STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265121	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village Chesterfield	15250 Village View Drive Chesterfield, MO 63017

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** 35394 Based on observation, interview and record review, the facility failed to ensure residents were free from accident hazards after one resident (Resident #2) reported an injury to the left ankle during a Hoyer lift (full body mechanical lift) transfer. The investigation found staff reported several improper transfers had occurred in the days preceding the injury, to include the resident being transferred with a sit to stand lift (mechanical lift that requires residents to be able to stand with assistance) several days before and one Certified Nursing Assistant (CNA) reported he/she operated the Hoyer lift alone one day instead of using two staff as required. In addition, observation showed the facility failed to ensure one resident was connected properly into the Hoyer lift resulting in the wheelchair that they sat in being lifted approximately one foot into the air with the resident seated (Resident #7). The sample was 8. The census was 85. Review of the facility's Mechanical Lift policy, dated August 2019, showed: -To ensure safe and appropriate behavior transfer techniques for residents per regulatory guidelines and professional standards of practice; -Purpose: To transfer a resident using mechanical means; -To help prevent resident and staff injury; -Supplies: -Mechanical lift; -Sling; -Two staff members; -Sit to stand lift: To be transferred with a sit to stand lift, the resident must have no medical contraindications for using the lift. The resident should have the following characteristics: -Alert; -Predictable and cooperative behavior; (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Able to follow simple commands; -Can at least partially bear weight and hold on to the hand grips; -Able to lean back into the sling; -Full mechanical total lift: To be transferred with the full mechanical total lift, the resident must have no medical contraindications for using the lift. The resident should have the following characteristics: -Unable to sit erect; -Frequent unpredictable behavior/cooperative during transfers; -Located on a low bed close to the floor level; -Resident in the floor (in lying or seated position); -Total dependence and/or bedfast. 1. Review of Resident #2's physical therapy progress and discharge summary, dated 6/19/24, showed: -Diagnoses included: Contracture (rigidity or loss of range of motion of a joint) right knee, contracture left knee, contracture left ankle, contracture right ankle, muscle weakness, unsteadiness on feet, and reduced mobility; -Functional deficits: Transfers, bed/chair: -Maximum assist x 2 people; -Transfers, sit/stand: maximum assist x2 people; -Device use, mechanical lift: Yes; -Analysis of functional outcome/clinical impression: Patient has ceased progress and is appropriate for discharge. Patient improved with sitting balance; however, did not progress with [NAME] flex lift (sit to stand lift), standing, or gait (walking); -Transfers: Patient unable to stand safely with [NAME] flex lift and Hoyer still recommended. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 10/4/24, showed: -Severe cognitive impairment; -Diagnoses included coronary artery disease (CAD, heart disease), high blood pressure, dementia, Parkinson's disease, anxiety, and depression; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Impairment on one side of the lower extremity; -Uses wheelchair; -Sit to stand: Not attempted due to medical conditions or safety concerns; -Chair/bed to chair transfer: Dependent, helper does all of the effort. Resident does none of the effort to complete the activity; -Tub/shower transfer: Dependent, helper does all of the effort. Resident does none of the effort to complete the activity. Review of the resident's care plan, in use during survey, showed: -Activities of Daily Living (ADL) rehab: Resident is alert and oriented to 1-2 with confusion. He/She is able to make his/her basic needs known but confused to his/her ability. He/She needs extensive to total assist with care and able to set up with meals and cues. He/She has dx of dementia, Parkinson's, tremor, and diagnosis of seizures. He/She can be anxious at times which may increasing his/her tremors. Resident receives hospice for care with diagnosis of dementia; -Transfer: Hoyer lift x 2. Review of the resident's hospice clinical summary, showed: -Mobility: Transfer using mechanical lift; -Narrative note: Unable to ambulate due to weakness and drop right foot. Review of the resident's progress notes, showed: -On 1/7/25 at 4:13 P.M., Hospice nurse here this A.M. and resident, writer informed that resident complained to pain to left foot and ankle and order was received per hospice doctor for x-ray of left ankle and foot. No further complaints voiced thru out the shift. X-ray tech here at this time to obtain x-ray; -On 1/8/25 at 4:43 P.M., Resident complained of right foot pain this morning, assessed, no bruising noted, non-pitting edema noted and foot internally rotated. Resident denied any pain to left foot, able to wiggle toes and move extremity without discomfort. Call placed to x-ray company at noon for x-ray results of left foot, at 12:45 P.M., received results: Minimally displaced sub-acute (fracture that occurred between 5-13 days prior) chip fracture along anterior (front) surface of talus (ankle bone). Nurse Practitioner (NP) here in facility and made aware of x-ray results, Director of Nursing (DON) made aware of results also. Resident seen by NP and stated that family was made aware of x-ray results; -On 1/8/25 at 6:38 P.M., New orders received from NP for Ibuprofen 400 milligram (mg), twice a day (BID) as needed (PRN) for breakthrough pain not relieved by Tylenol and non-weight bearing (NWB) to both lower extremities due to ankle contractures and left ankle fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation, showed: -Allegation type: Injury of unknown origin; -Date/time staff became aware of incident: 1/8/24 at 1:40 P.M.; -Allegation details: Resident receives hospice services, the morning of 1/7/25, attending hospice nurse reported to facility charge nurse Licensed Practical Nurse (LPN) D that the resident was complaining of left foot and ankle pain. An x-ray was ordered and taken on 1/7/25. Results of the x-ray reported on 1-8-25. Minimally displaced chip fracture along anterior surfaces of talus seen. Reduced bone density seen. Resident interviewed by Social Services reports not remembering anything that could have caused it, only that it hurts. Resident reports no adverse treatment from staff. Resident's family was informed of fracture by hospice. Attending physician was notified and we are waiting on call back and any new orders. Review of the resident's x-ray report, dated 1/7/25, showed: -X-ray: left ankle; -Reason for exam: pain; -Findings: Minimally displaced chip fracture along anterior surface of talus seen; -Avulsion (forceful tearing away) injury seen along medial malleolus (bump on the inner side of ankle) with adjacent soft tissue edema (swelling); -Reduced bone density seen; -Impression: Minimally displaced sub-acute chip fracture along anterior surface of talus seen. Avulsion injury seen along medial malleolus with adjacent soft tissue edema. Reduced bone density seen. Review of the DON's written statement, showed: -On 1/8/25 around 12:45 P.M., charge nurse reported that the resident's x-ray results to left ankle came back positive for fracture. Nurse had made me aware yesterday that hospice nurse ordered x-ray due to resident complaining of pain; -Spoke with CNA A who cared for resident Saturday through Monday who stated resident never complain of any discomfort. Spoke with bath aide from hospice who stated he/she visited the resident on Tuesday 1/7/25. Resident complained of pain and told him/her that on Monday 1/6/25, his/her foot got caught in the Hoyer. Aide reported this to hospice nurse who was also here for a visit. Hospice nurse and aide both visited on Friday 1/3/25 and resident complained of no pain or discomfort. After hospice aide reported pain on Tuesday 1/7/25, x-ray to left foot/ankle was ordered. Order for x-ray to right foot/ankle due to resident complaint; -Spoke with CNA E, who was assigned to resident on dayshift on 1/7/25, who also stated resident did not complain of any pain or discomfort that day; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 1/13/25 at 9:55 A.M., the resident's private caregiver said he/she comes on Monday through Friday. On Tuesday, 1/7/25, the resident was getting ready for hospice to give him/her a bed bath and the resident said he/she hit his/her foot on the Hoyer lift on Monday. He/she said it was jammed or something to that effect. It was hurting him/her. The caregiver was not at the facility on Monday, 1/6/25. He/she did see the resident's ankle at the time, and it was bruised. He/she took a picture and showed it to the surveyor. The resident's ankle in the pictures appeared reddened around the inner ankle and foot. There was dark bruising around the big toe; however, the picture cut off at that point. The private duty caregiver said he/she let the hospice nurse know and he/she said they would get an x-ray of it. The resident is transferred with a Hoyer lift, but he/she had witnessed staff use other devices. On 1/1/25, staff used a sit to stand. It was two CNAs that he/she saw before. The caregiver told staff the resident does not stand, and staff said it was ok, it will work out. They also used it on 1/3/25, but it was in the shower. The resident did verbalize he/she wanted to stand at that time to hospice. He/she asked are you sure you want to stand and are you sure you want to get in the shower and the resident said yes. He/She did not have complaints of pain at that time. The caregiver said he/she told CNA C that the resident was transferred in the sit to stand and then he/she stood again on 1/3/25 with hospice in the shower. The caregiver was not comfortable with the resident standing because he/she had not stood in a year. Review of CNA A's written statement, dated 1/8/25, showed CNA A worked with the resident on the weekend and Monday day shift. Resident did not complain about foot pain, but Saturday, his/her left foot was touching his/her foot peddle and CNA A put his/her foot on two pillows. During an interview on 1/15/25 at 9:13 A.M., CNA A confirmed he/she worked on Monday 1/6/25, during the day shift. He/She is familiar with the resident and the resident transfers with use of a Hoyer lift. He/She transferred the resident his/herself. There was no one else around and he/she did not see anyone, so he/she did it. The transfer went well. He/She transferred the resident to the side of the chair. He/She had difficulty describing it. The resident's chair was next to the Hoyer lift and the resident was transferred into the chair from the side and not the front of the chair. The resident did not have any complaints of pain during the transfer or after. There was no indication of an injury before or after the transfer. He/She was not aware of the resident transferred by use of another device, or it was not reported he/she stood up; however, somebody reported that someone used a stand-up lift. He/She learned the resident's ankle was fractured. He/she did not report to nursing that he/she operated the Hoyer lift alone. The resident is also a good transfer. The resident's private caregiver was there, but did not say anything. If he/she wanted to know how a resident is to be transferred, he/she would go to the nurse and ask what the resident's transfer status was. He/She was familiar with the care card on the resident of the resident's door. He/She did not know how often it was updated. Review of CNA C's written statement, dated 1/8/25, showed the resident's sitter came and said the resident's foot was broke because a CNA got it caught on the Hoyer and I need to tell my nurse because he/she does not listen anyway. Resident's sitter also said, they better watch out tomorrow because family will be here, watch. I saw hospice give the resident a shower using a sit to stand, but he/she was not sure of date. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 10:23 A.M., CNA C said he/she worked with the resident on Friday, 1/3/25. He/She is familiar with the resident and was aware the resident transferred with use of the Hoyer lift. The resident's private caregiver told him/her that someone used a sit to stand. He/She was not good at remembering dates, but the caregiver described them and said they were doing the resident's shower. CNA C also confirmed his/her written statement. He/she believed hospice used a sit to stand in the shower. CNA C did not witness the resident on it, but the Hoyer lift was never in the bathroom. He/She could not say he/she saw the resident on the sit to stand, but he/she put two and two together. Someone said they used a sit to stand on the resident and it was Friday, 1/3/25. It was discussed after the caregiver told CNA C. CNA C went to LPN D and said the caregiver said something about the resident. LPN D told CNA C to not be a go between for the caregiver. CNA C went back to the private caregiver and said LPN D needs to be informed by the caregiver and CNA C cannot be a go between. CNA C cannot say if LPN D followed up with the private caregiver and CNA C did not report it to management. If the private caregiver reports something regarding the resident, they go to the nurse depending on what happened. The caregiver can report to other staff. If he/she wanted to know how a resident transferred, he/she would go to charting or find the care card on the back of the door. It is updated quite often. Review of LPN D's written statement, dated 1/8/25, showed LPN D was the charge nurse for the resident on Saturday, 1/4/25 and resident did not complaint of any pain or discomfort and no one reported any issues. During an interview on 1/15/25 at 10:50 P.M., LPN D confirmed he/she worked on Friday, 1/3/25. He/She worked with the resident before and was aware he/she transferred with a Hoyer lift. It was not reported to him/her that the resident stood up prior to learning about the fracture. He/She did not receive any reports from the private caregiver. LPN D did instruct CNA C to not be a go between but that was on Tuesday, 1/6/25. CNA C did approach him/her and said, don't shoot the messenger, but and LPN D stopped CNA C mid-sentence and said if something needed to be reported, the caregiver needs to tell me. It was on Tuesday. The resident had already received the x-ray and hospice saw him/her. Whatever happened had already happened and he/she wanted the resident's caregiver to go to him/her, otherwise it is second hand information. During an interview on 1/15/25 at 2:40 P.M., the Administrator and DON said they would expect residents to be transferred appropriately per orders, policy, and care plan. If a resident required to be transferred with a Hoyer lift, it is not appropriate to use other devices. They would expect there to be two people. If staff cannot find a second person, they are expected to wait until someone is available. They were not aware the resident was transferred in the Hoyer lift with one staff on Monday, 1/6/25. There is no rule with whom the private caregiver has to report to; however, they would expect him/her to go to the nurse. The CNA could forget. They would have expected the CNA to report to the administrator or DON if he/she could not report information to the nurse from the caregiver. If it was reported that the resident stood on 1/1/25 and 1/3/25, they would expect staff to report it so the resident could have been assessed. It was not reported to them prior to 1/7/25 that staff believed hospice used a sit to stand to transfer the resident on 1/3/25. Staff are in-serviced/educated on mechanical lifts year or if there is an investigation. 2. Review of Resident #7's significant change MDS, dated [DATE], showed: -Moderate cognitive impairment; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included heart failure, depression, asthma, and respiratory failure; -Impairment to both sides of the upper and lower extremity; -Uses wheelchair; -Sit to stand: Not attempted due to medical condition or safety concerns; -Chair/bed to chair transfer: Dependent, helper does all the effort. Resident does none of the effort to complete the activity. Review of the resident's care plan, in use during survey, showed: -Activity of Daily Living (ADL) function rehab: Resident has a self-care deficit for ADL and mobility performance. He/She requires supervision and assist to complete cares. Related to decline in cognition as evidenced by St. Louis University Mental Status exam (SLUMS, 30 point test that assess cognitive function) of 21/30 (mild neurocognitive disorder), chronic back pain related to spinal stenosis (when spaces inside the bones of the spine get too small) in lumbar (lower back) region, unsteadiness on his/her feet, abnormalities of gait, history of falling, and generalized weakness; -Assist with ADLs as necessary with staff assist of limited-no weight bearing, set up at sink side have necessary items in place. Offer supervision and verbal cues. Segment tasks as needed to allow resident to complete tasks in efficient time, safe and quality manner; -Transfers: Extensive assist x1 using gait belt and wheeled walker (ww), may use EZ stand (a transfer assist device that helps people stand up) as needed x 2. Observation on 1/13/25 at 12:53 P.M., showed the resident sat in his/her wheelchair preparing to be transferred by CNA F and CNA G. Staff connected the Hoyer pad, that was located underneath the resident, and hooked it onto the Hoyer lift. Staff reminded the resident to give him/herself a bear hug. Resident crossed his/her arms. CNA F operated the Hoyer lift and lifted the resident. The resident's chair begun to rise with the resident seated, approximately one foot into the air before staff lowered the chair and re-assess. The resident did not show any signs of being scared, nervous, or anxious. The resident's shoe fell off. Staff re-assessed and checked the chair. CNA F operated the lift a second time and the resident was lift. The resident continued to keep arms crossed. CNA A guided the resident approximately six feet from the chair to the bed. The resident was lowered slowly onto his/her bed. The resident did not have any complaints. Observation of the resident's care card on the back of the door, showed extensive assistance x 2 using a gait belt. During an interview on 1/15/25 at 2:25 P.M., the administrator and DON said they were not aware of Resident #7's Hoyer transfer. They would expect staff to ensure the Hoyer pad is not hooked to the chair and ensure resident safety prior to lifting. Staff are able to find information on how a resident transfers on the back of their door and they can go to the DON. It is updated every three months or when there is a change in condition. Nursing or social worker is responsible for updating it. The DON would expect it to be updated timely. MO00247718