STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024

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 observation, interview, and record review, the facility failed to ensure the safety of one resident (Resident #2), a resident dependent on staff for bed mobility, when staff rolled the resident to his/her side in the bed to provide care, the resident reached out to the side opposite of staff, and fell from the bed to the floor. The resident was to have a fall mat in place on the floor per his/her care plan. No fall mat was in place at the time of the fall. Staff reported the resident often reached out during care, but the resident had not been reassessed for safety with bed mobility. The resident required hospitalization as a result of the fall and sustained injuries including intracranial hemorrhage (bleeding inside the head), epidural hematoma (collection of blood within the potential space between the outer layer of the dura mater and the inner table of the skull), subdural hematoma (occurs when a blood vessel in the space between the skull and the brain (the subdural space) is damaged) , concussion, and right rib fracture. Staff also failed to safely transfer Resident #1, a resident who required staff assistance for transfers. The resident had a rotator cuff tear, and after being transferred unsafely by two staff and a gait belt when the resident did not bear weight, told staff that they had caused pain in his/her injured shoulder during the transfer. The facility census was 62. 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; -Policy: the facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety; -A fall is the unintentional coming to rest on the ground, floor or other lower level. If a resident loses balance and would have otherwise fallen if not for someone intervening is considered a fall. Includes witnessed and unwitnessed falls. Includes with or without injury; -Serious injury includes but not limited to: fracture, laceration requiring sutures, any falls related injury requiring an evaluation to the emergency room or admission to the hospital; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 West Randolph Street Saint Charles, MO 63301	

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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	-The Fall Risk Data Collection should be completed at Admission/readmission, with the Minimum Data Set (MDS, a federally mandated assessment instrument completed by staff), schedule, and post fall incidents. The Fall Risk Data collection can be completed at any other time the facility deems appropriate; -Residents found to be at high risk for falls are placed on the Fall Program, and Interventions are implemented to meet individual needs; -Resident room or bed, or assistive devices are identified with a symbol that indicates risk; -If a resident has a fall, they should be enrolled in the program, regardless of prior assessment status; -Following any falls, the facility staff completes an occurrence report. Details of the fall will be recorded and potential casual factors identified and investigated. Interventions will be implemented and the care plan updated; -Falls patterns and trends should be discussed and recorded in the Quality Assurance minutes to enhance the success of the program. Review of the facility policy for Safe Lifting and Movement of Residents dated 1/2017 showed: -Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents; -Manual lifting of residents shall be eliminated when feasible; -Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, slide boards) and mechanical lifting devices; -Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques; -Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. Back-up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hours a day while batteries are being recharged; -Enough slings, in the sizes required by residents in need, will be available at all times; -Staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. Review of the undated Skills Checklist (a form used to assess the knowledge and ability of the care giver in using a gait/transfer belt) Transfer-Two Person Transfer showed in part: -Position chair/wheelchair/commode to the resident's strong side; -Apply the gait belt; (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-One Certified Nurse Aide (CNA) stands in front of the resident with one foot parallel to the wheelchair and one foot at right angle to the wheelchair; -The other CNA stands behind with foot between the bed and the wheelchair; -CNA in front of the resident grasps gait belt at the resident's sides; -CNA behind the wheelchair grasps gait belt at the residents back with hand furthest from the bed and grasps gait belt at the resident's side with the other hand; -On a count of 3 both aides help the resident to stand by lifting up on the gait belt while encouraging the resident to push up with arms on the arm rests; -Do not pull on the residents shoulders or let the resident put arms around your neck. 1. Review of Resident #1 face sheet showed the following: -admitted to the facility on [DATE]; -Diagnoses of pneumonia, alcohol induced dementia (is a type of alcohol-related brain damage), vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain. Cognition and brain function can be significantly affected by the size, location, and number of vascular changes.), muscle weakness, chronic obstructive pulmonary disease (COPD - an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs), and stroke. Review of the resident's care plan for fall risk dated 4/28/22 showed the following: -The resident is at risk for falls related to increased confusion, gait/balance problems and incontinence; -The resident will be free of injury; -Assistive devices will be within reach of the resident, call light within reach and encourage the resident use, educate resident/family/caregivers about calling for assistance prior to cares, and what to do if a fall occurs. Ensure personal items are within reach and a fall mat is beside the bed when the resident is in bed with initiation dates of 4/28/22. Review of the resident's care plan for Activities of Daily Living (ADL's) dated 8/29/23 showed the following: -The resident has an ADL self care performance deficit; -The resident will maintain current level of function; (continued on next page)

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	265518	A. Building B. Wing	09/18/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident is able to reposition independently but requires verbal prompting to do so. The resident requires one staff participation to reposition and turn in bed. The resident is not toileted at his/her request, he/she does not feel safe sitting on the toilet. Resident uses incontinent briefs to maintain dignity and requires one staff assist for changing the brief. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool required to be used by facility staff, dated 8/28/24 showed the following: -Alert and oriented and usually able to answer questions appropriately; -Able to understand others and make self understood; -Dependent upon staff for rolling side to side in bed; coming to a sitting position from a lying position and transfers; -No behaviors or rejection of cares; -Incontinent of bowel and bladder; -No history of falls; -No therapy services; -Height of five feet 10 inches, and weight of 140 pounds. Review of the resident's nurses notes dated 9/5/24 at 5:29 A.M., signed by Licensed Practical Nurse (LPN) A showed Certified Nurse Aide (CNA) B alerted this nurse that Resident #1 slid out of bed while he/she was providing care. The resident was on the floor on the left side of the bed with his/her left arm across his/her chest and legs fully extended. Resident was assessed with a small skin tear to the right forearm above the elbow. Called placed to the emergency contact and the physician with new orders for X-ray to thoracic, lumbar and right hip/pelvis. Review of the resident's nurses notes dated 9/5/24 at 12:31 P.M., showed at 10:00 A.M. contracted x-ray tech here to do resident x-ray. X-ray tech said the resident was uncooperative and he/she was unable to complete x-rays and was unable to do resident spinal x-ray due to the resident stiffening up and fighting against him/her. Review of the resident's nurses progress notes dated 9/5/24 at 2:45 P.M. showed family member here and requesting the resident go to emergency department for evaluation and treatment due to complaints of stomach and back pain. Physician here at this time and gave orders to send the resident to ER for evaluation and treatment. The Director of Nursing (DON) here and made aware. 911 called and advised of the resident requesting to be sent to ER for evaluation and treatment related to complaints of stomach and back pain. Review of the resident's progress note signed by the physician and dated 9/5/24 showed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Presenting Problem: Had a fall last night and acquired a skin tear, fell out of the bed. Had no complaints of pain until this morning and complained of pain to his/her mid back and low back pain on the right side. Has PRN (as needed) Tramadol (pain relief medication, specifically indicated for moderate-to-severe pain). Order given for 2-view thoracic, lumbar, and right hip/pelvis X-rays; -The resident is seen today for a follow up problem. X-ray reviewed and was unremarkable for the right hip, thoracic and lumbosacral spine though osteopenia (a decrease in bone mineral density (BMD) below normal reference values) was revealed. Family member insists that the resident be sent to the hospital for severe pain. Perhaps there is something we missed on the X-ray. Gave orders to send the resident to the hospital. Review of the resident's nurses noted dated 9/5/24 at 6:22 P.M., showed at 5:00 P.M. the Director of Nurses (DON) made aware of the resident being admitted to a local hospital. At 5:45 P.M. the physician was called to report status of the resident. The resident was admitted with diagnosis of a brain bleed and collapsed lung. Review of the resident's hospital records dated 9/5/24, showed the resident presented to the emergency department with a fall. Diagnoses included fracture, intracranial hemorrhage (bleeding inside the head), epidural hematoma (collection of blood within the potential space between the outer layer of the dura mater and the inner table of the skull), subdural hematoma (occurs when a blood vessel in the space between the skull and the brain (the subdural space) is damaged) , concussion, and right rib fracture. During an interview on 9/18/24 at 10:00 A.M. the DON said the following: -Resident #1 had a fall out of his/her bed on 9/4/24 on the evening shift; -CNA B was changing the resident and the resident reached out for the privacy curtain and rolled out of the bed; -LPN A assessed the resident and found no injuries other than a skin tear to the right forearm; -The physician was notified and orders were received to obtain X-rays of the right hip pelvis region; -On 9/5/24 he/she assessed the resident and found no injuries and the resident's neuro checks were within normal limits. The contracted X-ray staff was at the facility, but was unable to complete the X-ray as the resident was combative; -The resident's family member was in the facility and requested the resident be sent to the hospital; -The resident was admitted to the hospital for a subdural bleed, subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane (subarachnoid space), fractures of multiple ribs on the right side. During an interview on 9/18/24 at 6:55 P.M. LPN A said the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-CNA B informed him/her that the resident had rolled out of the bed as he/she was providing care; -He/She went to the resident's room and found the resident between the beds. The resident was alert and talking. The resident said the CNA had rolled him/her to give him/her care and he/she was reaching for something and fell out of the bed. The resident did not complain of pain. There was a skin tear of the right upper elbow. The resident's vital signs and neuro checks were within normal limits; -CNA B said the resident became stiff and resistive to care, the aide should have asked for help when the resident began to resist care. During an interview on 9/20/24 at 3:18 P.M. CNA B said the following: -The resident takes one person to change and two people to transfer in and out of the bed; -The resident usually does not get out of bed; -On 9/4/24 he/she was changing the resident by him/herself. He/She rolled the resident to the left side, the resident stiffened his/her body and reached for the privacy curtain; -The resident usually reached for the privacy curtain, he/she assumed this was something for him/her to hold on to; -Everything happened quickly, as the resident reached for the curtain, the resident rolled off the bed; -He/She did not see the resident land on the floor as he/she was on the opposite side of the bed; -There was no floor mat on the floor; -The resident laid on his/her side and there was a skin tear to his/her right elbow. The resident talked to him/her and then he/she left the room and got the nurse; -The resident said that he/she didn't think he/she hit his/her head, and said that his/her back hurt. During an interview on 9/18/24 at 1:30 P.M. the DON said the following: -Nurses can assess a resident for assistance needed for positioning and transfer; -If the resident was being uncooperative with cares, this needed to communicated to the nurses so the resident could have been assessed; -The resident was to have a fall mat placed at the side of the bed and this was not done, she would expect staff to follow the care plan and any safety measures that had been put into place; -She would have expected staff to communicate that the resident was resistive at times so he/she could have been assessed for bed safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/18/24 at 1;30 P.M. the Administrator said the following: -Staff was following the care plan and did not communicate that the resident was resistive to care at times; -He would expect staff to follow the care plan and to communicate to the nurses when a resident was resistive or combative so more help could be provided. 2. Review of Resident #2's face sheet showed: -admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis (a chronic inflammatory disorder that can affects the joints), peripheral vascular disease (is a slow and progressive disorder of the blood vessels), diabetes, kidney disease, and amputation of above the right knee. Review of the resident's quarterly MDS dated [DATE] showed the following: -The resident was able to make self understood and able to understand others; -Alert and oriented and able to make decisions; -Requires substantial assistance of staff for toileting, showering, lower body dressing, putting on and taking off showed; -Partial assistance from staff with upper body dressing; -Partial to moderate assist with chair to bed and bed to chair transfer; -Sit to stand mobility not attempted due to medical condition or safety concern; -Used a manual wheelchair. Review of the resident's care plan for Activity of Daily Living (ADL) dated 7/22/24 showed the following: -The resident has an ADL self care deficit; -Interventions included a restorative program with passive range of motion to both upper extremities; and the resident required two staff participation with transfers. Review of the physician's progress notes dated 9/5/24, showed the resident was seen today for a routine rounds. Complains of shoulder pain. Plan: Arthropathy (arthritis) of shoulder region continue Norco (narcotic pain medication) scheduled and Tramadol (narcotic pain medication) as needed (PRN). Consider orthopaedic consultation. Review of the resident's progress notes dated 9/12/24 at 3:07 P.M., showed physician here at the facility today and wrote new orders. Refer resident to orthopaedic surgeon for possible injection of the shoulder joints, and/or further management. X-ray of bilateral shoulder 4 view related to bilateral shoulder arthropathy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's X-ray report dated 9/12/24 showed the following: -X-ray left shoulder - arthritic changes, sclerosis of the humeral (bone in your upper arm) head; -X-ray of the right shoulder - diffuse osteopenia, (a condition where bone mineral density (BMD) is lower than normal) superiorly displaced humeral head and visualized proximal humerus. (the top part of the humerus, or upper arm bone, that connects to the shoulder joint) Review of the resident's nurses notes dated 9/13/24 at 12:09 P.M. showed physician aware of the X-ray results, the physician's nurse requested the resident be sent out to hospital based on results from right shoulder X-ray. Resident assessed and complained of pain 4/10 (pain scale is 0 being no pain and 10 being extreme pain). Review of the resident's nurses notes dated 9/13/24 at 12:09 P.M. showed received verbal order to have physical therapy (PT) evaluate the resident for transfer status. Review of the resident's nurses notes dated 9/13/24 at 1:31 P.M., showed report called from local hospital regarding resident status. Nurse said X-Rays were completed at ER and resident had a chronic rotator cuff tear. The resident soul be given PRN Tylenol for pain relief and would return to the facility. Resident returned to the facility. Review of the resident's hospital ER report dated 9/13/24 showed chronic rotator cuff tear with superior subluxation (an incomplete or partial dislocation of a joint) of the humeral head (A chronic rotator cuff tear with superior subluxation of the humeral head is a shoulder condition that occurs when a rotator cuff tear causes the humeral head to move out of the center of the shoulder socket and upward). Review of the resident's medical record from 9/13/24 through 9/17/24 showed no evaluation for transfer status by PT. During an interview on 9/17/24 at 10:45 A.M. Resident #2 said the following: -His/Her right shoulder has bothered him/her for some time; -Staff to transfer him/her using a Sit to Stand lift, would not always use the belt that helped lift him/her up in the lift and would not always use two staff during the transfer; -When the staff would not use the belt, this would pull on his/her arms and cause him/her pain; -After the injury to his/her arm, staff used a gait belt and two people to transfer him/her. Observation on 9/17/24 at 10:30 A.M. showed the following: -The resident sat in a wheelchair and informed CNA C and CNA D he/she needed to use the bathroom; -CNA C and CNA D moved the wheelchair into the bathroom and positioned the resident to the side of the toilet; (continued on next page)

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