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 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewis & Clark Gardens	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a comfortable and homelike environment free from the presence of persistent urine and fecal odors with the carpet maintained in good repair. The facility census was 86.Review of the facility policy, Housekeeping Department, Seven Steps of Cleaning a Resident Room, undated showed no dust, no spots, no smudges, no smells equaled clean. 1. Observations on 03/20/26 from 9:30 A.M. to 4:30 P.M. showed the following:-Upon entry to the facility, there was a very strong smell of air freshener throughout the lobby area;-C hallway carpeted with several areas of stained carpet and a strong smell of air freshener;-room [ROOM NUMBER] there was a strong urine smell;-room [ROOM NUMBER] there was a strong urine smell;-B hall way carpet with several areas of stained carpet and a faint smell of urine covered up by a strong smell of air freshener. Observations on 3/31/26 at 9:45 A.M. to 4:30 P.M. showed the following:-Upon entering the facility, a strong odor of urine was noted throughout the lobby area;-The A hallway was noted to have a strong odor of urine throughout the entire hall;-The B hallway was noted to have a strong odor of urine and feces close to the nurses station;-room [ROOM NUMBER] had a strong odor of urine and feces and there were several areas of stained carpet. Observations on 3/31/26 at 7:45 A.M. through 2:00 P.M. showed the following:-Upon entering the facility an odor of urine covered up by air freshener was noted in the lobby area;-A hallway was noted to have a strong odor of urine throughout the entire hall;-B hallway was noted to have an odor of urine covered up by a strong odor of air freshener. During an interview on 4/1/26 at 9:35 A.M. the Housekeeping Supervisor said the following:-There were two floor technician staff, and they rotated cleaning the carpets daily. A floor extractor was used and an odor cleaning agent to clean the carpets;-The carpets on each hall were cleaned every two to three days;-The odors in the facility were usually related to the floors;-One resident on the A hall would not allow staff in his/her room and that room had very strong odors;-Certain residents spilled their urinals often and cleaning the floors was a constant battle;-Some of the aides always sprayed some type of spring time air freshener spray to help with the odors. During an interview on 4/1/26 at 12:20 P.M. the Administrator said the following:-The facility did not have a policy specific to odors;-She would expect staff to find the source of any odor and eliminate it;-Carpets were cleaned daily with carpet extractors on a rotation of each hall and as needed for spills;-She would expect the facility to be homelike which included being odor free. 2963297

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: 265160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301	

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(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** Based on interview, and record review, the facility failed to consistently complete an investigation following falls to identify the root cause for the falls and failed to consistently evaluate the effectiveness of interventions and identify/revise interventions to prevent falls for two residents (Resident #5 and #1), in a review of 10 sampled residents. Staff failed to immediately report Resident #1's fall to the nurse per facility policy prior to assisting the resident off the floor following a fall. The facility census was 86. Review of the undated facility policy, Event Investigation, showed the following:-Purpose: to investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed. To identify any injuries after a resident sustains an event;-Any staff member who discovers, witnesses or is involved in an event should immediately report the event to the nurse in charge. The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing as soon as possible.-Description of the event: describe (known, factual details) the event and include pertinent comments made by the person involved and any witness comments;-Describe the exact location of the event: describe precisely where the event occurred;-Describe the type of event, the outcome of the event, any injures, vital signs, mental status, neurological (neuro, anything related to the nervous system, which includes the brain, spinal cords and nerves)status, range of motion and any pain;-Document any first aid that was given;-Actions taken to prevent recurrence: what was done immediately to prevent the event from happening again. Review of the undated guidelines for the facility's Fall Champion Program showed the following:-After the primary portion of the morning meeting is completed, every fall event should be reviewed to ensure appropriate interventions were implemented and documentation was complete;-This should include review of progress notes, fall event, neuro check information, labs, medications, therapy and/or restorative documentation where applicable;-An Interdisciplinary Team (IDT) note will be completed in the progress notes and should consist of the circumstances surrounding the fall, interventions already in place and new interventions;-Prior to the conclusion of the meeting, a fall risk assessment will also be completed for the resident. The care plan and the resident's care card must also be updated;-After 72 hours is complete, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) Coordinator will review the fall event and ensure all documentation is complete. The event must be closed until you have reviewed all the documentation. Progress notes, neuro checks and the care plan;-The community's IDT will meet weekly and discuss the community's falls and interventions put into place and their effectiveness. The fall champion will collaborate with the MDS Coordinator to ensure the resident's care plan was updated;-Post fall guidelines included stay close to the resident, provide emergency care as needed, take vital signs and assess condition of the resident, notify the physician, fall champion, and administrator, notify family and responsible party and document such in the fall event. The charge nurse will initiate preventative fall interventions immediately and document those in the resident's care plan. 1. Review of Resident #5's undated face sheet showed the following:-The resident was admitted to the facility on [DATE];-Diagnoses included repeated falls, dementia, cerebral infarction (stroke), difficulty walking and muscle weakness. Review of the resident's care plan, dated 11/28/25, showed the resident had a history of falling. Staff were to keep the resident's bed in the lowest position and brakes on. Review of the resident's event report, dated 2/23/26 at 4:25 A.M., showed the following:-The resident had an unwitnessed fall. The resident was found on the floor next to his/her bed. The resident had redness to his/her right knee and left hip;-Possible contributing factors included cardiac/respiratory disease, orthopedic condition and dementia;-Interventions included rest and hospice to order a fall mat. Review of the resident's care plan, dated 2/23/26, showed the following:-Initiated on 2/23/26, the resident (continued on next page)

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(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	rolled out of bed. Ordered fall mats and bolster mattress (mattress with raised sides to help prevent rolling out);-Initiated on 2/23/26, analyze resident's fall to determine pattern and trend. Review of the resident's event report, dated 03/06/26 at 10:30 A.M., showed the following:-The resident had an unwitnessed fall. The resident lay on the floor next to his/her bed and was face down. The resident had redness to the left side of his/her rib cage;-Complaint of pain to lower back. Pain observation: excruciating pain;-Possible contributing factors present were none;-Immediate measures taken were none;-Mat on floor and bed was in the low position. Review of the resident's care plan showed no documentation staff updated the care plan following the resident's fall on 03/06/26 and no documentation to show staff reviewed or revised current interventions to prevent additional falls.Review of the resident's progress note, dated 3/7/26 at 5:02 A.M., showed staff went to the resident's room at 1:15 A.M. and found the resident on the floor by the bed. On assessment, the resident had a skin tear on the right hand. Staff cleaned the skin tear and applied antibiotic ointment. Staff assisted the resident back to bed and administered as needed (PRN) medication for pain and anxiety.Review of the resident's medical record showed no documentation staff completed an event report, including possible contributing factors or analyzed for patterns or trends as directed by the resident's care plan.Review of the resident's care plan showed no documentation staff reviewed or revised the care plan interventions to address falls following the resident's fall on 03/07/26. Review of the resident's event report, dated 03/11/26 at 9:00 A.M., showed the following:-The resident had a witnessed fall from his/her wheelchair. The resident had a skin tear to left inner arm below the elbow;-The resident complained of back pain. Pain observation showed severe to horrible intense pain;-Immediate intervention was first aid;-Fall mat already in place next to bed;-No interventions used;-Called hospice to see if a Broda chair (specialized wheelchair that tilts and reclines) could be obtained. Review of the resident's medical record showed no evidence staff reviewed or revised the care plan or analyzed for patterns or trends following the fall on 03/11/26. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Short and long-term memory impairment;-Cognitive skills for daily decision making was severely impaired, never or rarely made decisions;-Dependent on staff for ADLs;-The resident had falls since the previous assessment;-The resident had two or more falls without injury and one fall with injury (except major) such as skin tears, lacerations, and abrasions. Review of the resident's event report, dated 03/16/26 at 6:56 A.M., showed the following:-The resident had an unwitnessed fall in his/her room;-The resident exhibited moderate pain in the right hip and right side;-The resident had redness to his/her right hip and the right side of his/her back;-Immediate measures taken: analgesics;-Preventative interventions implemented: adjust bed to the lowest level;-Interventions effective. Review of the resident's medical record showed no documentation staff reviewed or revised the care plan or analyzed for patterns or trends following the resident's fall on 03/16/26. Review of the resident's event report, dated 03/18/26 at 6:25 P.M., showed the following:-The resident had an unwitnessed fall. The CNA reported he/she found the resident on the floor. There was no fracture or injury noted;-Contributing factors, interventions taken, and preventative interventions implemented were not completed on the event report. Review of the resident's progress notes, dated 3/18/26 at 8:51 P.M., showed the resident had an unwitnessed fall at 6:00 P.M. The CNA reported he/she entered the resident's room and found the resident on the floor. There were no fractures or injury noted.Review of the resident's medical record showed no documentation staff reviewed or revised the care plan or analyzed for patterns or trends following the resident's fall on 03/18/26. Review of the resident's progress note, dated 3/20/26 at 5:35 P.M., showed the following:-The resident had an unwitnessed fall. An aide found the resident on the floor next to his/her bed and notified the nurse;-Upon arrival, no new injuries were noted. Review of the resident's medical record showed no documentation staff completed an event report, including any contributing factors and interventions, reviewed or revised the care plan or analyzed for patterns or trends following the fall on 03/20/26.Review of the resident's progress note, dated 03/25/26 at 6:35 P.M., showed an aide found the resident at 6:15 P.M. on the floor mat in his/her room. No new (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries noted at this time.Review of the resident's medical record showed no evidence staff completed an event report, including any contributing factors and interventions, or reviewed or revised current interventions that were in place or analyzed for patterns or trends following the fall on 03/25/26. During an interview on 4/1/26 at 9:50 A.M., Licensed Practical Nurse H said the following:-The resident had a lot of falls, and most of his/her falls were unwitnessed;-The only interventions in place to prevent falls were a fall mat, a low bed and bolsters, and staff tried to keep an eye on the resident;-The MDS Coordinator updated the care plans with any new interventions. During an interview on 4/1/26 at 11:20 A.M., the MDS Coordinator said the following:-Residents at risk for falls should have a care plan in place related to falls. The interventions should be individualized to each resident;-He/She was to add all falls to the care plan;-He/She was off work for a few weeks and was not aware Resident #5 had multiple falls in March;-He/She had not reviewed or revised any care plans with falls or new interventions related to falls for a while;-The facility did not have routine interdisciplinary meetings to discuss falls. During an interview on 4/1/26 at 1:15 P.M., the Director of Nursing (DON) said the following:-She was covering on the floor and was unable to review and audit charts for falls and interventions that were put in place. Also, routine interdisciplinary (IDT) meetings were not taking place to discuss and review falls;-Licensed nursing staff should review the residents' care plans after each fall and revise as needed. 2. Review of Resident #1's medical record showed no documentation to show staff completed a fall risk assessment.Review of the resident's nurse's note, dated 03/02/26 at 6:34 A.M., signed by Registered Nurse (RN) A, showed the resident had an unwitnessed fall in his/her room at 5:30 A.M. Staff assessed the resident and there were no fractures, but the resident complained of mild pain on his/her left shoulder. Staff administered pain medication.Review of the resident's medical record showed no documentation staff completed an event report with interventions to prevent falls after the resident fell on [DATE]. During an interview on 03/20/26 at 4:30 P.M., Registered Nurse (RN) A said the following:-He/She was the resident's nurse on 03/02/26;-When he/she returned from a break, a staff member told him/her the resident fell out of bed;-CNA C had already put the resident back into bed before he/she found out about the fall;-CNA C told him/her the resident fell out of bed and there were no injuries, so CNA C and CNA B put the resident back in bed. During an interview on 03/27/26 at 3:07 P.M., CNA C said he/she could not find RN A and the resident was asking to get off the floor, so he/she moved the resident's arms and legs and asked if the resident was hurt. He/She saw a lot of nurses do the assessment after a resident fell, and the resident did not complain of any pain. He/She and CNA B assisted the resident off the floor.Review of the resident's care plan showed no documentation staff developed a care plan with interventions to prevent falls after the resident fell on [DATE].Review of the resident's nurse's note, dated 03/18/26 at 6:36 A.M., showed another resident called staff to the resident's room. The resident was on the floor near the window. The resident could not say exactly what happened. On assessment, staff did not identify any injury.Review of the resident's medical record showed no documentation staff completed an event report with interventions to prevent falls after the resident fell on [DATE]. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 03/23/26, showed the following:-Moderate cognitive impairment;-Dependent upon staff for activities of daily living (ADLs);-Diagnoses of Alzheimer's disease and non-Alzheimer's dementia (various neurodegenerative diseases causing cognitive decline that are not caused by Alzheimer's disease) and spinal stenosis (a chronic, degenerative condition where the spaces within the spine narrow, compressing the spinal cord or nerves);-At risk for falls. Review of the resident's care plan, dated 03/24/26, showed there was no care plan developed for falls. There was no documentation of the fall that occurred on 03/18/26 and no interventions were in place to help prevent future falls. 3. During interviews on 04/01/26 at 8:00 A.M. and 2:15 P.M., the Administrator said the following:-It was not appropriate for CNAs to get up a resident after a fall before a nurse assessed the resident;-She expected staff to follow the facility event/accident policy for falls;-Any nurse can update the care (continued on next page)

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	265160	A. Building B. Wing	04/01/2026

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Lewis & Clark Gardens	1221 Boones Lick Road Saint Charles, MO 63301

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plans with interventions after a resident fell;-Staff should update the care plans with each fall. Staff should review the interventions after each fall and implement new interventions as needed;-The facility did not conduct routine IDT meetings to review falls. 27946112966988

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) worked in the facility completing the duties of the DON and did not work as a charge nurse when the facility had an average daily occupancy of over 60 residents. The facility census was 86.Review of the facility's Director of Nursing Job Description, dated May 2006, showed the following:-The primary purpose of the job position is to plan, organize, develop and direct the overall operation of our nursing service department in accordance with current federal, state and local standards, guidelines and regulations that govern our facility, and as directed by the Administrator and facility policies to ensure that the highest degree of resident care is maintained al tall times;-The DON must be in the facility or involved in other work-related activities, a minimum of eight hours per day, Monday through Friday. 1. Review of the facility's daily census recapitulation, dated March 2026, showed the total daily census for the month of March 2026 was 83 to 91 residents. Review of the facility staffing sheets, dated March 2026, showed the following:-On 03/02/26, the DON worked the floor as the charge nurse on the evening shift (2:00 P.M. to 10:00 P.M.)-On 03/07/26, the DON worked the floor as the charge nurse on the night shift (10:00 P.M. to 6:30 A.M.)-On 03/08/26, the DON worked the floor as the charge nurse on the night shift;-On 03/09/26, the DON worked the floor as the charge nurse on the evening shift;-On 03/10/26, the DON worked the floor as the charge nurse on the evening shift;-On 03/16/26, the DON worked the floor as the charge nurse on the evening shift;-On 03/17/26, the DON worked the floor as the charge nurse on the day shift;-On 03/17/26, the DON worked the floor as the charge nurse on the evening shift;-On 03/20/26, the DON worked the floor as the charge nurse on the night shift;-On 03/21/26, the DON worked the floor as the charge nurse on the evening shift;-On 03/21/26, the DON worked the floor as the charge nurse on the night shift;-On 03/22/26, the DON worked the floor as the charge nurse from 4:00 A.M. to 6:00 A.M on the night shift;-On 3/23/26, the DON worked the floor as the charge nurse on the evening shift;-On 3/27/26, the DON worked the floor as the charge nurse on the night shift;-On 3/28/26, the DON worked the floor as the charge nurse on the night shift;-On 3/29/26, the DON worked the floor as the charge nurse on the evening shift. During an interview on 04/01/26 at 1:15 P.M., the DON said the following:-She worked the floor on the evening and night shifts since December 2025 since the facility was short of licensed nursing staff;-She was unaware the DON could not cover the floor routinely with a census over 60 residents;-It was difficult to work the floor and complete her DON duties. She was unable to review and audit charts, such as falls and interventions that were put in place. Some days, she worked a few hours completing the DON duties on days she worked the floor, but it was exhausting. During an interview on 4/1/26 at 12:20 P.M., the Administrator said she was unaware the DON could not work the floor routinely with a census over 60. She expected the facility to follow the regulatory requirement regarding the DON and coverage on the floor.