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	06/22/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 ensure residents received adequate assistance to prevent accidents when Certified Nurse Aide (CNA) F provided improper transfers to two residents (Residents #3 and #4) resulting in injury. Resident #3 was identified by the facility as requiring a Hoyer lift for transfers. On 05/16/26, CNA F transferred the resident by picking up the resident without a lift, a gait belt, or another employee to assist. The resident's foot got caught, resulting in a fractured right tibia (shin bone) and fibula (calf bone). CNA F was suspended, re-educated on the facility's transfer policies, and returned to work. Resident #4 was identified by the facility as requiring two staff to assist with transfers. On 05/27/26, CNA F performed a transfer by him/herself to assist the resident to the bathroom. CNA F did not use a gait belt. The resident fell, resulting in a fractured fibula. The sample was 5. The census was 83.The Administrator was notified on 06/18/26 at 1:15 P.M. of an Immediate Jeopardy (IJ) which began on 05/16/26. The IJ was removed on 06/19/26, as confirmed by surveyor onsite verification. Review of the facility's Lifting Machine, Use of a Mechanical Device policy, updated 11/2025, showed:-Policy Statement: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device it is not a substitute for manufacturer's training or instructions;-General Guidelines: At least two qualified staff are needed to safely move a resident with a mechanical lift. Review of the facility's Gait Belt Utilization policy, updated 02/04/26, showed:-Policy Statement: The facility is committed to ensuring the safety, dignity, and well-being of our residents and staff. To minimize the risk of falls, injuries, and skin tears during transfers, a gait belt must be utilized for all residents who require physical assistance from staff during ambulation, transfers, or repositioning, unless clinically contraindicated;-Purpose: To protect residents from falls, friction injuries, and bruising during physical assistance;-Scope: Policy applies to all clinical staff, including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), CNAs, and physical/occupational therapy personnel employed or contracted by the facility;-General rules of use:--Prohibited Grips: Staff are expected to use the safest mode of assistance and should avoid lifting a resident by their arms, underarms, pants, or waistbands when practicable;--Mechanical Lifts: A gait belt is not a lifting device. If a resident cannot bear weight on at least one leg, a mechanical lift or sit-to-stand should be used. 1. Review of Resident #3's face sheet, showed diagnoses included protein-calorie malnutrition, adult failure to thrive, and generalized muscle weakness. Review of the resident' physician order sheet (POS), showed an order, dated 12/09/24, dependent transfers at baseline, requires total assistance from staff to transfer resident from bed, chair, toilet. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/20/26, showed:-Cognitively intact;-Dependent on assistance with showers/bathing and chair/bed-to-chair and tub/shower transfers. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has an activity of daily living (ADL) self-care performance deficit;-Interventions included resident required mechanical aide lift (Hoyer) and two staff for transfers;-Focus: Resident has potential/actual impairment for skin integrity related to immobility;-Interventions included on 05/15/26, resident (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	complained of pain to right ankle and some discoloration noted, resident stated it was hit during a transfer. X-ray order obtained. Review of the resident's progress notes, showed:-On 05/16/26 at 10:30 AM, staff documented the resident complained of increased pain to right foot. Assessed foot at this time and right ankle appeared discolored with bruising and tender to touch;-On 05/16/26 at 10:35 A.M., staff documented a call was placed to the Nurse Practitioner (NP), who was made aware of the complaint of right foot pain and discoloration. X-ray ordered;-On 05/16/26 at 12:30 P.M., staff documented a call was placed to the on-call for physician and spoke with NP. Informed of x-ray results of right foot and ankle. New order to send to emergency room (ER) for evaluation. Review of the resident's ER after visit summary, dated 05/16/26, showed a diagnosis of closed fracture of right tibia and fibula and acute right ankle pain. During an interview on 06/17/26 at 11:21 A.M., the resident said on 05/15/26 at around 8:30 A.M., CNA F came into his/her room to get him/her up without a Hoyer lift. CNA F assisted the resident to the side of the bed. The resident was dizzy. CNA F said he/she had the resident, and the resident would be okay. CNA F lifted the resident underneath his/her arms and transferred the resident to his/her Broda chair (reclining chair). During the transfer, the resident's foot hit the footrest, causing pain. The resident said he/she hit her foot, and it really hurt. CNA F said the resident would be okay. The pain was there all day and after supper, the resident told the nurse on duty what CNA F did and that his/her foot hurt. The next day, the resident reported it to a different nurse on duty and that nurse assessed it and called the physician. The resident received an x-ray and it showed his/her right ankle was broken and he/she was sent to the hospital. During an interview on 06/18/26 at 2:05 P.M., the resident's roommate, Resident #5, said he/she was in the room when the transfer without a lift occurred. Resident #3 told CNA F he/she did not want to get up, but CNA F transferred the resident anyway by placing his/her hands underneath the resident's arms and lifting the resident into his/her wheelchair. Resident #5 heard Resident #3's foot hit the wheelchair and the resident screamed at CNA F saying his/her foot hit the chair. CNA F ignored the resident. During an interview on 06/17/26 at 2:45 P.M., CNA F said he/she and CNA G transferred the resident without a Hoyer lift, because there were no pads. The resident's foot got caught on the chair. Later that day, the resident complained of foot pain. CNA F was suspended the next day. He/She received in-service training on transfers and was allowed to return to work. During an interview on 06/17/26 at 3:05 P.M., CNA G said he/she worked on the day of the resident's fall. He/She asked CNA F to finish getting the resident dressed and CNA G would return after to help with a transfer, because the resident was a Hoyer lift. By the time CNA G returned to the resident's room, the resident was already in his/her Broda chair in the hallway. Review of the facility's investigation, undated, showed:-A written statement from CNA F, dated 05/19/26, in which CNA F documented he/she was rushing to get the resident up. They didn't have any Hoyer pads, so CNA F put the resident in his/her chair and the resident held onto the rail of his/her bed;-A summary, dated 05/19/26, showed CNA F got the resident up into his/her chair on 05/15/26 for day shift with no Hoyer pad. The incident resulted in injury to the resident. CNA F was suspended. He/She admitted he/she got the resident up without using a Hoyer lift and he/she did not wait for a second person to assist with the transfer. CNA F will get corrective action and will complete a mechanical lift and correct transferring techniques inservice with return demonstration with the Therapy Director before allowed to work again;-CNA F was in-serviced by the Therapy Director on 05/20/26 on transfer and safety techniques. 2. Review of Resident #4's admission MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance with showers/bathing and tub/shower transfers;-Moderate to maximal assistance with chair/bed-to-chair and toileting-Diagnoses included peripheral vascular disease, right leg amputee, and right leg prosthesis. Review of the resident's care plan, in use at the time of survey, showed:-Focus, revised 05/13/26, of potential for falls related to decreased mobility, fall noted 05/12/26 in bathroom when toileting;-Interventions included monitor for toileting needs and transfer with two when toileting. Review of the resident's progress note, dated 05/27/26 at 4:13 P.M., showed the resident was alert, oriented x4, and able to make needs known. The resident had a witnessed fall (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in his/her bathroom. CNA F reported to the nurse that the resident was sitting on the floor. Upon assessment, the nurse observed the resident sitting upright on the floor holding his/her left ankle. Resident states, I heard my ankle pop. CNA F reported he/she was assisting the resident to the bathroom when the resident lost his/her balance and was lowered to the floor. The resident complained of left ankle pain/discomfort during the transfer. Nurse observed the resident was unable to bear full weight on left lower extremity. The NP notified and a stat x-ray of the left ankle was ordered. Review of the resident's ER after visit summary, dated 05/28/26, showed the diagnoses included an injury of the left ankle and a closed fracture of the distal end of the left fibula. During an interview on 06/17/26 at 1:12 P.M., the resident said CNA F helped him/her to the bathroom. The resident stood with his/her hands on a bar in the bathroom and he/she felt him/herself going down. CNA F did not have time to help as the resident went down. On the way down, he/she heard his/her ankle pop. During an interview on 06/17/26 at 2:45 P.M., CNA F said he/she assisted the resident to the bathroom without a gait belt and no other staff. CNA F told the resident to hold on to the grab bar when he/she stood up. The resident said he/she was going down and ended up on the floor. Review of the facility's investigation, showed:-A typed statement, dated 05/28/26, in which the Executive Assistant documented she spoke to the resident related to the incident. The resident stated he/she was trying to go to the bathroom. The resident raised him/herself up from the wheelchair and began to lose his/her balance. CNA F reached to try and catch the resident, but could not and lowered him/her to the ground. The resident heard something pop as he/she went down;-An undated written statement from CNA F, showed CNA F documented he/she took the resident to the bathroom and he/she lost his/her balance and the CNA helped the resident to the floor. The resident said his/her foot popped so CNA F got him/her up and to the toilet, then off the toilet to the chair;-An undated summary, showed CNA F assisted a resident in an improper transfer resulting in injury. This employee had a prior incident on 05/15/26 with another resident for improper transfers, also resulting in injury. This employee was given re-education on appropriate transfers from the Therapy Director with return demonstrations before being allowed to work after the first incident. Due to the severity of this incident, this employee has been terminated as of 05/28/26. 3. During an interview on 06/17/26 at 11:00 A.M., CNA I said a resident's transfer status is not documented anywhere. The nurse tells CNAs how to transfer a resident. CNA I had not received additional education about transfers after Resident #3's injury. During an interview on 06/17/26 at 11:12 A.M., Certified Medication Technician (CMT) D said nurses determine how a resident transfers. He/She did not know how to access this information in the resident's record. During an interview on 06/17/26 at 12:30 P.M., the Director of Nurses (DON) said CNA F was given a second chance after the incident involving Resident #3. CNA F transferred Resident #4 without a gait belt. The resident sustained a fractured ankle. CNA F was terminated after this incident. During an interview on 06/18/26 at 9:32 A.M., the Administrator said CNA F failed to utilize the proper transfer of a Hoyer with a two-person assist with Resident #3. After the incident, CNA F had to do competencies training with the Therapy Director before he/she could return to work. The resident failed to use a gait belt when transferring Resident #4. The Administrator expected all nursing staff to perform transfers in accordance with a resident's physician orders, care plan, and therapy recommendations. During an interview on 06/17/26 at 4:18 P.M., the physician for both residents said he was aware both residents had recent fractures. He was not aware the fractures occurred as a result of improper transfers. He expected nursing staff to follow orders, care plans, and therapy orders for how to transfer residents. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). 3023257