STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265852	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Chateau	811 North 9th Street Saint Joseph, MO 64501

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one resident to return to the facility without a documented reason that the resident's needs could not be met (Resident #1). This affected one resident of five residents sampled. The facility's census was 68.Request for the facility policy on Transfers and Discharges was not provided by the facility. 1. Review of Resident's admission Record, dated 9/11/25, showed:- Resident had a court appointed guardian as the responsible party;- Diagnosis included: major depressive disorder, diabetes, pulmonary disease (respiratory system), traumatic brain injury, Parkinson's disease, anxiety disorder, and paranoid schizophrenia;Review of Resident's Care Plan, revised on 8/21/25, showed:- Resident was adjusting to new surroundings and would like help getting comfortable in his/her new home. Staff should help resident maintain preferences in his/her daily living;- Resident and Guardian wish for resident to stay at the facility long term; Staff to evaluate discharge and long-term care goals annual and as needed;- Resident had the right to refuse cares;- Behaviors: Resident had a history of attention seeking behaviors;- Resident had made statements of self harm. Staff interventions to monitor closely, search room for dangerous items, send resident out for mental evaluation, utilize talk therapy, and provide medications as prescribed;- If Resident makes statements of self-harm, inform charge nurse and doctor immediately. Staff to take all reports of self-harm seriously and follow up on them;- Resident had history of depression and anxiety, administer medications as ordered and psychiatric services as needed;- Resident was at risk for elopement related to wandering;- Resident had the right to to remain in the nursing facility unless a transfer or discharge was ordered by the physician;- Resident had schizophrenia and takes antipsychotic medications and is at risk for behaviors and adverse effects of medications. Staff monitor for increased behaviors and report to physician or psychiatric services.Review of Resident's Physician Order Summary Report, dated 9/11/25, showed:- On 6/5/25 order to monitor for adverse reactions for use of antidepressant medications;- On 8/19/25 order to monitor for adverse reactions for use of antipsychotics;- On 6/5/25 order to record type of behaviors and number of episodes;- On 3/5/25 order refer to Hospital Psychiatric Outpatient Services;- On 5/5/25 or for restorative program three times weekly for walking as a therapeutic activity.Review of the Resident's Progress notes, showed:-On 6/19/25 documentation by Psychiatric-Mental Health Nurse Practitioner showed resident had previously been sent to ER for making suicidal statements. He/she displays significant drug seeking behaviors, and had moderately severe depression. Resident denied Suicidal Ideation (SI): Chronic baseline SI, no plan or intent expressed;-On 7/30/25 documentation by Psychiatric-Mental Health Nurse Practitioner showed chronic baseline SI, no plan or intent expressed;-On 8/2/25 documentation by Psychiatric-Mental Health Nurse Practitioner ordered to increase trazadone and nortriptyline to help resident with his/her anxiety;-On 8/4/25 at 10:10 P.M. The Director of Nursing (DON) reports resident reported SI;-On 8/4/25 at 10:22 P.M. The resident was transported to emergency facility for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation;-On 8/5/25 at 7:02 A.M. The resident returned to the facility accompanied by emergency medical services, no new orders;-On 8/5/25 at 8:37 A.M. Lab report from medical facility showed resident tested positive for UTI, cipro 500 MG ordered;-On 8/5/25 at 11:22 A.M. The Social Services Director (SSD) documented the resident had requested to move to another facility and SSD said they would try to accommodate the request with their guardian;-On 8/13/25 documentation by Medical review by Psychiatric-Mental Health Nurse Practitioner showed resident's mood appeared to be good and he/she was not tearful and smiled throughout the conversation. He/she did not appear to be overly anxious and did not display clinical symptoms of anxiety. -On 8/19/25 at 11:03 A.M. The Guardian was contacted and consented to current psychotropics that resident was taking;-On 8/20/25 at 12:25 P.M. The SSD documented that resident stated he/she did not have any urges to hurt himself/herself;-On 8/21/25 Psychotherapy visit documentation showed: The resident continues to be challenged by symptoms of anxiety and depression and demonstrates some disruptive behaviors. Resident was motivated to participate in psychotherapy and was cognitively able to benefit from treatment. Resident symptoms have had variable improvement and treatment goals have not been completed yet. Continue current treatment plan since progress towards treatment goals is evident, ongoing support will be necessary to maintain therapeutic gains;-On 8/29/25 at 6:45 P.M. the police arrived with a social worker stating the resident had called into the suicide hotline. Upon evaluation it was decided the resident needed to be seen at a facility emergency room for a full evaluation; -On 9/2/25 The Resident transferred to emergency room for SI;-On 9/2/25 at 10:17 A.M. Search of resident's room showed no dangerous items or medications;-On 9/2/25 at 10:41 A.M. Social Services and nursing staff requested guardian's permission to send referrals to alternative placements for the resident. Guardian agreed to facility attempting to find alternate placement;-On 9/5/25at 13:39 P.M. documentation showed One facility out of eight referrals for Skilled Nursing Facility agreed to accept resident. Discharge orders and pharmaceutical orders completed and signed. emergency room facility agreed to keep resident until resident's discharge on [DATE]. Guardian updated and agreed to transfer;-On 9/8/25 at 15:17 P.M. The Resident was then transferred to new accepting skilled nursing facility (SNF).Review of the Resident's Medical Record showed:- No discharge instructions, recapitulation of resident's stay, final summary status, or reconciliation of medications provided to the Guardian;- Discharge Notification, undated, showed the attending physician approved the discharge for 9/8/25 at 9:30 A.M. to another skilled nursing facility without providing any reason for the discharge;Record review of communication to the Guardian on 9/4/25 at 2:18 P.M., the Assistant DON (ADON) documented:- Resident is currently inpatient at a Mental Health Hospital. Due to resident making statements of SI, our team believes it in in his/her best interest not to return. The facility believes the Resident needs a higher level of care than we can provide due to ongoing SI. The facility admissions team will reach out to the Mental Health Hospital to communicate that the facility and the Guardian are in agreement with the resident not returning;Review of communication via email between the ADON, Administrator, and SSD on 9/4/25 at 2:56 P.M., the Guardian (A) said:- The Guardian agreed to allow the facility to look for an intake program for mental health evaluation while also looking for other permanent placement locations. The Guardian did not agree that the resident would not be returning to the facility while this search was ongoing. It is the Guardian's expectation that if there is no alternative setting to place the resident temporarily or otherwise, the resident will be returned to the facility. The SSD had already reassured the Guardian previously that the resident would indeed be accepted back until efforts to relocating him/her were successful.Record review of communication to the Guardian on 9/4/25 at 3:03 P.M., showed the facility had come to the conclusion that they cannot provide the level of safety that the resident (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required.During an interview on 9/11/25 at 3:15 P.M., the Mental Health Hospital RN (A) said:- Initially on 8/29/25 when the resident was transferred to the Mental Health Hospital, the facility said the resident required a psychiatric evaluation for SI and that he/she would be returning back to the facility;- On 9/4/25 the SSD at the facility contacted the Mental Health Hospital and said they would not take the resident back because they could not make it safe for him/her due to the resident's statements about SI. The hospital's viewpoint was that this was a common verbal behavior from the resident, and he/she was not in any danger and could be transferred back to the facility;- The Guardian at no time communicated through the Mental Health Hospital or during numerous conversations that they wanted or initiated a transfer of the resident from their home at the facility to a new skilled nursing facility (SNF);- The resident had a diagnosis of anxiety and his/her mother and sister both live in the city of his/her current facility. Transferring the resident to the new SNF would place the resident at least one hour away by car from his/her family.During an interview on 9/11/25 at 10:40 AM., the Guardian (A) said:- The facility was informed that any plans to discharge the resident would require a 30-day notice. The SSD and ADON were informed that he would appeal the discharge if they did not provide a 30-day notice and not return the Resident back to the facility;- The Guardian never received a notice of discharge for the resident;- The Guardian was told from the Mental Health Hospital that the facility was not going to take the resident back on 9/5/25;- The facility found another SNF to take the resident and since the resident was not being allowed to go back to his/her home he then only agreed to transfer the resident to the new SNF;- The Guardian met with the resident at the Mental Health Hospital and the resident was agreeable to go back to their room at the facility;- The Guardian does not know much about the new facility due to the short lead time of the SNF accepting the resident and the subsequent transfer by the resident's facility;- The Guardian felt pressured to accept the new SNF for the resident due to the circumstances imposed by the resident's home facility of not wanting to take the resident back;- The Mental Health Hospital sent a discharge plan to the Guardian. The Guardian never received any information on the Ombudsman or his/her right to appeal the transfer from the resident's home facility.During an interview on 9/11/25 at 12:35 P.M., the SSD said:- The resident stated he/she wanted to go to another facility because this one didn't meet his/her mental intellect;- The facility got permission from the Guardian to send out referrals because the resident did not want to return to the facility. The reason the resident was being transferred is because they didn't want to transfer;- The resident is not their own person, he/she had a guardian;- The resident had a history of going back and forth on their decisions and wants;- The resident wanted more traditional long-term care and there was no input obtained from the Guardian on where he/she needed to go;- The resident needs diabetic care, ADL assistance, daily monitoring and coping mechanisms for the resident's behaviors. The accepting SNF did not say anything about the SI of the resident when agreeing to accept him/her. The SSD did not screen the SNF to make sure they had all of the services in place to take care of the resident, she expected the accepting SNF to properly review the resident's needs to make sure they could properly provide cares;- The Guardian was told the facility would take the resident back if there was no one that would accept the resident. The facility's main concern at the time of discharge was that the resident was going to harm himself/herself. The facility could employ one on one monitoring to assure the resident's safety;- The Guardian wanted the resident to transfer and gave permission because the resident wanted to transfer from the facility;- Discharge planning wasn't done because the resident wanted to transfer;- A discharge notice and Bed Hold Policy was sent to the Guardian but the Ombudsman was not contacted about the transfer.During an interview on 9/11/25 at 1:05 P.M., the DON said:- The facility could take care of the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident because they have put in a lot of interventions to engage with the resident. The resident voiced concern because he/she could not leave the facility on his/her own and that was a level of independence he/she desired;- The Resident would express SI which resulted in therapy and one on one monitoring to keep the resident safe. Addressing the resident's anxiety issues was also an important factor;- All of these interventions were care planned;- The resident had the behavior of changing their mind on desires and needs from day to day;- The staff would look for other places the resident could go but then the resident would change his/her mind and they would stop looking;- During the resident's most recent hospital stay they were able to find another SNF for him/her but the facility would have taken the resident back if required;- There was not an emergency situation which required the immediate transfer of the resident due to SI;- The facility had been able to handle the last two incidents of SI with the resident. There had not been any concern that the facility could not keep the resident safe. The facility were adjusting medications as an intervention to help with the behaviors of the resident;During the investigation exit interview on 9/11/25 at 1:40 P.M., the Corporate Representative for the facility said:- The resident is not their own person but they can be transferred from the facility if a physician deems it is in the best interest and safety of the resident;- The resident had been transferred due to SI and their potential to be a harm to himself/herself.During an interview on 9/23/25 at 12:30 P.M., Guardian (B) said:- He/she did not initiate the transfer of the resident and would have preferred that the resident did not transfer from the facility after his/her hospital discharge;- He/she had a complete record of interactions with the facility and Mental Health Facility that he/she would provide for review;Review of Guardian notes, dated 9/4-9/5/25, showed:- On 9/4/25 at 1:14 P.M. Guardian (B) received a call from the DON stating that the resident had been sent to a hospital facility for SI and persistent demands for controlled medications. The DON asked permission to send referrals to seek other treatment facilities or placement for him/her. Guardian (B) stated that he/she would authorize sending referrals for another temporary treatment or mental health unit for mental evaluation. - On 9/4/25 at 2:36 P.M. The Mental Health Hospital called and said the resident is ready to transfer back to the resident's facility tomorrow. The doctor reported the resident still has some SI and requests that a mouth check be done when the resident takes his/her medications, and he/she is watched if he/she is given a razor. - On 09/4/25 at 3:00 P.M. Guardian (C) visited with the resident and the resident stated he/she wanted to go back to the facility. Guardian (C) was informed by Mental Health Hospital RN (A) that the resident's facility was refusing to readmit him/her because of his/her SI and they are currently seeking other placement for the resident.- On 9/5/25 at 9:43 A.M. Mental Health Hospital RN (A) told Guardian (B) that the resident was ready to discharge today. Guardian (B) relayed that Guardian (C) had spoken with the facility SSD yesterday and it was agreed that the resident would go back to his/her facility today. - On 9/5/25 at 10:25 A.M. Guardian (B) received a call from the facility Corporate Representative (CR) (B) who wanted to discuss the involuntary discharge of the resident. It was explained by Guardian (B) that an involuntary discharge was unacceptable, and he/she would consider a temporary transfer to a psychological hospital for mental evaluation for the resident. Guardian (C) had worked out with the facility SDD yesterday that the facility would take the resident back and he/she would require a 30-day notice of discharge. CR (B) said the facility would need to do one on one monitoring on the resident until the resident relocates and he/she would have to discuss this with the facility Administrator.- On 9/5/25 at 10:30 A.M. CR (B) called and said the facility could not take on the liability of the resident and was refusing to take him/her back. The facility was reminded by Guardian (B) that they would have to send a 30-day discharge notice and could not just leave the resident or refuse to (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return him/her to the home facility. CR (B) said they did not have staffing to monitor the resident one on one until he/she was discharged to a new facility. Guardian (B) reminded the facility of the regulations and requirements for a discharge of the resident. CR (B) said that the facility would just have to take the deficiency in this case.- On 9/5/25 at 11:40 A.M. Resident called asking if they were looking for a new place for him/her to go to since the facility would not take him/her back.- 9/5/25 at 12:01 P.M. Mental Health Hospital RN (A) informed Guardian (B) that the home facility would not take the resident back. Guardian (B) asked Mental Health Hospital RN (A) to put in a hotline complaint with the Department of Health and Senior Services since they had not gotten a 30-day notice and it was an abandonment of the resident. - 9/5/25 12:32 P.M. Received a call from the SSD saying another SNF would accept the resident. Guardian (B) agreed to the transfer since there was nowhere else for the resident to go from the Mental Health Hospital. Complaint 2609355

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written 30-day notice of discharge, the bed hold policy, a discharge summary, and the reason for discharge to one resident's (Resident #1) representative in writing out of the 5 residents sampled, and additionally failed to provide the statement of appeal rights, or the name, address, or telephone number of the Office of the State Long Term Care Ombudsman (advocates for the residents in nursing facilities) and failed to notify the Ombudsman that the resident was discharged . The facility's census was 68.A request was made for the facility's Discharge Policy but was not provided.1. Review of Resident's admission Record, dated 9/11/25, showed:- Resident had a court appointed guardian as the responsible party;- Diagnosis included: major depressive disorder, diabetes, pulmonary disease (respiratory system), traumatic brain injury, Parkinson's disease, anxiety disorder, and paranoid schizophrenia;Review of the Resident's Care Plan, revised 8/21/25, showed:- Resident had been adjusting to his/her new surroundings and would like help getting comfortable in his/her new home. Staff should help Resident maintain his/her preferences in his/her daily living;- Resident and Guardian wished for resident to stay at the facility long term; Staff to evaluate discharge and long-term care goals annually and as needed;- Resident had history of recent hospitalizations at a psychiatric unit facility and the psychiatrist deemed the resident as not a threat to self or others. - If Resident makes statements of self-harm, inform charge nurse and doctor immediately. Staff to take all reports of self-harm seriously and follow up on them;- Resident had the right to receive a 30 day notice of discharge/transfer which includes reason, effective date, location to which the Resident will be transferred/discharged with the telephone number of the Ombudsman;- Resident had the right to appeal the 30 day notice;- Resident had the right to remain in the nursing facility unless a transfer or discharge was ordered.Review of the progress notes, showed on 8/29/25 at approximately 6:45 P.M. the police arrived with a social worker stating the Resident had called into the suicide hotline. Upon evaluation it was decided Resident needed to be seen at a facility emergency room for a full evaluation; Review of the Resident's Medical Record showed:- No bed hold notice provided, no notification of right to appeal discharge, and No Ombudsman contact information for the transfer of Resident on 8/29/25 in the record;- No discharge instructions, recapitulation of resident's stay, final summary status, or reconciliation of medications provided to the Guardian;- A discharge notification signed by attending physician and did not contain reason for discharge.Review of request for Bed Hold Notice for 8/29/25, showed:- Social Services Director (SSD) was only able to provide an old Bed Hold Notice from 8/4/25 which was not in electronic Medical Record;- No Bed Hold Notice for 8/29/25 was provided;Record review of communication to the Guardian on 9/4/25 at 2:18 P.M., the Assistant Director of Nursing (ADON) documented:- Resident was currently inpatient at a Mental Health Hospital and due to resident making statements of SI if they are returned to the facility, the team believes it in in his/her best interest for the resident not to return. The facility believes the Resident needs a higher level of care that they are unable to provide due to ongoing SI. The facility admissions team would reach out to the Mental Health Hospital to communicate that as Power of Attorney you are in agreement with him/her not returning.Review of the progress notes, showed: -Resident transferred to emergency room facility on 9/2/25 for suicidal ideations. -On 9/2/25 at 10:17 A.M. Search of the Resident's room showed no dangerous items or medications;- On 9/2/25 at 10:41 A.M. Social Services and nursing staff requested guardian's permission to send referrals to alternative placements for the Resident. Guardian agreed to facility attempting to find alternate placement;- On 9/5/25 at 1:39 P.M. One facility out of eight referrals agreed to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accept the resident. Discharge orders and pharmaceutical orders completed and signed. emergency room facility agreed to keep resident until resident's discharge on [DATE]. The Guardian updated and agreed to transfer;- On 9/8/25 at 3:17 P.M. Resident was then transferred to another skilled nursing facility (SNF).Record review of communication between the ADON, Administrator, and SSD on 9/4/25 at 2:56 P.M., the Guardian said:- As Guardian it was agreed to allow the facility to look for an intake program for mental health evaluation while also looking for other permanent placement locations. I did not agree that the Resident would not be returning to the facility while this search was ongoing. It is my expectation that if there is no alternative setting to place the resident temporarily or otherwise that the Resident be returned to the facility. The SSD had already discussed previously about the Resident not returning to the facility when offering to send out referrals for new permanent placement and reassured me that the resident would indeed be accepted back until efforts to relocating him/her were successful.Record review of communication to the Guardian on 9/4/25 at 3:03 P.M., showed the facility has come to the conclusion that they cannot provide the level of safety that the resident requires;During an interview on 9/11/25 at 3:15 P.M., the Mental Health Hospital RN (A) said:- Initially on 8/29/25 when the Resident was transferred to the Mental Health Hospital the facility said the Resident required a psychiatric evaluation for SI and that he/she would be returning back to the facility;- On 9/4/25 the SSD at the facility contacted the hospital and said they would not take the resident back because they could not make it safe for him/her due to Resident's statements about using a razor with SI. The hospital's viewpoint was that this was a common behavior from the Resident, and he/she was not in any danger and could be transferred back to the facility;- The Guardian at no time communicated through the Mental Health Hospital or during numerous conversations that they wanted or initiated a transfer of Resident from their home at the facility to a new facility;- The Resident had a diagnosis of anxiety and his/her mother and sister both live in the city of the current facility. Transferring the Resident to the new SNF identified by the facility is one hour away by car and is not a benefit to the Resident and a hardship for his/her family to visit.During an interview on 9/11/25 at 10:40 AM., the Guardian said:- The facility was informed that any plans to discharge the resident would require a 30-day notice. The SSD and ADON were informed that he/she would appeal the discharge if they did not provide a 30-day notice and not return the Resident back to the facility;- He never received a notice of discharge for the resident;- He had been told from the Mental Health Hospital that the facility was not going to take the resident back on 9/5/25;- The facility found another Skilled Nursing Facility (SNF) to take the Resident and since the Resident was not being allowed to go back to his/her home we agreed to transfer the Resident to the new SNF;- The Guardian met with the resident at the Mental Health Hospital and the Resident was agreeable to go back to their home at the facility;- The facility did not send a discharge plan to the Guardian, the Guardian never received any information on the Ombudsman or his/her right to appeal the transfer from the Resident's facility.During an interview on 9/11/25 at 12:35 P.M., the SSD said:- The resident stated he/she wanted to go to another facility because this one didn't meet his/her mental intellect;- The facility got permission from the Guardian to send out referrals because the Resident didn't want to return to the community. The reason the Resident was being transferred is because they didn't want the resident to come back;- The Resident is not their own person, he/she had a Guardian;- The Guardian was told the facility would take the Resident back if there was no one that would accept the resident. The facility's main concern was that the resident was going to harm themselves. The facility would employ one on one monitoring to assure the Resident's safety if needed;- The Guardian wanted the resident to transfer and gave permission because the resident wanted to transfer from the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility;- Discharge planning wasn't done because the resident wanted to transfer;- A discharge notice and Bed Hold Policy was sent to the Guardian but the Ombudsman was not contacted about the transfer.During an interview on 9/11/25 at 1:05 P.M., the Director of Nursing (DON) said:- The facility could take care of the resident because they have put in a lot of interventions to engage with the Resident. The Resident voiced concerned because they could not leave the facility on his/her own and that was a level of independence he/she desired;- The Resident would express SI which resulted in therapy and one on one monitoring to keep the Resident safe. - The resident had the behavior of changing their mind on desires and needs from day to day;- The staff would look for other places the Resident could go but then the resident would change his/her mind and they would stop looking;- During the Resident's most recent hospital stay they were able to find another SNF for him/her but the facility would have taken the resident back if required;- The Resident was not in an emergency situation which required his/her immediate transfer;- The facility had been able to handle the last two incidents of SI with the resident so there wasn't a worry they couldn't keep him/her safe and they were adjusting medications as an intervention to help with the behaviors;Complaint 2609355