STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265518	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Estates of St Charles	2150 West Randolph Street Saint Charles, MO 63301

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** 34003 Based on interview and record review, the facility failed to ensure the safety of one resident (Resident #1), of five sampled residents, who was dependent upon staff for transfers and at risk for falls. Staff left the resident in bed positioned on mechanical lift mat with the bed in the high position and then left the room, leaving the resident unattended. The resident slid off the bed and fell to the floor sustaining a fracture of the left leg. The facility census was 60. The administrator was notified on 7/30/24 at 10:00 A.M., of the Past Non-Compliance which occurred on 7/16/24. On 7/16/24, the administrator became aware of the injury to Resident #1 which resulted from a fall from the bed. The facility began an investigation and determined that the resident was left unattended and had a fall from the bed which resulted in a fractured left leg. The facility began in-servicing all staff on safety, transferring the resident and not to leave a resident unattended while in bed. Residents were assessed for bed safety and care plans interventions were added for Resident #1 and any resident who had concerns with positioning in bed or safety when left unattended. The G grid deficiency was removed and corrected on 7/18/24. Review of the facility policy for Falls dated 9/17/19 showed the following: -The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life. The Fall Management Program promotes safety, prevention and education of both staff and residents; -Residents found to be at high risk for falls are placed on the Fall Program, and interventions are implemented to meet individual needs. 1. Review of Resident #1's face sheet showed the following: -The resident admitted to the facility on [DATE]; -Diagnoses of heart failure and and stage 5 chronic kidney disease (kidney failure requiring dialysis), below the knee amputation of the right leg, and muscle weakness. Review of the resident's care plan for falls dated 5/9/24 showed the following: (continued on next page)

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	-The resident is at risk for falls due to deconditioning (the decline in physical function of the body as a result of physical inactivity and/or bed rest or an extremely sedentary lifestyle); - Ensure call light is within reach, personal items within reach, low bed with wheels locked, place wheelchair next to bed, and mechanical lift for transfers. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 5/10/24 showed: -The resident is able to make him/herself understood and able to understand others; -Alert and oriented and makes appropriate decisions; -No behaviors; -Impairment on one side of the body; -Dependent upon staff for bed mobility, transfers and wheelchair mobility. Review of the resident's nurses note dated 7/15/24 at 9:27 P.M., signed by Registered Nurse (RN) A, showed at 8:45 A.M. he/she heard the resident asking for help. Upon entering room, observed the resident on his/her left side on the floor between his/her bed and the roommate's bed. The resident said, The bed is just slippery, and I rolled out of bed onto the floor. The resident was alert and oriented and able to make needs known. The resident complained of left knee pain. The left knee noted to be swollen. Resident assisted off the floor with a mechanical lift and three staff. Nurse Practitioner in the facility and informed of the fall. Orders received to send the resident to the emergency room for evaluation. Review of the resident's nurses notes dated 7/15/24 at 4:49 P.M. showed the resident returned from emergency room with diagnosis of fractured left tibia (large bone in the lower leg). During an interview on 7/30/24 at 11:40 A.M. the resident said the following: -A staff member was helping him get ready to go to dialysis and had rolled him/her to one side of the bed. He/She was close to the edge of the bed. The aide told him/her to stay and not move and left the room. He/She felt him/herself begin to slide off the bed and then rolled off the bed onto the floor. He/She began to yell for help. His/her left lower leg hurt. A nurse and two other staff members came into the room and helped him/her off the floor; -He/She went to the hospital to get an x-ray and returned to the facility. His/Her left lower leg was broken. During an interview on 7/30/24 at 11:55 A.M. Resident #2, Resident #1's roommate, said the following: -He/She heard a thud and saw Resident #1's arm was sticking up over the edge of his/her bed; -The curtain was partially pulled between his/her bed and Resident #1's bed; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She knew that Resident #1 had rolled off the bed; -Staff had just left the room; -He/She pushed the call light to get Resident #1 help; -Only a few minutes had passed and three staff members came in the room and helped get Resident #1 off the floor. During an interview on 7/30/24 at 12:46 P.M. Certified Nurse Aide (CNA) B said the following: -He/She was getting Resident #1 ready to go to dialysis; -When he/she rolled the resident onto his/her side he/she noticed the resident had scratched his/her back with something and it was bleeding; -He/She told the resident not to move, he/she would be right back and left the room to get the nurse; -Only a few minutes went by until RN A came and got him/her and another staff member to get the resident off the floor. During an interview on 7/31/24 at 8:28 A.M. RN A said the following: -He/She had checked on the resident earlier in the shift to make sure he/she was ready to go to dialysis; -A short while later, he/she was walking down the hall and heard the resident call for help; -When he/she entered the room, the resident was on the floor on the right side of the bed between his/her and the Resident #2's bed; -Resident #1 complained of pain in the left leg and there was swelling in the left knee; -The resident said that he/she slid off the bed, that the mattress was slippery; -He/She and two other staff members got the resident off the floor and he/she called the physician and got an order to send the resident to the hospital for an x-ray; -The resident returned from the hospital with a fractured left tibia. During an interview on 7/30/24 at 1:30 P.M. the Director of Nursing said the following: -After the incident all staff were in-serviced not to leave a resident unattended on the side of a bed; -While giving care and a staff member has to leave the room, staff should position the resident in the middle of the bed before leaving the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/24 at 10:45 A.M. and 2:00 P.M. the Administrator said the following: -It was reported to him/her on 7/15/24 that a staff member was assisting the resident with getting ready to go to dialysis. The resident said his/her back was itching and the resident was attempting to scratch his/her back using a back scratcher. The staff member had the resident dressed and the mechanical lift pad under him/her and told the resident not to move, that he/she was going to get the nurse. When the staff member came back, the resident was on the floor. A nurse assessed him/her and noted that the left leg was swollen. The resident was sent to the emergency room and returned. The resident sustained a fractured left leg. All staff have been in-serviced not to leave a resident on the edge of the bed but to use the call light if needing help. The resident's care plan has been updated to reflect that he/she was not safe to be left unattended while at the side of the bed; -All direct care staff had been in-serviced to position the resident in the center of the bed if they need to leave the resident room for any reason; -Staff should never leave a resident on the side of the bed and leave the room. MO239102