

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure residents with orders for psychotropic medications (medications that alter the brain's chemical makeup to treat mental illnesses) were informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or options and to choose the alternative or option he or she prefers for two residents (Residents #1 and #11) out of 18 sampled residents and one resident (Resident #5) outside the sample. The facility census was 86. The facility did not provide a policy regarding psychotropic consents.</p> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 04/08/15;</li> <li>- Diagnoses of schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs);</li> <li>- An order for amitriptyline (antidepressant) 50 milligrams (mg), give one tablet by mouth at bedtime for depression, dated 01/28/25;</li> <li>- An order for Cymbalta (antidepressant) 60 mg, give one capsule by mouth one time a day related to cerebral infarction, dated 01/10/25;</li> <li>- An order for trazodone (antidepressant) 50 mg, give one tablet by mouth one time a day for insomnia, dated 04/10/25;</li> <li>- An order for Vraylar (antipsychotic) 1.5 mg, give one capsule by mouth one time a day related to acute upper respiratory infection, dated 01/10/25;</li> <li>- An order for Anti-Depressant Medication Use - Observe resident closely for significant side effects: 0-No Side effects, 1-Anxiety, 2-Constipation, 3-Dizziness, 4-Drowsiness, 5-Dry Mouth, 6-Weight, 7-Other, every shift for monitoring related to major depressive disorder. Code the appropriate number that reflects any and all side effects. Notify Physician if any side effects are noted.</li> <li>- No documentation the resident or the representative was informed of risks and benefits prior to initiating psychotropic medications.</li> </ul> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 265395	If continuation sheet Page 1 of 48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment to be completed by the facility), dated 07/05/25, showed:</p> <ul style="list-style-type: none"> <li>- No cognitive impairment;</li> <li>- The resident received antipsychotic and antidepressant medication in the seven-day lookback period.</li> </ul> <p>2. Review of Resident #5's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 11/14/17;</li> <li>- Diagnoses of dementia (memory loss and thinking problems), cognitive communication deficit (difficulty with memory, understanding, or expressing thoughts), schizophrenia (serious mental illness affecting thoughts, emotions, and behavior), major depressive disorder, and anxiety disorder (excessive worry, fear, or nervousness);</li> <li>- An order for quetiapine (antipsychotic) 25 mg, one and a half tablets by mouth, one time a day for schizophrenia, dated 03/11/25;</li> <li>- An order related to Antipsychotic Medication Use - Observe resident closely for significant side effects: 0-No Side effects, 1-Constipation, 2-Agitation, 3-Confusion, 4-Drowsiness, 5-Weight Changes, 6-Involuntary Movement, 7-Falls, 8-Blurred Vision, 9-Sedation, 10-Hypersalivation, 11-Dry Mouth, 12-Disturbed Gait, 13-Other, dated 03/11/25;</li> <li>- No documentation the resident or the representative was informed of risks and benefits prior to initiating psychotropic medication.</li> </ul> <p>Review of the resident's annual MDS, dated [DATE], showed cognitive impairment.</p> <p>3. Review of Resident #11's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 12/22/17;</li> <li>- Diagnoses of paranoid schizophrenia (mental health disorder characterized by persistent delusions and hallucinations, primarily involving paranoia and persecution), major depressive disorder, and anxiety disorder;</li> <li>- An order for lorazepam (anxiety medication) 1 mg, give one tablet by mouth two times a day for anxiety, dated 12/20/24;</li> <li>- An order for Seroquel (antipsychotic) 200mg, give one tablet by mouth two times a day for schizophrenia, dated 06/28/24;</li> <li>- An order for sertraline (antidepressant) 50 mg, give one tablet by mouth one time a day for depression, dated 06/28/24;</li> <li>- An order for antidepressant: Monitor for side effects of concern include orthostatic hypotension, dry mouth, urinary retention, blurred vision, constipation, sedation, weight gain, every shift for</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>monitoring, dated 06/28/24;</p> <ul style="list-style-type: none"> <li>- An order for anti-anxiety: Monitor for serious side effects of anti-anxiety drugs including: suicidal thoughts, dry mouth, elevated blood pressure, blurred vision, abnormal heartbeat, low blood pressure when standing (orthostatic hypotension, every shift for monitoring, dated 06/28/24;</li> <li>- An order for antipsychotic: Does resident have or show side effects of antipsychotic medications they are on i.e., weight gain, blurred vision, dry mouth, drowsiness, muscle spasms or tremors, involuntary movement like lip smacking, protruding the tongue, or grimacing, every shift for monitoring, dated 06/28/24;</li> <li>- No documentation the resident or the representative was informed of risks and benefits prior to initiating psychotropic medications.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Severe cognitive impairment;</li> <li>- The resident received antipsychotic, anti-anxiety, and antidepressant medication in the seven-day lookback period.</li> </ul> <p>During an interview on 08/29/2025 at 2:22 P.M., the Director of Nursing (DON) said they should be completing psychotropic medication consents, but she knows there are some that do not have them. However, they should be completed under the assessment tab in the electronic records.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, DON, and Director of Operations said they would expect psychotropic consents to be completed for residents taking psychotropic medications.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation and interview, the facility failed to keep survey results in a readily accessible area where individuals may review without asking. The facility census was 86. Review of the facility's policy, Compliance with Laws and Professional Standards, revised August 2020, showed:- Facility policies and procedures are developed and maintained in accordance with local, state and federal laws and with currently accepted professional standards and principles;- The facility will post in a place readily accessible to residents, family members, and legal representatives, the results of the most recent facility surveys;- Reports related to any surveys, certifications and complaint investigations for the preceding three years and any plan of correction are maintained in a binder, located in the Administrator's office and available for review upon request;- A notice of availability of such reports will be posted in a prominent and accessible area of the facility;- Survey results and plans of correction are incorporated in the Quality Assessments and Assurance audits and plans. Observations from 08/26/25 through 08/28/25 showed:- On 08/26/25 at 10:15 A.M., no posted survey results available:- On 08/27/25 at 8:40 A.M., no posted survey results available:- On 08/28/25 at 11:05 A.M., no posted survey results available: During a resident council meeting on 08/28/25 at 11:00 A.M., residents collectively said there had been a survey result binder near the front offices in the lobby, but it wasn't there anymore. During an interview on 08/28/25 at 11:09 A.M., the Social Services Director said the survey binder had been on a table in the front lobby, but he/she was no longer aware of the location. During an interview on 08/28/25 at 11:10 A.M., Receptionist A searched and found the survey results on his/her desk along with various other binders. During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect survey results to be available for residents and families to read without asking.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment. This deficient practice affected one resident (Resident #52) outside the sample and had the potential to affect all residents in the facility. The facility census was 86. Review of the facility's Resident Room and Environment policy, revised August 2020, showed:</p> <ul style="list-style-type: none"> <li>- The facility provides residents with a safe, clean, comfortable and home-like environment;</li> <li>- Residents will be provided a pleasant environment with person-centered care that emphasizes resident comfort, independence, and personal needs/preferences;</li> <li>- Residents receive care and services safely.</li> </ul> <p>Observation on 08/26/25 at 11:48 A.M., of room [ROOM NUMBER] showed two sections of the cove base pulling away from the wall at a seam in an approximately eight-inch section on the left side and an approximately ten-inch section on the right side, exposing the unfinished drywall.</p> <p>Observation on 08/26/25 at 12:17 P.M. showed the small dining room with a strong urine odor.</p> <p>Observation on 08/26/25 at 12:34 P.M. showed room [ROOM NUMBER] with a strong urine odor.</p> <p>Observation on 08/29/25 at 5:36 P.M. of Shower Room One showed:</p> <ul style="list-style-type: none"> <li>- Strong odor of feces and urine;</li> <li>- Floor drain with debris and loose hair, thick around the edges and two gnats flying around;</li> <li>- A wipe soiled with a brown substance on the floor;</li> <li>- A soiled brief on the bottom of a sit-to-stand (patient lift designed to help individuals who are unable to stand safely on their own move from a seated position to a standing position);</li> <li>- Two hospital gowns thrown over a plastic container with a lid;</li> <li>- Hospital identification bracelets on a storage container.</li> </ul> <p>Observations on 08/29/25 at 5:40 P.M. of Shower Room Two showed:</p> <ul style="list-style-type: none"> <li>- A strong musty urine odor;</li> <li>- A floor drain full of hair and debris;</li> <li>- A wet washcloth on the floor;</li> <li>- A shampoo bottle behind the toilet;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- A toilet containing a yellow liquid;</li> <li>- A trash can with pink-red stained disposable underwear draped over the edge;</li> <li>- Orange-red stains all around the shower tiles and on part of the wall in the shower area;</li> <li>- A shower chair with metal legs placed on top of a foam shower mattress;</li> <li>- Foam shower mattress with an approximate seven-inch rip along the edge;</li> <li>- Medical gloves wadded up and placed under a piece of paper which read Shower In Use written in marker;</li> <li>- A black shoe and a black foot brace in the corner of the shower room;</li> <li>- An approximate one-inch by two-inch hole in the wall by the shower and another, approximately the same size, on the wall to the right of the door.</li> </ul> <p>Observations on 08/29/25 at 5:45 P.M. of Shower Room Three showed:</p> <ul style="list-style-type: none"> <li>- A strong musty urine odor;</li> <li>- A bath chair with several towels on the seat;</li> <li>- Several dirty towels spread out on the floor;</li> <li>- A half full bottle of baby oil with no lid, on top of a plastic storage container along with a bottle of perfume with no cap;</li> <li>- A soggy broken piece of a pretzel in the floor;</li> <li>- A hospital gown and a used face mask on a shelf;</li> <li>- A missing piece of tile approximately two inches by six inches, missing from the tile trim of the floor;</li> <li>- A crack in the shower wall, approximately six inches long.</li> </ul> <p>Observations on 08/29/25 at 5:50 P.M. of Shower Room Four showed:</p> <ul style="list-style-type: none"> <li>- A musty odor;</li> <li>- An Out of Order sign on the door;</li> <li>- A toilet containing a yellow liquid with a yellow color inside the toilet bowl and no toilet paper on the holder;</li> <li>- A fork and spoon beside a bottle of body wash on a storage container;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- A crossword puzzle, a brief, and several paper towels on a storage container.</p> <p>Observation on 08/29/25 at 6:57 P.M. showed an approximately three-foot long missing handrail on the wall near the restroom across from the large dining room.</p> <p>During an interview on 08/26/25 at 3:18 P.M., Resident #52 said the shower rooms are gross and very cluttered. There is one shower that hardly has any water coming out at all.</p> <p>During a Resident Council Meeting on 08/28/25 at 10:32 A.M., the residents collectively said shower rooms need to be cleaned, not just mopped.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Operations and Director of Nursing said they would expect shower rooms to be free from garbage, hair, pests, and floors, toilets and walls to be clean, sanitary and in good repair.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for psychotropic medications (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) for three residents (Resident #1, #9, and #11) out of 18 sampled residents and failed to provide an appropriate diagnosis for the use of an antipsychotic (medications used to treat psychosis, a mental health condition characterized by delusions, hallucinations, and disorganized thinking) medication and antidepressant medication for one resident (Resident #1) out of 18 sampled residents. The facility census was 86. Review of the facility's policy Documentation and Communication of Consultant Pharmacist Recommendations, dated 08/20, showed:</p> <ul style="list-style-type: none"> <li>- The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion;</li> <li>- A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, prescribers, and the care planning team. This should include: Documentation of the date each medication regimen review is completed and notation of the findings in the medical record or other designated manner; potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review;</li> <li>- Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible prescriber or physician's designee is contacted by the consultant pharmacist or the facility, and the prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record;</li> <li>- Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. If the prescriber that does not respond is also the Medical Director, the Director of Nursing and the Administrator will address the requirements with the Medical Director and/or pursue more formal actions if necessary to facilitate compliance.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 04/08/15;</li> <li>- Diagnoses of schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs);</li> <li>- An order for amitriptyline (antidepressant) 50 milligrams (mg), give one tablet by mouth at bedtime for depression, dated 01/28/25;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An order for Cymbalta (antidepressant) 60 mg, give one capsule by mouth one time a day related to cerebral infarction, dated 01/10/25;</p> <p>- An order for trazodone (antidepressant) 50 mg, give one tablet by mouth one time a day for insomnia, dated 04/10/25;</p> <p>- An order for Vraylar (antipsychotic) 1.5 mg, give one capsule by mouth one time a day related to acute upper respiratory infection, dated 01/10/25;</p> <p>- No documentation of any attempted GDRs;</p> <p>- No documentation the consultant pharmacist or physician addressed the need for appropriate diagnoses for Cymbalta and Vraylar.</p> <p>Observation on 08/27/25 at 3:06 P.M. showed Resident #1 sat in a wheelchair wearing smoking apron, ready to go to therapy.</p> <p>2. Review of Resident #9's medical record showed:</p> <p>- An admission date of 07/29/15;</p> <p>- Diagnoses of schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), bipolar II (a mood disorder with extreme mood swings, including emotional highs and extreme lows), anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life), major depressive disorder, and borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships);</p> <p>- An order for Cymbalta (antidepressant) 30 mg, give one capsule by mouth at bedtime for bipolar II disorder and anxiety, dated 07/30/24;</p> <p>- An order for Risperdal (antipsychotic) 1mg, give one tablet by mouth two times a day for schizophrenia, dated 08/05/24;</p> <p>- An order for Cymbalta (antidepressant) 60mg, give one capsule by mouth daily for depression, dated 08/07/24;</p> <p>- No documentation of any attempted GDRs.</p> <p>Observation on 08/26/25 at 12:13 P.M. showed Resident #9 sat upright in bed in his/her room, getting ready for lunch.</p> <p>3. Review of Resident #11's medical record showed:</p> <p>- An admission date of 12/22/17;</p> <p>- Diagnoses of paranoid schizophrenia (mental health disorder characterized by persistent delusions and hallucinations, primarily involving paranoia and persecution), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>life), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities);</p> <ul style="list-style-type: none"> <li>- An order for lorazepam (anxiety medication) 1 mg, give one tablet by mouth two times a day for anxiety, dated 12/20/24;</li> <li>- An order for Seroquel (antipsychotic) 200mg, give one tablet by mouth two times a day for schizophrenia, dated 06/28/24;</li> <li>- An order for sertraline (antidepressant) 50 mg, give one tablet by mouth one time a day for depression, dated 06/28/24;</li> <li>- No documentation of any attempted GDRs.</li> </ul> <p>Observation on 08/27/25 at 3:00 P.M. showed Resident #11 sat in a wheelchair near the smoking door visiting with his sister.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect GDRs to be completed per regulatory guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital and to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for three residents (Resident #1, #9, and #75) out of 18 sampled residents and one resident (Resident #94) outside the sample. The facility census was 86.</p> <p>Review of the facility's policy, Bed Hold, revised 06/20, showed:</p> <ul style="list-style-type: none"> <li>- Upon admission, the Facility advises residents or his/her personal representative in writing that the Facility has a bed hold policy and will hold the resident's bed for the state specified period, if the resident is transferred to a general acute care hospital, as long as the resident or their representative notifies the Facility within twenty-four (24) hours of the transfer that they wish to have the Facility hold the resident's bed;</li> <li>- The Facility notifies the resident or his/her representative, in writing, of the bed hold policy any time the resident is transferred to a general acute care hospital even if the Facility has not met the occupancy requirements.</li> </ul> <p>Review of the facility's policy, Transfer and Discharge, revised 06/20, showed:</p> <ul style="list-style-type: none"> <li>- The Facility may use Notice of Transfer/Discharge or another comparable form to provide the resident of his/her personal representative with advance notice of the transfer or discharge. The notice will include the following information: The reason the resident is being transferred/discharged ; The effective date of the transfer/discharge; The name, complete address and telephone number to which the resident is being transferred; A statement that the resident has the right to appeal the action to the state, contact information for the state entity which receives appeal hearing requests, and information for how to request an appeal; The name, address, and telephone number of the State Long Term Care Ombudsman; For residents with intellectual or developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; and For residents with a mental disorder, the mailing address and telephone number of the agency responsible for the protection and advocacy for individuals with mental disorders;</li> <li>- The Facility will also send a copy of the Notice of Transfer/Discharge to the State Long Term Care Ombudsman for Facility initiated discharges;</li> <li>- Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, the Facility will: Notify the resident's Attending Physician; Notify the receiving facility that the transfer is being made; Prepare the resident for transfer; Prepare a transfer form to send with the resident; Notify the resident's personal representative; and Assist in obtaining transportation;</li> <li>- When a resident is transferred/discharged , Social Service Staff include a copy of the written notice of transfer/discharge provided to the resident or his/her personal representative in the resident's medical record.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE];</li> <li>- The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE];</li> <li>- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.</li> </ul> <p>2. Review of Resident #9's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>-The resident transferred to the hospital on [DATE] and returned to the facility on [DATE];</li> <li>- The resident transferred to the hospital on [DATE] and returned to the facility on 06//27/25;</li> <li>- No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfers to the hospital.</li> </ul> <p>3. Review of Resident #75's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- The resident transferred to the hospital on [DATE] and returned to the facility on [DATE];</li> <li>- No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.</li> </ul> <p>4. Review of Resident #94's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- The resident transferred to the hospital on [DATE] and did not return to the facility;</li> <li>- No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital.</li> </ul> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect residents or their families to be notified in writing of transfers and bed hold forms to be completed per regulation.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of two residents (Resident #94 and #96) outside of the 18 sampled residents. The facility census was 86. The facility policy titled, Care Planning, revised 06/20/20, showed:- To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs;- The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines;- The Care Plan serves as a course of action where the resident, resident's family and/or guardian or other legally authorized representative, resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental, and psychosocial needs;- A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with Omnibus Budget Reconciliation Act (OBRA - federal budget laws that include significant health care provisions, including the Nursing Home Reform Act of 1987) and Minimum Data Set (MDS - a federally mandated assessment completed by the facility) guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed basis;- The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission;- The Baseline Care Plan will include at least the following information: summary of medications and dietary instructions, services or treatments to be administered, updated information based on completion of the Comprehensive Care Plan, as indicated;- The Facility may choose to provide a copy of the Baseline Care Plan instead of a summary, as long as it includes the required information;- The Baseline Care Plan summary must be provided to the resident and/or the resident's representative by the time the Comprehensive Care Plan is completed;- The Baseline Care Plan will be updated to reflect changes in the resident's condition or needs occurring prior to the development of the Comprehensive Care Plan;- The Facility may choose to develop a Comprehensive Care Plan in place of the Baseline Care Plan if the Comprehensive Care Plan is completed within 48 hours of admission and contains initial goals based on admission, physician and dietary orders, therapy services, social services and Pre-admission Screening and Resident Review (PASARR- a federally mandated screening process for individuals that prevent inappropriate placement in nursing facilities) recommendations, if applicable;- If the Comprehensive Care Plan is completed within 48 hours instead of a Baseline Care Plan, then a written summary of the Comprehensive Care Plan must be provided to the resident and/or the resident's representative;- Once the Baseline Care Plan is completed, the Facility must provide the resident and/or the resident's representative with a written summary of the Baseline Care Plan that includes: Initial goals of the resident, summary of medications and dietary instructions, services or treatments to be administered, updated information based on completion of the Comprehensive Care Plan, as indicated;- The Facility may choose to provide a copy of the Baseline Care Plan instead of a summary as long as it includes the required information.1. Review of Resident #94's medical record showed:- admitted to the facility on [DATE];- Diagnoses of cognitive communication deficit (trouble thinking and communicating clearly), breast cancer, severe protein calorie malnutrition (serious lack of nutrition from too little protein and calories), acute kidney failure, and localized edema (swelling in a specific area of the body);- No documentation of a baseline care plan completed for the resident;- The facility failed to complete a baseline care plan within 48 hours of admission.2. Review of Resident #96's medical record</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>showed:- admitted to the facility on [DATE];- Diagnoses of sepsis due to methicillin-susceptible staphylococcus aureus (life-threatening infection in the blood caused by a specific type of staph bacteria), non-Hodgkin's lymphoma (cancer of the lymphatic system), schizophrenia (serious mental illness affecting thinking and behavior), cardiomegaly (enlarged heart), and stroke;- No documentation of a baseline care plan completed for the resident;- The facility failed to complete a baseline care plan within 48 hours of admission. During an interview on 08/29/25 at 2:22 P.M., the Director of Nursing (DON) said nursing should start the baseline care plan and then social services should complete a portion and once they are done, medical records should lock it. She would expect them to be completed within 48 hours of the resident being admitted to the facility. During an interview on 08/29/25 at 7:30 P.M., the Administrator, DON, and Director of Operations said they would expect baseline cares to be completed within 48 hours of admission.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide showers for three residents (Resident #1, #60, and #81) out of 18 sampled residents and two residents (Resident #5 and #34) outside the sample. The facility census was 86.</p> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 04/08/15;</li> <li>- Diagnoses of muscle weakness, need for assistance with personal care, and spastic hemiplegia of left non-dominant side (characterized by stiffness and muscle tightness on one side of the body, affecting motor function, coordination, and balance).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment to be completed by the facility), dated 07/10/25, showed:</p> <ul style="list-style-type: none"> <li>- No cognitive impairment;</li> <li>- Impairment on one side for both upper and lower extremities;</li> <li>- Substantial/maximal assistance from staff for upper and lower body dressing;</li> <li>- Substantial/maximal assistance from staff for personal hygiene;</li> <li>- Dependent on staff for showering.</li> </ul> <p>Review of the facility's shower schedule showed the resident's scheduled shower days were Tuesday and Friday.</p> <p>Review of the resident's shower sheets from 06/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- No shower sheets provided for the month of June 2025 with eight out of eight opportunities missed for showers;</li> <li>- Three shower sheets for July: 07/02/25, 07/06/25, and 07/09/25 with six out of nine opportunities missed for showers;</li> <li>- Nine shower sheets for August: 08/01/25, 08/05/25, 08/08/25, 08/12/25, 08/15/25, 08/19/25, 08/22/25 (leave of absence), 08/23/25 (chair bath), 08/26/25, and 08/27/25 with zero out of nine opportunities missed;</li> <li>- A total of 14 opportunities missed out of 26 opportunities for showers.</li> </ul> <p>During an interview on 08/27/25 at 3:06 P.M., the resident said he/she is not getting showers.</p> <p>2. Review of Resident #5's medical record showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An admission date of 11/14/17;</p> <p>- Diagnoses of muscle weakness, need for assistance with personal care, dementia (memory loss and thinking problems), and chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it hard to breathe).</p> <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Cognitive impairment;</li> <li>- Partial/moderate assistance from staff for dressing;</li> <li>- Partial/moderate from staff for personal hygiene;</li> <li>- Showering/bathing not attempted due to medical condition or safety.</li> </ul> <p>Review of the facility's shower schedule showed the resident's scheduled shower days were Monday and Thursday.</p> <p>Review of the resident's shower sheets from 06/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- One shower sheet for June: 06/30/25 with eight out of nine opportunities missed for showers;</li> <li>- Five shower sheets for July: 07/03/25, 07/06/25, 07/22/25, 07/24/25, and 07/27/25 with four out of nine opportunities missed for showers;</li> <li>- A total of 12 opportunities missed out of 25 opportunities for showers.</li> </ul> <p>Observation on 08/27/25 at 1:30 P.M. showed the resident sat in a wheelchair with greasy hair.</p> <p>3. Review of Resident #34's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 01/18/24;</li> <li>- Diagnoses of morbid (severe) obesity, muscle weakness, and need for assistance with personal care.</li> </ul> <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- No cognitive impairment;</li> <li>- Impairment on both sides of lower extremities;</li> <li>- Partial/moderate assistance on staff for upper body dressing;</li> <li>- Dependent on staff for lower body dressing;</li> <li>- Setup or clean-up assistance from staff for personal hygiene;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Dependent on staff for showering.</p> <p>Review of the facility's shower schedule showed the resident's scheduled shower days were Monday and Thursday.</p> <p>Review of the resident's shower sheets from 06/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- Two shower sheets for June: 06/26/25 and 06/30/25 with a total of seven out of nine missed opportunities for showers;</li> <li>- Four shower sheets for July: 07/03/25, 07/06/25, 07/24/25, and 07/31/25 with a total of five out of nine missed opportunities for showers;</li> <li>- Six shower sheets for August: 08/07/25, 08/14/25, 08/21/25, 08/22/25, 08/26/25, 08/28/25 (refused) with a total of two out of eight missed opportunities for showers.</li> </ul> <p>During an interview on 08/26/25 at 12:48 P.M., Resident #34 said he/she isn't getting showers the way he/she should. He/She has wounds and doesn't want a night shower because wound care isn't here at night. He/She is only getting a shower once a week if that and sometimes it's not even that often.</p> <p>4. Review of Resident 60's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 01/31/20;</li> <li>- Diagnoses of chronic respiratory failure (long-term breathing failure), cognitive communication deficit (difficulty with memory, understanding, or expressing thoughts), need for assistance with personal care, chronic obstructive pulmonary disease with acute exacerbation (flare-up of chronic lung disease making breathing worse), and altered mental status (confusion, not acting normally).</li> </ul> <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- No cognitive impairment;</li> <li>- Partial to moderate assistance from staff for upper body dressing;</li> <li>- Substantial/maximum assistance from staff for lower body dressing;</li> <li>- Supervision or touching assistance for personal hygiene;</li> <li>- Substantial/Maximum assistance with showering/bathing.</li> </ul> <p>Review of the facility's shower schedule showed the resident's scheduled shower days were Wednesday and Saturday.</p> <p>Review of the resident's shower sheets from 06/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- No shower sheets for June 2025 with eight out of eight opportunities missed for showers;</li> <li>- Two shower sheets for July: 07/02/25 and 07/09/25 with seven out of nine missed opportunities for</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>showers;</p> <ul style="list-style-type: none"> <li>- Four shower sheets for August: 08/06, 08/08, 08/13, and 08/27 with four out of eight opportunities missed for showers;</li> <li>- A total of 16 opportunities missed out of 26 opportunities for showers.</li> </ul> <p>During an interview on 08/27/25 at 10:21 A.M., the resident said he/she wished staff would give him/her showers more often. Staff have improved over the last month about showering him/her, but previously he/she had gone months with no shower. He/she expressed frustration that he/she had to go so long with no shower.</p> <p>5. Review of Resident #81's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 04/24/25;</li> <li>- Diagnoses of metabolic encephalopathy (brain dysfunction caused by problems with body chemistry, such as liver or kidney disease), cognitive communication deficit, need for assistance with personal care, morbid severe obesity due to excess calories (very high body weight caused by overeating), and altered mental status.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- No cognitive impairment;</li> <li>- Substantial/maximum assistance from staff for upper body dressing;</li> <li>- Dependent on staff for lower body dressing;</li> <li>- Substantial/maximum assistance from staff for personal hygiene;</li> <li>- Dependent of staff for bathing.</li> </ul> <p>Review of the facility's shower schedule showed the resident's scheduled shower days were Monday and Thursday.</p> <p>Review of the resident's shower sheets from 06/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- No shower sheets for June 2025 with nine out of nine opportunities missed for showers;</li> <li>- Two shower sheets for July: 07/08/25 and 07/21/25 with seven out of nine missed opportunities for showers;</li> <li>- Seven shower sheets for August: 08/04/25, 08/15/25, 08/18/25, 08/19/25, 08/21/25, 08/25/25, and 08/28/25 with one out of eight missed opportunities for showers;</li> <li>- A total of 17 opportunities missed out of 26 opportunities for showers.</li> </ul> <p>Observation on 08/27/25 at 12:32 P.M. showed the resident lay in bed, wearing a hospital gown with (continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>disheveled hair.</p> <p>During an interview on 08/27/25 at 12:34 P.M., the resident said he/she wished staff would give him/her showers more often. That is his/her main complaint about the facility is the lack of and inconsistency when it comes to getting showered. It is unsettling to miss showers so often and he/she depends on staff to shower him/her.</p> <p>During an interview on 08/29/2025 at 2:10 P.M., the Lead Certified Nurse Aide (CNA) and Staffing Coordinator said the aide on the hall is assigned to do the showers for the hall they are working. The charge nurse for the day will divide out the hall to give assignments for the showers. The aides should complete a shower sheet with every shower or bed bath. They are supposed to report any change of condition to the charge nurse. If a resident refuses, the aides are supposed to have the charge nurse speak with the resident prior to marking them as a refusal. The residents should sign the shower sheet if they are able to sign and then the aide and charge nurse should sign every shower sheet. Once completed, the shower sheet should be given to the wound nurse.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect shower sheets to be completed, signed, dated, and refusals marked for all showers. They would expect residents to be showered per the shower schedule, which is twice a week for each resident.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the resident's bilateral nephrostomy tube (a thin flexible tube inserted into both kidneys to drain urine directly into a drainage bag) drainage bags containing urine were lower than kidney level and exposed drainage bags were covered by privacy bags for one resident (Resident #12) out of one sampled resident. The facility census was 86. Review of the facility's policy, Catheter, Care Of, revised 06/20, showed:- Purpose: to prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary;- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible;- Daily catheter care: wash hands, don gloves prior to handling the catheter, drainage system or bag;- Explain the procedure to the resident and provide privacy;- Cleanse the area;- Remove gloves and wash hands;- Position the catheter drainage system and bag utilizing gravity to facilitate drainage;- Empty the collection bag each shift or more often as indicated. Use a separate container for each resident and avoid touching the spigot to the container;- Report the following signs and symptoms to the attending Physician;- Any sign or symptom of urinary tract infection: fever, change in urine, such as foul odor or bloody/cloudy appearance, no urine output or decreased urine output, leakage or urine, hematuria, urethral erosion, pain, swelling, irritation, complaints of urinary related pain, bladder spasms;- Use standard precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system;- Collection bags should always be kept below the level of the bladder, including during transport;- The resident's privacy and dignity will be protected by placing cover over drainage bag when the resident is out of bed.The facility did not provide a policy regarding nephrostomy tube care.Review of Resident #12's medical record showed:- admitted on [DATE];- Diagnoses of malignant neoplasm (cancerous tumor) of the bladder (hollow, stretchy organ that holds urine), artificial openings to the urinary tract (a surgical opening created to direct urine away from damaged or obstructed bladder or urethra (a tube like structure that lets urine and waste products leave your body)), hydronephrosis (excessive fluid buildup in a kidney due to a backup of urine) with renal and ureteral calculus obstruction (occurs when a kidney stone (calculus) blocks the flow of urine from the kidney or through the ureter (a tube that transports urine from the kidneys to the urinary bladder) and obstructive and reflux uropathy (occurs when urine flow is blocked in the urinary tract, leading to a buildup of urine and pressure in the kidneys).Review of the resident's Physician's Order Sheet (POS), dated August 2025, showed:- Suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen (pubic area) into the bladder to drain urine) drainage bag, change every month and as needed, dated 08/27/25;- Wound Care: bilateral nephrostomy drains: cleanse site with normal saline (a solution of salt and water) wound cleanser, pat dry, apply dry dressing daily and as needed, every day shift, dated 08/27/25;Review of the resident's medication administration record (MAR) for the month of August, showed:- Bilateral suprapubic catheter care every shift and PRN (as needed) every shift for catheter care, dated 06/13/25;- Catheter care performed on day shift from 08/01/25-08/28/25;- Catheter care performed on night shift 08/01/25-08/12/25, then coded with a 9 (code to refer to nurse notes) on 08/13/25-08/17/25, performed on 8/18/25-08/21/25, coded with a 9 on 08/22/25, performed on 08/23/25-08/24/25, coded with a 9 on 08/25/25 and 08/26/25.Review of the resident's care plan, reviewed on 08/29/25, showed:- The resident has bilateral nephrostomy tubes;- Goal: to remain free of tube-related trauma through the review date;- Check tubing for kinks, and maintain drainage bag off the floor;- Monitor and document intake and output per facility</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>policy;- Monitor for signs and symptoms of discomfort on urination and frequency;- Monitor and document for pain/discomfort due to catheter;- Monitor record/report to medical doctor (MD) for signs and symptoms of a urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behavior and changes in eating patterns;- The resident has behaviors;- The resident will wear his/her nephrostomy tubes around his/her neck like a necklace;- Goal: there will be no evidence of behavior problems by review date;- Resident has been educated that the nephrostomy tubes need to be lower than his/her kidneys for proper drainage, verbalized understanding, continues to wear around his/her neck.Observation on 08/26/25 at 12:00 P.M. showed the resident in his/her room in a wheelchair with nephrostomy tube collection bags laying in the wheelchair seat, one bag on the right and the other on the left side of the resident with no privacy bag on either bag.Observation on 08/27/24 at 8:35 A.M. showed the resident sat in his/her room in a wheelchair with right and left nephrostomy tube collection bags hanging around his/her neck from a white stretchy band with no privacy bag on either bag.Observation on 08/28/25 at 8:50 A.M. showed the resident sat in his/her room in a wheelchair with right and left nephrostomy tube collection bags laying in the wheelchair seat, one on the right side and the other on the left side of the resident, with no privacy bag on either bag.Observation on 08/28/25 at 12:15 P.M. showed the resident sat in his/her wheelchair on the 100 hall, with right and left nephrostomy tube collection bags hanging around his/her neck from a white stretchy band with no privacy bag on either bag.Observation on 08/29/25 at 1:30 P.M. showed the resident sat in his/her bed with both nephrostomy tube collection bags laying on the bed behind him/her with no privacy bag on either bag.During an interview on 08/27/25 at 8:35 A.M., the resident said he/she has not had a privacy bag to put on collection bags since the last time he/she went out to the hospital. He/she left with them on and returned without them. He/she said it is gross and nasty to have urine hanging from his/her neck. Nobody wants to see that, and it bothers him/her for others to see the bags of piss.During an interview on 08/29/25 at 1:30 P.M., the resident said he/she still hasn't gotten any privacy bags, even after requesting them. It's just plain nasty and makes him/her feel bad.During an interview on 08/29/25 at 7:30 P.M., the Administrator and Director of Nursing (DON) said that they would expect residents with nephrostomy tube collection bags to be covered with privacy/dignity bags and for the bags to be positioned lower than their kidneys.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure communication forms that reflected ongoing coordination and collaboration between facility staff and the dialysis staff were sent with two residents (Resident #20 and #48) out of two sampled residents on all dialysis days. The facility census was 86. Review of the facility's Dialysis Care Policy, revised June 2020, showed:</p> <ul style="list-style-type: none"> <li>- The facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment and providing for all dialysis needs during the time period when dialysis is received;</li> <li>- The facility will maintain a contract with dialysis service provider;</li> <li>- The facility will arrange dialysis care for residents as ordered by the physician;</li> <li>- The facility will arrange transportation to and from dialysis, as well as meals, medication and a method of communication between the dialysis center and facility;</li> <li>- The nursing staff will communicate pertinent information in writing to the dialysis staff which may include medication changes, recent change in condition, and/or tolerance of dialysis procedures;</li> <li>- The dialysis provider will communicate resident's current vital signs, pre and post dialysis weight, and any problems encountered while resident was at the dialysis provider;</li> <li>- Nursing staff use Nurse Dialysis Communication Record, or comparable form in the electronic medical record, to convey information to the dialysis provider.</li> </ul> <p>1. Review of Resident #20's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- Diagnoses of end stage renal disease (ESRD-a condition in which the kidneys lose ability to remove wastes and balance fluids), dependence on renal dialysis (a medical treatment that helps remove waste products and excess fluid from the blood when kidneys are unable to do so), and adult failure to thrive.</li> </ul> <p>Review of the resident's Physician's Order Sheet (POS), dated 08/29/25, showed:</p> <ul style="list-style-type: none"> <li>- An order to assess dialysis device fistula: Location: left upper arm, monitor for bruit (blowing or whistling sound heard with a stethoscope over an artery or blood vessel)/thrill (vibration felt on the skin over a blood vessel) every shift related to ESRD, dated 01/08/25;</li> <li>- An order for dialysis on Monday, Wednesday, and Friday in the morning related to ESRD, dated 01/08/25;</li> <li>- An order to assess dialysis shunt site every shift for signs and symptoms of infection, bleeding, pulsation, or aneurysm, left upper arm fistula, every shift related to ESRD, dated 01/08/25;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An order for Patient returned from dialysis appointment on Monday, Wednesday, and Friday in the afternoon for documentation that patient returned from dialysis related to ESRD, dated 01/08/25.</p> <p>Review of the resident's Care Plan, last revised on 07/22/25, showed:</p> <ul style="list-style-type: none"> <li>- Resident receives hemodialysis (medical treatment that helps removes waste products and excess fluid from the blood when the kidneys are unable to do so);</li> <li>- Resident is resistive to care and refuses to go to dialysis and was educated related to non-compliance with dialysis, including negative outcome;</li> <li>- Monitor vital signs and notify physician of significant abnormalities;</li> <li>- Monitor/document/report new/worsening edema, weight gain. Monitor/document/report as needed any signs and symptoms of infection to access site: redness, swelling, warmth or drainage;</li> <li>- Resident has potential for impairment to skin related to dialysis site.</li> </ul> <p>Review of the resident's Dialysis Communication Forms from 05/01/25 through 08/28/25 showed:</p> <ul style="list-style-type: none"> <li>- Seven forms completed for 05/08/25, 05/09/25, 06/13/25, 07/28/25, 07/30/25, 08/01/25, and 08/20/25.</li> </ul> <p>Review of the resident's Medication Administration Record (MAR) from May 2025 through August 2025 showed the resident attended dialysis a total of 27 times for a total of 20 missed opportunities for communication forms to be completed.</p> <p>2. Review of Resident #48's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- Diagnoses of ESRD, dependance of renal dialysis, renovascular hypertension (high blood pressure caused by the kidneys' response to the narrowing arteries that supply the kidneys) and intestinal malabsorption (inability to absorb nutrients correctly).</li> </ul> <p>Review of the resident's POS, dated 08/29/25, showed:</p> <ul style="list-style-type: none"> <li>- An order for dialysis three times a week on Monday, Wednesday and Friday, dated 08/26/25;</li> <li>- An order to assess dialysis port in right chest, for signs of infection or bleeding, dated 08/26/25.</li> </ul> <p>Review of the resident's care plan, revised on 08/24/25, showed:</p> <ul style="list-style-type: none"> <li>- Resident has ESRD and on hemodialysis;</li> <li>- Monitor fluid intake and signs/symptoms of infection from dialysis site.</li> </ul> <p>Review of the resident's Dialysis Communications Forms from 07/30/25 through 08/27/25, showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Seven communication forms completed on 08/01/25, 08/13/25, 08/15/25, 08/20/25, 08/22/25, 08/25/25, and 08/27/25;</p> <p>- Six missed opportunities for communication forms to be completed.</p> <p>During an interview on 08/28/2025 at 2:20 P.M., Resident #48 said he/she goes to dialysis every Monday, Wednesday, and Friday via a transport company. The facility staff packs his/her lunch on those days, takes his/her vital signs, weight, and any blood sugar checks or medications needed. He/she takes a communication form, brings it back, and it is given to the charge nurse.</p> <p>During an interview on 08/29/2025 at 12:50 P.M., the Director of Nursing (DON) said they recently had to terminate several nurses that they realized had not been doing things correctly and that is why she is here. She has already done in-services on this issue, and staff should be good moving forward. Resident #48 had just started dialysis on 07/30/25. Resident #20 has a history of refusing dialysis at times.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, DON, and Director of Operations said they would expect residents to have a communication form appropriately filled out on dialysis days.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to assess residents for the risk of entrapment and review possible risks and benefits of bed rails prior to installation or use. The facility also failed to obtain informed consent from the resident and/or the resident's representative for five residents (Resident #1, #2, #10, #72 and #81) out of 18 sampled residents and three residents (Resident #18, 34 and #64) outside the sample. The facility census was 86. Review of the facility's Bed Rail policy, revised June 2020, showed:</p> <ul style="list-style-type: none"> <li>- Decisions to use or discontinue the use of bed rails will be made in the context of an individual assessment;</li> <li>- The facility will regularly review resident's condition and circumstances to reduce the use of bed rails as restraints while ensuring safety;</li> <li>- The assessment should include an evaluation of alternatives to the use of bed rails attempted and how the alternatives failed to meet resident needs;</li> <li>- If bed rails are used, assess the resident for risk of entrapment and ensure the bed's dimensions are appropriate for the resident's size and weight;</li> <li>- The manufacturer's recommendations and specifications for installing and maintain bed rails will be followed;</li> <li>- If the bed rail is an enabler, the resident/resident representative consent will be obtained by the Licensed Nurse or physician;</li> <li>- The resident's care plan will be updated to reflect use of bedrails;</li> <li>- After installation, the Interdisciplinary Team (IDT) will document the review of the use of side rails at a minimum of quarterly;</li> <li>- Maintenance or Designee will assess the bed dimensions no less than quarterly by utilizing the Maintenance Inspection Checklist;</li> <li>- Maintenance will also check bed rails to assure they remain installed correctly, as rails may shift or loosen over time.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- Diagnoses of muscle weakness, need for assistance with personal care, and spastic hemiplegia affecting left non-dominant side (characterized by stiffness and muscle tightness on one side of the body, affecting motor function, coordination, and balance);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- No documentation of the side rail assessment, entrapment risk assessment, or informed consent for use of side rails;</li> <li>- No physician order for side rails.</li> </ul> <p>Review of Resident #1's care plan, last reviewed 07/09/25, showed:</p> <ul style="list-style-type: none"> <li>- The resident has an activities of daily living (ADL) self care performance deficit;</li> <li>- Roll left to right: substantial/maximal assist;</li> <li>- Sit to lying: substantial/maximal assist;</li> <li>- Lying to sitting at the edge of the bed: substantial/maximal assist;</li> <li>- Sit to stand: substantial/maximal assistance;</li> <li>- Left side mobility bar to promote independence and assist with repositioning and mobility;</li> <li>- On 08/15/25, the half side rail changed to mobility bar.</li> </ul> <p>Observation on 08/29/25 at 5:05 P.M. showed the resident's bed with a U-shaped grab bar on the left side. The resident was not in the room.</p> <p>2. Review of Resident #2's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- Diagnoses of fracture to lower end of left femur (broken upper thigh bone), muscle weakness, chronic pain, morbid obesity (a disorder that involves having too much body fat), and the need for assistance with personal care;</li> <li>- No documentation of the side rail assessment or informed consent for the use of side rails;</li> <li>- No physician order for side rails.</li> </ul> <p>Review of the resident's care plan, last reviewed 08/04/25, showed bilateral side rails attached to bed for bed mobility.</p> <p>Observation on 08/26/25 at 12:15 P.M. showed the resident in bed with quarter rails on both sides of the bed; the right rail in the down position, and the left bar in the upright position.</p> <p>During an interview on 08/26/25, at 12:15 P.M., the resident said he/she uses the left rail to help reposition himself/herself since he/she has a broken leg and has been bedbound since.</p> <p>3. Review of Resident #10's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Diagnoses of muscle weakness, need for assistance with personal care, and history of falling;</p> <p>- No documentation of the side rail assessment, entrapment risk assessment, or informed consent for use of side rails;</p> <p>- No physician order for side rails.</p> <p>Review of the resident's care plan, last reviewed 07/27/25, did not address side rails.</p> <p>Observation on 08/26/2025 at 1:27 P.M. showed the resident sat in a wheelchair in his/her room with half rails on the bed bilaterally.</p> <p>4. Review of Resident #18's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- Diagnoses of reduced mobility (inability to move freely without pain), chronic fatigue (extreme exhaustion that lasts more than 6 months), muscle weakness, and the need for assistance with personal care;</p> <p>- No documentation of the side rail assessment or informed consent for the use of side rails;</p> <p>- Physician's order for bilateral bed mobility bars, dated 02/28/25.</p> <p>Review of the resident's care plan, last reviewed 08/12/25, showed:</p> <p>- The use of bilateral mobility bars to promote independence, assist with mobility and repositioning.</p> <p>Observation on 08/26/25 at 12:45 P.M. showed the resident in bed with quarter rails in the upright position on both the right and left sides.</p> <p>5. Review of Resident #34's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- Diagnoses of muscle weakness, morbid obesity, and need for assistance with personal care;</p> <p>- No documentation of the side rail assessment, entrapment risk assessment, or informed consent for use of side rails;</p> <p>- No physician order for side rails.</p> <p>Review of the resident's care plan, last reviewed 07/25/25, did not address side rails.</p> <p>Observation on 08/26/2025 at 12:48 P.M. showed the resident sat in a motorized wheelchair in his/her room with half rails on the bed bilaterally.</p> <p>6. Review of Resident #64's medical record showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- admitted on [DATE];</p> <p>- Diagnoses of anoxic brain damage (brain damage that occurs when the brain is without oxygen for an extended period of time), NSTEMI (a type of heart attack where there is partial blockage of a heart artery), and history of sudden cardiac arrest (sudden, unexpected loss of heart function, breathing and consciousness);</p> <p>- No documentation of side rail assessment or signed consent for the use of side rails;</p> <p>- No physician order for side rails.</p> <p>- Review of the resident's care plan, last reviewed 02/27/25, did not address side rails.</p> <p>Observation on 08/26/25 at 12:10 P.M. showed the resident up in a Broda (a specialized wheelchair for positioning) chair in his/her room with a quarter rail in the upright position on the right side of the bed.</p> <p>7. Review of Resident #72's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- Diagnoses included pain in left hip, diplopia (seeing double), dizziness, and age-related physical debility;</p> <p>- No documentation of the side rail assessment or informed consent for use of side rails;</p> <p>- No physician order for side rails.</p> <p>Review of the resident's Care Plan, last revised 07/17/25, showed:</p> <p>- Half rails up per physician orders for safety during care;</p> <p>- To assist with bed mobility;</p> <p>- Observe for injury or entrapment;</p> <p>- Reposition as necessary to avoid injury.</p> <p>Observation on 08/26/25 at 1:30 P.M. showed the resident in bed with half side rails up on both sides.</p> <p>During an interview on 08/26/25 at 1:30 P.M., the resident said the rails helped with mobility.</p> <p>Observation on 08/28/25 at 12:55 P.M. showed the resident not in the room and side rails up on both sides of the bed.</p> <p>8. Review of Resident #81's medical record showed:</p> <p>- admitted on [DATE];</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Diagnoses of metabolic encephalopathy (brain dysfunction caused by problems with body chemistry, such as liver or kidney disease), cognitive communication deficit (difficulty with memory, understanding, or expressing thoughts), need for assistance with personal care, morbid severe obesity due to excess calories (very high body weight caused by overeating), and altered mental status (confusion, not acting normally).</p> <p>- No documentation of the side rail assessment or an informed consent for the use of side rails;</p> <p>- Care plan did not address the resident's use of side rails;</p> <p>- No physician order for use of the side rails.</p> <p>Observation on 08/26/2025 at 12:50 P.M. showed the resident lay in bed with upper quarter bed rails in raised position on upper both sides of the bed.</p> <p>During an interview on 08/26/25 at 12:50 P.M., the resident said he/she can use the rails to pull to one side, but cannot turn or move in the bed completely without assistance from staff.</p> <p>During an interview on 08/29/2025 at 2:22 P.M., the Director of Nursing (DON) said the facility had not been doing the safety assessments, bed rail consents, or maintenance checks for the side rails; however, they should be. The DON said he/she would expect the safety assessments to be completed quarterly or when a change occurs. He/she would expect maintenance to assess them monthly, but when he/she spoke with the maintenance director, he/she was not aware he/she was supposed to do them.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, DON, and Director of Operations collectively said they would expect bed rail safety assessments, maintenance assessments and signed consents to be completed for residents that have side rails.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on interview and record review, the facility failed to ensure four out of the four sampled Certified Nurse Aides (CNAs) received an annual performance review. The facility census was 86. The facility did not provide a policy for CNA annual performance reviews. 1. Review of CNA F's personnel file showed:- Hire date of 09/19/24;- No documentation of an annual performance review. 2. Review of CNA G's personnel file showed:- Hire date of 07/16/24;- No documentation of an annual performance review. 3. Review of CNA N's personnel file showed:- Hire date of 07/01/24;- No documentation of an annual performance review. 4. Review of CNA O's personnel file showed:- Hire date of 07/01/24;- No documentation of an annual performance review. During an interview on 08/29/25 at 2:35 P.M., the Director of Nursing (DON) said CNA Performance Reviews are to be done by the DON, but they are probably not being done. During an interview on 08/29/25 at 7:30 P.M., the Administrator and DON said they would expect nurse aides to have a performance review completed every 12 months.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on interview and record review, the facility failed to ensure that medication usage was evaluated on an ongoing basis, by not providing documentation of monthly medication regimen reviews by the pharmacy for three residents (Resident #1, #9, and #11) out of 18 sampled residents and one resident (Resident #5) outside the sample. The facility census was 86. Review of the facility's policy titled Documentation and Communication of Consultant Pharmacist Recommendations, dated 08/2020, showed:</p> <ul style="list-style-type: none"> <li>- The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion;</li> <li>- A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, prescribers, and the care planning team. This should include documentation of the date each medication regimen review is completed and notation of the findings in the medical record or other designated manner.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 04/08/15;</li> <li>- Diagnoses of schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs);</li> <li>- An order for amitriptyline (antidepressant) 50 milligrams (mg), give one tablet by mouth at bedtime for depression, dated 01/28/25;</li> <li>- An order for Cymbalta (antidepressant) 60 mg, give one capsule by mouth one time a day related to cerebral infarction, dated 01/10/25;</li> <li>- An order for trazodone (antidepressant) 50 mg, give one tablet by mouth one time a day for insomnia, dated 04/10/25;</li> <li>- An order for Vraylar (antipsychotic) 1.5 mg, give one capsule by mouth one time a day related to acute upper respiratory infection, dated 01/10/25;</li> <li>- No documentation of the pharmacist completing monthly medication regimen reviews.</li> </ul> <p>2. Review of Resident #5's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 11/14/17;</li> <li>- Diagnoses of dementia (memory loss and thinking problems), cognitive communication deficit (difficulty with memory, understanding, or expressing thoughts), schizophrenia (serious mental illness affecting thoughts, emotions, and behavior), major depressive disorder, and anxiety disorder (excessive</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>worry, fear, or nervousness);</p> <ul style="list-style-type: none"> <li>- An order for quetiapine (an antipsychotic medication) 25 mg, one and a half tablet by mouth, one time a day for schizophrenia, dated 03/11/25;</li> <li>- No documentation of the pharmacist completing monthly medication regimen reviews.</li> </ul> <p>3. Review of Resident #9's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 07/29/15;</li> <li>- Diagnoses of schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), bipolar II (a mood disorder with extreme mood swings, including emotional highs and extreme lows), anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life), major depressive disorder, and borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships);</li> <li>- An order for Cymbalta (antidepressant) 30 mg, give one capsule by mouth at bedtime for bipolar II and anxiety, dated 07/30/24;</li> <li>- An order for Risperdal (antipsychotic) 1 mg, give one tablet by mouth two times a day for schizophrenia, dated 08/05/24;</li> <li>- An order for Cymbalta (antidepressant) 60 mg, give one capsule by mouth one time a day for depression, dated 08/07/25;</li> <li>- No documentation of the pharmacist completing monthly medication regimen reviews.</li> </ul> <p>4. Review of Resident #11's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admission date of 12/22/17;</li> <li>- Diagnoses of paranoid schizophrenia (mental health disorder characterized by persistent delusions and hallucinations, primarily involving paranoia and persecution), major depressive disorder, and anxiety disorder;</li> <li>- An order for lorazepam (anxiety medication) 1 mg, give one tablet by mouth two times a day for anxiety, dated 12/20/24;</li> <li>- An order for Seroquel (antipsychotic) 200 mg, give one tablet by mouth two times a day for schizophrenia, dated 06/28/24;</li> <li>- An order for sertraline (antidepressant) 50 mg, give one tablet by mouth one time a day for depression, dated 06/28/24;</li> <li>- No documentation of the pharmacist completing monthly medication regimen reviews.</li> </ul> <p>During an interview on 08/29/2025 at 2:22 P.M., the Director of Nursing (DON) said the pharmacist</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>should be completing medication reviews each month; however, they were not being completed. The DON had recently met with the pharmacist to discuss the monthly medication reviews and was planning to add it to Quality Assurance and Process Improvement (QAPI).</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, DON, and Director of Operations said they would expect monthly medication reviews to be completed by the pharmacist and signed by the doctor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on interview and record review, the facility failed to have a Quality Assurance and Performance Improvement (QAPI - a program to improve the processes for the delivery of health care and quality of life for the residents) program in place with protocols describing how the facility will identify and correct its own quality deficiencies. This deficient practice had the potential to affect all residents in the facility. The facility census was 86. Review of the facility's QAPI Program policy, revised 10/24/22, showed:- The purpose is to ensure that all services provided by the facility to resident meet quality standards;- The facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality and resolve identified problems;- The goal is to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety; to reinforce and build upon effective systems of service and positive care measures; to provide a structure and process to correct identified quality deficiencies; to establish and implement plans to correct deficiencies and to monitor the effects of these action plans on resident outcomes; to help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; and to establish a system and process to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program;- The governing body of the facility shall be ultimately responsible for the QAPI Program;- The Administrator is responsible for ensuring that the facility's QAPI Program complies with local, state, and federal regulatory requirements;- The Quality Assessment &amp; Assurance (QAA) Committee oversees implementation of the QAPI Program;- The QAA Committee will make good faith attempts to identify and correct quality deficiencies;- The QAA Committee oversees and authorizes QAPI activities, including data-collection tools, monitoring tools, and the effectiveness of QAPI activities;- The facility will develop and implement a written QAPI Plan that will be reviewed and revised annually or more frequently as needed;- The facility obtains feedback from direct care staff, other staff, residents and resident representatives, as well as other sources, to identify problems that are high-risk, high-volume, and/or problem-prone, as well as opportunities for improvement;- The facility also communicates feedback about the QAPI Program information to direct care staff, other staff, residents, and resident representatives. Review of the facility's Compliance with Laws and Professional Standards policy, revised 08/2020, showed:- The purpose is to ensure that Facility staff provide services in compliance with federal, state, and local laws, regulations, codes and professional standards, as applicable;- Survey results and plans of correction are incorporated in the Quality Assessment &amp; Assurance audits and plans;- Designated individuals are responsible for overseeing the implementation and ongoing monitoring of corrective actions. Review of the facility's QAPI material, provided by the Administrator, showed:- A QAPI Meeting sign in sheet, dated May (no year);- No personalized QAPI plan that contained the necessary protocols describing their quality deficiencies, how they would track and measure performance, and establish goals and thresholds for performance measurement. During an interview on 08/29/25 at 5:49 P.M., the Administrator said she only had the May sign-in sheet for QAPI. She doesn't have anything from the prior management/administration. There are no Performance Improvement Projects (PIPs) open. They were supposed to have a meeting in June, but couldn't. During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they expect the facility to have a QAPI program in place to include data collections, feedback, monitoring, analysis, and action and to develop a performance improvement plan based on those results.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility census was 86. Review of the facility's QAPI Program policy, revised 10/24/22, showed:- The purpose is to ensure that all services provided by the facility to residents meet quality standards;- Goals are: to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety; to reinforce and build upon effective systems of services and positive care measures; to provide a structure and process to correct identified quality deficiencies; to establish and implement plans to correct deficiencies and to monitor the effects of these action plans on resident outcomes; to help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; and to establish a system and process to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program;- The QAA Committee will make good faith attempts to identify and correct quality deficiencies;- The QAA Committee meet at least quarterly to review reports, evaluate the significance of data, and monitor quality related activities of all departments;- The QAA committee oversees and authorizes QAPI activities, including data-collection tools, monitoring tools, and the effectiveness of QAPI activities;- As a part of the facility's performance improvement activities, the facility will conduct distinct performance improvement projects;- The number and frequency of performance improvement projects (PIPs) will reflect the scope and complexity of the facility's services and available resources, consistent with the Facility Assessment;- Improvement projects must include a project that focus on high-risk or problem-prone areas identified through data collection and analysis through the QAPI Program;- One PIP must be completed at least annually.During an interview on 08/29/25 at 5:49 P.M., the Administrator said she doesn't have anything from the prior management/administration. There are no PIPs open. They were supposed to have a meeting in June, but couldn't.During an interview on 08/26/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect the facility to have a QAPI program in place to include data collections, feedback, monitoring, analysis, and action and to develop a performance improvement plan based on those results.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview, the facility failed to maintain quarterly Quality Assurance &amp; Performance Improvement (QAPI) meetings with the required members. The facility census was 86. Review of the facility's Quality Assessment and Assurance (QAA) Committee policy, revised 06/20, showed:- The purpose is to promote the quality of resident care by overseeing, identifying, tracking, addressing, and follow-up on all quality issues;- The QAA Committee consists of the following individuals: Director of Nursing Services; A minimum of one physician; Pharmacist Consultant; Director of Activities; Infection Control Coordinator; Director of Dietetic Services; Director of Medical Records; Director of Rehabilitation Services; and Director of other departments as necessary;- The QAA Committee meets monthly;- The QAA Committee maintains minutes of all meetings that include at least the following information: Date and time of meeting; members present/absent; findings and recommended corrective action; follow up action, as appropriate; time of adjournment; signature of chairperson; and other information deemed appropriate by the committee.Review of the QAPI Quarterly Meeting sign in sheet, dated May (no year) and provided by the Administrator, showed Activities Director, Housekeeping, Social Services Director, Medical Director, Medical Records, Minimum Data Set (MDS - a federally mandated assessment completed by the facility) Coordinator, and Director of Nursing present.During an interview on 08/29/25 at 5:49 P.M., the Administrator said the sign in sheet dated May was all she had for QAPI. She doesn't have anything from the prior management/administration. They were supposed to have a meeting in June, but couldn't.During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect a QAPI meeting to be held at least quarterly with the minimum required members.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during nephrostomy (a thin flexible tube that lets urine drain from the kidney through an opening in the skin on the back) care for one resident (Resident #12) and failed to perform proper hand hygiene during wound care for one resident (Resident #3) out of 18 sampled residents and one resident (Resident #34) outside the sample. The facility failed to sanitize glucometers per manufacturer's directions in between each resident for four of four sampled residents (Residents #15, #16, #22, and #33). The facility census was 86. Review of the facility's policy titled, Blood Glucose Monitoring, revised 01/25, showed:</p> <ul style="list-style-type: none"> <li>- Licensed nurses will perform blood glucose testing as ordered by the physician, following the manufacturer's instructions for the testing device, and facility protocols;</li> <li>- Manufacturer's recommendations will be followed for the use, maintenance and storage of blood glucose testing devices and supplies;</li> <li>- The blood glucose meter will be cleaned after each use as noted in the manufacturer's instructions and infection control policies.</li> </ul> <p>Review of the facility's policy titled, Handwashing/Hand Hygiene, revised August 2019, showed:</p> <ul style="list-style-type: none"> <li>- This facility considers hand hygiene the primary means to prevent the spread of infections;</li> <li>- All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors;</li> <li>- Wash hands with soap (antimicrobial or non-antimicrobial) and water when hands are visibly soiled;</li> <li>- Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty; before and after direct contact with residents; before and after handling an invasive device (e.g. urinary catheters); before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; after removing gloves; and before and after entering isolation precaution settings;</li> <li>- Hand hygiene is the final step after removing and disposing of personal protective equipment;</li> <li>- The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections;</li> <li>- Single-use disposable gloves should be used before aseptic procedures; when anticipating contact with blood or body fluids; and when in contact with a resident, or the equipment or environment of a resident who is on contact precautions;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Perform hand hygiene before applying non-sterile gloves; when applying, remove one glove from the dispensing box at a time, touching only the top of the cuff; when removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out; hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove; perform hand hygiene.</li> </ul> <p>Review of the facility's policy titled, Catheter, Care Of, revised 06/20, showed:</p> <ul style="list-style-type: none"> <li>- Purpose: to prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary;</li> <li>- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible;</li> <li>- Daily catheter care: wash hands, don gloves prior to handling the catheter, drainage system or bag;</li> <li>- Explain the procedure to the resident and provide privacy;</li> <li>- Cleanse the area;</li> <li>- Remove gloves and wash hands;</li> <li>- Position the catheter drainage system and bag utilizing gravity to facilitate drainage;</li> <li>- Empty the collection bag each shift or more often as indicated. Use a separate container for each resident and avoid touching the spigot to the container;</li> <li>- Report the following signs and symptoms to the attending Physician;</li> <li>- Any sign or symptom of urinary tract infection: fever, change in urine, such as foul odor or bloody/cloudy appearance, no urine output or decreased urine output, leakage or urine, hematuria, urethral erosion, pain, swelling, irritation, complaints of urinary related pain, bladder spasms;</li> <li>- Use standard precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system;</li> <li>- Collection bags should always be kept below the level of the bladder, including during transport;</li> <li>- The resident's privacy and dignity will be protected by placing cover over drainage bag when the resident is out of bed.</li> </ul> <p>Review of Super Sani-Cloth Manufacturer's Guidelines for Use showed:</p> <ul style="list-style-type: none"> <li>- Use a wipe to remove visible soil prior to disinfecting;</li> <li>- Unfold a clean wipe and thoroughly wet surface;</li> <li>- Allow treated surface to remain wet for two minutes, allow to air dry;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Do not reuse towelette. Dispose of used towelette in the trash.</p> <p>1. Observation on 08/28/25 at 12:15 P.M., of Resident #22's fingerstick blood sugar (FSBS) testing showed:</p> <ul style="list-style-type: none"> <li>- Registered Nurse (RN) E obtained a glucometer, lancet, and alcohol wipe from the nurse cart, donned a gown and gloves and obtained a FSBS on the resident;</li> <li>- RN E removed gown and gloves and exited the room;</li> <li>- RN E sanitized hands and donned gloves, wiped off the glucometer with a Super-Sani cloth for approximately ten seconds and placed it on a paper towel inside the nurse cart;</li> <li>- RN E did not keep the glucometer wet for the two-minute kill time per the manufacturer's guidelines.</li> </ul> <p>2. Observation on 08/28/25 at 12:30 P.M., of Resident #16's FSBS testing showed:</p> <ul style="list-style-type: none"> <li>- RN E obtained a glucometer, lancet, and alcohol wipe from the nurse cart, donned a gown and gloves and obtained a FSBS on the resident;</li> <li>- RN E removed gown and gloves and exited the room;</li> <li>- RN E sanitized hands and donned gloves, wiped off the glucometer with a Super-Sani cloth for approximately ten seconds and placed it on a paper towel inside the nurse cart;</li> <li>- RN E did not keep the glucometer wet for the two-minute kill time per the manufacturer's guidelines.</li> </ul> <p>3. Observation on 08/28/25 at 12:40 P.M., of Resident #33's FSBS testing showed:</p> <ul style="list-style-type: none"> <li>- RN E obtained a glucometer, lancet, and alcohol wipe from the nurse cart, donned a gown and gloves and obtained a FSBS on the resident;</li> <li>- RN E removed gown and gloves and exited the room;</li> <li>- RN E sanitized hands and donned gloves, wiped off the glucometer with a Super-Sani cloth for approximately ten seconds and placed it on a paper towel inside the nurse cart;</li> <li>- RN E did not keep the glucometer wet for the two-minute kill time per the manufacturer's guidelines.</li> </ul> <p>4. Observation on 08/28/25 at 1:14 P.M., of Resident #15's FSBS testing showed:</p> <ul style="list-style-type: none"> <li>- RN E obtained a glucometer, lancet, and alcohol wipe from the nurse cart, donned a gown and gloves and obtained a FSBS on the resident;</li> <li>- RN E removed gown and gloves and exited the room;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- RN E sanitized hands and donned gloves, wiped off the glucometer with a Super-Sani cloth for approximately ten seconds and placed it on a paper towel inside the nurse cart;</p> <p>- RN E did not keep the glucometer wet for the two-minute kill time per the manufacturer's guidelines.</p> <p>During an interview on 08/28/25 at 1:40 P.M., RN E said he/she just wiped off the glucometers and never wrapped them. He/She didn't know there was a certain amount of time the glucometers had to stay wet and didn't know what the kill time was for the Super-Sani cloths.</p> <p>4. Observation on 08/29/25 at 1:30 P.M., of Resident #12's nephrostomy tube care showed:</p> <p>- RN P sanitized hands and gathered a normal saline (a sterile solution of salt and water used for cleansing wounds) syringe, two drainage sponges, and some gauze pads and placed them on a paper towel barrier on top of the nurse cart;</p> <p>- RN P donned a gown, mask, and gloves before entering the resident's room;</p> <p>- RN P gathered supplies off the nurse cart and entered the resident's room;</p> <p>- RN P placed the paper towel barrier and supplies on the bedside table;</p> <p>- RN P touched the wheelchair handles and moved the wheelchair out of the way to get to the resident's bed;</p> <p>- RN P, wearing the same gloves, started to remove the left-sided drainage sponge and tape from the resident's back;</p> <p>- The resident requested Medi pore tape be used, and RN P left the room to get the specific tape;</p> <p>- RN P removed gloves, gown, and mask, placed in the resident's trash can, did not sanitize hands, and left the room;</p> <p>- RN P sanitized hands, donned gown, gloves and mask;</p> <p>- RN P removed left-sided drainage sponge and tape;</p> <p>- Wearing the same gloves, RN P removed the right-sided drainage sponge and tape;</p> <p>- RN removed gloves, washed his/her hands and donned gloves;</p> <p>- RN P picked up a gauze pad and a saline flush from the barrier, used it to cleanse the skin around the tube insertion site on the left side and down the tubing, then threw the used gauze in the trash;</p> <p>- Wearing the same gloves, RN P picked up clean gauze, used the same saline flush to cleanse skin around the insertion site on the right side and down the tubing, then threw the used gauze in the trash;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Wearing the same gloves, RN P taped the right drainage sponge in place, then taped the left drainage sponge in place;</li> <li>- RN P removed gown, gloves, and mask and placed in the trash;</li> <li>- RN P sanitized his/her hands;</li> <li>- RN P wrote the date on each drainage sponge and exited the room.</li> </ul> <p>During an interview on 08/29/25 at 1:50 P.M., RN P said that since both sides were considered dirty, he/she did not need to change gloves between each side when removing the dressings. When asked about cross contamination, he/she said you could spread infections from one area to the other, so that made sense to change gloves in between sides, and he/she should have changed gloves when changing from right and left sides.</p> <p>5. Observation on 08/28/25 at 1:01 P.M., of Resident #34's wound care showed:</p> <ul style="list-style-type: none"> <li>- Licensed Practical Nurse (LPN) B gathered supplies from the treatment cart, put several pairs of gloves in his/her pants pocket and donned a gown;</li> <li>- LPN B placed the wound care supplies on a barrier on the resident's bed;</li> <li>- Certified Nursing Assistant (CNA) C donned a gown and put several pairs of gloves in his/her pants pockets;</li> <li>- LPN B and CNA C went into the resident's restroom to wash their hands and put on new gloves they retrieved from their pockets;</li> <li>- CNC C positioned the resident's left leg while LPN B put normal saline on gauze in a cup and cleansed the resident's left leg with normal saline and applied skin prep;</li> <li>- LPN B removed his/her gloves and, without performing hand hygiene, donned new gloves that he/she retrieved from his/her pocket;</li> <li>- CNA C positioned the resident's right leg while LPN B cleansed the four open areas to the resident's right leg with normal saline, moving in a circular motion over all four wounds with the same gauze;</li> <li>- LPN B retrieved scissors from his/her pants pocket, cut Xeroform (gauze dressing impregnated with petroleum), applied to the wounds, placed the scissors on the barrier on the bed, and applied a bordered gauze dressing to the resident's right leg.</li> <li>- LPN B and CNA C removed their gowns and washed their hands;</li> <li>- LPN B held the scissors in a glove when leaving the room.</li> </ul> <p>During an interview on 08/28/25 at 1:20 P.M., LPN B said he/she just started working here yesterday as a wound care nurse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Observation on 08/29/25 at 2:37 P.M., of Resident #3's wound care showed:</p> <ul style="list-style-type: none"> <li>- LPN B and CNA C put several pairs of gloves in their pants pockets and washed their hands in the resident's restroom;</li> <li>- LPN B and CNA A each donned a gown and gloves;</li> <li>- LPN B removed the dressing from the wound on the resident's right forearm, removed his/her gloves, and threw the gloves and dressing in the trash;</li> <li>- LPN B, without performing hand hygiene, donned new gloves he/she retrieved from his/her pants pocket, removed the dressings from the resident's abdomen, and threw the gloves and dressings in the trash;</li> <li>- LPN B, without performing hand hygiene, donned new gloves that he/she retrieved from his/her pants pocket and opened a plastic bag of supplies on a barrier on the resident's bedside table;</li> <li>- LPN B applied normal saline to gauze in a cup, obtained new gauze from the cup each time to cleanse the three abdominal wounds with separate gauze on each wound, without changing gloves in between each wound;</li> <li>- LPN B retrieved scissors from his/her pants pocket and cut Xeroform with scissors, placed scissors on the barrier, put Xeroform on the resident's left forearm wound and covered the wound with bordered gauze;</li> <li>- LPN B cut hydrofera blue (foam dressing to manage wound bacteria and absorb wound drainage) and applied it to the top right abdominal wound, then cut another piece and applied to the left middle abdominal wound, then cut a third piece and applied to the left bottom abdominal wound and covered all abdomen wounds with bordered gauze;</li> <li>- LPN B removed his/her gloves and realized he/she had no more gloves in his/her pants pocket. CNA C opened the door with his/her gloved hand and obtained more gloves from the resident's supply hanging on the door with his/her gloved hand, handed a pair to LPN B, then put the rest of the gloves down into LPN B's pants pocket. Then, without performing hand hygiene, LPN B donned new gloves and removed the dressing to the resident's left heel with his/her left hand, obtained gauze soaked in normal saline from the cup on the barrier and cleansed the wound to the resident's left heel with his/her right hand;</li> <li>- LPN B removed his/her gloves and, without performing hand hygiene, donned new gloves retrieved from his/her pants pocket, and prepared and applied Santyl (ointment used to remove dead tissue from chronic skin ulcers), Xeroform, and a dry dressing to the heel wound;</li> <li>- LPN B removed gloves and, without performing hand hygiene, donned new gloves retrieved from his/her pants pocket and removed the dressing to the resident's buttocks and, without performing hand hygiene, donned new gloves retrieved from his/her pants pocket, obtained scissors from the barrier on the bedside table and cut hydrofera blue, placed in buttock wound, and applied bordered gauze dressing;</li> <li>- CNA C emptied the resident's urinal hanging on the side of the trash can while LPN B gathered the</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>trash on the barrier. CNA C removed the trash bag from the trash can and put the empty urinal back on the side of the trash can;</p> <p>- LPN B and CNA C removed gowns and washed their hands and LPN B cleaned the scissors in the sink. CNA C donned a glove to take the trash from the resident's room.</p> <p>During an interview on 08/29/25 at 3:00 P.M., LPN B said he/she cleaned his/her scissors as soon as he/she took them out with an alcohol wipe or purple wipes, but he/she was out of purple wipes. He/She had never been told he/she should wash or sanitize with glove changes. The doctor treated the wound to the back of Resident #34's right leg as one wound, so he/she cleaned it as one wound, but said he/she would treat them as separate wounds if they had different organisms, like Methicillin-resistant Staphylococcus aureus (MRSA - a type of staph that can be resistant to several antibiotics), in them.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator and Director of Nursing (DON) said they would expect glucometers to be cleaned and sanitized per manufacturer's guidelines, for staff to change their gloves in between wound sites, and to perform hand hygiene with glove changes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility staff failed to conduct regular inspections of all bed frames, mattresses and side rails as part of a regular maintenance program for five residents (Residents #1, #2, #10, #72, and #81) out of 18 sampled residents and three residents (Resident #18, #34, and #64) outside the sample. The facility census was 86. Review of the facility's Bed Rail policy, last reviewed June 2020, showed:</p> <ul style="list-style-type: none"> <li>- Decisions to use or discontinue the use of bed rails will be made in the context of an individual assessment;</li> <li>- The facility will regularly review residents' condition and circumstances to reduce the use of bed rails as restraints while ensuring safety;</li> <li>- The assessment should include an evaluation of alternatives to the use of bed rails attempted and how the alternatives failed to meet resident needs;</li> <li>- If bed rails are used, assess the resident for risk of entrapment and ensure the bed's dimensions are appropriate for the resident's size and weight;</li> <li>- The manufacturer's recommendations and specifications for installing and maintaining bed rails will be followed;</li> <li>- If the bed rail is an enabler, the resident/resident representative consent will be obtained by the Licensed Nurse or physician;</li> <li>- The resident's care plan will be updated to reflect use of bedrails;</li> <li>- After installation, the Interdisciplinary Team (IDT) will document the review of the use of side rails at a minimum of quarterly;</li> <li>- Maintenance or Designee will assess the bed dimensions no less than quarterly by utilizing the Maintenance Inspection Checklist;</li> <li>- Maintenance will also check bed rails to ensure they remain installed correctly, as rails may shift or loosen over time.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted on [DATE];</li> <li>- No documentation of maintenance assessments.</li> </ul> <p>Observation on 08/29/25 at 5:05 P.M. showed the resident's bed with a U-shaped grab bar on the left side.</p> <p>2. Review of Resident #2's medical record showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- admitted on [DATE];</p> <p>- No documentation of a maintenance assessment for side rails.</p> <p>Observation on 08/26/25 at 12:15 P.M. showed the resident in bed with quarter rails on both sides of the bed; the right rail was in the down position, and the left bar was in the upright position.</p> <p>During an interview on 08/26/25, at 12:15 P.M., the resident said he/she uses the left rail to help reposition himself/herself since he/she has a broken leg and has been bedbound since.</p> <p>3. Review of Resident #10's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- No documentation of maintenance assessments.</p> <p>Observation on 08/26/2025 at 1:27 P.M. showed the resident sat in a wheelchair in his/her room with half rails on the bed bilaterally.</p> <p>4. Review of Resident #18's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- No documentation of a maintenance assessment for side rails.</p> <p>Observation on 08/26/25 at 12:45 P.M. showed the resident in bed with quarter rails in the upright position on both the right and left sides.</p> <p>5. Review of Resident #34's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- No documentation of maintenance assessments.</p> <p>Observation on 08/26/2025 at 12:48 P.M. showed the resident sat in his/her room in a motorized wheelchair with half rails on the bed bilaterally.</p> <p>6. Review of Resident #64's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- No documentation of a maintenance assessment for side rails.</p> <p>- Observation on 08/26/25 at 12:10 P.M. showed the resident sat in a Broda chair (a specialized wheelchair for positioning) in his/her room with a quarter rail in the upright position on the right side of the bed.</p> <p>7. Review of Resident #72's medical record showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- admitted on [DATE];</p> <p>- No documentation of maintenance assessments.</p> <p>Observation on 08/26/25 at 1:30 P.M. showed the resident lay in bed with half rails up on both sides resting in bed.</p> <p>Observation on 08/28/2025 at 12:55 P.M., showed the resident not in the room and side rails up on both sides of the bed.</p> <p>8. Review of Resident #81's medical record showed:</p> <p>- admitted on [DATE];</p> <p>- No documentation of a maintenance assessment for side rails.</p> <p>Observation on 08/26/2025 at 12:50 P.M. showed the resident lay in bed with upper quarter bed rails in raised position on both sides of the bed.</p> <p>During an interview on 08/26/25 at 12:50 P.M., the resident said he/she can use the rails to pull to one side, but cannot turn or move in the bed completely without assistance from staff.</p> <p>During an interview on 08/29/2025 at 2:22 P.M., the Director of Nursing (DON) said the facility had not been doing the safety assessments, bed rail consents, or maintenance checks for the side rails; however, they should be. The DON said he/she would expect the safety assessments to be completed quarterly or when a change occurs. He/she said he/she would expect maintenance to assess them monthly, but when he/she spoke with the maintenance director, he/she was not aware he/she was supposed to do them.</p> <p>During an interview on 08/29/2025 at 3:50 P.M., the Maintenance Director said he was not aware of the assessments needed for bedrails, but was told there would be forms to use soon.</p> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect bed rail safety assessments, maintenance assessments and signed consents to be completed for residents that have side rails.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of overbed light fixtures in seven resident rooms. Storing items on the overbed light creates a hazard of the items falling on the resident below, and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 86.</p> <p>The facility did not provide a policy regarding storing objects on resident light fixtures.</p> <p>1. Observation on 08/26/25 of resident rooms showed:</p> <ul style="list-style-type: none"> <li>- At 12:30 P.M., room [ROOM NUMBER] Bed B with a picture on the overbed light;</li> <li>- At 1:13 P.M., room [ROOM NUMBER] Bed A with two ball caps on the overbed light;</li> <li>- At 1:15 P.M., room [ROOM NUMBER] Bed C with a stuffed fish and an orange blanket folded up on the overbed light;</li> <li>- At 2:05 P.M., room [ROOM NUMBER] Bed B with several hats across the overbed light.</li> </ul> <p>2. Observation on 08/27/2025 of resident rooms showed:</p> <ul style="list-style-type: none"> <li>- At 10:30 A.M., room [ROOM NUMBER] Bed A with a picture on the overbed light and Bed B with a necklace on the overbed light.</li> </ul> <p>3. Observation on 08/29/25 of resident rooms showed:</p> <ul style="list-style-type: none"> <li>- At 5:00 P.M., room [ROOM NUMBER] Bed A with stuffed animals, papers, popsicle stick art, and various other items on the overbed light;</li> <li>- At 5:01 P.M., room [ROOM NUMBER] Bed A with a framed photo and canvas art on the overbed light.</li> </ul> <p>During an interview on 08/29/25 at 7:30 P.M., the Administrator, Director of Nursing, and Director of Operations said they would expect lights to be free from objects.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2025
NAME OF PROVIDER OR SUPPLIER  Maple Grove Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Corisande Hills Road Fenton, MO 63026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on interview and record review, the facility failed to provide the required trainings for three of three sampled Certified Nurse Aides (CNAs). This deficient practice had the potential to affect all residents. The facility census was 86. The facility did not provide a policy regarding the required annual nurse aide training requirements. 1. Review of CNA F's in-service record showed:- A hire date of 11/25/24;- No documented hours of in-services from 11/25/24 through 08/15/25;- No documented training on dementia care/management, abuse prevention, neglect, areas of weakness that might need extra training, special needs of residents or training for cognitively impaired residents. 2. Review of CNA G's in-service record showed:- A hire date of 07/16/24;- A total of 51 in-services dated from 09/20/24 through 08/15/25;- No documented training on dementia care/management, special needs of residents, or training for cognitively impaired residents. 3. Review of CNA N's in-service record showed:- A hire date of 07/01/24;- A total of 46 in-services dated from 09/20/24 from 08/15/25;- No documented training on dementia care/management, special needs of residents, or training for cognitively impaired residents. During an interview on 08/29/25 at 2:10 P.M., the Lead CNA/Staffing Coordinator said he/she has multiple in-services a week, most of the time three per week. They include handwashing, bedside manners, patient care, and lift use. They reeducate often. During an interview on 08/29/25 at 7:30 P.M., the Administrator and Director of Nursing (DON) said they would expect nurse aides to have at least 12 hours of in-services a year and for the in-services to include the required trainings.</p>		