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 03/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice when staff failed to ensure ordered medications were available for administration for two residents (Resident #1 and Resident #2), in a review of four sampled residents. The facility census was 61. 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of infection of a joint prosthesis and low back pain. Review of the resident's physician orders dated 2/18/25 showed an order for Tramadol (medication used to relieve moderate to moderately severe pain, including pain after surgery) 50 milligrams (mg) every six hours as needed (PRN) for pain. Review of the resident's nurses note dated 2/19/25 at 6:03 P.M., showed staff notified the physician about the resident complaints of lower back pain, that Tramadol had not been delivered at this time and the physician needed to sign a script for the medication. The physician gave an order for Tylenol 500 mg every four hours PRN for pain; this nurse administered the medication. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 2/20/25 showed the following: -Able to make self understood and able to understand others; -Alert and oriented and able to make decisions; -Occasional pain rated a four (0 being no pain and 10 being excruciating pain). Review of Medication Administration Record (MAR) dated 2/25 showed an order for Tramadol 50 mg every six hours for pain with an order date of 2/18/25 with no medication documented as given. Review of the resident's Medication Administration Record (MAR) dated 2/25 showed Tylenol ES (extra strength) 500 mg every four hours PRN for pain with an order date of 2/19/25 and administered as at 6:28 P. M. for a pain level of six with no documentation if the medication was effective. Review of the resident's nurses notes dated 2/23/25 at 1:11 P.M. showed Tramadol 50 mg every six hours PRN, new script required, notified physician. (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 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the resident's MAR dated 2/23/25 at 1:11 P.M. showed Tramadol 50 mg. not available.

During an interview on 3/3/25 at 2:30 P.M. Family Member (FM) A said the resident had an infection in his/her right hip prosthesis and had to have it removed several years ago, this has caused him/her pain since. When the resident admitted to the facility on [DATE], the hospital gave the facility an order for Tramadol for pain. The resident would call him/her crying in pain and the facility did not have the medication. He/she called the facility numerous times asking about the medication and was told a physician had to write a script. On 2/23/25, an agency nurse told him/her that the physician had been out of town and a different physician had to be called to get a script for the Tramadol. He/She did not know if the medication was delivered or not, he/she took the resident to another facility on 2/25/25.

During an interview on 3/4/25 at 1:00 P.M. Licensed Practical Nurse (LPN) A said on 2/20/25 he/she notified the physician on call for the resident's primary physician asking for a script for the resident's Tramadol. He/She received a text message from the physician saying the script had been sent to the pharmacy. He/She called the pharmacy and the pharmacy relayed they did not receive the script. The pharmacy said they attempted to call the physician, but had no return call back. No one from pharmacy contacted the facility regarding the script. He/She was not told that the medication was not delivered to the facility.

During an interview on 3/5/25 at 9:10 A.M. Registered Nurse (RN) B said he/she received a phone call from FM A on 2/23/25 very upset that the resident's Tramadol had not been available and that the resident had called him/her in extreme pain. He/She called the resident's physician and found out the physician was out of town, so he/she called the back up physician who then sent a script to the pharmacy for the medication. This was the first time he/she had worked with the resident and the resident had not expressed any pain for necessitating staff give the medication.

During an interview on 3/4/25 at 2:00 P.M. the Director of Nursing said the following:

-Medications should be available when ordered;

-Narcotics require a script to be sent to the pharmacy, these scripts should be available upon admission;

-Staff should follow up and ensure that medications are delivered from the pharmacy.

2. Review of Resident #2's face sheet showed admitted to the facility on [DATE] with diagnoses of cellulitis (a common bacterial infection of the skin and underlying tissues) of the right lower leg, diabetes with a foot wound, osteomyelitis (an infection of the bone) of the right foot and ankle.

Review of the admission MDS dated [DATE] showed the following:

-Able to make self understood and able to understand;

-Alert and oriented and able to make decisions;

-Received intravenous (IV) medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses notes dated 2/25/25 at 5:12 P.M. showed the resident arrived per private vehicle. Resident is alert and oriented, able to make needs known. Resident has a single PICC (peripherally inserted central catheter (PICC) is a thin, flexible tube that's inserted into a vein in the arm, leg, or neck. It's used to deliver fluids, blood, and drugs intravenously, and to draw blood) lumen to right upper arm. Resident will be receiving IV antibiotics every 8 hours for 34 days. Review of the nurses notes dated 2/25/25 at 9:37 P.M. showed the following: -Cefazolin (used to treat bacterial infections in many different parts of the body) in sodium chloride intravenous solution 2-0.9 GM/100 ml, use 2 gram intravenously every 8 hours for wound for 34 Days; -New Admission. Spoke with pharmacy and medication is set for delivery on 2/26/25. Medication not in cubex (emergency medication box). Review of the MAR dated 2/25 showed the following: -Cefazolin 0.9 grams per 100 liters for 2 grams every 8 hours IV for wound infection for 34 days; -Documented on 2/25/25 at 10:00 P.M. as not available, 2/26/25 at 6:00 A.M. as not available and 2:00 P.M. as not available. During an interview on 3/4/25 at 11:00 A.M. Resident #2 said the following: -He/She has a severe infection in the right foot; -He/She was supposed to get an IV antibiotic three times a day; -He/She did not receive several doses when he/she was first admitted . During an interview on 3/4/25 at 11:15 A.M. Licensed Practical Nurse (LPN) A said the following: -The resident admitted around 3:00 P.M. on 2/25/25; -The hospital did not send the medication orders prior to the resident's arrival; -They were not aware that the resident had IV medications until the resident arrived at the facility with the orders; -Staff contacted the pharmacy and received the medication the next day. The resident missed several doses. During an interview on 3/4/25 at 12:20 P.M. the Admissions Coordinator said the following: -He/She received information regarding new admissions from the hospital; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She will send the information to their admission clinical liaison staff who was not at the facility. They reviewed the paperwork and made a decision if the facility was capable of meeting the prospective resident's needs; -Resident #2 was approved by the clinical liaison for admission and he/she sent the admission paperwork to the Director of Nursing via email on 2/25/25 at 11:40 A.M. with the resident's medication orders for the IV medication. Observation on 3/4/25 at 1:45 P.M. P.M. of the facility cubex showed cefazolin 2 gm available for IV administration. During an interview on 3/11/25 at 5:14 P.M. the facility's pharmacy consultants manager said the following: -Resident #1's Tramadol order did not come with a prescription for the narcotic when the resident was admitted ; -The pharmacy will communicate with the physician the need for the prescription; -The pharmacy received the prescription for the Tramadol on 2/24/25 and the medication was delivered to the facility on [DATE] at 9:43 P.M.; -Resident #2's cefazolin medication order was received by the pharmacy after the cut off time in the afternoon, the medication was delivered to the facility on [DATE] early in the evening; -Cefazolin medication was in the facility cubex and could have been pulled from there and administered from the emergency kit supply. During an interview on 3/4/25 at 2:00 P.M. the Director of Nursing said the following: -New admissions are screened by a clinical liaison who is not on site. The facility was not always aware of the resident's medications or needs prior to a resident being admitted to the facility; -If he/she was sent an email regarding the resident's admission, he/she did not read it; -Residents with IV medication orders should not miss doses, the medication should be communicated to the pharmacy as soon as possible and the medication and the equipment needed for the administration should be at the facility upon the resident's arrival; -She would expect the nurses to notify the physician if medications are not available and get orders for what they would want to have administered until the medication arrived; -She would expect the nurses to call the pharmacy to see when the facility could expect IV medication. During an interview on 3/4/25 at 2:10 P.M., the Administrator said he would expect medications to be given as ordered by the physician and if the medication was not available, the physician should be notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/17/25 at 12:15 P.M. the Medical Director said the following: -She would expect the facility to notify the physician when a medication was not available; -She would expect the facility to call the pharmacy to see why the medication was not not sent when ordered by the physician; -She would expect the facility to check the cubex to see if the medication was available and administer the medication from the cubex. MO250247 and MO250170