STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265539	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aegis Health and Rehabilitation	1441 Charic Drive Wildwood, MO 63021

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the facility's policy and acceptable standards of practice when staff failed to accurately complete a post (after) fall observation report for 72 hours by not obtaining current vital signs for two residents sampled (Resident #1 and #3) and failed to complete post fall observations for 72 hours for one resident (Resident #2). The facility failed to notify the physician and emergency contact when one resident (Resident #1) had a fall. The facility failed to update the residents' care plans timely after falls for two residents (Resident #1 and #3) and failed to update the care plan for one resident (Resident #2). The facility failed to document Resident #2 had a fall in the nurse progress notes. The sample was 3. The census was 62.Review of the facility's Incident and Accident policy, revised 9/1/22, showed:-Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident;-Definitions: -Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident; -An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member;-Policy Explanation: The purpose of incident reporting can include: -Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care; -Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences; -Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements; -Meeting regulatory requirements for analysis and reporting of incidents and accidents;-Compliance Guidelines: -1. Incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information; -2. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root causes; -5. The following incidents/accidents require an incident/accident report but are not limited to: -Falls; -Observed accidents/incidents; -6. In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm; -7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions; -8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events; -9. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury; -10. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document on the neurological flow sheet. Abnormal findings will be reported to the practitioner; -11. The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital; -12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information; -13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions; -15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing (DON) and/or Administrator. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/28/25, showed:-Cognitively intact;-Always continent of bowel and bladder;-Falls since admission/entry or reentry or the prior assessment, No;-Diagnoses included inflammatory bowel disease, diabetes, malnutrition, syncope (temporary loss of consciousness) and collapse. Review of the resident's care plan, in use during the survey, showed:-Focus: Resident had an actual fall, date initiated 8/14/25;-Goal: The resident will resume usual activities without further incident, date initiated 8/14/25;-Interventions: -If fall is unwitnessed or Resident hits head during fall: begin Neuro-checks x per facility protocol, date initiated 8/14/25; -On 8/5/25 resident had an unwitnessed fall in room. Encourage resident to use call light and call for assistance for transfer assist; date initiated 8/14/25; -For no apparent acute injury, determine and address causative factors of the fall, date initiated 8/14/25. Review of the risk management incident report (not part of the medical record) dated 8/5/25 at 5:45 P.M., showed:-Nursing description: Unwitnessed, resident reported fall;-Resident description: Resident reports falling in her room while trying to transfer to her wheelchair and got herself up and back into her wheelchair. Resident rolled up to nurses station to report fall. Resident reports some pain in right hip;-Immediate action taken: -Description: Nurse Practitioner (NP) notified. New order for x ray; -Resident taken to hospital: No;-Injury type: No injuries observed at time of incident;-Level of consciousness: Alert and Oriented times (x) 4 (person, place, time and situation);-Level of pain: No documentation;-Predisposing environmental factors: Clutter;-People notified: Physician on 8/5/25 at 5:55 P.M., DON on 8/5/25 at 5:55 P.M.;-Notes: -On 8/8/25, reviewed resident's fall documentation, resident reported to staff that he/she fell in his/her room and got himself/herself up. Resident complained of hip pain. Xray done: No fracture noted. Intervention: Resident reminded to call for assistance if she is feeling weak or light headed prior to attempting to ambulate. Review of the resident's progress notes, showed no nursing progress notes the resident had a fall on 8/5/25. Review of the resident's pain evaluation, showed:-Effective date: 8/5/25 at 8:00 P.M.;-Should a pain interview be conducted: Yes;-Ask resident: Have you had pain or hurting at any time in the last 5 days?: Yes;-Ask resident: How much of the time have you experienced pain or hurting over the last 5 days?: Almost constantly;-Ask resident: Over the past 5 days, has pain made it hard for you to sleep at night?: No;-Ask resident: Over the past 5 days, have you limited your day-to-day activities because of pain?: No;-Most Recent Pain Level (pain scale 0 - 10, 0 = No pain, 1 - 3 mild pain, 4 - 7 moderate pain, 8 - 9 is severe pain, 10 = worst pain possible): Pain level: Zero, Pain scale: Numerical, Date: 8/5/25 at 8:39 A.M.;-Frequency with which resident complains or shows evidence of pain or possible pain: Indicators of pain daily;-Received as needed (PRN) pain medications? Yes;-Describe administration patterns, any side effects and effectiveness: Hydrocodone (pain medication that treats moderate to severe pain);-Signed date: 8/13/25. Review of the resident's post fall observation, showed:-Effective date: 8/6/25 at 2:54 A.M.;-Vital Signs: -Temperature (T, normal 98.6 degrees (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not for the current day or shift. Review of the resident's post fall observation, showed:-Effective date: 8/7/25 at 2:58 A.M.;-Vital Signs: -T, 97.7 degrees F, date 7/8/25 at 10:09 A.M.; -P, 78, date 7/8/25 at 10:09 A.M.; -R, 16, date 7/8/25 at 10:09 A.M.; -Most recent BP 85/58, 7/24/25 at 5:29 P.M.;-Pain:-Most Recent Pain Level: -Pain level: 0, Date: 8/6/25 at 7:43 P.M.;-Does the resident or caregiver report a change in pain level (new or worsened)?: No;-If resident has pain, what is the current pain management regimen? No changes in pain reported;-Post fall observation:-Injury: Has there been any reports of swelling, bruising or other signs/symptoms of injury since the event? Yes;-Cognition: Does the resident or caregiver report a change in mental status or cognition? No;-Function: Does the resident or caregiver report a change in ADL ability or mobility? No;-Orders: Has there been any change in physician orders related to this event? No;-Sleep Patterns: Has the resident or care giver reported any change in sleep pattern such as inability to stay asleep or frequent waking? No;-Date signed: 8/9/25;-Vital signs documented T, P, R, BP and pain were not for the current day or shift. Review of the resident's post fall observation, showed:-Effective date: 8/8/25 at 11:19 A.M.;-Vital Signs: -T, 97.7 F, date 7/8/25 at 10:09 A.M.; -P, 78, date 7/8/25 at 10:09 A.M.; -R, 16, date 7/8/25 at 10:09 A.M.; -Most recent BP 85/58, 7/24/25 at 5:29 P.M.;-Pain:-Most Recent Pain Level: -Pain level: 2, Date: 8/8/25 at 9:10 A.M.;-Does the resident or caregiver report a change in pain level (new or worsened)?: No;-If resident has pain, what is the current pain management regimen? No changes in pain reported;-Post fall observation:-Injury: Has there been any reports of swelling, bruising or other signs/symptoms of injury since the event? Yes;-Cognition: Does the resident or caregiver report a change in mental status or cognition? No;-Function: Does the resident or caregiver report a change in ADL ability or mobility? No;-Orders: Has there been any change in physician orders related to this event? No;-Sleep Patterns: Has the resident or care giver reported any change in sleep pattern such as inability to stay asleep or frequent waking? No;-Date signed: 8/9/25;-Vital signs that were documented T, P, R, and BP were not for the current day or shift. Review of the resident's medical record, showed no neuro checks completed for fall on 8/5/25 (unwitnessed fall). 2. Review of Resident #1's MDS, dated [DATE], showed:-Cognitively intact;-Frequently incontinent of bowel and bladder;-Falls since admission/entry or reentry or the prior assessment, No;-Diagnoses included diabetes, malnutrition, anxiety, depression, cognitive communication deficit and need for assistance with personal care. Review of the resident's care plan, in use during the survey, showed:-Focus: Resident is at risk for falls, revised 5/8/25;-Goal: Resident will be free of falls through the review date, revised 5/28/25;-Interventions: -Anticipate and meet the resident's needs, date Initiated 4/11/24; -Be sure the resident's call light is within reach and encourage the resident to use itfor assistance as needed. The resident needs prompt response to all requests for assistance, date initiated 4/11/24; -The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide rails as ordered, handrails on walls, personal items within reach, revised 5/7/25; -No interventions listed for fall on 8/15/25. Review of the resident's progress notes showed:-On 8/15/25 at 8:39 P.M., Resident stated that he/she was trying to put himself/herself in bed from his/her wheelchair on his/her own, but with Certified Nurse Aide (CNA) staff as a stand by assist (SBA, the presence of another person within arm's reach required to prevent injury) as the resident attempted to transfer himself/herself CNA noticed the resident was struggling, so the CNA grabbed resident and guided him/her to the floor preventing a fall. The nurse was called in after episode was over and resident stated that CNA helped him/her to regain his/her balance by guiding him/her to the floor. The nurse got resident in bed with no other issues to report;-No notifications to the physician or emergency contact (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. Review of the resident's medical record, showed:-No pain evaluation completed;-Post fall observations completed for the 72 hours after the fall. During an interview on 9/16/25 at 8:22 A.M., the Administrator said if a resident lost his/her balance and needed to be lowered to the floor by a CNA, that would be considered a fall. He said if something happened that caused the resident to lose balance, he would want that documented and followed up on. He said the care plan may need to be updated and the resident may need to be evaluated by therapy. Interventions need to be looked at to make sure it doesn't happen again. During an interview on 9/16/25 at 11:30 A.M., the Regional Nurse Consultant (RNC) said a fall is considered an unintentional change in plane. She said if a resident loses his/her balance during a transfer and the CNA has to lower the resident to the floor, that is considered a fall. 3. Review of Resident #3's MDS, dated [DATE], showed:-Cognitively intact;-Occasionally incontinent bladder;-Frequently incontinent of bowel;-Falls since admission/entry or reentry or the prior assessment, No;-Diagnoses included high blood pressure, diabetes, depression, muscle weakness and need for assistance with personal care. Review of the resident's care plan, in use during the survey, showed:-Focus: Resident is at risk for falls, revised 5/28/25;-Goal: Resident will have reduced risk of falls and falls with major injury through the review date, revised 5/28/25;-Interventions: -Dycem (brand of non-slip material used to enhance grip and prevent sliding) to wheelchair, date initiated 1/24/25; -Anticipate and meet the resident's needs, date Initiated: 1/24/25; -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, date initiated 1/24/25; - Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair, date initiated 1/24/25;-Focus: Resident had an actual fall with minor injury, date initiated 4/27/25;-Goal: Resident will resume usual activities without further incident through the review date, revision date 5/28/25;-Interventions: -If fall is unwitnessed or Resident hits head during fall: begin Neuro-checks per facility protocol, revision 4/28/25; -Reeducate resident in wheelchair positioning for safety, date initiated 4/27/25; -Check range of motion per facility protocol and PRN, revision 4/28/25; -Monitor/document /report PRN for 72 hours to physician for signs and symptoms of pain, bruises, change in mental status, any new onset: confusion, sleepiness, inability to maintain posture, agitation, date initiated 4/27/25; -On 8/3/25, Resident was in electric wheelchair outside leaning over to pick up cell phone from ground, minor injury. Advised resident to ask for help even when sitting outside, date initiated: 8/22/25;-Intervention for fall on 8/3/25 not implemented timely. Review of the risk management incident report (not part of the medical record), dated 8/3/25 at 3:10 P.M., showed:Incident description: Resident checked out at the front desk to go outside at 2:20 P.M. Resident was told to stay under the awning by this nurse. Vehicle was emitting exhaust fumes while the resident was outside. The resident stated he/she was going across to the sidewalk because of the exhaust fumes. Resident was checked on by staff throughout his/her break outside. Resident dropped his/her cell phone on the concrete. Resident bent over to pick up his/her cell phone, lost his/her balance and fell face forward out of the wheelchair onto the concrete; witnessed fall (by another resident). Staff responded immediately. Resident was found face down on the concrete with his/her right foot underneath his/her wheelchair. Staff manually lifted the chair off the resident's leg. Resident was rolled supine (lying on back) while supporting c-spine (the top seven vertebrae (C1-C7) located in your neck, just below your skull). Resident insisted on sitting up right, resident was alert and oriented (A&O) times (x) 4 (Level of awareness of (1) self, (2) place, (3) time, and (4) situation. The higher the number, the better oriented a person is considered. Healthcare providers score a person's orientation on a scale of 1 to 4.) baseline. 911 was called and Emergency Medical Services (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	balance, and fell face-forward out of chair onto concrete (witnessed);-Injuries: Laceration to left eyelid (sutured with dissolvable sutures) Abrasion to left forehead 2 x 2 inch hematoma on right forehead/hairline;-Immediate Care: C-spine supported, EMS called, transported to emergency room;-CT head: Negative; laceration repair;-Returned to facility; ice packs for pain/swelling, wound care instructions;-Current Orders: Monitor hematoma. Keep left eyelid wound clean/dry. Review of the resident's post fall observation, showed:-Effective date: 8/4/25 at 1:06 P.M.;-Vital Signs: -T, 97.6 F, date 8/1/25 at 9:22 A.M.; -P, 66, date 8/3/25 at 8:24 A.M.; -R, 20, date 8/1/25 at 8:27 A.M.; -Most recent BP 146/82, 8/4/25 at 10:16 A.M.;-Pain:-Most Recent Pain Level: -Pain level: 5, Date: 8/4/25 at 1:06 P.M.;-Does the resident or caregiver report a change in pain level (new or worsened)?: No;-If resident has pain, what is the current pain management regimen? Morphine routine;-Post fall observation:-Injury: Has there been any reports of swelling, bruising or other signs/symptoms of injury since the event? No;-Cognition: Does the resident or caregiver report a change in mental status or cognition? No;-Function: Does the resident or caregiver report a change in ADL ability or mobility? No;-Orders: Has there been any change in physician orders related to this event? No;-Sleep Patterns: Has the resident or care giver reported any change in sleep pattern such as inability to stay asleep or frequent waking? No;-Date signed: 8/4/25;-Vital signs that were documented T, P and R were not for the current day or shift. Review of the resident's post fall observation, showed:-Effective date: 8/4/25 at 9:10 P.M.;-Vital Signs: -T, 97.6 F, date 8/1/25 at 9:22 A.M.; -P, 66, date 8/3/25 at 8:24 A.M.; -R, 20, date 8/1/25 at 8:27 A.M.; -Most recent Blood pressure, BP 153/96, 8/8/25 at 7:59 A.M.;-Pain:-Most Recent Pain Level: -Pain level: 8, Date: 8/4/25 at 5:00 P.M.;-Does the resident or caregiver report a change in pain level (new or worsened)?: No;-If resident has pain, what is the current pain management regimen? No change in pain;-Post fall observation:-Injury: Has there been any reports of swelling, bruising or other signs/symptoms of injury since the event? Yes;-Cognition: Does the resident or caregiver report a change in mental status or cognition? No;-Function: Does the resident or caregiver report a change in ADL ability or mobility? No;-Orders: Has there been any change in physician orders related to this event? No;-Sleep Patterns: Has the resident or care giver reported any change in sleep pattern such as inability to stay asleep or frequent waking? No;-Date signed: 8/9/25;-Vital signs that were documented T, P and R were not for the current day or shift;-Vital signs that were documented pain was from previous shift not current shift;-Vital signs that were documented BP was listed as a future date and time from the date the assessment was completed. Review of the resident's post fall observation, showed:-Effective date: 8/5/25 at 5:12 A.M.;-Vital Signs: -T, 97.6 F, date 8/1/25 at 9:22 A.M.; -P, 66, date 8/3/25 at 8:24 A.M.; -R, 20, date 8/1/25 at 8:27 A.M.; -Most recent BP 153/96, 8/8/25 at 7:59 A.M.;-Pain:-Most Recent Pain Level: -Pain level: 8, Date: 8/4/25 at 5:00 P.M.;-Does the resident or caregiver report a change in pain level (new or worsened)?: No;-If resident has pain, what is the current pain management regimen? No change in pain;-Post fall observation:-Injury: Has there been any reports of swelling, bruising or other signs/symptoms of injury since the event? Yes;-Cognition: Does the resident or caregiver report a change in mental status or cognition? No;-Function: Does the resident or caregiver report a change in ADL ability or mobility? No;-Orders: Has there been any change in physician orders related to this event? No;-Sleep Patterns: Has the resident or care giver reported any change in sleep pattern such as inability to stay asleep or frequent waking? No;-Date signed: 8/9/25;-Vital signs that were documented T, P, R and pain were not for the current day or shift;-Vital signs that were documented BP was listed as a future date and time from the date the assessment was completed. During an interview on 9/16/25 at 10:01 A.M., the resident said he/she had a fall on 8/3/25 outside. The resident said he/she dropped his/her cell (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265539	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aegis Health and Rehabilitation	1441 Charic Drive Wildwood, MO 63021

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone on the ground and when he/she bent over to pick up the cell phone, the sleeve of his/her shirt caught the controller for his/her electric wheelchair, and he/she had not powered down the chair. The sleeve caused the wheelchair to go backwards, and he/she fell forward. The resident said staff called 911 and he/she went to the hospital. The resident said after he/she returned to the facility the same day, the staff did not come in and take his/her vital signs to monitor him/her. The resident said the staff did not monitor his/her vital signs for three days after the fall. 4. During an interview on 9/16/25 at 8:22 A.M., the Administrator said when a resident falls, he expected the nurse to assess the resident. He expected the nurse to complete a risk management incident report, complete the post fall assessment for 72 hours. He preferred that falls were documented in a nurses note but if a nurses note was not completed regarding the fall, the information would be in risk management. Neuros are to be completed if a resident has an unwitnessed fall or if the resident hit their head. During an interview on 9/16/25 at 11:13 A.M., the RNC said when a resident has a fall, she expected the nurse to assess the resident, complete a risk management incident report, make notifications to the physician, and family, transcribe and new orders the physician may give. If there is not a nurse progress note regarding the fall, the information can be found in the risk management incident report. After a fall