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	04/03/2026

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. Based on observation, interview, and record review, the facility failed to ensure residents received adequate assistance to prevent accidents when staff failed to use a gait belt and to lock a resident's wheelchair during an assisted transfer, causing the resident to fall (Resident #1). The sample was 3. The census was 92.The administrator was notified on 4/3/26 of the past non-compliance, which occurred on 12/15/25. The facility in-serviced staff regarding safe transfer protocols and staff demonstrated understanding. The deficiency was corrected on 12/16/25. Review of the facility's Transfer Techniques policy, dated August 2019, showed:-Purpose: To transfer the resident from bed to chair and chair to bed safely;-General Instructions:--Identify if resident is wearing proper fitting, non-skid footwear with laces tiedsecurely;-- Resident should move toward the unaffected side (exception: transfer toward affected side when getting into bathtub; transfer toward unaffected side when getting out of the tub);--Keep the resident in good alignment;--Bed and/or wheelchair brakes must always be locked, and foot pedals raised;-Procedure:-Transfer from bed to wheelchair:--Brakes on wheelchair should be locked, foot pedals raised, and chair placed at an angle at the side of the bed nearest resident's unaffected side. If special chair cushion or non-slid is indicated on the care plan, be sure to place in wheelchair;--Obtain assistance of another individual as indicated in the care plan for safe transfer;--Lower bed if needed. Lock the wheels on the bed;--Assist the resident to the side of the bed;--Assist resident to a sitting position;--Have resident sit on edge of bed with feet uncrossed and resting on the floor. Put on gait belt and proper fitting, non-skid footwear;--With your knees flexed and your legs slightly apart, face the resident. As the resident is slightly leaning forward, grasp the gait belt from underneath the belt on both sides. Raise to a standing position, at a prearranged signal (i.e. on the count of 3), by straightening your knees and supporting the resident's knees. Allow the resident to gain his/her balance before proceeding. Support weak leg with your knee if necessary. NOTE: The caregiver may either support the resident on the affected side or stand in front of resident. Support will be provided with a firm grip on the gait belt;--Resident then pivots slightly and places unaffected arm on wheelchair arm farthest away from him/her, while in a smooth motion, pivots on his/her unaffected leg, feels location of chair with back of leg and assist the resident to slowly lower self to the chair while leaning forward slightly. Do not allow him/her to fall into the chair;-- Position the resident so that the resident's hips are placed at the back of the chair and body is in good alignment with back is as straight as possible;--Remove gait belt gently. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/5/25, showed:-Severe cognitive impairment;-Upper and lower extremity impairment on both sides;-Substantial/maximal assistance for transfers - helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort;-Fall any time in the last month prior to admission/entry: No information;-Fall any time in the last two to six months prior to admission/entry: No information;-Diagnoses included heart failure, high blood pressure, diabetes, Alzheimer's disease, and reduced mobility. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: Resident has a self-care and mobility deficit performance. Resident requires supervision and assist to complete cares;-Goal: Resident's needs will be (continued on next page)

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
	265121	A. Building B. Wing	04/03/2026

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	anticipated and gestures will be used as able to determine her needs through the next review date;-Interventions included:---Assist with activities of daily living (ADLs) as necessary with staff extensive assist. Assist resident to complete tasks in efficient time, safe and quality manner;--Bed mobility: One person assist;--Transfer: Contact guard assist (CGA, level of physical assistance that maintains light, hands-on contact with a resident often with a gait belt to provide stability and safety during transfers or walking) to extensive assist (requires significant, weight-bearing help from a caregiver to move between surfaces) times (x) one person to stand and pivot. Review of the resident's incident report, dated 12/15/25 at 7:30 A.M., showed:-Describe the incident: Per certified nurse aide (CNA), he/she was transferring resident from bed to chair and resident slid off the bed and fell onto the floor;-Note, dated 12/16/25 at 9:40 A.M.: Interdisciplinary team (IDT) per CNA, he/she was transferring resident from bed to chair and resident slid off bed and fell to floor. Nurse entered room due to virtual sense technology (VST, detects if a resident has fallen) alerting. Observed resident and CNA on the floor. Nurse assessed no injuries noted. Neurological assessment (neuro checks) within normal limits (WNL) for resident. Review of an email sent to Administrator and Director of Nursing (DON) from the resident representative (RR) on 12/15/25 at 11:09 A.M., showed:-RR wrote the resident fell this morning because the aide who got him/her up did not follow protocols. RR did not see the fall happen in real time but only later when going back over video to see how the resident's morning started out. The primary reason the resident fell is the aide did not lock his/her wheelchair;-A video attached to email, dated12/15/25, showed:--At 7:14 A.M., CNA A came into the resident's room and began changing the resident and getting the resident dressed;--At 7:25 A.M., CNA A left the resident's room, and the resident was lying in bed;--At 7:25 A.M., CNA A returned to the resident's room with a mechanical lift;--At 7:28 A.M., CNA A sat the resident up on the edge of the bed and changed the resident's shirt and placed a jacket on the resident;--At 7:31 A.M., CNA A pulled the resident's wheelchair to the left side of the resident and CNA A. CNA A did not lock the wheelchair. With his/her right hand, CNA A began to pull the resident's pants up while CNA A's left hand was positioned underneath the resident's right arm. CNA A began counting, One, two, three, and lifted the resident by pulling the resident's pants and holding underneath the resident's right arm. CNA A pivoted to the wheelchair and attempted to sit the resident on the wheelchair. The resident sat on the end of the wheelchair, which rolled backward. The resident and CNA A fell to the floor. The resident landed on the floor, on his/her right side. CNA A did not use a gait belt during the transfer. Review of facility's investigation summary, dated 4/7/26, showed:-On 12/15/25, at approximately 11:10 a.m., the DON received an email from the RR regarding a fall involving the resident that had occurred earlier that morning. The email included a video clip and indicated the fall was allegedly due to staff not following established safety protocols. Specifically, it was noted that the assigned aide, CNA A, did not utilize a gait belt during the transfer;-On the same day, the DON spoke with CNA A regarding the incident. Initially, CNA A reported the resident slid off the bed. After informing CNA A that the family had provided a video showing that the resident did not slide off the bed, CNA A clarified that he/she attempted to transfer the resident and lost his/her balance because the wheelchair was not locked. CNA A said he/she initially provided inaccurate information out of concern about potential disciplinary action;-DON educated CNA A on the importance of honesty in reporting incidents and reviewed appropriate transfer techniques to ensure resident safety. DON and CNA A discussed alternative actions that could have resulted in a safer outcome. CNA A verbalized understanding of the expectations;-A one-on-one training session was conducted with CNA A on 12/15/25, at approximately 12:00 P.M., covering one-person transfers, two-person transfers, stand-up lift usage, and Hoyer lift procedures. Additionally, facility-wide staff training on proper transfer and safety protocols was completed on 12/16/25 and 12/17/25. During an interview on 4/7/26 at 10:12 A.M., CNA A said he/she was getting the resident dressed on the side of the bed and the resident started to slide, so CNA A grabbed the wheelchair and tried to put the resident into the wheelchair. CNA A was not going to transfer the resident and that is why he/she did not have a gait belt on 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
	265121	A. Building B. Wing	04/03/2026

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	resident. When he/she attempted to put the resident into the wheelchair, the wheelchair moved and they both fell. When transferring a resident, a gait belt should be used and the wheelchair should be locked. During an interview on 4/7/26 at 1:47 P.M., Licensed Practical Nurse (LPN) B said staff should always use a gait belt when transferring a resident and the wheelchair should always be locked prior to transferring that is standard practice. During an interview on 4/3/26 at 9:15 A.M., the DON said the RR sent a video of the attempted transfer and the resident and CNA A falling. The DON watched the video. CNA A did not have a gait belt on the resident and CNA A did not lock the wheels to the resident's wheelchair. When CNA A attempted to transfer the resident to the wheelchair, the wheelchair moved back because the wheels were not locked, and CNA A and the resident fell. The DON expected staff to use a gait belt during transfers and expected staff to lock the wheels to wheelchairs prior to transfers. The DON expected staff to be knowledgeable of and to follow facility policies. During an interview on 4/3/26 at 3:00 P.M., the Administrator and DON said they expected staff to be knowledgeable of and to follow facility policies. They expected staff to use gait belts when transferring residents and to lock the wheelchair prior to transferring a resident. 2966916