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	08/07/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to maintain the main parking lot. The facility census was 68. Observation on 8/7/25 at 12:45 P.M. and again at 7:30 P.M. showed the facility front driveway and parking lot with a large area of damaged asphalt. The area was approximately ten feet in diameter and approximately 8-10 inches in depth at the center. This area was at the end of the visitor parking area and would affect any vehicle using the area for travel. During an interview on 8/15/25 at 2:00 P.M. the Administrator said he was aware the area needed repair, there were several projects in the works; he would expect the area to be repaired. Complaint #2566328

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure four residents (Resident #1, #3, #4, and #6), of eight sampled residents, who required assistance with Activities of Daily Living (ADL's) received the necessary care and services to maintain good grooming when staff failed to provide nail care. The facility census was 63.Review of the undated facility policy for Activities of Daily Living showed this facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Review of the undated facility policy for Foot Care showed the following:-This community will ensure that all residents receive proper treatment and care to maintain mobility and good foot health by providing foot care and treatment in accordance with professional standards or practice including prevention of complications from a resident's medical condition and assisting the resident in making appointments with a qualified person and arranging for transportation to and from podiatry appointments;-All foot care and treatment will be provided within professional standards of practice and state of practice as applicable;-Toenail clipping for residents without complicating disease processes will be provided by direct care staff who have received training and in-service and have demonstrated competency in toenail clipping at the time of each bathing experience as needed;-If a resident has any contributing disease process including but not limited to diabetes, peripheral vascular disease, neuropathy, or immobility affecting foot condition, a podiatrist will perform toenail clipping. 1. Review of Resident #1's face sheet showed the resident admitted on [DATE] with diagnosis of Alzheimer's disease. Review of the resident's care plan dated 4/25/23 showed no care plan to address nail care. Review of the quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 6/26/25 showed the following:-Unable to make decision;-Required staff assistance with ADL's. During interview on 8/7/25 at 2:00 P.M. Family Member A said the following:-He/She had just cut Resident #1's fingernails and cleaned them;-He/She had taken pictures of the resident's fingernails prior to cutting them and showed the surveyor the pictures. The pictures showed the resident's fingernails on both hands were long and jagged, with black debris noted around the nails and thick black debris under the nails.Observation on 8/7/25 at 6:45 P.M. with the assistance of Licensed Practical Nurse (LPN) B showed the following:-The resident's toenail on the right foot, big toe was short and jagged with black debris around the edges of the nail;-The second, third and fourth toenails were long and curved toward the other toes with the nail touching the other toes; there was black debris under the nails;-The toenails on the left foot were long and curved toward the other toes with a black debris under the nails. During an interview on 8/7/25 at 6:45 P.M. LPN B said the following:-The resident was seen by a contracted podiatrist who comes every other month;-Nursing could cut and clean the resident's toenails between visits;-Nursing should clean under the residents fingernails as needed. During an interview on 8/15/25 at 4:00 P.M. FM A said it was obvious by the looks of Resident #1's toenails on 8/7/25 that the resident was not seen by podiatry in July. 2. Review of Resident #3's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses of fracture of left arm and Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement). Review of the resident's care plans dated 6/16/25 showed no care plan to address nail care. Review of the resident's comprehensive MDS dated [DATE] showed the following:-Able to make self understood and understands others;-Alert and oriented and able to make some decisions;-Requires assistance with ADL's. Observation on 8/7/25 at 3:00 P.M. showed the resident's toenails on both feet were long, thick with gray debris under the big toenail. During an interview on 8/7/25 at 3:00 P.M. the resident said he/she would like to have his/her toenails cut, they were too long and hurt in some of his/her shoes. 3. Review of Resident #4's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses of diabetes. Review of the resident's care plan for diabetes dated 3/13/25 showed the following:-The resident has diabetes;-The resident will have no complications related to diabetes;-There were no interventions to address nailcare for the resident with diagnosis of diabetes. Review of the resident's quarterly MDS dated [DATE] showed the following:-Able to make self understood and usually understands others;-Alert and oriented and able to make some decisions;-Required assistance with ADL's. During an interview on 8/7/25 at 2:50 P.M. the resident said:-His/Her toenails were long and he/she would like to see a podiatrist. Observation on 8/7/25 at 2:50 P. M. showed the resident's toenails on both feet were thick and long with gray debris under the nails. 4. Review of Resident #6 face sheet showed:-admitted to the facility on [DATE] with diagnoses of multiple sclerosis (MS- a chronic, autoimmune disease that affects the central nervous system (brain and spinal

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #9) of ten sampled residents, with a history of pressure ulcers received the necessary care and services, when staff failed to identify the presence of, history or risk of pressure ulcers including a pressure ulcer on admission on the resident's sacrum. The resident was identified eight days following admission [DATE]) with a Stage III pressure ulcer on his/her sacrum with an old dressing prior to the resident's transfer to a hospital. The facility had no documentation to show prior identification of the ulcer, assessment, treatment or a care plan to address the pressure ulcer. The facility census was 72.Review of the facility's policy, Wound Prevention, dated August 2023 showed the following:-Educate residents, their families, and staff members about wound prevention techniques and best practices;-Implement regular assessments and screening to identify residents at risk of developing wounds;-Create personalized service plans for residents with specific wound prevention needs;-Provide ongoing staff training and education on wound care prevention and management;-Encourage open communication and collaboration among staff, residents and health care providers to address any concerns or issues related to wound prevention promptly;-Conduct a comprehensive assessment upon admission to identify any existing wounds, skin conditions, or risk factors for wound development;-Perform routine skin assessments on all residents during regular monthly assessments;-Document and review the assessed information to establish appropriate wound prevention measures for each resident;-Provide good hygiene practices, including regular showering, and regular changing of soiled garments or incontinence products;-Encourage residents to change positions as necessary;-Educate staff about proper body alignment techniques, especially for residents with limited mobility;-Provide initial and ongoing training to all clinical staff members on wound prevention techniques, early identification of wounds, and appropriate care interventions;-Document all wound prevention measures, assessments, and interventions in resident's service plans and medical records;-Promptly report any new wounds, changes in skin conditions, or concerns related to wound prevention to appropriate healthcare personnel. Review of the National Pressure Ulcer Advisory Panel (NPUAP) guidelines, dated September 2016, showed the following definitions:-Stage III pressure ulcer is a full thickness loss of skin, where adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and eschar may be visible, but do not obscure the extent of tissue loss. The depth of tissue damage varies by the location on the body. Undermining may occur. Fascia (a thin sheath of fibrous tissue), muscle, tendon, ligament, cartilage or bone are not exposed;-Deep Tissue Pressure Injury (DTI) is an intact or non-intact skin with localized area of persistent non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. 1. Review of Resident #9's hospital history and physical, dated 7/14/25 at 1:01 P.M., showed the following: -The resident lived alone, had a history of dementia and was brought in by emergency medical services after a fall;-Wound care note/reason for consult: Sacrum (a triangular bone in the lower back formed from vertebra situated between the two hip bones of the pelvis) and deep tissue injury;-Pressure injury location: sacrum;-Site assessment: Black; purple/red;-Shape: circular;-Peri wound (the skin area extending from the wound's edges outwards) fragile;-Dressing: foam with a protective barrier. Review of the resident's Post Acute Discharge Instructions from the hospital, dated 8/22/35 at 2:00 P.M., showed recapitulation of the resident stay included mobility and positioning assistance, skin management and wound care. There were no orders included for wound care. Review of the resident's undated face sheet showed the following:-The resident admitted to the facility on [DATE];-Diagnoses included dementia, urinary tract infection and repeated falls. During an interview on 9/2/25 at 2:30 P.M. the resident's family member said the following:-The resident recently admitted to the facility;-He/She thought the resident had a sore on his/her bottom when he/she admitted to the facility on [DATE]. Review of the resident's physician order sheets dated August 2025 showed no orders for treatment of pressure ulcers. Review of the resident's admission Assessment form, dated 8/22/25 at 5:02 P.M., showed the following:-The resident was understood and understands others;-The resident was alert to person and place;-The resident required one staff assistance with transfers, dressing, toilet use, personal hygiene, bathing, and with locomotion on and off the unit;-The resident required set up help with bed

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure staff prepared and served food at a safe and appetizing temperature. The facility census was 68. Review of the undated facility policy for Monitoring Food Temperatures for Meal Service showed:-Food temperatures will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures;-Prior to serving a meal, food temperatures will be taken and documented for all hot and cold foods to ensure proper servicing temperatures. Any food item not found at the correct holding/serving temperature will not be served unless appropriate action is taken, such as reheating;-If the serving/holding temperature of a hot food item is not at 135 degrees Fahrenheit (F) or higher (check state specific regulations) when checked prior to meal service, the item will be reheated to at least 165 degree F for a minimum of 15 seconds-If the serving/holding temperature of a cold food item or beverage is not at 41 degree F or below (for less than four hours in duration) when checked prior to meal service, the item will be chilled on ice or in the freezer until it reaches 41 degree F (or less) before service;-Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degree F or greater to promote palatability for the resident.;-All room trays are sent to the room with a meal card and documentation of the time the meal was delivered when it should be served to assure the tray is delivered to the correct resident and to assure that it is not held longer than needed for palatability and safety.1. During an interview on 8/7/25 at 2:30 P.M. Resident #4 said he/she eats meals in his/her room, the food was not hot when served.2. During an interview on 8/7/25 at 2:40 P.M. Resident #3 said he/she ate in his/her room. The food was not hot when served.3. During an interview on 8/7/25 at 2:50 P.M. Resident #5 said he/she ate meals in his/her room, and the food was not hot when served. 4. During an interview on 8/7/25 at 4:30 P.M. Resident #7 and Resident #8 said the following:-They prefer to eat their meals in the assist dining room;-The food was usually not hot when served.5. Observation on 8/7/25 at 4:45 P.M. showed staff began the evening meal service from the steam table to the main dining room which included roast pork, mashed potatoes, and corn. Observation on 8/7/25 at 5:03 showed staff begin to prepare room trays for the 200 hall. Staff plated meals to include roast pork, mashed potatoes, and corn, then covered the plate with plastic film and placed the completed trays on an open metal cart with no covering. -There was a metal pan with approximately a half inch of water on the bottom of the cart with several cartons of milk, tea, and juice for service;-Dietary staff pushed the cart out into the hallway;-At 5:16 P. M. nursing staff received the cart, took it to the 200 hall and began delivering the meal trays to residents;-Staff delivered the last meal tray at 5:34 P.M.Observation on 8/7/25 at 5:34 P.M. of the test tray, after the last resident was served, showed the following food temperatures:-Roast pork was 110 degrees F and cool to taste;-Mashed potatoes were 89.1 degrees F and cool to taste;-Corn was 118 degrees F and warm to taste;-Milk from a carton was 51.4 degrees F and warm to taste.During an interview on 8/7/25 at 6:15 P.M. [NAME] A said the following:-The meat should be at 199-200 degrees, the potatoes and should be at 178 degrees when served;-He/She usually takes the temperature of the food before he/she puts the food on the steam table;-At the steam table the dietary aides should take the food temperatures, but they did not;-There were two wells on the steam table that were not currently working to keep the food warm, and that could be the difference in the food temperatures;-The dietary aides set up the drinks, the drinks should be kept on ice.During an interview on 8/7/25 at 5:45 P.M. the Dietary Manager said the following:-The facility did not have any insulated plate covers to help keep the food warm;-Dietary was dependent upon when staff were available to begin serving the room trays;-The hot foods should be at 160 degrees when served;-The beverages, especially milk should be kept on ice to keep cool.During an interview on 8/7/25 at 7:00 P.M. the Administrator said he would expect the food to be at the proper temperature when served to the residents. Complaint #2566328