STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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 0561 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0561 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) D, an agency CNA, respected Resident #24's right to remain in bed. On 10/2/25, the CNA transferred the resident out of bed for a shower after the resident told the CNA he/she did not want to get out of bed. The resident said he/she was upset about being made to get up, the transfer was rough and felt like a tussle. During the transfer, the resident sustained a large skin tear, approximately ten centimeters (cm) long, to the left lower leg. The resident was sent to the hospital where five sutures were required to close the skin tear. The facility investigated the incident and in-serviced some nursing staff on transfer training. The facility investigation failed to identify the resident's right to self-determination had been violated, and no interventions regarding resident's rights were implemented. The census was 90. Review of the facility Resident Rights Policy, dated 9/19/24, showed:-Policy Statement: The facility will protect and promote the rights of each resident to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The requirements concerning resident rights are guaranteed to them under Federal and State law;-Procedure:-Information regarding resident rights and facility rules will be posted in a conspicuous location in the facility and copies will be provided to anyone requesting this information;-Staff Competencies in Resident Rights information will include the following: Understanding of abuse, neglect, misappropriation of resident property, and exploitation. Demonstrate respect for residents through actions and interactions. Plan and provide individualized care and services as the resident prefers. Ability to provide residents with quality care and services with respect. Follows resident preferences in care decisions and choices;-Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality;-Right to Self Determination: Choices of activities, schedules, health care, and providers, including attending physician. Reasonable accommodation of needs and preferences. Request, refuse, and/or discontinue treatment.Review of the facility Resident Handbook, revised 6/22, showed:-Our goal is not to maintain but enrich lives. We respect personal dignity and promote independence;-Our Mission: Empower elders and their caregivers through choices and options that foster a vital life;-We believe that you have the right to make decisions about your medical care, including the right to refuse care;-Resident Responsibilities (includes): Assist in planning your own care;-Nursing Home Residents' Rights (include): -Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality. Quality of life is maintained or improved;-Right to Self-Determination (includes): Choice of activities, schedules, health care, and providers, including attending physician. Reasonable accommodation of needs and preferences. Request, refuse, and/or discontinue treatment.Review of Resident #24's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 8/11/25, and located in the electronic medical record (EMR), showed:-Hearing: Minimal difficulty;-Speech Clarity: Clear speech - distinct intelligible words;-Makes Self Understood: Understood;-Ability To Understand Others: Understands;-Chair/bed-to-chair/transfer: Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort;-Diagnoses of high blood pressure, arthritis, weakness and chronic pain.Review of the resident's care plan, dated 10/2/25, and located in the EMR, showed:-8/11/25, Focus: ADL (activities of daily living) self-care performance deficit. Goal: Resident will maintain current level in ADLs. Interventions: Transfers - partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort;-8/11/25, Focus: Communication problem. Goal: Will be able to make basic needs known on a daily basis. Intervention: Allow adequate time to respond. Repeat as necessary. Do not rush. Request clarification from the resident to ensure understanding. Ask yes/no questions if appropriate.Review of the resident's physician's order sheet (POS), located in the EMR, showed:-9/8/25: Shower/Bath every Monday and Thursday.Review of the resident's progress note, located in the EMR, showed:-10/2/25 (Thursday) at 9:52 A. M., Licensed Practical Nurse (LPN) B documented: This nurse made aware that the resident had a skin tear to the left leg. Upon assessment, resident was observed with a deep laceration to the lower part of left leg. Pressure was applied. Physician was called and wants resident to go get stitches. Director of Nursing (DON) and Administrator notified.Review of the Executive Director's/Administrator's initial report to the Department of Health and Senior Services (DHSS) on 10/2/25 at 7:35 P.M., showed:-Resident #24 was transferred today from his/her bed to his/her wheelchair. During the transfer, resident hit his/her leg on his/her wheelchair