Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07694	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LOUIS HILLS ASSISTED LIVING AND MEMORY CA	6543 CHIPPEWA SAINT LOUIS, MO 63109

(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
A3201	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed and shall be maintained in good repair and in accordance with the construction and fire safety rules in effect at the time of initial licensing. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure all areas of the facility were maintained in good repair when several baseboards, walls and doors were damaged with various sizes of scuff marks and multiple ceiling tiles had water damage and/or were missing. The census was 69. 1. Observation on 9/26/25 between 6:40 A.M. and 4:00 P.M., of resident room 315, showed the following: -Inside the bathroom; -The inside of the toilet bowl was rusted and encrusted; -The ceiling in the front left corner, above the shower, the ceiling material was ripped and hanging down, which exposed pipes and wires. The area measured approximately 3 feet long; -In the shower, on the back left ledge of the shower, which attached to the wall, covered with orange rust. The area measured 1 foot long; -The kitchenette sink and counter top were removed, which exposed the plumbing underneath. The kitchenette and counter top sink were placed in the shower. 2. Observation on 9/26/25 between 6:30 A.M. and 4:30 P.M., of the dining room, in the back of the room near the private dining room, showed three ceiling tiles missing which exposed wires and	A3201		

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A3201	Continued From page 1 pipes. 3. Observation on 9/26/25 between 6:30 A.M. and 3:00 P.M., of the dining room, in the front of the room near the front lobby, showed five ceiling tiles with brown circles of water damage and by the sprinkler head, two ceiling tiles with light brown circles of water damage. 4. Observation on 9/26/25 between 6:35 A.M. and 4:00 P.M., of the second floor, showed one broken ceiling tile, above resident room 209. Part of the ceiling tile was missing. 5. Observation on 9/26/25 between 6:50 A.M. and 4:00 P.M., of the third floor area of refuge, adjacent to resident room 305, showed the air conditioning unit cover had been removed, which exposed the air conditioning wires. 6. Observation on 9/26/25 between 6:55 A.M. and 4:00 P.M., of the fourth floor area of refuge, adjacent to resident room 409, showed the air conditioning unit had been removed from the wall, which exposed wires. 7. Observation on 9/26/25 between 7:00 A.M., and 4:00 P.M., showed the bottom of the door of resident room 419, covered in black and white scuff marks. 8. Observation on 9/26/25 between 7:05 A.M. and 4:00 P.M., showed the hallway baseboard between resident room 417 to 419, covered in black scuff marks. 9. Observation on 9/26/25 between 7:10 A.M. and 4:00 P.M., showed the bottom of the door of resident room 409, covered in black scuff marks. The scuff marks were deep and exposed the light	A3201		

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A3201	Continued From page 2 colored wood of the door. During an interview on 9/26/25 at 7:25 A.M., Level One Medication Aide B said he/she had never seen anyone paint the doors or baseboards since he/she started about three months ago. 10. Observation on 9/26/25 between 8:30 A.M. and 4:00 P.M., by resident room 210, showed two ceiling tiles missing, which exposed wires. 11. During an interview on 9/26/25 at 3:59 P.M., the Administrator said the ceiling tiles have been like that and she asked the Maintenance Director to be replace the ceiling tiles but he had not. She did not know why they were not replaced, but thought it was because she did not have enough Maintenance staff to complete the task. She said the baseboards, doors, and walls were not on a schedule. She said the maintenance staff might have a schedule, but she just was not aware of it. *The higher the classification merited due to extent of the violation.	A3201		
A3224	19 CSR 30-86.032(23) Rooms Neat, Orderly, Cleaned Daily Rooms shall be neat, orderly and cleaned daily. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure resident rooms were kept clean and orderly when resident rooms were found with dried feces and food debris on the floor, doorframes and other areas and were filled with	A3224		

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A3224	Continued From page 3 excessive clutter. The census was 69. 1. Observation on 9/26/25 between 7:10 A.M. and 4:00 P.M., of resident room 309, showed the following: -The shower floor, in the bathroom, covered with several areas of dried feces; -The floor in front of the toilet, covered with a very thick layer of yellow/orange colored urine. The area extended out from the front of the toilet about 18 inches. The smell of feces and urine permeated the room; -The bathroom floor, covered with several areas of dried feces; -The sink, in the kitchenette, filled with dirty brown, foul smelling water, up to the rim; -The entire room floor, covered with debris and food particles, with a heavy concentration in front of the resident's brown leather recliner; -The floor, in front of the recliner, covered with several areas of dried feces; -The recliner covered with feces smears and dried food and debris; -The closet doors, covered with a large area of dried feces; -The outside doorframe, which lead into the bathroom, covered with a large area of dried feces. 2. Observation on 9/26/25 between 12:30 P.M. and 4:00 P.M., in resident room 217, showed the following: -Against the wall on the left side of the chair: -Approximately 12 boxes filled with various household belongings; -A brown paper bag filled with paper towels; -A large piece of Styrofoam from an empty box placed on top of the pile; -A cardboard banana box filled with baskets and other bags;	A3224		

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A3224	Continued From page 4 -A cardboard chip box frilled with a plastic trashcan and a floormat; -A shower chair placed on top of the pile of other items; -Articles of clothing tucked between the boxes; -In the chair: -Several articles of clothing thrown on the chair; -In the kitchenette sink: -Soiled food containers. 3. Observation on 9/26/25 between 1:00 P.M. and 4:00 P.M., of resident room 304, showed the following: -The entire room covered with cardboard boxes, which were filled with various household items such as kitchen utensils, paper products, books, lamps and empty containers; -Several walkers, rollators and canes were scattered throughout the room; -The entire kitchenette counter covered in clean and dirty dishes stacked on each other; -Old, dried food sat on the television stand; -A pile of rocks and onions were on top of a red microwave; -A broken lamp on the bedside table; -Soiled clothes on the floor and on top of the boxes in front of the television; -The resident lay on one side of his/her bed and on the other side of the mattress were more boxes filled with various items; -A used urinal sat on his/her bedside table which dripped urine on the beside table. 4. Observation on 9/26/25 between 7:00 A.M. and 4:00 P.M., of resident room 315, showed the following: -Several large plastic wrappers on the floor; -Several unopened boxes of gloves scattered	A3224		

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A3224	Continued From page 5	A3224		

throughout the floor;
-Three cardboard boxes of opened flooring propped up against a wall;
-Several cardboard boxes filled with various items and one cardboard box pilled high with blankets, sheets and a mop head;
-A small paint roller on the floor;
-Empty cleaning supply boxes;
-A broom head without the handle;
-Soiled rags.

5. Observation on 9/26/25 between 10:00 A.M. and 4:00 P.M., of the bathroom in resident room 319, showed dried yellow urine on the tiles around the toilet. The bathroom had an extreme urine odor which permeated the bathroom and spread out into the bedroom and hallway.

6. During an interview on 9/26/25 at 3:46 P.M., the Regional Director of Nursing said she was in resident room 304 last month and she had to remove about 20 Amazon boxes. She had not been in that room since then, but remembered breaking down several boxes with the resident. She was not aware the resident's room was cluttered again. She understood it could be considered a fall hazard because of how cluttered the room was.

7. During an interview on 9/26/25 at 3:45 P.M., the Administrator said the staff clean the resident rooms once a week. She did not know the regulation read the resident rooms required to be cleaned daily. She said she did not ensure the staff were cleaning the resident rooms because she gave that task to the Housekeeper Supervisor. She said she had not been in resident room 304 recently. She said she did not know the resident rooms were in this condition.

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A3224	Continued From page 6 *The higher the classification merited due to the extent of the violation.	A3224		
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to provide proper care per the resident's individualized service plan (ISP) when the facility staff did not follow the resident's ISP indicating the resident required the assistance of a Hoyer lift (mechanical lift) for one of seven sampled residents (Resident #1). The census was 69. Review of Resident #1's medical record, showed the facility admitted the resident on 9/29/23, with diagnoses which included high blood pressure and Alzheimer's disease. Review of the resident's ISP dated 2/28/24, showed the resident required staff assistance transferring with use of Hoyer lift. During an observation and interview on 9/26/25 at 10:40 A.M., showed Care Partner (CP) E and Certified Medication Technician (CMT) F entered the resident's room. The resident lay in bed. There was a Hoyer lift against the wall across from the resident's bed. CP E and CMT F provided care to the resident. CP E moved the resident's Broda Chair (a specialized reclining wheelchair) next to the resident's bed. CMT F	A4777		

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A4777	Continued From page 7 said the resident was a two person Hoyer transfer, but the staff did not use the Hoyer lift. He/she said the staff did not like the sheet/pad that was with the Hoyer lift and the resident moved too much. CMT F lifted the resident under the resident's arms and CP E lifted the resident around the waist. At the same time, they sat the resident up from laying position in the bed and lifted the resident to the Broda chair. During an interview on 9/26/25 at 2:15 P.M., the Administrator said the staff should have used the Hoyer lift to transfer the resident, they are not qualified to make those decisions themselves.	A4777		
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to follow physician's orders when residents did not receive their medications according to their Physician's orders (POS) for three of nine sampled residents (Residents #8, #9 and #15). The census was 69. 1. Review of Resident #8's medical record, showed the facility admitted the resident on 3/21/22, with diagnoses which included dementia with Lewey bodies (a type of dementia characterized by changes in sleep, behavior,	A4798		

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A4798	Continued From page 8 cognition, movement, and regulation of automatic bodily functions), muscle weakness and difficulty in walking. Review of the resident's POS dated 8/2025, showed the following: -Alendronate (used to treat osteoporosis), 70 milligrams (mg). Take one tablet by mouth once week; -Anoro Ellipta, (used to treat chronic obstructive pulmonary disease (COPD)), one puff. Inhale one puff one time daily; -Aspirin (used as a blood thinner), 81 mg. Give one tablet by mouth one time daily; -Clindamycin (antibiotic), 300 mg. Give one capsule by mouth three times daily for seven days; -Clonazepam (used to treat panic disorders), 0.5 mg. Dissolve one tablet under the tongue two times daily; -Clotrimazole (antifungal), 1-0.05%. Apply topically to affected area two times daily; -Donepezil (used to treat dementia), 5 mg. Give one tablet by mouth at bedtime; -Duloxetine (used to treat depression), 120 mg. Give two capsules by mouth every morning; -Ferrosol (used to treat iron deficiency), 325 mg. Give one tablet by mouth one time daily; -Gabapentin (used to treat pain), 100 mg. Give two capsules by mouth two times daily; -Gemtesa (used to treat an overactive bladder), 75 mg. Give one tablet by mouth one time daily; -Loperamide (used to treat diarrhea), 2 mg. Give on capsule by mouth two times daily; -Melatonin (promotes sleep), 3 mg. Give on tablet by mouth at bedtime; -Metoprolol (used to teat high blood pressure), 25 mg. Give one tablet by mouth on time daily; -Mirtazapine (used to treat depression), 30 mg. Give on tablet by mouth at bedtime;	A4798		

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A4798	Continued From page 9 -Nystatin powder (antifungal). Apply topically to affected area two times daily; -Omeprazole (used to treat acid reflux), 40 mg. Give one capsule by mouth one time daily; -Pentoxifylline (used to treat leg pain), 400 mg. Give one capsule by mouth one time daily; -Potassium chloride (used to treat low potassium levels), 10 milliequivalent (meq). Give one tablet by mouth two times daily with meals; -Preservision (used to help vision). Give one capsule by mouth one time daily; -Rexulti (used to treat depression), 1 mg. Give on tablet by mouth in the morning; -Solifenacin (used to treat overactive bladder), 10 mg. Give one tablet by mouth one time daily; -Vitamin B-12, 500 micrograms (mcg). Give one tablet by mouth one time daily; -Vitamin B-6, 50 mg. Give one tablet by mouth one time daily; -Vitamin D, 50000 unit. Give one capsule by mouth one time weekly. Review of the resident's medication administration record (MAR) dated 8/2025, showed the following: -Alendronate not administered to the resident on 8/4, with /no documentation as to why; -Anoro Ellipta not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Aspirin not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Clindamycin not administered to the resident on 8/1, for the noon timeframe and 8/4, for the morning time, with no documentation as to why; -Clonazepam not administered to the resident on 8/4, for the morning dose, on 8/15, for both the morning and evening dose, on 8/24, for the morning dose, with no documentation as to why. On 8/25, the resident was not administered the medication, with "not available" documented;	A4798		

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A4798	Continued From page 10 -Clotrimazole not administered to the resident on 8/4, for the morning dose, with no documentation as to why. The resident did not receive the medication on 8/9, for the morning dose, with "not here" documented. The resident did not receive the medication on 8/15, for the morning and evening dose; -Donepezil not administered to the resident on 8/25, with "not in cart" documented; -Duloxetine not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Ferrosol not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Gabapentin not administered to the resident on 8/4, for the morning dose and on 8/15, for the morning and evening dose, with documentation as to why; -Gemtesa was not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Loperamide not administered to the resident on 8/4, for the morning dose, on 8/15, for the morning and evening dose, with no documentation as to why. The resident did not receive the medication on 8/26, with "not in cart" documented; -Metoprolol not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Mirtazapine not administered to the resident on 8/27, with "not in cart" documented; -Nystatin powder not administered to the resident on 8/4, for the morning dose and 8/15, for the morning and evening dose, with no documentation as to why; -Omeprazole not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Pentoxifylline not administered to the resident on 8/4, for the morning dose and 8/15, for the morning and noon dose, with no documentation as to why. The resident did not receive the	A4798		

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A4798	Continued From page 11 medication on 8/25, for the evening dose, with "not in cart" documented and on 8/29, with "not available" documented; -Potassium chloride not administered to the resident on 8/4, for the morning dose and 8/15, for the morning and evening dose, with no documentation as to why; -Preservision not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Rexulti not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Solifenacin not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Vitamin B-12 not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Vitamin B-6 not administered to the resident on 8/4 and 8/15, with no documentation as to why; -Vitamin D not administered to the resident on 8/4, with no documentation as to why. Review of the resident's POS dated 9/2025, showed the following: -Alendronate, 70 milligrams. Take one tablet by mouth once a week; -Clonazepam, 0.5 mg. Dissolve one tablet under the tongue two times daily; -Gabapentin, 100 mg. Give two capsules by mouth two times daily; -Gemtesa, 75 mg. Give one tablet by mouth one time daily; -Pentoxifylline, 400 mg. Give one capsule by mouth one time daily. Review of the resident's MAR dated 9/2025, showed the following: -Alendronate not administered to the resident on 9/29, with no documentation as to why; -Clonazepam not administered to the resident on 9/22, for the evening dose, with no documentation as to why;	A4798		

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A4798	Continued From page 12 -Gabapentin not administered to the resident on 9/12, for the evening dose with no documentation as to why; -Gemtesa not administered to the resident on 9/3, with "not on hand" documented and on 9/4, with "medication unavailable" documented; -Pentoxifylline not administered to the resident on 9/6, for the evening dose, with "order" documented and for 9/7-9/10, for the evening dose, with "not available" documented. The resident did not receive the medication on 9/14 and 9/15, for the evening dose, with "not available" documented. 2. Review of Resident #9's medical record, showed the facility admitted the resident on 4/1/20, with diagnoses which included diabetes, edema, high blood pressure and kidney disease (stage 3). Review of the resident's POS dated 8/2025, showed the following: -Atorvastatin (used to treat high blood pressure), 10 mg. Give one tablet by mouth one time daily; -Benzonatate (used to treat a cough), 100 mg. Give one capsule by mouth three times daily; -Blood sugar checks. Check and record blood glucose two times daily before breakfast and dinner; -Breo Ellipta (used to treat COPD). Inhale one puff one time daily, rinse mouth after use; -Butenafine (used to treat fungus infections). Apply topically to left foot two times daily until healed; -Carvedilol (used to treat heart disease), 3.125 mg. Give on tablet by mouth two times daily with meals; -Clotrimazole, 1%. Apply topically to affected area two times daily; -Fluticasone spray (used to treat allergies), 50	A4798		

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	07594	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LOUIS HILLS ASSISTED LIVING AND MEMORY CA	6543 CHIPPEWA SAINT LOUIS, MO 63109

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A4798	Continued From page 13	A4798		

mcg. Use two sprays in each nostril daily;
-Furosemide (used to treat fluid retention), 40 mg. Give one tablet by mouth two times daily;
-Humalog (insulin, used to treat diabetes), 100 milliliters. Injected 5 units two times daily before breakfast and dinner, if blood glucose is greater than 200. If blood glucose is less than 200, hold;
-Jardiance (used to treat diabetes), 25 mg. Give one tablet by mouth in the morning;
-Oyster shell (used for calcium), 500 mg. Give on tablet by mouth two times daily;
-Potassium chloride, 10 meq. Give one tablet by mouth one time daily;
-Triamcinolone (used as an anti-inflammatory) 0.1%. Apply topically to affected areas two times daily;
-Vitamin B-12, 500 mcg. Give one tablet by mouth one time daily.

Review of the resident's MAR dated 8/2025, showed the following:
-Atorvastatin not administered to the resident on 8/6 and 8/21, with no documentation as to why;
-Benzonatate not administered to the resident on 8/1, for the noon dose, with "refill requested, not administered" documented. The resident did not receive the medication on 8/3, 8/6, 810, and 8/12, for the noon dose, with no documentation as to why. The resident did not receive the medication on 8/15, for the morning and evening dose, with no documentation as to why. The resident did not receive the medication on 8/20 and 8/21, for the noon dose, with no documentation as to why;
-Blood sugar check not completed on 8/6, for the morning time, with no documentation as to why. The blood sugar check not completed on 8/15 and 8/17, for the evening time, with no documentation as to why. The blood sugar check not completed on 8/21, for the morning time, with "no working meters" documented. The blood

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A4798	Continued From page 14 sugar check not completed on 8/27, for the morning time, with "not given" documented; -Breo Ellipta not administered to the resident on 8/9, with "not here" documented. The resident did not receive the medication on 8/15, with no documentation as to why; -Butenafine not administered to the resident on 8/15, with no documentation as to why; -Carvedilol not administered to the resident on 8/3, for the evening dose, with no documentation as to why. The resident did not receive the medication on 8/6, 8/12, 8/20, 8/21 and 8/27, for the evening dose, with no documentation as to why; -Clotrimazole not administered to the resident on 8/3, 8/6, 8/10 and 8/12, for the evening dose, with no documentation as to why. The resident did not receive the medication on 8/13, for the evening dose, with "not on hand" documented. The resident did not receive the medication on 8/15, 8/20 and 8/21, for the evening dose, with no documentation as to why; -Fluticasone not administered to the resident on 8/15, with no documentation as to why; -Furosemide not administered to the resident on 8/15, for both the morning and evening dose, with no documentation as to why; -Humalog not administered to the resident on 8/6, for the morning dose, with no documentation as to why. The resident did not receive the medication on 8/15 and 8/17, for the evening dose, with no documentation as to why. The resident did not receive the medication on 8/21, for the morning dose, with no documentation as to why; -Jardiance not administered to the resident on 8/15, with no documentation as to why; -Oyster shell not administered to the resident on 8/15, for the evening dose, with no documentation as to why;	A4798		

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A4798	Continued From page 15 -Potassium chloride not administered to the resident on 8/15, with no documentation as to why; -Triamcinolone not administered to the resident for the morning and evening dose on 8/15, with no documentation as to why; -Vitamin B-12 not administered to the resident on 8/15, with no documentation as to why. Review of the resident's POS dated 9/2025, showed the following: -Atorvastatin, 10 mg. Give one tablet by mouth one time daily; -Blood sugar checks. Check and record blood glucose two times daily before breakfast and dinner; -Carvedilol, 3.125 mg. Give on tablet by mouth two times daily with meals; -Clotrimazole, 1%. Apply topically to affected area two times daily; -Humalog, 100 milliliters. Injected 5 units two times daily before breakfast and dinner if, blood glucose is greater than 200. If blood glucose is less than 200, hold. Review of the resident's MAR dated 9/2025, showed the following: -Allopurinol not administered to the resident on 9/18, with no documentation as to why; -Blood sugar checks not completed on 8/21, for the evening time and on 8/23, for the morning time, with no documentation why; -Carvedilol not administered to the resident on 9/14, with no documentation as to why; -Clotrimazole not administered to the resident on 9/14, with no documentation as to why; -Humalog not administered to the resident on 9/21, for the evening dose and 9/23 for the morning dose, with no documentation as to why.	A4798		

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A4798	Continued From page 16 3. Review of Resident #15's medical record, showed the facility admitted the resident on 5/11/24, with diagnoses which included high blood pressure and hyperlipidemia (too many lipids in the blood). Review of the resident's POS dated 6/2025, showed the following: -Eliquis (a blood thinner), 5 mg. Give one tablet by mouth two times daily; -Fluticasone (used to treat allergies), 50 mcg. Use two sprays in each nostril daily; -Hydrochlorothiazide (used to treat high blood pressure), 25 mg. Give 1/2 a tablet (12.5 mg) by mouth one time daily; -Loratadine (used to treat allergies), 10 mg. Give one tablet by mouth one time daily; -Losartan (used to treat high blood pressure), 50 mg. Give one tablet by mouth one time daily; -Vitamin D-3, 5000 unit. Give one capsule by mouth one time daily. Review of the resident's MAR dated 6/2025, showed the following: -Eliquis not administered to the resident on 6/2, for the afternoon dose, with no documentation as to why; -Fluticasone not administered to the resident on 6/2 and 6/9, with no documentation as to why. The resident did not receive the medication on 6/11, with "not available" documented; -Hydrochlorothiazide not administered to the resident on 6/2, for the evening dose, 6/7-6/9 for the morning dose, and on 6/13, for the morning dose, with no documentation as to why; -Loratadine not administered to the resident on 6/2 for the evening dose and on 6/9, for the morning dose, with no documentation as to why; -Losartan not administered to the resident on 6/2, for the evening dose, 6/7-6/9 for the morning	A4798		

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A4798	Continued From page 17 dose and on 6/13, for the morning dose, with no documentation as to why; -Vitamin D-3 not administered to the resident on 6/2, for the evening dose and on 6/9, for the morning dose, with no documentation as to why. 4. During an interview on 9/26/25 at 3:55 P.M., the Regional Director of Nursing said if there was a blank in the resident's MAR, it was safe to say the resident did not get their medication. She said she expected the staff to document a reason why the resident did not receive the medication and then follow up with the resident's Physician to let them know, as well as document that conversation with the Physician. She said she expected the staff to pass the medications following Physician's orders appropriately. She said there should not be blanks in the resident's MARs. 5. During an interview on 9/26/25 at 3:57 P.M., the Administrator said she was not aware there were blanks in some resident's MARs. She said the staff should have documented something on the resident's MAR and she expected the staff to contact the resident's Physician and let them know the medication was not administered. She said the conversation with the Physician should be documented in the resident's medical record as well. She said there should not be blanks in the resident's MARs. *The higher the classification merited due to the extent of the violation. MO00257918 MO00256025	A4798		

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A6011	Continued From page 18	A6011		
A6011	19 CSR 30-87.020(11) No Deodorizers/Sprays to Eliminate Odors Deodorizers or sprays shall not be used to cover up odors. Odors shall be eliminated to the source by prompt cleaning of bedpans and commodes, floors, furniture and equipment and by proper ventilation. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to eliminate odors at the source when an extremely strong urine odor was present through half of a hallway, in the elevator and in a resident's room. The odor was so strong it offended other residents. The census was 69. Observation on 9/26/25 between 6:30 A.M. and 7:30 A.M. and between 11:00 A.M. and 12:00 P.M., in the back of the dining room, near the elevator, showed an extremely strong urine odor present. The odor came from Resident #16. The resident was dressed in dirty clothes and his/her hair was greasy and matted. The resident's legs were exposed and were covered with layers and dry flaky skin. At 11:00 A.M., the resident was seated back at the same table in the dining room. The resident was still dressed in the same dirty clothes. A strong urine smell permeated around the area the resident sat. During an interview on 9/26/25 at 12:35 P.M., Resident #13 said he/she smelled the urine odor in the dining room, and it offended him/her. He/she said the odor comes and goes and when he/she smelled it, he/she thought "ugh" and the resident proceeded to shake his/her head. The resident sat at the table directly across from	A6011		

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A6011	Continued From page 19 Resident #16's table. Observation on 9/26/25 between 7:14 A.M. and 4:00 P.M., of the third floor between resident rooms 309 and 319, showed an extremely strong urine odor was present and permeated throughout the hallway. The urine odor became unbearable the closer the Regulatory Auditor got to resident room 319. Observation on 9/26/25 at 12:22 P.M., in resident room 319, near the third floor elevator, showed a heavy urine odor inside the resident's room. Upon entrance to the resident's room, the odor was so strong, it burnt the Regulatory Auditor's nose. When the Regulatory Auditor opened the resident's bathroom door, she had to hold her breath because the urine odor was breathtaking. During an interview on 9/26/25 at 2:25 P.M., Resident #10 said he/she smelled the odors on and near the elevator multiple times a day. He/she said the odor was "very offensive." During an interview on 9/26/25 at 2:34 P.M., Resident #11 said he/she did not leave his/her room that much, but when he/she did leave the room, he/she noticed a urine odor. He/she said, "it's not clean back by the elevator." The resident said he/she did not go to the dining room that often, but when he/she did, he/she smelled the urine odor there too. The resident resided on the third floor, near room 319. During an interview on 9/26/25 at 3:35 P.M., Resident #14 said he/she smelled the urine odor all over the facility but mainly on the third floor and inside the elevators. He/she said the odor was "a little offensive."	A6011		

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A6011	Continued From page 20 During an interview on 9/26/25 at 4:03 P.M., the Regional Director of Nursing said she knew there was an odor coming from Resident #16, but did not know the odor was strong enough to be affecting other residents at this point. During an interview on 9/26/25 at 4:02 P.M., the Administrator said she knew there was an odor coming from Resident #16, who refused any care from the staff and refused showers most days. She was not aware the odor had gotten so bad, to the point it was affecting other residents. *The higher classification merited due to the extent of the violation. MO00257918	A6011		

PLAN OF CORRECTION

Provider/Supplier Name:	St. Louis Hills Assisted Living and Memory Care
Street Address, City, Zip:	6543 Chippewa Street, St. Louis, MO 63109
Date of Survey:	09/26/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A3201 19 CSR 30-86.032	SUBSTANTIALLY CONSTRUCTED & MAINTAINED -The Executive Director has conducted a walk through 10/21 and 10/22 to identify areas of concern. -The Maintenance team will ensure there are no missing ceiling tiles throughout the community, and all damaged tiles be replaced. • An audit will be completed 2x weekly by ED to ensure completion by 11/10/25 and 1x weekly thereafter for maintenance. -All internal doors will be cleaned and painted so there is no chipped paint or visible wood. Any visible cracks in the walls will be assessed, then filled and new paint applied. All missing or damaged thresholds will be replaced. • An audit will be completed 2x weekly by ED to ensure completion by 11/10/25 and 1x weekly thereafter for maintenance. • The Director of Maintenance or designee will continue to do semi-monthly inspections of interior walls, interior doors, floors, etc. to ensure the community is being maintained properly. - All doors will be inspected for proper functioning, including lock and latch working appropriately. • Any doors not working properly will be repaired by 11/10/25. - The Executive Director or designee will do monthly inspections of interior landscape to ensure the building is maintained and safe for staff and residents.	11/30/25
A3224 19 CSR 30-86.032	ROOMS NEAT, ORDERLY, CLEANED DAILY -On 10/17/25, meeting held with housekeeping team to discuss the daily housekeeping schedule and review of housekeeping cleaning checklist. -Each housekeeper will be individually trained on the proper way to clean resident rooms.	11/30/25

	-At scheduled All Staff meeting on 10/27/25, caregivers will be educated on daily room touches to include trash pick up, incontinence accident clean ups, and picking clothing up off the floor as a daily task. - ED or designee will complete audit of 4 rooms 2x weekly to ensure rooms are being cleaned properly and as scheduled.	
A4777 19 CSR 30-86.047	PROPER CARE PER INDIVIDUAL SERVICE PLAN -DON or designee will ensure that all residents have a current Individual Service Plan developed, outlining residents' current needs and preferences by 10/31/25. -All community staff will be in-serviced on what an Individualized Service Plan is, expectations of care to be completed per ISP, and when and how to document refusals of care. -DON or designee will conduct at least 2 weekly spot checks of care and document findings and provide education when needed. -DON and/or designee will conduct 3 ISP audits weekly for 8 weeks then 1 ISP audit weekly ongoing.	11/30/25
A4798 19 CSR 30-86.047	PHYSICIANS ORDERS FOLLOWED - DON and Regional Director of Compliance will in-service all staff licensed to administer medications on proper medication administration and the importance of following physician's orders by 11/30/25. - DON or designee will observe 1 medication pass weekly for 8 weeks. - DON or designee ongoing will observe 2 med pass monthly, staff will be educated as needed documentation of observations and training will be completed and provided for review. -DON or designee will review medication exception report and passed medication report 3x weekly for 8 weeks and 1x weekly ongoing.	11/30/25
A6011 19 CSR 30-87.020	NO DEODORIZERS/SPRAYS TO ELIMINATE ODORS -All unapproved deodorizers and sprays will be eliminated from the building by 10/24/25. - All staff will be in-serviced on proper protocol on the cleaning of odors or source of odors by 10/27/25. -ED or designee will complete audit of 4 rooms and 1 common area 2x weekly to ensure the absence of odors.	11/30/25

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.

Jillian Kaplan 10-23-25

Missouri Department of Health and Senior Services

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A2231	19 CSR 30-86.022(7)(G) Stairways/Corridors Free of Obstructions Exits, Stairways, and Fire Escapes. (G) All stairways and corridors shall be easily negotiable and shall be maintained free of obstructions. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the areas of refuge were easily negotiable and maintained free of obstructions, when medical equipment, desks, large pieces of drywall, resident furniture, and office equipment were stored within the space. The census was 70. 19 CSR 30-86.045(2)(A) Area of refuge- A space located in or immediately adjacent to a path of travel leading to an exit that is protected from the effects of fire, either by means of separation from other spaces in the same building or its location, permitting a delay in evacuation. An area of refuge may be temporarily used as a staging area that provides some relative safety to its occupants while potential emergencies are assessed, decisions are made, and evacuation has begun. 1. Observations on 01/06/26 between 10:00 A.M. and 4:00 P.M., of the second floor area of refuge, on the right side, showed the following: -A broom; -Four dining room chairs; -Part of a metal scale; -A briefcase; -Two lamps; -A large Route 66 picture; -A glass vase; -A black trash can.		1/14/26 Inspected all AOF/stairwells/ corridors/pathways for any items 1/20/26 Signs posted in all AOR stating "no storage allowed" 1/20/26 all AOR cleared 2/17/26 All staff education will be educated about storage in AOR 2x weekly for 4 weeks and weekly after- audits will be completed by Maintenance Director or designee to ensure no items are stored in AOF	2/17/2026

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A2231	Continued From page 1 2. Observations on 01/06/26 between 10:15 A.M. and 4:00 P.M., of the fourth floor area of refuge, on the right side, showed the following: -A black trash can; -An aloe plant; -A broom and dust pan; -A headboard of a bed; -A baseboard of a bed; -A wooden top, black metal desk; -A mechanical lift; -A pair of white slippers; -Two wheelchairs. 3. Observations on 01/06/26 between 10:24 A.M. and 4:00 P.M., of the fifth floor area of refuge, on the right side, showed the following: -A vacuum; -A stepstool; -A rollator; -A wheelchair; -A gait-belt; -Six very large pieces of drywall; -A sit-to-stand lift; -The top part of an air conditioning unit; -A lamp. 4. Observations on 01/06/26 between 10:07 A.M. and 4:00 P.M., of the third floor area of refuge, on the right side, showed the following: -Two computer routers; -An exit sign in the corner of the room. 5. Observations on 01/06/26 between 1:56 P.M. and 4:00 P.M., of the seventh floor south area of refuge, showed the following: -A piano and bench; -A bowling set; -A dining table; -Two wheelchairs; -Three walkers;	A2231		

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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
A2231	Continued From page 2 -A pile of clothes and blankets; -A box of disposable briefs; -One dining chair. 6. Observations on 01/06/26 between 2:03 P.M. and 4:00 P.M., of the sixth floor south area of refuge, showed the following: -A folding table; -Two chairs; -One easel; -One hat rack. 7. Observations on 01/06/26 between 11:10 A.M. and 4:00 P.M., of the third floor south area of refuge, showed two dining chairs. 8. During interviews on 01/13/26 at 10:20 A.M. and on 01/27/26 at 12:04 P.M., the Director of Administration said the staff should not be storing items in the areas of refuge. She said the drywall should be stored in the maintenance room. She said staff usually stored things in the vacant licensed resident rooms which were currently under renovation. During an interview on 01/13/26 at 10:24 A.M., the Administrator said the items stored in the areas of refuge should be stored in a storage room. She said a lot of it probably had to do with the building being six floors, and it was easier for staff to store things in the areas of refuge. She said she needed to let the staff know why it was important to keep the areas clear, for things like emergencies.	A2231		
{A3201}	19 CSR 30-86.032(2) Substantially Constructed & Maintained The building shall be substantially constructed	{A3201}		

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	07594	A. BUILDING: _____ B. WING _____	R-C 01/13/2026

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{A3201}	Continued From page 3 and shall be maintained in good repair and in accordance with the construction and fire safety rules in effect at the time of initial licensing. II/III This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, please refer to the Statement of Deficiencies dated 09/26/25. Class II* Based on observation and interview, the facility failed to ensure all areas of the facility were maintained in good repair when several baseboards, walls, and doors were damaged with various sizes of scuff marks and multiple ceiling tiles had water damage and/or were missing. The census was 70. 1. Observations on 01/06/26 between 1:32 P.M. and 4:00 P.M., of resident room 315, showed the following: -Inside the bathroom: -The inside of the toilet bowl was rusted and encrusted; -The ceiling in the front left corner, above the shower, the ceiling material was ripped and hanging down, which exposed pipes and wires. The area measured approximately 3 feet long; -In the shower, on the back left ledge, which attached to the wall, covered with orange rust. The area measured 1 foot long; -The kitchenette sink and counter top were removed, which exposed the plumbing underneath. The kitchenette and counter top sink were placed in the shower. Observations on 01/06/26 between 12:00 P.M. and 4:00 P.M., of resident room 514, showed the following:	{A3201}	1/14/26 full community walk through was completed by Maintenance and ED designee 1/14/26 Maintenance work order book placed at the front desk Weekly maintenance rounds will be completed by ED and Director of Maintenance or designees 2/17/26 all staff education will be completed about the work order process	3/1/26

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{A3201}	Continued From page 4 -A sign on the door which read, "under major reconstruction"; -The carpet in front of the sink covered with a large black area, which measured approximately 2 feet long and 1 foot wide; -The cabinet doors of the sink were completely covered in dried, red dots; -There was a hole in the wall to the left of the sink which measured approximately 1 foot long and 6 inches wide; -The air conditioning unit was torn apart which exposed several wires. During an interview on 01/13/26 at 10:08 A.M., the Director of Administration said there should not be a hole in the ceiling in room 315. She said since resident rooms 315 and 514 were not in use, it was not a top priority. During an interview on 1/13/26 at 10:10 A.M., the Administrator said there should not be a hole in the ceiling in room 315. She said resident rooms 315 and 514 were not the biggest priority because they were vacant rooms. Room 514 has been under construction for a few months. 2. Observations on 01/06/26 between 1:33 P.M. and 4:00 P.M., showed the bottom of the door of resident rooms 409, 417, and 419, covered in black scuff marks. The scuff marks were deep and exposed the light colored wood of the door. Observations on 01/06/26 between 10:20 A.M. and 4:00 P.M., of the back of the dining room, showed one ceiling tile with a large area of water damage. The area was brown in color. Observations on 01/06/26 between 11:00 A.M. and 4:00 P.M., of the basement near the therapy center room, showed two ceiling tiles missing	{A3201}		

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{A3201}	Continued From page 5 which exposed the piping above and five other ceiling tiles covered in water damage which were dark brown in color and circle shaped. Observations on 01/06/26 between 11:10 A.M. and 4:00 P.M., in the basement by the stairs, showed the ceiling tiles near the sprinkler head, covered with water damage which was light brown in color and circle shaped. Observations on 01/06/26 between 1:28 P.M. and 4:00 P.M., of the second floor, showed one broken ceiling tile, above resident room 209. During an interview on 01/13/26 at 10:08 A.M., the Director of Administration said she did not know which part of the ceiling the Regulatory Auditors looked at, but there was a flood on the fourth floor and a lot of the ceiling tiles were on back order. She was not aware of the ceiling tiles on the second floor or in the basement. During an interview on 1/13/26 at 10:10 A.M., the Administrator said she was not aware of the ceiling tiles having water damage. She did not know why the baseboards and doors were not fixed after the first visit. 3. Observations on 01/06/26 between 11:30 A.M. and 4:00 P.M., of the women's bathroom in the basement, showed the automatic faucet was connected but did not turn on when the sensor was triggered. During an interview on 01/06/26 at 3:45 P.M., Physical Therapist F said the faucet had been like that for over a month and he/she had to use the men's bathroom to wash his/her hands. He/she thought the management team knew the faucet was broken.	{A3201}		

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{A3201}	Continued From page 6 *The higher the classification merited due to the extent of the violation.	{A3201}		
{A3224}	19 CSR 30-86.032(23) Rooms Neat, Orderly, Cleaned Daily Rooms shall be neat, orderly and cleaned daily. II/III This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, please refer to the Statement of Deficiencies dated 09/26/25. Class II* Based on observation and interview, the facility failed to ensure resident rooms were kept clean and orderly when resident rooms were found with dried feces and urine, thick layers of dust, and debris under beds and in walkways. The census was 70. 1. Observations on 01/06/26 between 11:45 A.M. and 4:00 P.M., of resident room 319, showed the following: -Small black specs on the floor covering an area of approximately 3 feet wide from the side of the bed to the bathroom; -Dried feces in the base of the toilet in the bathroom; -Streaks of a yellowish film on the base of the step to the walk in shower in the bathroom; -Streaks of a yellowish build up in the bottom corners of the shower in the bathroom; -Black discoloration to the base of the sink cabinet, approximately 2 inches high, surrounding the base of the cabinet at the floor line in the	{A3224}	2/13/26 Whole house audit will be completed for cleanliness 2/16/26 Education with housekeeping staff on housekeeping schedule and expectations 2/17/26 All staff education will be completed on overall expectations for daily housekeeping needs 2/27/26 2 new housekeepers hired 2/27/26 Residents education will be completed on reporting housekeeping needs Weekly housekeeping audit will be completed by ED or designee on 5 resident room and common areas	3/1/26

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{A3224}	Continued From page 7 bathroom; -Dark yellow stains surrounding the base of the sink cabinet, approximately 4 inches wide, on the floor in the bathroom; -Built up black substance in the corner, at the back of the sink base cabinet on the wall in the bathroom. 2. Observations on 01/06/26 between 9:54 A.M. and 3:53 P.M., of resident room 419, showed the following: -In the bedroom: -Five empty soda cans on the counter; -Three used plates in the sink; -The floor around the kitchen sink and underneath the bed covered in dust, hair, food crumbs and white fuzz; -Between 1:00 P.M. and 3:53 P.M., the lunch meal tray was placed on the counter; -In the bathroom: -In the left side of the toilet bowl, a quarter size piece of feces; -The toilet bowl was covered in a splashed brown substance; -The toilet lid covered brown and yellow streaks; -On the floor around the toilet and in front of it, several spots of a dried yellow substance covered the area. During an interview on 01/06/26 at 10:01 A.M., the resident said it bothered him/her to use the toilet when it looked like that. He/she said the Housekeepers had not cleaned his/her room in a couple weeks at least. 3. Observations on 01/06/26 between 8:12 A.M. and 3:45 P.M., of resident room 412, showed the following: -Inside the bedroom:	{A3224}		

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(A3224)	Continued From page 8 -Several soda cans covered the windowsill; -The kitchen sink covered in dried brown liquid; -Inside the bathroom: -The toilet seat, lid, bowl, and the base of the toilet, completely covered in a dried yellow substance; -The floor around the toilet, covered in a dried, crusty, yellow substance; -Inside the toilet bowl, on the sides, several areas of dried feces; -The entire floor covered in ripped pieces of toilet paper and paper towels; -The sink completely covered in hair. During an interview on 01/06/26 at 8:15 A.M., the resident said the bathroom had been in the condition it was in for a while. He/she said it bothered him/her to use the restroom in the condition it was in. He/she said the Housekeepers did not want to come into his/her room and clean it. The resident said his/her bedroom and bathroom are "the worst" on the weekends when the Housekeepers do not come into his/her room. 4. Observations on 1/6/26 between 9:30 A.M. and 3:52 P.M., of combined resident rooms 404 and 406, showed the following: -In the bedroom: -Underneath the bed, the floor, covered in a thick layer of dust, pieces of paper, hair and food crumbs; -The television stand covered in dust; -The kitchen sink filled with dirty dishes; -Inside the bathroom: -The bathroom floor around the toilet, covered in black and brown dried splashes; -Inside of the toilet bowl, on the seat and lid were covered in a dried, brown substance.	(A3224)		

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{A3224}	Continued From page 9 During an interview on 01/06/26 at 9:37 A.M., a resident said it had been a while since the Housekeepers had come to the room. The resident said he/she would like the Housekeepers to come more often than they do. During an interview on 1/6/26 at 9:40 A.M., another resident said he/she thought the Housekeepers did not come into his/her room often enough and said the bathroom's condition bothered him/her when he/she used it. During an interview on 01/06/26 at 9:34 A.M., the residents' family member said the room usually looked like that and he/she wished it was cleaner for his/her family members. 5. Observations on 01/06/26 between 1:34 P.M. and 4:00 P.M., of resident room 417, showed the following: -Small scraps of paper across the floor near the bed and chairs; -Cat litter on the floor under the kitchenette sink by the front door of the room. During an interview on 01/6/26 at 1:35 P.M., the resident said he/she would like more help with cleaning his/her room and asked to have someone come in to help him/her clean. He/she said it had been quite some time since anyone had been in to clean his/her room. 6. Observations on 01/06/26 between 1:20 P.M. and 3:56 P.M., of resident room 513, showed the following: -In the bedroom: -Behind the recliner, the floor covered in a thick layer of dust; -The trash can was full, and overflow laid on	{A3224}		

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{A3224}	Continued From page 10 the floor next to the trash can; -In the bathroom: -The toilet bowl covered in brown spots, both dried and wet; -The toilet seat covered in dried brown spots. During an interview on 1/6/26 at 2:16 P.M., the resident said his/her significant other had "raised hell" multiple times to the staff about the condition of his/her room and the staff started to clean it and then would stop again. The resident said the last time his/her significant other "raised hell" was on Thanksgiving. 7. Observations on 01/06/26 between 9:39 A.M. and 4:00 P.M., of resident room 214, showed urine stains on the floor of the bathroom around the base of the toilet between the commode and sink base. 8. Observation on 01/06/26 at 9:00 A.M., of resident room 204, showed the the kitchen counter covered in to-go containers of various sizes, pieces of paper, and there was plastic wrap around the faucet. 9. Observations on 01/06/26 between 9:40 A.M. and 3:51 P.M., of resident room 415, showed the following: -In the bedroom: -Underneath the television stand, a thick layer of dust; -On top of the television stand, a layer of dust; -In the bathroom: -The toilet bowl covered in brown spots; -The toilet lid covered in a dried yellow substance; -The floor around the toilet had small black and brown spots and pieces of toilet paper.	{A3224}		

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{A3224}	Continued From page 11 10. During an interview on 01/13/26 at 10:11 A.M., the Director of Administration said last week she talked to the Housekeepers about her expectation of cleanliness in the resident rooms. She said as soon a resident would leave for the hospital, the room needed to be deep cleaned, and sheets stripped. During an interview on 01/13/26 at 10:13 A.M., the Administrator said she thought she needed to hire another Housekeeper to ensure the resident rooms were clean. She said the rooms were not up to her expectations. She said the building was six floors and there were only three Housekeepers. She said the facility may need more Housekeepers than what they thought. She said it had been a while since she had gone behind a Housekeeper to ensure their work was completed. MO00260087 *The higher classification merited due to the extent of the violation.	{A3224}		