STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265430	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor View Nursing and Rehabilitation	6400 the Cedars Court Cedar Hill, MO 63016

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to perform a proper transfer from the chair to the bed for one resident (Resident #1), of four sampled residents. The facility census was 83.The facility did not provide a safe transfer policy and procedure.Observation of a video, dated 09/27/2025, from a camera in Resident #1's room, showed:At 8:08 P.M, Certified Nurse Aid (CNA) entered the resident's room and removed the foot pedals attached to the Geri-chair Resident #1 reclined in. Resident #1 begins to scream, kick out at the CNA;CNA A leaves and comes back with Certified Medication Technician (CMT) B;The resident begins to scream;As the resident continues to scream and thrash his/her extremities, CNA A lifts the resident by the back of the resident's pants while CMT B holds the resident's arms together, lifting the resident from the Geri-chair to directly over the bed. CNA A and CMT B release the resident quickly into the bed.Review of Resident #1's admission assessment showed:The resident was admitted on [DATE];Diagnoses included Traumatic Brain Injury (TBI) - (an injury to the brain causing multiple issues with cognition and the ability to process information), cognitive communication deficit (an inability to communicate and understand what is being communicated), muscle weakness, Chronic Kidney Disease (CKD), (a progressive disease in which the kidney loses the ability to filter waste), Aphasia (an inability to speak), depression, Schizophrenia (a mental disease that may lead to hallucination and delusions, and Post Traumatic Stress Disorder (PTSD) - (a mental health condition that develops after experiencing a traumatic event).Review of the resident quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 09/23/25, showed:The resident has difficulty understanding and being understood;The resident is total assist with all ADLs;The resident is cognitively intact;Review of the resident's Care Plan, last updated 08/25/25, showed:The resident is totally dependent upon staff for all ADLs;Allow the resident time to verbalize feelings, perceptions and fears with each interaction;When conflict arises, remove to a calm safe environment and allow to vent and share;Do not push the resident, step out and contact the Guardian/sister;There was no information on requirements for transfers. During an interview on 10/20/25 at 12:00 P.M., the Administrator (ADM) said Resident #1 notified his/her guardian and told him/her there had been an incident on 09/27/2025 The Guardian then called the ADM and requested to meet at the facility and watch the video. The ADM and guardian viewed the video and agreed no abuse occurred, but determined that the resident had been upset and unable to calm. The ADM said they did not do a proper transfer and did not follow the care plan.During an interview on 10/20/25 at 2:00 P.M., Licensed Practical Nurse (LPN) C said CNAs are trained to walk away if a resident is upset and unable to redirect. LPN C did not know why CNA A did not walk away.During an interview on 10/20/25 at 2:45 PM, the Director of Nurses (DON), said CNAs should use the appropriate technique for transferring the residents. She would expect a staff member to use a gait belt on a one person assist and the transfer was performed in an unsafe manner. During an interview on 10/20/25 at (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:10 P.M., CMT B said CNA A came to the hallway and asked for assistance putting Resident #1 to bed. Upon entering the room, the resident was obviously upset, and they are trained to walk away. CMT B was not sure why CNA A did not walk out and come back later, but continued with transferring the resident from the chair to the bed. CMT B said he/she was not going to assist, but then felt he/she had to step in to prevent injury to the resident because CNA A did not have a gait belt. They are trained to always use a gait belt for transferring. During an interview on 10/20/25 at 7:10 P.M., CNA A said they were told if the resident was upset and would not calm down to put the resident in the bed. CNA A said the resident had been in the chair for more than 2 hours and that is why he/she had to go to bed. The CNA A said she never uses a gait belt when she transfers Resident #1 and he/she normally does not fight her during transferring.Complaints MO2647279, 2646309