

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Friendship Village Chesterfield		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35394</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with respect and dignity. One resident (Resident #3) required staff assistance with mobility and personal care needs. Staff left the resident alone in the bathroom while seated on the toilet and again while the resident hovered over the toilet. Staff made comments about their dislike of the job and/or level of care the resident required. In addition, during a transfer from the wheelchair to the bed, the resident was not properly assisted into bed and was left with legs hanging off the bed. The sample was five. The census was 82.</p> <p>The administrator was notified on 2/21/25, of the past non-compliance. The facility has in-serviced staff and are monitoring staff and resident interactions. The deficiency was corrected on 2/20/25.</p> <p>Review of the facility's undated Resident Rights policy, showed:</p> <ul style="list-style-type: none"> <li>-Each resident is encouraged and assisted in making grievances and recommendations, and the resident is ensured against any form of reprisal or intimidation. The Administrator, Director of Nursing (DON), and Social Services will receive these grievances at anytime;</li> <li>-Each resident shall be treated with consideration, respect, and full recognition of his/her dignity and individuality including privacy in treatment and care for personal needs;</li> <li>-Each resident shall participate in the decision-making process, including individual preferences in such things as menus, clothing, religious activities, friendships, activity and entertainment. This includes planning his/her total care and medical treatment;</li> <li>-Residents shall not have their personal lives regulated or controlled beyond reasonable meal schedules and other policies that may be necessary for the orderly management of facility.</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS, a federally mandated instrument completed by facility staff), dated 2/24/25, showed:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> </ul> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  265121	Facility ID:  265121  If continuation sheet Page 1 of 5

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included high blood pressure, orthostatic hypotension (when the blood pressure drops suddenly when changing position and can result in falls), acid reflux, dementia, Parkinson's disease, and depression;</p> <p>-Impairment to both sides of the lower extremities;</p> <p>-Used a wheelchair;</p> <p>-Required supervision or touching assistance with toileting hygiene;</p> <p>-Required supervision or touching assistance with sit to stand;</p> <p>-Required partial/moderate assistance with chair/bed to chair transfer;</p> <p>-Required partial/moderate assistance with toilet transfer.</p> <p>Review of the resident's care plan, in use at the time of the investigation, showed:</p> <p>-Cognitive loss/dementia: Impaired cognition related to dementia, Parkinson's, depression, and anxiety. The resident's specific information: He/She has poor short-term memory, difficulties with word finding at times and becomes anxious if he/she does not recall where he/she is or what to expect. He/She benefits from frequent cueing and reassurances;</p> <p>-He/She will main or improve level of cognitive functions as evidenced by answering simple yes/no questions x 90 days;</p> <p>-Identify baseline cognition as follows: Oriented to x 2 (person and place only);</p> <p>-Use a calm, slow approach;</p> <p>-Explain all procedures before beginning and repeat during procedure as necessary;</p> <p>-Bring out to area of activity to enhance mental stimulation;</p> <p>-Encourage use of familiar objects;</p> <p>-Activities of Daily Living (ADL) functional 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 need extensive to total assist with care and able to set up meals and cues. He/She has diagnosis of dementia, Parkinson's, tremor, and diagnosis of seizures. He/She can be anxious at times which may increase his/her tremors. Resident receives Hospice for care with diagnosis of dementia;</p> <p>-Will maintain ADL function in the next 90 days;</p> <p>-Assist with ADLs as necessary with staff assist x 1;</p> <p>-Provide sufficient time to complete tasks. Avoid rushing, but keep on task and assist to complete as needed;</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Walking in room: not ambulate;</p> <p>-Walking in hallway: not ambulate;</p> <p>-Toileting: extensive to total assist x 1 with check and change every two hours while awake;</p> <p>-Personal hygiene: extensive to total assist x 1;</p> <p>-Bed Mobility: extensive assist x 1.</p> <p>Observation and interview on 2/21/25 at 11:19 A.M., showed the resident lay in his/her bed. Family Member A was in the room with the resident. The resident was asked if he/she wanted to talk to the surveyor. He/she said, not really. Family Member A said the resident was about to take a nap, so he/she was tired.</p> <p>During an interview on 2/21/25 at 11:19 A.M., Family Member A said the resident has Parkinson's and dementia and believed that gets lost with facility staff. They have a camera in the room and were able to see staff interacting with the resident. There are videos of staff rudeness and harsh movements. The aide was seen dancing around in the room. After he/she watched the events that occurred on 2/14/25, he/she called the facility and requested the Certified Nurse Aide (CNA) to be re-assigned. He/She receive a confirmation from nursing that the aide was re-assigned and Family Member A confirmed it on the camera. Family Member A sent the video footage to facility management. The resident would not recall the events that happened due to the dementia. If someone asked him/her about something right when it happens, he/she would be able to tell you, but at this point, the resident would not recall what happened. At 2:20 P.M., Family Member A said the facility needed to work on educating their staff in having more compassion towards the residents.</p> <p>Review of the camera footage, dated 2/14/25 at 9:07 P.M., showed the camera positioned to show the resident's room, hallway outside the resident's room, and bathroom. The video begins with the resident seated on the toilet in the bathroom. The walker was in front of the resident. He/she was alone in the bathroom. At 15 seconds, CNA B walked into the resident's room. CNA B walked into the bathroom and said, you finished. The resident spoke to CNA B, but the resident's words were indistinct/inaudible. CNA B responded to the resident, all night, all night and I don't have to, I am waiting for you to get up. CNA B and the resident have another exchange, but the words were inaudible. The resident leaned down on the top of the walker with his/her hands covering his/her face. CNA B stood in the doorway and watched the resident. CNA B leaned back on the frame of the bathroom door. CNA B looked over at the resident and said sit up for me so you don't fall. The resident started to lean down while seated on the toilet. CNA B walked closer to the resident and said, sit up honey so you won't fall. The resident sat back up straight and continued to be seated on the toilet. The aide said thank you. The aide then said, do not lean back on the toilet, you have to sit up. The resident responded to the aide, sit up, but the rest of what was said was inaudible. The aide responded to the resident, I didn't say stand up. The resident said, I didn't mean stand up, but I don't have anything to hold on to. CNA B responded, hold on to the rail. The video ends.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the camera footage, dated 2/14/25 at 9:12 P.M., showed the camera footage started with the resident seated on the toilet in the bathroom. He/She was seen doing his/her own personal care. CNA B stood in the doorway of the bathroom. CNA B continued to stand in the doorway as he/she observed the resident doing personal care on him/herself. CNA B started to clap his/her hands few times, snap fingers, and move side to side while standing in the doorway. CNA B continued to move around in the doorway, looking over at the resident. He/she stood in the doorway, leaning against the door frame. The resident continued to clean him/herself up without staff assistance. CNA B started snapping fingers again and begun to sway from side to side in the doorway of the bathroom. CNA B pulled out his/her phone from his/her jacket pocket, looked at it, and placed it back into his/her pocket. CNA B stood in the doorway until the last eight seconds of the video when CNA B entered the bathroom. No words were exchanged during the two-minute video.</p> <p>Review of the camera footage, dated 2/15/25 at 9:14 P.M., showed the resident seated on the toilet in the bathroom. The resident had his/her walker in front of him/her. CNA B was in the bathroom with the resident, grabbing supplies and placing it on the counter. CNA B said stand up, but did not assist the resident with standing. CNA B placed gloves on his/her hands, standing approximately two to three feet away from the resident, in front of the sink. CNA B asked the resident to stand up. The resident began to lean forward but did not stand up. The resident was told again stand up, stand up for me. CNA B walked toward the resident as the resident lifted his/herself off the toilet seat, holding on to the walker in front of him/her. CNA B lifted the back of the resident's gown and started to clean the resident's backside. CNA B then attempted to put a brief on the resident. The resident's backside continued to hover over the toilet. CNA B said stand up and you're not standing. The resident's started to lower him/herself down until he/she sat back on the toilet seat. CNA B said, stand up, 1-2-3 and assisted the resident to stand up. The resident stood up slightly, leaned forward, and started to slouch down, but was not seated on the toilet seat. CNA B dropped the brief on the bathroom counter, walked out the bathroom, and said I can't, I can't as he/she walked out of the resident's room. The resident was left in the standing/slouch position off the toilet. The resident sat back on the toilet a few seconds later. The resident said, you shouldn't be doing this job if you can't, honey. CNA B, who was out of the resident's room and seen in the hallway, was heard calling out to staff help me with him/her please, please me get him/her off this toilet, he/she was not trying to stand, he/she was trying to fall, and who wants to fall. CNA B walked back into the resident's room with CNA C. CNA B said, it does not take, but the rest was inaudible. The video stops.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the camera footage, dated 2/15/25 at 9:16 P.M., showed the camera footage continued after CNA B and CNA C entered the resident's bathroom. CNA C took the resident's wheelchair and moved it into the bathroom with the resident and CNA B. CNA C began to fix up sheets and blankets on the resident's bed. CNA B, in the bathroom with the resident, placed towels on the seat of the resident's wheelchair. A third staff entered the room. CNA B and CNA C said, we got it. The third employee said, you got it and thank you as exits the resident's room. CNA B asked the resident to stand up, 1-2-3. The resident begun to stand; however, CNA C walked into bathroom and obstructed the view as the resident was transferred to his/her wheelchair from the toilet. CNA C re-positioned the resident back in the wheelchair. The resident was seen wearing a gait belt around the upper body. The resident was transferred in the wheelchair from the bathroom to his/her bed. The resident was seated in the wheelchair as staff lowered the resident's bed. The resident was told to sit up, the resident leaned forward while CNA C reached around the resident to grab the gait belt and quickly pulled the resident out of the wheelchair onto the bed. The resident was heard saying ooh twice as he/she was positioned on his/her left side in the bed. The resident's legs were hanging off the bed as the resident's right arm reached out. CNA C exited the room. CNA B placed a brief under the resident as he/she was positioned on his/her left side with legs off the bed. CNA B placed the brief under the resident and told the resident to turn on the other side as he/she lifted the resident's legs up and turned the resident. CNA B told the resident to go that way as he/she was turned on his/her right side. CNA B was seen with the brief in his/her hand and the video ends.</p> <p>Review of the camera footage, dated 2/14/25 at 9:18 P.M., showed CNA B placed a brief under the resident and repositioned the resident on his/her back. CNA B secured the resident's brief, covered him/her with a blanket and lowered the bed. CNA B moved the wheelchair back into the resident's bathroom. The resident lay in bed and asked the aide a question that was inaudible. CNA B moved the resident's bedside tray closer to him/her and handed the resident a pack of hand wipes. CNA B turned the light off and exited the room. The resident was seen pulling a wipe out of the pack and cleaning his/her hands until the video ends.</p> <p>During an interview on 2/21/25 at 3:00 P.M., the DON said the nursing supervisor emailed her and informed her that the family did not want to the two aides working with the resident. The family said staff needed more compassion. The DON received the video footage from the resident's room and watched it. The resident will try to move, get up or stand. The aides were moving too fast as well. The DON spoke to CNA C. He/She watched the video and admitted he/she was going too fast and needed education. He/She was educated by the DON. CNA B was contacted, but it sounds as if he/she was in a place with a lot of people, and he/she gave a one word answers after he/she was told the family had concerns. CNA B resigned the next day. It was not appropriate for the resident to be left alone on the toilet. The DON would have expected staff to ask resident if he/she could help him/her. CNA B behavior when he/she said, I can't and yelling down the hall was not appropriate. It was not appropriate for CNA C to transfer the resident the way he/she did and would have expected him/her to continue to assist the resident in bed, so the lower half was not hanging out of bed. The DON would have also expected CNA B to assist the resident instead of standing in the doorway.</p> <p>During an interview on 2/21/25 at 10:45 A.M., the Administrator said that he reviewed the videos sent by the family. The behavior of the aides was not appropriate and that is not how staff are expected to treat residents. They have addressed the issue and will continue to monitor care.</p> <p>MO00249621</p>		