

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301	

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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping services to maintain a clean, sanitary and orderly environment for one resident, (Resident #1) out of seven sampled residents. The facility census was 69.</p> <p>The facility did not provide a policy for housekeeping services or clean and comfortable homelike environment.</p> <p>1. Review of Resident #1's face sheet showed the following:</p> <p>-admitted to the facility on [DATE];</p> <p>-Diagnosis of Huntington's disease (a hereditary neurodegenerative disorder that causes the progressive breakdown of nerve cells in the brain. It affects movement, cognition, and behavior, and there is currently no cure).</p> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 5/28/25 showed the following:</p> <p>-Sometimes able to make self understood and sometimes able to understand;</p> <p>-Requires assistance with Activities of Daily Living (ADL's);</p> <p>-History of falls.</p> <p>Review of video footage from a camera inside the resident's room supplied by Family Member (FM) A dated 6/13/25 showed the following:</p> <p>-Certified Nurse Aide (CNA) A in the resident's room with a broom, sweeping up numerous Styrofoam plates, cups, plastic silverware, and napkins that covered the resident's bedroom floor;</p> <p>-A trash can sat next to the resident's bed and was full of Styrofoam plates with food, cups and napkins;</p> <p>-Dark colored stains on the resident's bed linens on the bed.</p> <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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 6/20/25 at 1:55 P.M. showed the following:</p> <ul style="list-style-type: none"> -The resident in his/her room sitting on the bed. There was dried food debris on the bed linens and the same dark colored stains remained on the linens seen in the video camera footage; -The over the bed table was caked with dried food and spilled drinks with gnats flying around the table. Several forks and knives were on the table and caked with dried food; -Disposable plates, cups and bowls with food in some were on the floor, and next to a small trash by the resident's bed; -The toilet in the resident's bathroom had a dark brown ring around the inside of the bowl with dirty toilet tissue and empty rolls of toilet tissue on the bathroom floor. The paper towel dispenser was empty and there was no trash can in the bathroom; -Dirty and clean clothing on the floor around the bathroom entrance and closet along with several clothes hangers; -The bed closest to the entrance door had dried brown debris on the sheets. The bed frame had dried brown debris on the frame and the front wheels of the bed were broken off the frame; -A water pitcher on the floor under the first bed; -The resident stood up off the bed, his/her arms moved continuously; -The resident said he/she would like some paper towels in the bathroom and proceeded to walk to the bathroom with bare feet on the trash that covered the floor. <p>Observation on 6/20/25 at 2:30 P.M. showed FM A in the resident's room picking up the trash off the floor while the resident sat on the bed.</p> <p>During an interview on 6/20/25 at 2:30 P.M. FM A said the following:</p> <ul style="list-style-type: none"> -The resident could not help spilling food and drinks on the floor due to Huntington's disease; -The resident will refuse to let staff clean the room, because staff do not talk to the resident and begin throwing items away including important papers without asking the resident first; -If staff would talk to the resident and ask before they start throwing items away then the resident would not be upset with staff; -He/She had asked for a bigger trash can for the resident due to the resident's uncontrollable movements, it was difficult for him/her to throw items in the trash can -Staff do not understand the resident's Huntington's disease. <p>During an interview on 6/20/25 at 2:30 P.M. the Director of Housekeeping Services said the following:</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The former administrator told his staff they did not have to go into the resident's room to clean, as the resident had attacked one of the housekeepers. They had not been in the room for over a week;</p> <p>-He did not know if the room has been cleaned.</p> <p>During an interview on 6/20/25 at 3:00 P.M. the Administrator said the following:</p> <p>-She was not aware staff did not clean the resident's room or that the prior administrator told housekeeping they did not have to go into the resident's room;</p> <p>-Staff should be picking up the trash and emptying the resident's trash can;</p> <p>-She was unaware of the request for the bigger trash can;</p> <p>-She would expect staff to clean the resident's room.</p> <p>MO255918 and MO255925</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1), in a review of seven sampled residents, was free from abuse and neglect when Certified Nurse Aide (CNA) A while sweeping the resident's room, refused to assist the resident with his/her request to retrieve paper from the floor and grabbed the resident's left hand/arm pushing the resident back causing the resident to fall onto the foot board of the bed. The resident fell onto the bed then slid off the bed onto the floor. CNA A stood watching the resident with no attempt to prevent the fall or assist the resident. The resident then scooted on the floor towards the door of the room, while CNA A continued to sweep the floor telling the resident to stay in the room, with no attempt to call for assistance or a nurse to assess the resident. The resident had diagnosis of Huntington's Chorea (a hereditary neurodegenerative disorder that causes the progressive breakdown of nerve cells in the brain. It affects movement, cognition, and behavior) and was at risk for falls. The resident sustained a large bruise to the right buttock area from the fall and pain in the area. The facility had not assessed the resident after the fall that occurred on 6/13/25 until 6/23/25 when the surveyor brought the resident's complaint of pain in the area of his/her hip to the facility's attention. The facility census was 69.</p> <p>Review of the undated facility policy for Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy supplied by the facility and used as training for facility employees showed the following:</p> <p>-It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion. Additionally, residents will be protected from abuse, neglect, harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.</p> <p>Review of the undated facility policy for Abuse Prevention and Procedure list showed:</p> <p>-Freedom from abuse, neglect, and exploitation: the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptom.</p> <p>-Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse;</p> <p>-Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>1. Review of Resident #1's face sheet showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-admitted to the facility on [DATE];</p> <p>-Diagnoses of Huntington's disease, major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly interfere with daily life), traumatic subdural hemorrhage (a condition where blood collects between the brain and its outer covering (the dura mater) due to head trauma) and anxiety.</p> <p>Review of the resident's Care Plan for Falls dated 6/18/24 showed the following:</p> <p>-The resident was at risk for falls related to impaired mobility, impaired safety awareness, unsteady gait, lower extremity weakness, and becoming angry slamming doors causing balance to be thrown off;</p> <p>-Remind resident to ask staff to assistance when getting things off the floor, encourage the resident to ask for assistance related to balance related to Huntington's disease; staff to assist as needed, staff to emphasize and attempt to get the resident to slow down and try not to be so upset, and to express him/herself in a calmer manner, ensure pathway was free of clutter, encourage the resident to slow down.</p> <p>Review of the resident's Care Plan for Behavior Symptoms dated 6/28/24 showed the following:</p> <p>-I sometimes have behaviors related to my frustration of having Huntington's disease process.</p> <p>-I will calm with staff intervention and my basic care needs will be met;</p> <p>-Speak to me unhurriedly and in a calm voice, talk to me upon approaching me and try to explain what you want to do for me.</p> <p>Review of the resident's Care Plan for Activities of Daily Living (ADL's) dated 5/27/25 showed the following:</p> <p>-The resident has Huntington's disease;</p> <p>-Staff to be aware that this is very frustrating disease for the resident;</p> <p>-Staff will assist with care.</p> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 5/28/25 showed the following:</p> <p>-Sometimes able to make self understood and sometimes able to understand;</p> <p>-Difficulty with making decisions;</p> <p>-Requires assistance with Activities of Daily Living (ADL's);</p> <p>-History of falls.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of video camera footage from the camera inside the resident's room placed by the family time stamped 6/13/25 at 5:15 P.M. with the Administrator and the Director of Nursing on 6/20/25 at 10:30 A.M. showed the following:</p> <ul style="list-style-type: none"> -Certified Nurse Aide (CNA) A sweeping up trash in the resident's room. The door to the resident's room was open, the resident 'walked in the room with his/her shorts by his/her knees and underwear exposed. CNA A said, Pull your pants up and did not close the door. As CNA A swept up trash on the floor, he/she said, this is disgusting; -The resident stood up from the bed and walked over to a piece of paper on the floor, bends over and attempts to pick it up off the floor, he/she loses his/her balance and begins to fall backwards, CNA A grabs his/her left wrist and begins to push him/her back towards the bed, causing the resident to land of the foot board of the bed on his/her right buttock. The resident then lands onto the bed and then slides off the bed onto to the floor, as CNA A did not attempt to break the residents fall but continues to sweep the floor. CNA A says Listen, sit down. -The resident is then seen scooting on the floor to retrieve a piece of paper on the floor saying this is my appointment. CNA A says something, but unable to determine what is said; -CNA A continues to sweep the floor at the resident scoots on his/her bottom on the floor to the doorway of the room, CNA A continues to sweep and did not attempt to help the resident up, or call for the nurse to assess the resident. <p>During an interview on 6/20/25 at 2:30 P.M. Resident #1 said:</p> <ul style="list-style-type: none"> -He/she was mad at CNA A because he/she was throwing away his/her snacks and papers; -Stated He/she would not listen to me when I asked him/her to stop; -When asked about the fall, the resident said that he/she began to fall and CNA A put his/her hand on his/her body and pushed him/her causing him/her to fall onto the foot board of the bed and then onto the floor; -He/she did not call for the nurse, so he/she scooted on the floor as CNA A was sweeping because he/she was throwing away his/her appointment papers; -CNA A was not nice to him/her and he/she does not want CNA A to be in his/her room again. <p>During an interview on 6/20/25 at 2:30 P.M. Family Member (FM) A said:</p> <ul style="list-style-type: none"> -He/she watched the video on 6/13/25 and seen where CNA A was sweeping the floor and when Resident #1 asked him/her to stop, the CNA continued to sweep and would not listen to the resident; -It appeared that when the resident began to fall, CNA A grabbed the resident's hand and pushed him/her causing the resident to fall onto the foot board of the bed; -The resident cannot help spilling things due to his/her uncontrolled movements caused by Huntington's disease; <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The staff do not take their time with the resident and he/she feels the staff does not understand the disease process.</p> <p>During an interview and observation on 6/23/25 at 11:33 A.M. Resident #1 said:</p> <p>-CNA A pushed me as I was falling and I hit my hip on the foot board of the bed. It is sore;</p> <p>-Licensed Practical Nurse (LPN) D performed a skin assessment of the resident's hips and found a large purple/yellow/greenish colored bruise that was approximately the size of large orange to the right hip, when LPN D pressed on the bruise, the resident said the area was very sore.</p> <p>During an interview on 6/20/25 at 1:44 P.M. Registered Nurse (RN) C said:</p> <p>-He/she became aware of Resident #1 falling and scooting on the floor when he/she walked down the hall;</p> <p>-CNA A was still sweeping the floor in the resident's room;</p> <p>-CNA A told him/her that the resident was coming out of the bathroom and lunged at him/her and fell;</p> <p>-The resident was very upset about something;</p> <p>-He/She did not do a skin assessment after he/her had helped the CNA get the resident off the floor;</p> <p>-Several hours later, a family member called and stated that he/she had just watched the video at home and felt CNA A had pushed the resident down, and that the resident was upset because some containers of food had been thrown away;</p> <p>-He/She got the containers out of the trash, they were covered with dried food, so he/she cleaned them up and returned them to the resident;</p> <p>-He/she informed the DON that evening when the DON came to relieve him/her.</p> <p>During an interview on 6/20/25 at 11:00 A.M. the Director of Nursing (DON) said;</p> <p>-She had been informed of the incident after the guardian had called the administrator;</p> <p>-After watching the video with the audio, CNA A did not call for the nurse and did not look like he/she assisted the resident to sit down.</p> <p>During an interview on 6/20/25 at 10:30 A.M. the Administrator said:</p> <p>-She was notified by the residents guardian on 6/16/25 of the video that was taken on 6/13/25 from the camera that is in the resident's room;</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The guardian said that he/she was contacted by the residents family member who supplied the video footage to the facility.</p> <p>-In viewing the video footage, she suspended CNA A pending their investigation;</p> <p>-After review of the video with the audio, CNA A did not call for the nurse as he/she said, and did not assist the resident to sit down;</p> <p>-The investigation into the incident will need to reopened.</p> <p>During an interview on 6/23/25 at 4:11 P.M. the Administrator said:</p> <p>-Abuse is not tolerated and cannot happen;</p> <p>-CNA A did not attempt to break the resident's fall;</p> <p>-She would consider this abuse;</p> <p>-Staff need to report any allegation or suspicion of abuse immediately for investigation;</p> <p>-Staff need to be aware of the resident's disease process and how to provide care for the resident.</p> <p>MO255918 and MO255925</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse when one Resident (Resident #2) of seven sampled residents, reported to staff another staff had threatened to hit him/her with a closed fist and the resident was fearful of retaliation. The facility census was 66.</p> <p>Review of the undated facility policy for Abuse Prohibition showed:</p> <p>-All staff are to report to the Administrator and/or Designees any alleged (all allegations) violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property;</p> <p>-The Administrator or designee must report to the State Survey agency no later than two hours after the allegation is made if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury;</p> <p>1. Review of Resident #2's face sheet showed the following:</p> <p>-admitted to the facility on [DATE];</p> <p>-Diagnosis of Parkinson's disease (a progressive neurological disorder that primarily affects movement. It's characterized by symptoms like tremors, stiffness, and slowness of movement).</p> <p>Review of the resident's care plan for physical functioning deficit dated 5/21/25 directed staff to assist with grooming and dressing needs and provide assistance of one staff member.</p> <p>Review of the resident's Care Plan for Falls due to Parkinson's disease dated 5/21/25 directed staff to provide individualized toileting interventions based on needs/patterns.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 5/25/25 showed the following:</p> <p>-Able to make self understood and usually understands others;</p> <p>-Alert and oriented and able to make some decisions;</p> <p>-Requires assistance with Activities of Daily Living (ADL's), standing, transfers and ambulation;</p> <p>-Diagnosis of Parkinson's disease.</p> <p>During an interview on 6/20/25 at 11:00 A.M. the resident said the following:</p> <p>-Last week he/she told a therapy aide that on the night shift an aide came in and answered his/her call light;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-When he/she asked the aide to get the urinal because he/she could not walk to the bathroom as his/her legs locked up from his/her Parkinson's disease;</p> <p>-The aide handed him/her the urinal. He/she told the aide his/her hands were not working and he/she needed some help with the urinal. The aide walked away. The resident picked up the urinal and threw it at the aide. The aide then came toward him/her, drew back his/her fist, got up in his/her face and said do it yourself before walking out of the room;</p> <p>-He/she was afraid that the aide was going to hit/him.</p> <p>During an interview on 6/23/25 at 1:27 P.M. Family Member B said the following:</p> <p>-Last week, either Thursday, June 12 or Friday, June 13, the resident reported problems on the midnight shift with an aide. The resident said he/she threw a urinal at the aide because the aide member refused to help him/her with the urinal. The aide raised his/her fist and threatened the resident;</p> <p>-The resident had reported this to staff, but could not remember who;</p> <p>-Family Member B reported this to the Social Services Director last week;</p> <p>-The SSD said she was aware of the incident.</p> <p>During an interview on 6/20/25 at 12:20 P.M. the Therapy Program Manager said the following:</p> <p>-Resident #2 had come to therapy and told him/her that last week an aide on the midnight shift accused him/her of throwing the urinal at the aide, the aide drew his/her arm or fist back and threatened to hit the resident;</p> <p>-He/She reported this to the Social Services Director who said she was already and had taken care of it.</p> <p>During an interview on 6/20/25 at 12:18 P.M. the Social Services Director (SSD) said the following:</p> <p>-Last week she overheard a couple of aides at the nurses station talking about the resident and how a staff member on the midnight shift refused to help the resident, had raised his/her fist at the resident and threatened the resident;</p> <p>-The therapy manager also told her that the resident had reported this to her;</p> <p>-She tried to talk to the resident, but he/she was using the bathroom so she went and reported the incident to the Director of Nursing and the Assistant Director of Nursing.</p> <p>During an interview on 6/20/25 at 12:28 P.M. Licensed Practical Nurse(LPN)/Assistant Director of Nursing (ADON) said the following:</p> <p>-Last night before the SSD left, the SSD reported the resident's family member told her the resident said an aide on the midnight shift had raised his/her fist to the resident;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She worked the midnight shift and did not do anything with this information until about 15 minutes ago when he/she reported this to the Administrator.</p> <p>During an interview on 6/20/25 at 10:45 A.M. the Director of Nursing said he was not aware of any incident of possible abuse involving the resident and a staff member.</p> <p>During an interview on 6/20/25 at 1:00 P.M. and 6/23/25 at 4:11 P.M. the Administrator said the following:</p> <ul style="list-style-type: none"> -She was just told what Resident #2 had reported; -She was beginning an investigation. -Abuse was not tolerated; -Staff should report any allegation or suspicion of abuse immediately for investigation. <p>MO255941</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive, person-centered care plan for one resident (Resident #1), of seven sampled residents, to address care of a resident with diagnosis of Huntington's disease (a hereditary neurodegenerative disorder that causes the progressive breakdown of nerve cells in the brain. It leads to a decline in cognitive function, mood disturbances, and uncontrolled movements). The facility census was 69.</p> <p>Review of the facility policy for Care Planning Guidelines dated 10/1/2015 showed the following:</p> <p>-It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, any published interim RA manual errata documents, and applicable federal guidelines as the authoritative guide for completion of MDS, Care Area Assessments (CAA) and resident care planning.</p> <p>1. Review of Resident #1's face sheet showed the following:</p> <p>-admitted to the facility on [DATE];</p> <p>-Diagnoses of Huntington's disease, traumatic subdural hemorrhage (a condition where blood collects between the brain and its outer covering (the dura mater) due to head trauma) and anxiety.</p> <p>Review of the resident's Care Plan for Behavior Symptoms dated 6/28/24 showed the following:</p> <p>-I sometimes have behaviors which include aggression toward staff and refusal of care related to my frustration of having Huntington's disease process. I have actually attacked staff before or chased staff down the hallway because they could not give me what I wanted, example Ibuprofen;</p> <p>-I have a recording device in my room; make sure I am not in pain or uncomfortable; my behaviors may include refusal of care. Notify my physician and family if/when my behavior interferes with staff's ability to address my basic needs; administer medications as orders; speak to me unhurriedly and in a calm voice, talk to me upon approaching me and try to explain what you want to do for me.</p> <p>Review of the resident's Care Plan for Activities of Daily Living (ADL's) dated 5/27/25 showed the following:</p> <p>-The resident has Huntington's disease;</p> <p>-Staff to be aware that this was a very frustrating disease;</p> <p>-Staff will assist with care.</p> <p>Review of the resident's Care Plan for Communication dated 5/27/25 showed the following:</p> <p>-The resident makes decisions but they are not always in the best interest or something that staff cannot meet:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Approaches in part: Most of the time the resident will not listen to reason, he/she is delusional and when he/she has something in his/her head and he/she request it whether it is rationale or not he/she will not work with staff, he/she becomes frustrated, yells, lunges at other and very violently slams the door multiple times;</p> <p>-The staff try to keep him/her from falling and offer to help with ADL's.</p> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 5/28/25, showed the following:</p> <p>-Sometimes able to make self understood and sometimes able to understand;</p> <p>-Has delusions, verbal behaviors occur daily, other behaviors four to six days and rejection of care.</p> <p>-Difficulty with making decisions;</p> <p>-Requires assistance with Activities of Daily Living (ADL's);</p> <p>-History of falls.</p> <p>Review of the resident's care plans showed no care plan specific to Huntington's disease, including symptoms and care to address the symptoms and resident experience of living with this disease.</p> <p>During an interview on 6/20/25 at 1:55 P.M. Resident #1 said the following:</p> <p>-The staff do not listen to him/her;</p> <p>-He/She could not help that he/she spilled things, it is my disease.</p> <p>During an interview on 6/20/25 at 2:00 P.M. Certified Medication Technician (CMT) B said the following:</p> <p>-Staff were afraid of the resident;</p> <p>-The resident was mean to everyone, he/she has been hit by the resident before;</p> <p>-The resident will not let staff clean his/her room;</p> <p>-He/She did not know what Huntington's disease was.</p> <p>During an interview on 6/23/25 at 1:00 P.M. Housekeeper E said the following:</p> <p>-He/She will go in and attempt to clean the resident's room and the resident frightened him/her;</p> <p>-He/She does not know what Huntington's disease was or how to approach or communicate with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/23/25 at 2:30 P.M. the Director of Housekeeping said the following:</p> <ul style="list-style-type: none"> -Staff were afraid of the resident; -He/She had heard of Huntington's disease, but was not aware of what a resident would experience with the disease. <p>During an interview on 6/20/25 at 2:30 P.M. Family Member (FM) A said the following:</p> <ul style="list-style-type: none"> -Staff do not know how to care for a person with Huntington's disease; -Everyone thought the resident had control over his/her movements and emotions and thinks the resident was mean and having behaviors; -Staff do not take the time and talk with the resident; -He/She has watched the camera footage from the resident's room and staff do not knock on the door, will just barge in and begin to pick up things, or sit food down on the table without talking with the resident and explaining what they are doing. <p>During an interview on 6/23/25 at 3:15 P.M. Registered Nurse (RN) C said the following:</p> <ul style="list-style-type: none"> -He/She was responsible for the development of the care plan; -After review of the resident's care plans, there was no care plan for Huntington's disease process. There should be a plan specific to this to educate staff and to direct staff when providing care to the resident and to understand the disease process. <p>During an interview on 6/23/25 at 4:11 P.M. the Administrator said:</p> <ul style="list-style-type: none"> -She would expect staff to develop care plans to address the residents disease process with interventions that are appropriate; -She would expect staff to be aware of what Huntington's disease is and how to care for the resident. <p>MO255918</p> <p>MO255925</p>