STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265236	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the resident's representative after the resident fell, for one out of three residents sampled for falls. (Resident #1). The census was 75.Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/10/25, showed:-Cognitive intact;-Diagnoses included: diabetes, high blood pressure, end stage renal failure (ESRD, chronic irreversible kidney failure) dependence on renal dialysis (a life-sustaining treatment that filters waste products and excess fluid from the blood when the kidneys are no functioning properly);-Mobility devices: wheelchair and walker;-One fall since admission/entry or reentry;-Partial/moderate assistance (helper does less than half of the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) for chair/bed-to-chair transfers. Review of the resident's care plan in the use at the time of survey, showed:-Focus: The resident has had an actual fall with no Injury, minor injury, serious injury;-Interventions: On 11/9/25, resident encouraged to use call light when needing any assistance; Monitor/document /report as needed times 72 hours to physician for signs and symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, agitation. Review of the progress notes dated 11/9/25 at 7:20 P.M., showed the nurse was called down to room, the resident was on the floor in the bathroom. States he/she did not lock his/her wheelchair before getting back in it from using the restroom. Vitals stable. Denies hitting his/her head. Able to move extremities within resident's normal limits. Alert and oriented times four (person, place, time and situation). Neurological checks within normal limits. Denies pain. Message left for Medical Doctor (MD);-There was no documentation showing the resident's representative was notified. During an interview on 12/18/25 at 11:05 A.M., Licensed Practical Nurse (LPN) A said if a resident fell, he/she would assess the resident and get the resident up, if the resident was able. The Director of Nursing (DON), MD and the resident representative (RP) are then notified. During an interview on 12/18/25 at 11:35 A.M., LPN B said if a resident fell, he/she would do a head-to-toe assessment and notify the MD and the RP. Falls are documented under risk management, and in the progress notes. During an interview on 12/19/25 at 10:41 A.M., the Assistant Director of Nursing (ADON) said staff should notify management, the physician and the family when a resident falls and document it in the progress notes. During an interview on 12/19/25 at 1:30 P.M., the Administrator said she had no documentation to show the family was notified after the fall. She would expect the nurse to assess any resident who falls and notify the physician and family, and document it. 2688707

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services meet professional standards of quality by failing to follow physician orders to call the physician when blood sugar levels were out or range and/or obtaining blood sugar checks as ordered. In addition, staff failed to obtain a physician order for when staff should notify the physician of blood glucose (sugar) levels that are out of range for three residents (Residents #6, #1, and #4). The sample was 6. The census was 75.Review of the facility's Nursing Care of the Older Adult with Diabetes's Mellitus (DM, metabolic disease) policy, undated, showed:-Glycemic targets (a personalized blood glucose goal set by a healthcare provider to manage diabetes): use a glucometer (blood sugar meter) for capillary blood sampling to measure current blood glucose levels;-The target range for healthy older adults is considered 90-130 milligrams (mg)per deciliter (dl), (fasting or pre-prandial glucose (blood glucose level just before eating);-Establish provider notification protocols, for example: Call provider immediately if the resident is hypoglycemic (low blood glucose level) less than 70 mg/dl. Review of the facility's mealtimes, showed:-The main dining room, breakfast at 7:30 A.M.; lunch at 12:00 P.M.; and dinner at 5:30 P.M.-The hall trays, breakfast at 7:00 A.M.; lunch at 11:20 A.M.; and dinner at 5:00 P.M. 1. Review of Resident #6's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/25, showed the resident cognitively intact. Diagnoses included diabetes. Review of the resident's care plan in use at the survey, showed:-Focus: DM;-Goal: will have minimized risk of complications related to diabetes through the review date;-Interventions: diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the Medication Administration Record (MAR) dated 12/1/25 through 12/31/25, showed:-A physician order for Humalog (short acting insulin), inject as per sliding scale: if above 300, give 8 units and call physician, subcutaneously (injection under the skin) with meals. Scheduled administration times 7:00 A.M., 12:00 P.M., and 6:00 P.M.:--At 7:00 A.M., six out of 15 opportunities the blood sugar measured above 300;--At 12:00 P.M., five out of 15 opportunities the blood sugar measured above 300;--At 6:00 P.M., three out of 15 opportunities the blood sugar measured above 300. Review of the resident's December 2025 progress notes, showed:-On 12/5/25 at 6:43 A.M., resident voiced that spike in blood sugar was due to eating peanut butter and jelly this morning before the blood sugar check. Resident given 8 units and medical doctor (MD) aware;-No other documentation showed the MD was notified when the blood sugar was above 300. During an interview on 12/19/25 at 10:41 A.M. the Assistant Director of Nursing (ADON) said she did not see any other documentation the physician was notified when the blood sugars were outside the perimeter. 2. Review of Resident #4's quarterly MDS dated [DATE], showed the resident cognitively intact. Diagnoses included diabetes. Review of the resident's care plan in use at the time of survey, showed:-Focus: the resident has potential for hypoglycemia (low blood glucose level);-Goal: the resident will be free from any signs and symptoms of hypoglycemia through the review date;-Interventions included: monitor/document/report to medical doctor as needed signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Review of the resident's MAR dated 11/11/25 through 11/30/25, showed:-A physician order dated 11/11/25, for Humalog solution, inject as per sliding scale: if 181 - 220 = 2 Give 2 units; 221 - 260 = 3 Give 3 units; 261 - 300 = 4 Give 4 units; 301 - 350 = 5; give 5 units, subcutaneously before meals for diabetes, (blood sugar) greater than 350 give 6 units and notify physician;-Documentation showed: blood glucose monitoring was scheduled and completed at 6:30 A.M., 8:00 A.M. and 11:00 A.M.;-No blood glucose monitoring completed before supper. Review of the resident's MAR dated 12/1/25 through 12/18/25, showed:-A physician order for Humalog, inject as per sliding scale: if 181 - 220 = 2 Give 2 units; 221 - 260 = 3 Give 3 units; 261 - 300 = 4 Give 4 units; 301 - 350 = 5; give 5 units, subcutaneously before meals for diabetes, (blood sugar) greater than 350 give 6 units and notify physician;-Documentation showed: blood glucose monitoring was scheduled and completed at 6:30 A.M., 8:00 A.M. and 11:00 A.M.;-No blood glucose monitoring completed before supper. Review of the progress notes dated 11/18/25 through 12/18/25, showed no documentation showing the physician order was changed. During an interview on 12/19/25 at 10:41 A.M. the ADON said she would expect staff to complete the blood sugar checks before each meal as ordered. 3. Review of Resident #1's admission MDS, dated [DATE], showed the resident cognitively intact. Diagnoses included diabetes. Review of the resident's care plan in use at the time of survey, showed:-Focus: the resident has non-insulin dependent diabetes;-Goal: the

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly and accurately assess and document a resident's surgical wound upon admission, then weekly per the facility's policy for one resident (Resident #1). The sample was 6. The census was 75.Review of the facility's Skin Integrity-Pressure and Non-Pressure policy, undated, showed:-Purpose: to establish guidelines for assessing, monitoring and documentation the presence of the skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented;-Guidelines: non-pressure skin conditions (surgical wounds) will be assessed for healing process and signs of complications or infection;-A skin condition assessment will be completed at the time of admission/readmission;-Resident identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/10/25, showed:-Diagnoses included: open wound of left hand; cellulitis (bacterial infection of the skin and the tissues beneath it) of left finger; abscess (swollen area within the skin containing accumulation of pus) of left hand and diabetes;-Had a surgical wound. Required surgical wound care. Review of the resident's medical record, showed:-A care plan in the use at the time of survey, failed to show the wound(s) on left hand;-The progress notes dated 11/3/25, showed no admission note documented;-An admission skin assessment dated [DATE], showed resident admitted with the following skin issues: site: left hand (palm). Description: infected wound. Comments: blank. The assessment failed to show the wound on the left thumb and failed to give a description of the wound;-An order dated 11/4/25 for wound care. Cleanse left hand open area with wound cleanser. Fill wound bed with Hydrofera Blue (advanced, antibacterial foam wound dressings). [NAME] with dry dressing everyday shift. Documented as completed as ordered;-A skin assessment dated [DATE], showed no new changes this week. Site and description: blank. Review of the facility's wound report (a report that tracks wounds for all facility residents and is not part of the resident's medical record) dated 11/7/25 through 11/21/25, showed the following for the resident:-On 11/7/25 and 11/14/25, the resident was not included on the wound report;-On 11/21/25: Left hand palm, surgical wound, size: 0.8 centimeters (cm) length X 2.5 cm width X 0.5 cm depth; no odor or drainage, 100 % granulation (new tissue). Left thumb, surgical wound, size: 0.6 x 2.0 X 0; no drainage or odor; 100% eschar (dead tissue). Review of the resident's wound weekly evaluation-non pressure assessment dated [DATE], showed:-Location of wound: left hand (palm), surgical wound present on admission. Size: 0.2 X 2.0 X 0.4. Wound unchanged;-Location of wound: left hand (palm) left thumb, surgical wound present on admission. Size: 0.6 X 2.0 X 0. Wound unchanged. During an interview on 12/18/25 at 11:35 A.M., Licensed Practical Nurse (LPN) B said if a resident had a new wound, he/she would assess the wound, call the physician and get orders and document it under risk management. During an interview on 12/19/25 at 8:30 A.M., the Wound Nurse said a skin assessment is completed on admission, then weekly by the floor nurse. She was responsible for documenting the wounds weekly. Both pressure and non-pressure wounds are documented weekly under assessments. The note should include the location, size, if there is any drainage and/or odor and what the surrounding tissue looked like. An infected wound would have an odor, drainage and redness around the wound edges. The resident had surgical wounds on his/her hand and thumb. Both were present on admission. The wound on the thumb did not change. The wound on the hand was getting smaller. There was no wound documentation completed in the medical record until 12/1/25. During an interview on 12/19/25 at 10:41 A.M., the Assistant Director of Nursing (ADON) said skin assessments are completed on admission and weekly after that. Wound assessments are documented weekly including non-pressure wounds by the wound nurse and documented under assessments. She would expect skin assessments to be accurately completed on admission, noting all wounds. During an interview on 12/19/25 at 1:30 P.M., the Administrator said non-pressure wounds should be documented weekly. She would expect staff to follow the facility's policies and procedures. 2688707