STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265321	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	700 Garden Path O Fallon, MO 63366

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 - 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 ensure the safety of one resident (Resident #1) with a history of falls, in a review of five sampled residents, when staff did not routinely check on the resident at least every two hours per the facility's expectations throughout the night. On the morning of 5/30/26, staff found the resident on the floor in his/her room with the door closed for an undetermined amount of time with dried blood on his/her hair, face, and hands. The resident was admitted to the hospital following evaluation. The resident remained in the hospital for four days with discharge diagnoses of traumatic hematoma (collection of pooled, clotted blood that forms outside of a blood vessel, usually caused by injury or trauma) of head and traumatic rhabdomyolysis (a serious medical condition where severe physical injury causes skeletal muscles to rapidly breakdown). The facility census was 84. On 07/01/26 at 01:40 P.M., the Administrator was notified of the past noncompliance which occurred on 05/30/26. On 05/30/26, the Director of Nursing became aware of Resident #1's fall and the resident lay on the floor for an undetermined amount of time before staff found him/her on the floor. During the Director of Nursing's investigation, she determined Certified Nurse Assistant (CNA) H and CNA I did not check on the resident throughout the night. Licensed Practical Nurse (LPN) J did not ensure the staff conducted routine rounds on the resident every two hours. The Director of Nursing terminated CNA H and CNA I's employment, gave LPN J a warning, and provided one-on-one education to LPN J. The deficiency was corrected on 06/01/26. Review of the facility's policy, Safety and Supervision of Residents, revised 11/2025, showed the following:-The staff shall use various sources to identify risk factors for residents, including information obtained from the medical history, physical exam, observation of the resident, and the Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff);-Implementing interventions to reduce accident risks and hazards should include the following:Communicating specific interventions to all relevant staff;Assigning responsibility for carrying out interventions;Providing training, as necessary;Ensuring that interventions are implemented;Documenting interventions;-To ensure the safety and well-being of the residents, nursing staff should make routine resident checks throughout their shift and according to resident needs;-Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any changes in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 1. Review of Resident #1's admission summary, dated [DATE] at 3:31 P.M., showed the resident arrived at the facility on 5/28/26 at approximately 1:00 P.M. Review of the resident's care plan, dated 5/29/26, showed the following:-The resident was at risk for falls related to gait/balance problems, incontinence, psychoactive drug use and history of falls; -Anticipate and meet the resident's needs;-Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance;-The resident needed a safe environment with even floors, free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at (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 - Actual harm Residents Affected - Few	night; handrails on walls, and personal items within reach. Review of the resident's health status note, dated 05/29/26 at 9:07 P.M., showed the following:-The resident walked around the hallway most of the shift;-He/She was very confused. Review of the resident's health status note, dated 05/30/26 at 08:41 A.M., showed the following:-Around 7:00 A.M., the certified nurse assistant (CNA) notified the nurse the resident was found on the floor in his/her room;-The resident was unable to say what happened;-The resident had a large hematoma the right side of his/her forehead. Review of the facility's investigation, dated 5/30/26, showed the following:-CNA H and CNA I left their shift without conducting walking rounds with CNA B (who worked the oncoming shift);-CNA B found the resident during his/her rounds at 6:45 A.M.;-The resident had a large hematoma on his/her forehead and was bleeding;-CNA B said when he/she found the resident, the resident was lucid (able to think clearly);-The resident said he/she was going to the bathroom and did not remember hitting the floor. He/She crawled around trying to get up and could not. The door was closed and he/she guessed no one heard him/her when he/she called for help. He/She pulled a pillow and a blanket off the bed and had it on the floor with him/her. He/She tried to clean up the blood with the blanket but smeared it everywhere. When staff asked the resident if he/she was okay, the resident responded, yes. Review of the resident's emergency room physician note, dated 05/30/26 at 10:34 A.M., showed the following:-Per the emergency medical services, the overnight staff did not see the resident;-The resident arrived with a large hematoma to his/her forehead;-The blood was completely dried in his/her hair and appeared to be there for a prolonged period of time;-Lab results caused concern for rhabdomyolysis for his/her prolonged downtime. Review of the resident's hospital history and physical, dated 05/30/26 at 10:48 A.M., showed for treatment of the rhabdomyolysis, the staff continued with intravenous hydration at 125 milliliters (ml) an hour and close monitoring of the resident's respiratory status while on the intravenous fluids. During an interview on 07/01/26 at 12:56 P.M., CNA B said the following:-CNA H and CNA I worked the night shift on 5/30/26 and left the facility without giving report to the oncoming staff;-While he/she was working on rounds, he/she found the resident's room door was closed;-The resident's door was not supposed to be closed when he/she was in his/her room, because the resident was at risk for falls; -He/She found the resident on the floor with dried blood on his/her hair, face and hands; -The resident said he/she yelled for help, but no one answered;-He/She thought the resident was headed to the restroom prior to the fall because the resident was holding an incontinence brief;-He/She stayed with the resident until emergency medical services (EMS) arrived;-He/She overheard the EMS staff say the resident had to be on the floor longer than two hours. During an interview on 07/01/26 at 10:00 A.M., LPN A said the following:-The day shift started at 6:45 A.M.;-At around 7:00 A.M., CNA B yelled to come quickly because the resident was on the floor;-The resident lay on his/her back with his/her feet pointing towards the door with dried blood on his/her face, hair, and hands;-LPN J did not report any problems with the resident during hand off report that morning;-The resident had a history of falls prior to being admitted , so the staff were supposed to check on him/her at least every two hours;-When the resident lay in bed, he/she usually stayed there, but the staff should have continued to check on him/her every two hours;-LPN A thought the resident's fall was related to him/her ambulating to the restroom without his/her walker. During an interview on 07/01/26 at 1:10 P.M., the Director of Nursing said the following:-She completed an investigation regarding the resident's fall;-The last time CNA H and CNA I checked on Resident #1 was at 12:00 A.M.;-The last time LPN J checked on the resident was at 4:00 A.M.;-She terminated CNA H's and CNA I's employment due to the incident;-She gave LPN J a warning and provided one-on-one education about ensuring the staff working with him/her completed checks every two hour and LPN J's responsibility of ensuring all residents' safety;-The facility provided monthly training for staff regarding checking on residents at least every two hours and would continue to do so;-She expected all nursing staff to complete a face check on every resident at least every two hours, especially the residents who could not physically use or remember to use the call light for assistance;-She also expected staff to know the interventions to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reduce the risk of falls for all residents. During an interview on 07/01/26 at 1:20 P.M., the Administrator said the following:-She expected the staff to complete a face check for all residents at least every two hours;-She also expected the staff to know the interventions to reduce the risk of falls for residents. 3028697