheets and a three inch in width tear going down the center of the mattress from one end to the next.</p> <p>4. Observation on 1/8/24 at 9:38 A.M., of room 18, showed the following: -A four drawer dresser, covered with a thick layer of dust; -On the floor, in the corner of the northeast wall, near the cabinet, a thick layer of white powder, approximately a foot in diameter; -The entire floor was covered with dirt, dust and debris.</p> <p>5. Observation on 1/8/24 at 9:43 A.M., of room 15, showed the following: -Under the resident's bed, a thick layer of dust, dirt and debris; -The window seal, covered with a thick layer of layer of dust; -The television and a five dresser drawer, covered with a thick layer of dust.</p> <p>6. Observation on 1/8/24 at 9:57 A.M., of room 17, showed the floor covered with dust, dirt and debris. A six dresser drawer, covered with a thick layer of dust.</p> <p>7. During an interview on 1/11/24 at 9:50 A.M., the Administrator said she was not aware resident rooms were dirty. She said there is no housekeeper and all staff members were to clean</p>	A3224		

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A3224	Continued From page 6 residents' rooms but she will have to hire a cleaning company to clean the residents' rooms because it can be a lot of responsibility for staff to clean the resident rooms and perform their other duties. MO00227359 MO00229339 MO00227394	A3224		
A8017	19 CSR 30-88.010(17) Discharge Appeal Rights No resident may be discharged without full and adequate notice of his or her right to a hearing before the department's Administrative Hearings Unit and an opportunity to be heard on the issue of whether his or her discharge is necessary. Such notice shall be given in writing no less than thirty (30) days in advance of the discharge except in the case of an emergency discharge and must comply with the requirements set forth in 19 CSR 30-82.050. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to follow proper discharge policies and regulations when two residents (Resident #1 and Resident #2) were not readmitted after appealing a discharge issued to them. The census was 18. Review of the facility's discharge policy, undated, showed the following: -The discharge procedures will occur if the resident's need cannot be met directly or indirectly by this facility; -Coordination will be made with the community resources, resident, family or replacement	A8017		

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A8017	<p>Continued From page 7</p> <p>agency;</p> <p>-A facility representative will explain and discuss with the resident where he/she will be placed and how he/she will arrive as well as a discharge explanation;</p> <p>-The resident had the right to appeal this notice. Filing an appeal will allow you to remain in the facility until a hearing has been held unless a hearing official finds otherwise. The resident had 30 days to send an appeal;</p> <p>-The resident had the right to contact the regional long term care Ombudsman office as well;</p> <p>-The resident with developmental disabilities may contact the Missouri Protection and Advocacy Agency.</p> <p>1. Review of Resident #1's medical record, showed the facility admitted the resident on 12/19/23, with diagnoses which included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and diabetes.</p> <p>Review of the resident's progress notes, showed the following:</p> <p>-On 12/19/23, the resident was a new admission from the hospital who transferred from a sister facility. The resident was alert and orientated times 3 (to person, place and time). The resident was able to make his/her needs known. The resident had missing teeth with some broken and discolored. The resident was admitted to the hospital with suicidal thoughts. The resident denied current suicidal thoughts. The nurse was required to have a one-on-one session with the resident each month. The resident's medications were faxed to the pharmacy to be filled;</p> <p>-On 12/21/23, the nurse was made aware the</p>	A8017		

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A8017	<p>Continued From page 8</p> <p>resident told staff in the evening of 12/19/23, he/she was feeling anxious. The staff attempted to calm the resident down. The resident stated he/she swallowed a battery. The resident said he/she had called the crisis hotline and an ambulance will pick him/her up. The staff called the supervisor to inform them. The resident was sent to the emergency room. The resident was issued an immediate discharge. The resident was unable to return to the facility unless a one-on-one sitter was provided by the guardian.</p> <p>Review of the resident's hospital record, dated 12/19/23, showed the following:</p> <ul style="list-style-type: none"> -As discussed with the resident's legal guardian and primary team, the two would work with the social worker to find a facility where the resident can have appropriate supervision and behavior/psychosocial resources; -The resident was placed in a sister facility temporarily but was brought to the emergency department due to aggressive behavior (yelling and disturbing other residents/staff) and admitted to the hospital for a week. The resident was discharged on 12/19/23 to the facility where the resident reported he/she was called a "white cracker" by the staff and "mistreated" which triggered him/her to swallow a battery to kill him/herself via exploding his/her lungs; -Per the guardian, the resident called the hospital immediately to seek help; -The resident was brought back to the hospital for further evaluation and confirmed he/she swallowed a battery; -The resident said he/she would not want to come back to the facility and does not feel safe there given the negative interactions with the staff and owner; -In the setting of the stressors related to his/her placement and possibility of him/her getting back 	A8017		

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A8017	<p>Continued From page 9</p> <p>to the facility, he/she reported ongoing suicidal ideation and homicidal ideation (would like to beat the manager of the facility though the resident said he/she would not do that because it would hurt him/her for future placement efforts); -The guardian reported to the social worker he/she would look for a similar facility for the resident.</p> <p>During an interview on 1/9/24 at 10:54 A.M., Level One Medication Aide (L1MA) A said the resident was a new admit and had hung out in the nurse's office throughout the day with him/her. L1MA A said he/she knew the resident was struggling with his/her anxiety during the day and had kept a close eye on the resident. L1MA A asked the resident to step out of the nurse's office for a minute while he/she administered medication to other residents. The resident stepped out of the office and L1MA A did not know where he/she went. L1MA A then saw the resident come back down the stairs and asked the resident if he/she wanted to help him/her put away some Christmas decorations. The resident helped L1MA A put the Christmas decorations away and then went back upstairs for a brief moment. The resident came back downstairs and asked L1MA A if he/she could use a phone. L1MA A said the phone he/she could use was upstairs. The resident went back upstairs. L1MA A said shortly after, he/she received a call from paramedics who informed him/her the resident called them stating he/she had swallowed a battery. L1MA A called the resident back downstairs and into the nurse's office. L1MA A then called his/her supervisor, and the supervisor told him/her to write an immediate discharge letter and give it to the resident. When the paramedics arrived at the facility, they asked L1MA A if the resident was going to come back to</p>	A8017		

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A8017	<p>Continued From page 10</p> <p>the facility and L1MA A told them per his/her supervisor, the resident could not return to the facility.</p> <p>Review of the resident's discharge documentation showed the following:</p> <ul style="list-style-type: none"> -A face sheet with a handwritten note on top which read, "The resident was an immediate discharge, is not to return to facility, cannot meet (his/her) needs."; -An incident report dated 12/19/23 at 8:00 P.M., the resident started to complain of anxiety and the staff member asked him/her to explain the symptoms. The resident said "it was just a little bit of feeling overwhelmed by being in a new facility." The staff member asked the resident if he/she would like to help out with some of the Christmas decorations and the resident said yes. The resident wrapped a few boxes and decorated them. When the resident was done, he/she went upstairs to phone call a friend. Fifteen minutes later, the paramedics called the facility and said the resident had called them; -No other documentation was provided by the facility regarding the discharge letter to the resident. <p>During an interview on 1/11/24 at 9:34 A.M., the Guardian said he did not get the physician's paperwork stating the resident required a facility that could meet him/her psychiatric needs and to not go back to the facility until after he had appealed the discharge. The Guardian said the Owner told him the facility did not have enough staff to sit with the resident. The Guardian said the Owner did not ask him to get a sitter. The Guardian said the resident never went back to the facility but instead went to three different hospitals. The Guardian said the resident was still in the hospital at this time.</p>	A8017		

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A8017	<p>Continued From page 11</p> <p>During an interview on 1/8/24 at 10:51 A.M., the Owner said she did not re-admit Resident #1 because she could not provide a sitter for the resident which is what the resident required. The Owner said the Guardian told her he would get the sitter but never did. The Owner was not aware the resident required readmission until the appeal was completed.</p> <p>2. Review of Resident #2's medical record, showed the facility admitted the resident on 11/1/23, with diagnoses which included seizures, high blood pressure, alcohol dependency and chronic back pain.</p> <p>Review of the resident's progress notes, showed the following: -On 12/26/23, the Nurse heard a loud commotion in the dining area. The resident had got into an altercation with another resident. Both of the residents started fighting. Another staff member came between the two residents to stop the fight. Resident #2 refused to stop fighting and tried to bite the other resident. The fight was stopped by staff. Once the two residents were separated (further away from each other in the dining room) Resident #2 picked up a chair to throw it at the other resident. The resident was hard to re-direct but put the chair down. Male staff had to re-direct the resident into another room. The nurse called the manager who said the resident required an immediate discharge due to violent behavior. The resident was sent to the hospital; -On 12/30/23, the Nurse made the manager aware the resident returned to the facility on 12/28/23. The resident informed the Nurse he/she was discharged from the hospital on 12/26/23 and was sent to another hospital which discharged him/her due to not having paperwork.</p>	A8017		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04078C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/19/2024
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NAME OF PROVIDER OR SUPPLIER SMILEY MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5415 THEKLA AVE SAINT LOUIS, MO 63120
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8017	<p>Continued From page 12</p> <p>Resident was displaced to another facility.</p> <p>Review of the resident's immediate discharge letter dated 12/26/23, showed the resident became physically aggressive with another resident and staff. The resident had a history of aggression with several other residents. At the bottom of the letter, there was a handwritten note which read, "May not return." The immediate discharge letter did not have a notification to the resident of the right to appeal or another location for the resident to be displaced to.</p> <p>Review of the resident's discharge appeal dated 12/27/23, filled out by a hospital Social Worker, showed the resident wanted to appeal his/her discharge from the facility. The hospital was able to discharge the resident back to his/her facility since the appeal was filed.</p> <p>Review of the resident's progress note from the hospital, written by a Social Worker, dated 12/27/23, showed the resident said he/she was not informed of his/her immediate discharge by the facility staff and said the physician at the hospital was the first person to tell him/her he/she could not return to the facility. The Social Worker asked the resident if he/she was given documentation from the facility regarding the discharge and the resident said he/she was only given an envelope including resources and an after-visit summary from the previous hospital he/she was at. The resident was able to locate his/her relative's house and returned to a hospital because he/she was not able to get a medication. The resident told the Social Worker he/she had family members, but he/she was not able to live with them and he/she desired to go back to the facility.</p>	A8017		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04078C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/19/2024
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NAME OF PROVIDER OR SUPPLIER SMILEY MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5415 THEKLA AVE SAINT LOUIS, MO 63120
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A8017	<p>Continued From page 13</p> <p>Review of the decision and order of the appeals unit dated 12/29/23, showed the discharge letter the resident was provided failed to include a written notice to the resident in a language and manner reasonably calculated to be understood by the resident, the reason for transfer or discharge, the effective date of transfer or discharge, the resident's right to appeal the transfer or discharge notice to the director of the Department of Health and Senior Services, notification of filing an appeal would allow the resident to remain in the facility until the hearing is held unless a hearing official finds otherwise, a location to which the resident was transferred or discharged, the contact information of the Ombudsman's office and lastly the discharge letter did not contain the contact information of the Missouri Protection and Advocacy Agency .</p> <p>During an interview on 1/12/24 at 10:04 A.M., Resident #7 said he/she was not hit by Resident #2, Resident #2 just lifted a chair up and acted as if he/she would throw chair at him/her. Resident #7 said he/she was uncomfortable with Resident #2 returning to the facility.</p> <p>During an interview on 1/2/24 at 2:34 P.M. and on 1/8/24 at 10:30 A.M., the Owner said the resident came back to the facility on 12/29/23, from the hospital. The Owner said the hospital gave the resident a list of facilities and he/she told the Owner which facility he/she wanted to go to because he/she had friends there. The Owner called the facility and the facility told her they would accept the resident. The Owner packed all of his/her belongings and drove the resident to the facility. The Owner had the resident sign a paper showing the resident wanted to go to said facility. The Owner said the resident got into an altercation with another resident. The Owner said</p>	A8017		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04078C	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/19/2024
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NAME OF PROVIDER OR SUPPLIER SMILEY MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5415 THEKLA AVE SAINT LOUIS, MO 63120
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8017	<p>Continued From page 14</p> <p>the resident had a history of aggression with other residents. The resident had been pushing other residents when they were lined up washing their hands before lunch during the afternoon of 12/26/23. The Owner said the Nurse had re-directed the resident several times, telling him/her not to push or rush other residents when washing their hands. The resident got up from a dining room table and hit Resident #7. The resident then picked up a chair and acted like he/she would throw the chair at Resident #7. The resident was re-directed and put the chair back down. The resident was re-directed and left the dining room. The resident went upstairs and called his/her family members. A few of the resident's family members showed up to the facility "ready to fight" Resident #7. The family members were made to leave the premise. Resident #7 told the Owner he/she was uncomfortable with Resident #2 returning to the facility from the hospital.</p> <p>During an interview on 1/8/24 at 10:51 A.M., the Owner said she did not re-admit Resident #2 when he/she appealed the discharge because the resident got into a physical altercation with another resident which made that resident uncomfortable and feared Resident #2 coming back to the facility and "beating (him/her) up." The Owner was not aware the resident required readmission until the appeal was completed.</p> <p>MO00229637 MO00229065 MO00229023</p> <p>*The higher the classification merited due to the extent of the violation.</p>	A8017		

(2)

PLAN OF CORRECTION		
Provider/Supplier Name:	Smiley Manor RCF	
Street Address, City, Zip:	5415 Thekla Ave, St Louis, MO 63120	
Date of Survey:	4/8/24	
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
A3224	19CSR30-86.032(23)	3-14-24
	<p>Residents are encouraged to throw trash away and make sure rooms are tidy for the day. Facility required to provide minimal assistance unless it is determined that more assistance is needed. Statute only states that rooms must be cleaned daily but does not state by whom. Manager will ensure compliance by making rounds during shift. If resident room is in need of deep cleaning and employee will be assigned to that room for cleaning. If resident does not wish for that employee to clean their room manager shall be notified. A plan then be implemented for a cleaning company to be scheduled to come to facility and clean.</p> <p>Maintenance personell hired to focus more on the equipment and furniture. New mattresses were ordered for beds. Residents knowingly destroying furniture will be counseled on the matter. Facility nurse and psych doctor will also be notified in an effort to prevent reoccurrence. Manager will ensure compliance by going over problem areas listed on maintenance log with worker and signing after task completed</p>	
A8017	19CSR30-88.010(17)	1/19/24
	Resident #1 was a danger to his/herself and needs could not be met at facility.	
	Resident #2 was a danger to others and needs could not be met at facility.	
	Both residents were sent to facilities that could meet their needs. Plan was coordinated with resident #2 once he/she returned back to facility unannounced from hospital.	
	Res #2 was safely transported to another facility by staff with personal belongings.	
	Res #1 was safely transported to hospital by EMS so xrays could be done after stating she consumed a battery.	
	Manager will ensure compliance of this reg by training staff on	3/22/24

