STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary behavioral health care services for four residents' psychosocial well-being when staff did not address the resident's behaviors, which included repeatedly violating the Drug and Alcohol Abuse, Out on Pass, Visiting and Contraband policies and demonstrating physical and verbal aggression toward other residents and staff (Residents #4, #1, #7 and #5). The sample was 11. The census was 80. Review of the facility's behavior management policy, revised June 2020, showed:-Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. To ensure facility staff performs a timely and appropriate assessment of the resident's behavioral symptoms and implement appropriate interventions before and after the resident begins taking psychotherapeutic medications. The facility is responsible for providing behavioral health care and services which create an environment to promote emotional and psychosocial well-being, meet each resident's needs and include individualized approaches to care;-Upon observing the adverse behavioral symptom, staff will do the following as indicated: -Ensure the safety of the resident as well as all other residents; -Document the incident on the 24-hour report.-The Charge Nurse will assign a staff member(s) to monitor/shadow the resident as needed;-Such monitoring is for the protection of the resident as well as all others, and is not meant to restrict their movement or mobility;-Nursing Staff will continue to monitor the resident's behavior to determine what event(s), if any, precipitated the behavior and document the following information as indicated:-Date and time of behavior;-Location of resident when the behavior occurred;-Description of the behavior (e.g., what the resident said or did and if the behavior intensified);-Non-verbal cues;-What seemed to cause the behavior; and -Any interventions used and their effect.-In assessing the resident for potential causal factors, licensed nursing staff will consider the following factors and document their findings in the medical record:-Physical conditions (e.g., pain or discomfort, hunger or thirst, fatigue, toileting needs, incontinence);-Environmental conditions;-Psychosocial or emotional stressors (e.g., change in resident's customary routine, loneliness, frustration, fear of the unknown, possible abuse by staff or other residents, incompatibility with roommate, inability to communicate needs, lack of support system, loss of control due to changes in physical condition);-Medical conditions that require treatment; -Mental health conditions, which may contribute to resident's behavior;-It is also important for the facility to use an interdisciplinary team (IDT) approach which includes the resident, their family, or resident representative. Review of the facility's Out on Pass policy, revised August 2020, showed:-It is the policy of the facility to meet resident's physical and psychosocial needs to go out on pass. The facility will make reasonable efforts to ensure the resident's safety and uphold residents rights;-When a resident requests to go out on pass, the IDT will assess the resident's ability to participate in activities (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:03 P.M., LOA;-On 12/4/25 at 5:28 A.M., the resident outside of building smoking with peer from facility;-On 12/6/25 at 1:30 P.M., the resident requested 4:00 P.M., dose stating he/she was leaving facility and would not be back before 4:00 P.M. The Nurse gave the resident the medication, he/she got on the elevator with his/her significant other and returned to his/her room alone 10 minutes later. Review of the resident's care plan, dated 12/9/25, showed:-No documentation of the resident bringing his/her friend into the facility all hours of the day and interventions staff should provide if he/she refused to leave;-No documentation of the resident leaving the facility throughout the day without signing in or out and what interventions staff should provide if the resident did not return to the facility when expected;-No documentation of the resident bringing contraband into the building and what interventions staff should provide to prevent this to ensue the safety of residents who might wander into the resident's room;-No documentation of behavioral interventions put in place to deal with the resident's refusal to follow facility policies. Observation and interview on 12/10/25 at 11:00 A.M., showed Licensed Practical Nurse (LPN) C knocked on the resident's door and asked to enter the room. The resident opened the door and immediately reached over and shut the bathroom door. The resident said his/her friend was in the bathroom. The resident said the friend was his/her boy/girlfriend and he/she only visited during the day. When asked if the Nurse and the surveyor could meet the friend, the resident went into the bathroom and shut the door. While standing in the resident's room waiting for him/her to come out of the bathroom with his/her guest, observations were made of the room. In the corner of the room, sat a large white 5-gallon bucket of black wires. On the resident's bed were two lighters and a small metal tube. On the resident's bedside table sat a plastic package of long thin utility blades. In the resident's open drawer were two box cutters with blades in them, a set of metal pliers and a full pack of cigarettes. During interviews on 10/10/25 at 10:30 A.M. and 11:30 A.M., LPN C said when the resident first admitted , he/she pretty much kept to him/herself. Then he/she started bringing the guest in overnight. The friend was staying in the facility pretty much all the time and the resident would hide him/her in the bathroom if staff knocked on the door. The resident got hostile if anyone said anything to him/her about the guest and denied having him/her in the room. The resident would ask for two doses of his/her suboxone at once saying he/she was going to be leaving the facility but would then not leave. If the LPN refused or said he/she was going to call the resident's Physician, the resident would make threats to him/her. The staff do not know if he/she is taking the medication or if he/she is giving it to his/her friend. The LPN reported this to the DON but was told the resident is his/her own responsible party, so they are to give him/her the medication if he/she requests it and says he/she is leaving the building. The LPN tried calling the resident's Physician a couple of times, but the DON told him/her the resident had an order to take his/her medications out on pass, so the Physician did not need to be called each time. The resident leaves out at all hours of the day, and when he/she returned, sometimes he/she acted strangely and more aggressive. The LPN could not assess the resident because he/she would not let the nurse in his/her room and would become threatening if he/she tried to talk to him/her. The DON notified all of the staff that they were not supposed to go back and forth with the resident. They just stayed out of his/her room and left him/her alone. The staff knew the resident brought items in from the community like the wires and the boxcutter. The Administrator would remove them, but then the resident would go right out and get more. The Nurse was not given any instructions on what to do when administration was not in the building and the resident got aggressive. He/She worried for the safety of the residents and staff. During an interview on 12/12/25 at 12:40 P.M., Certified Nurse's Aide (CNA) B said there have been issues with the resident because he/she sneaks the guest into the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	building at night when all the bosses are gone. The staff do not confront him/her because he/she is aggressive. The CNA knew he/she brought in scraps and junk from outside the facility like the boxcutter and the staff would remove it if they saw it, but the resident did not want staff going in his/her room. During an interview on 12/12/25 at 12:15 P.M., CMT E said the resident brings his/her guest into the facility after hours when administration is gone. The staff had been told the guest had to leave by 10:00 P.M. or they should call the police if he/she did not leave. The CMT did not work evenings, so he/she had not had to ask the guest to leave. He/She knew the resident brought a boxcutter into the facility. The resident was always bringing stuff into the facility. He/She did not know who was supposed to monitor the room for contraband. He/She thought it would be housekeeping since they would have access to the resident's room. He/She had been told they could not search a resident's room unless they had permission. During an interview on 12/12/25 at 9:10 A.M., the Social Worker said the resident's behavior is sneaky. He/She goes out in the community and brings multiple things back into the facility and hoards them in his/her room. She knew the resident had a guest that stayed in the room sometimes. Administration had gone in there and talked to him/her about it and told the resident it was okay if the guest stayed longer if the resident let the Administrator know when it was going to happen. Then it became a problem. She knew the resident was leaving the facility at all hours of the day and night, but a person was going to do what they were going to do. She had offered a drug rehabilitation program to the resident, but he/she had declined it. The psychiatrist came to the facility once a month and saw residents, but this resident was never in the building when they came. She did not know there was a problem with the resident bringing contraband into the facility. The resident was not on a behavior contract because he/she was not displaying any behaviors. When he/she was in the facility, he/she stayed in his/her room. She knew the facility had issued a 30-day discharge to the resident and thought it was due to his/her not following the facility rules. She did not believe they could meet the resident's needs, as he/she was non-compliant with the facility's policies. During an interview on 12/12/25 at 1:00 P.M., the DON said the resident is volatile. The Administrator had talked to him/her numerous times about the rules and had removed several items out of his/her room. Staff do not go in his/her room because of his/her demeanor. He/She would put you out of the room and[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. Staff failed to accurately and thoroughly document the controlled substance shift change inventory tracker sheets, for one of the two facility floors. The census was 80.Review of the facility's Controlled Substance Prescriptions policy, revised August 2020, showed the following:-Policy: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations;-The Director of Nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications;-Documentation of a Controlled Substance Prescription: --Each controlled substance prescription is documented in the resident's medical record with the date and time of receipt and the signature of the person receiving the prescription. The prescription is recorded on the physician order sheet or telephone order sheet or posted elsewhere in the record and recorded on the Medication Administration Record (MAR); --Each prescription is recorded in the patient's health record in accordance with facility policy;-Security and Recordkeeping: --Controlled substances are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents. The pharmacy will include an individual resident-controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident unless directed otherwise by the facility; --Controlled substance medications are stored at the facility under double lock or as required by state regulations, separate from all other medications and counted at each change of custody or in accordance with facility policy. The access key to controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. Back up keys to all medication carts may be obtained from the provider pharmacy. Review of the facility's Shift Change Controlled Substance Inventory Count Sheet on 12/12/25, showed:-Nurse coming on to shift must verify count of all controlled substances with nurse coming off shift or any time the medication cart keys are exchanged;-Nurses must count total number of cards/containers and total number of count sheets, both for individual residents and applicable contingency supplies with controlled drugs;-Nurses must verify actual drug counts (#tabs, caps, patches, vials etc.) against each individual resident count sheet;-Any discrepancies must be reported immediately to director of nursing or nursing supervisor;-Every controlled substance medication and count sheet added or removed from the medication cart must be documented below;-There were areas to document the date, shift/time, nurse signatures, total number of cards/containers, total number of count sheets, medication and count sheets added (with space for the resident's name, medication and strength, and number of cards and count sheets) and medications and count sheets removed (with resident's name and medications). Review of the first floor Shift Change Controlled Substance Inventory sheets for 11/1 through 11/30, showed:-On 11/2/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/3/25, one nurse signature for the morning shift change;-On 11/4/25, one nurse signature for the evening shift change;-On 11/6/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/7/25, one nurse signature for the morning shift change and one nurse signatures for the evening shift change;-On 11/8/25, one nurse signature for the evening shift change;-On 11/9/25, one nurse (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signature for the morning shift change and nurse signature for the evening shift change;-On 11/11/25, one nurse signature for the morning shift change;-On 11/12/25, no documentation of any nurse signatures for the evening shift change;-On 11/17/25, one nurse signature for the morning shift change. No documentation of any nurse signatures for the evening shift change;-On 11/19/25, one nurse signature for the morning shift change;-On 11/20/25, no documentation of nurse signatures for the morning shift change and no nurse signature for the evening shift change;-On 11/21/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 11/23/25, one nurse signature for the evening shift change;-On 11/24/25, one nurse signature for the evening shift change;-On 11/25/25, one nurse signature for the evening shift change;-On 11/26/25, one nurse signature for the morning shift change. Staff documented the total number of cards at 24 for the morning shift and 25 for the evening shift, with no documentation of a resident's medication added;-On 11/27/25, one nurse signature for the evening shift change. Review of the first floor Shift Change Controlled Substance Inventory Sheets for 12/1 through 12/12/25, showed:-On 12/3/25, no documentation of any nurse signature for the evening shift change;-On 12/4/25, one nurse signature for the evening shift change;-On 12/5/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 12/7/25, one nurse signature for the morning shift change and one nurse signature for the evening shift change;-On 12/9/25, one nurse signature for the evening shift change;-On 12/10/25, no documentation of total number of cards for the evening shift. During an interview on 12/12/25 at 11:05 A.M., Licensed Practical Nurse D said he/she is supposed to count the narcotics on his/her floor at the beginning of his/her shift and at the end of his/her shift with another nurse. They are both supposed to sign off on the narcotic inventory tracker sheet. He/She always does this when he/she works. He/She never counts the narcotics by him/herself. If there was a signature missing when he/she worked, then the other staff member who was supposed to sign off with him/her must have forgotten to sign the sheet. During an interview on 12/12/25 at 1:20 P.M., the Director of Nursing said she expected staff to count the narcotics and sign off on the controlled substance inventory tracker. She expected this to be done at the beginning of each shift and when they opened the narcotic box for any reason. This documentation would be signed off by two nurses. During an interview on 12/12/25 at 2:10 P.M., Administrator B said he expected the nursing staff to count the narcotics and sign off on the controlled substance inventory tracker before they accepted the keys from outgoing staff. This should also be done if staff opened the narcotic box for any reason during the shift. He would have expected two nursing staff members to sign off on every entry.