STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265495	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clair Nursing Center	1035 Plaza Court North Saint Clair, MO 63077

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. Based on interview and record review, facility staff failed to prevent an injury to one resident (Resident #1) when a Certified Nursing Assistant (CNA) rolled the resident during care, without the assistance of second staff member, as directed in the resident's Plan of Care. The facility census was 57.The administrator was notified on 03/04/26 of past Non-Compliance which occurred on 02/08/26. On 02/08/26 the Director of Nursing (DON) investigated the fall, immediately educated Licensed Practical Nurse (LPN) B and CNA A on proper transfers, two person assist with care, and communication with other staff. The DON in-serviced all direct care staff on where to find information on resident care plans, and the need for two assists for the resident. 1.Review of the facility's Accident and Supervision Policy, undated, showed the purpose of the policy is for the resident environment to remain as free of accident hazards as possible, and to provide adequate supervision and assistive devices to prevent accidents. Review showed accident defined as any unexpected or unintentional incident which results in injury or illness to a resident. Review showed to reduce a resident's risk from hazards in the environment, staff should communicate the interventions to all relevant staff, provide training as needed, and ensuring staff are implementing the interventions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/17/26, showed staff assessed the resident with cognitive impairment, impairment on both upper and lower sides, dependent for on staff for: toileting, bathing, dressing, rolling in bed, and transfers, and has had a fall with a major injury since admission or prior assessment. Review of the resident's care plan, revised dated 02/18/26, showed staff documented the resident with a diagnosis of severe weakness or total paralysis of one side of the body, and weakness on one side of the body that cause limited mobility, loss of balance, muscle fatigue, and difficulty grasping objects. Staff documented the resident is at risk for falls due to the inability to control his/her body and having poor personal safety awareness and required two staff assistance for daily care, to include bed mobility due to bilateral hand contractures and paralysis of all four limbs and the torso. Review of the resident's nurses' notes, dated 02/08/26, showed Licensed Practical Nurse (LPN) B documented at 3:05 P.M. CNA A notified him/her the resident fell from the bed to the floor. Staff documented the resident was on the floor next to the bed on his/her left side, with complaints of severe pain related to his/her left lower extremity. Staff documented injury and deformity noted to the resident's left lower extremity. Review of the facility's investigation, dated 02/08/26, showed the administrator documented staff notified him/her on 02/08/26 the resident fell from his/her bed and staff sent him/her to the hospital for knee swelling and pain. He/She documented the DON became aware CNA A was alone in the resident's room at the time of the fall. He/She documented the nurse exited the room and the CNA continued to provide care to the resident who fell out of bed. Review of the resident's hospital records, dated 02/08/26, showed hospital staff documented the resident diagnosed with a fracture of near the end of the thigh bone a fracture in the thigh bone that is adjacent to an orthopedic implant, and (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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(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	a tendon tear fracture of left kneecap. During an interview on 2/19/26 at 10:30 A.M., the administrator said LPN B and CNA A were assisting the resident with changing the resident's adult brief. He/She said LPN B went out into the hallway to the treatment cart, CNA A continued to provide care to the resident, the resident's legs slid off the bed, and the resident fell. During an interview on 02/19/26 at 12:20 P.M., LPN B said the resident requires two staff members to assist with all care, and did not have side rails on his/her bed. He/She said he/she provided catheter care for the resident and then stepped into the hallway to the medication cart. He/She said he/she did not tell CNA A he/she was coming back into the room immediately. He/She said CNA A came to him/her in the hallway and notified him/her the resident fell. During an interview on 02/19/26 at 12:27 P.M., CNA A said the resident required one staff member for assistance with peri care and dressing, and two staff members to assist with transfers. He/She said he/she and LPN B were in the resident's room to provide treatments, peri care, and to get the resident out of bed. He/She said LPN B was her second staff member to assist with the transfer, and believed LPN was coming back into the room immediately. He/She said LPN B provided catheter care and then stepped into the hallway. He/She said the resident had a bowel movement, he/she began cleaning up the resident, and he/she assisted the resident to roll onto his/her left side. He/She said the resident began to slide off the left side of the bed. He/She said he/she attempted to prevent the resident from rolling off the bed from his/her position on the right side of the bed, but the resident fell to the floor. CNA said he/she knew the resident was a two person assist for transfers, but did not know it was two for all care. He/She said the resident appeared to raise up his/her hip to help him/her get the resident clean of feces. They were not attempting to transfer him/her or adjust him/her in bed at the time, so he/she did not think he/she needed another staff to assist. During an interview on 2/19/26 at 2:40 P.M., the DON said the resident requires two staff members to assist with all care, and the information is in the resident's care plan. He/She said CNA A should have waited to provide peri care for the resident until another staff member was positioned on the other side of the bed. He/She said LPN B would have been the second staff member assigned to assist CNA A with providing the resident's care.Complaint #2737823