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	02/07/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 09456 40424 Based on observation, interviews, and record review facility staff failed to safely propel three residents (Resident #23, #263, and #5) in a wheelchair. Facility staff failed to safely store hazardous materials in a manner to prevent accidents in one shower room and one storage room. The facility census was 58. 1. Review of the facility's Wheelchair Mobility policy, dated 2023, showed staff were directed that if a resident needs to be propelled and does not generally move or propel the wheelchair on their own, proper foot positioning on wheelchair pedal will be maintained and provided. 2. Review of Resident #23's quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 10/21/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Wheelchair dependent; -Diagnosis of Alzheimer. Observation on 02/04/25 at 11:30 A.M., showed an unknown staff propelled the resident on the 200 hall dinning area to the 300 hall living room. Observation showed the resident bilateral feet slid on the floor and his/her right wrist rubbed the wheelchair wheel. 3. Review of Resident #263's admission MDS dated [DATE] showed staff assessed the resident as follows: -Diagnosis of arthritis and Alzheimer's; -Impairment of both upper extremities; -Wheelchair dependent. (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 - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/05/25 at 8:33 A.M., showed an unknown staff propelled the resident to the dining room. Observation showed the wheelchair did not have foot pedals and the resident lifted his/her feet. The staff member stopped in the hall and said to the resident he/she needed to find the resident's foot pedals before they continued. Observation showed another unknown staff person began to push the resident to the dining room. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Wheelchair dependent; -Diagnosis of Alzheimer and dementia. Observation on 02/05/25 at 10:30 A.M., showed the Activity Director propelled the resident from the 200 hall dinning area towards the hallway without foot pedals on the wheelchair and both feet slid and bounced off the floor. During an interview on 02/05/25 at 10:31 A.M., the Activity Director said he/she should have gone and got the pedals for the wheelchair before pushing the resident. He/She said normally they lift their feet up when being pushed. 5. During an interview on 02/06/25 at 2:10 P.M., Licensed Practical Nurse (LPN) C said pushing a resident in a wheelchair without foot pedals could cause an injury. During an interview on 02/07/25 at 8:51 A.M., the Director of Nursing (DON) said staff should put foot pedals on a wheelchair prior to pushing a resident. This will prevent injuries or falls. During an interview on 02/07/25 at 11:08 A.M., the administrator said staff should make sure foot pedals are on a wheelchair before pushing a resident for safety. If a residents foot hit the floor it could cause injury. 5. Review of the facility's Chemical Usage and Storage policy, dated 01/01/20, showed all chemicals should be stored in a secure location when not in direct use, and should never be left out in the open where others may accidentally come into contact with it. 6. Observation on 02/05/25 at 9:40 A.M., showed the medical supply room on the 200 hall, unlocked. Observation showed an unlocked cabinet below the sink contained a bottle of odor control solution, two bottles of cleaning solution and one bottle of calcium, lime and rust remover with precautionary statements which indicated hazards. During an interview on 02/05/25 at 9:45 A.M., the maintenance director said no one had ever asked him/her to place a lock on the supply room door so he/she never thought about the risks of the cleaning chemicals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Observation on 02/06/25 at 1:50 P.M., showed the 100 hallway shower room door open. Observation showed an unlocked storage cabinet with an open box of disposable razors. Observation showed multiple residents walked by the open shower room door. During an interview on 02/06/25 at 1:50 P.M., CNA A said shower room doors are to be locked when not in use. He/She said the 100 hall shower room and cabinets can not be locked. Residents could be harmed if they came into contact with chemicals. 8. During an interview on 02/06/25 at 2:01 P.M., CNA B said storage cabinets and showers are supposed to be locked to prevent injury to the residents. During an interview on 02/06/25 at 2:10 P.M., LPN C said showers and cabinets should be locked because anyone could get in. Chemicals could injure a resident. During an interview on 02/07/25 at 8:51 A.M., the DON said residents should not have access to chemicals or other hazardous materials. He/She said hazardous materials should be locked up to prevent resident injury. During an interview on 02/07/25 at 11:08 A.M., the administrator said residents should not have access to any hazardous materials due to the risk to their health. These materials should be in a locked cabinet or room. 47193