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	05/19/2026

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide residents with a safe, clean, and homelike environment, including providing housekeeping and maintenance services necessary to maintain an orderly, odor free, and comfortable interior. The facility census was 72. 1. During an interview on 05/19/26 at approximately 1:30 P.M., the Regional Nurse Consultant said the facility did not have a specific policy related to homelike environment. 2. Observation on 05/11/26 at 3:50 P.M. showed the shared closet door in occupied resident room [ROOM NUMBER] was off the track and dragged on the floor. During an interview on 05/11/25 at 3:50 P.M., the resident who resided in room [ROOM NUMBER] said the closet door dragged on the floor and got off the track. Staff would fix it and then it would break again. 3. Observation on 05/11/26 at 4:05 P.M., showed bed A in occupied resident room [ROOM NUMBER] would not lower to a low position and bed B was difficult to raise up and down. During interviews on 05/11/26 at 4:05 P.M. and 4:06 P.M., both residents who resided in room [ROOM NUMBER] voiced concerns about their beds not working correctly. One resident said his/her bed was broken and would not lower. He/She reported it numerous times to numerous staff and it still was not fixed. The resident was unaware if staff completed a maintenance request. The other resident said he/she used to have an electric bed that quit working so staff changed beds. The current bed he/she had was also broken and would not raise or lower and was not electric. He/She was unable to manually raise and lower the bed. The resident said the staff were aware he/she could not manipulate a manual bed. 4. Observations on 05/11/26 at 4:15 P.M. and 05/19/26 at 11:15 A.M., showed the door to the shared closet in occupied resident room [ROOM NUMBER] was off the track and difficult to open. During an interview on 05/19/26 at 11:15 A.M., the resident who resided in room [ROOM NUMBER] said his/her family member fixed the closet door every time he/she brought in clean laundry and the door didn't stay fixed for very long. He/She was sure the facility knew about it, because his/her family member reported it numerous times. 5. Observation on 05/12/26 at 8:05 A.M., showed the following:-A strong urine odor throughout the 100 hall;-A full, soiled linen receptacle was parked in the 100 hallway. 6. Observation on 05/13/26 at 5:05 A.M., showed the following: -A strong urine odor throughout the 100 hall;-A full soiled linen receptacle was parked in the hall outside room [ROOM NUMBER]; -An open bag of trash containing soiled incontinence supplies lay on the floor next to the soiled linen receptacle;-A strong urine odor on the 200 hall;-A full soiled linen receptacle was parked outside room [ROOM NUMBER];-An open bag of soiled linens lay on the floor in room [ROOM NUMBER];-Two incontinence briefs, soiled with urine, lay in a wheelchair parked at the foot of Resident #42's bed on the 200 hall. 7. Observation on 05/13/26 at 6:14 A.M. of the 200 hall shower room showed the following:-A foul, pungent odor upon entering the shower room;-The shower room was not in use;-Used gloves, soiled with a tan colored filmy substance, were on the floor inside the door;-Used paper towels, wrinkled and formed into a loose wad, were on the sink;-A shower chair (a specialized, waterproof chair used a shower) was soiled with a brown substance on the braces beneath the seat of the chair in one stall;-A folded, wet, medicated patch, dated 5/12 and 7 AM, lay on the floor under the shower chair;-Feces was on the floor under the shower chair;-A water-soaked (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265518	A. Building B. Wing	05/19/2026

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 - Some	towel was on the floor under the shower chair;-An approximately 5 feet long by 3 feet wide and 0.5 inch deep area of standing water on the floor around the drain;-Two wet towels lay on the counter beside the sink; -Used gloves, soiled with a white powdery substance, lay on the counter beside the sink; -Two soiled linen receptacles full of soiled and odorous linens and clothing;-A sit-to-stand lift (a mobility device that helps individuals transition from a seated to a standing position) was soiled at the base with hair, dirt and grime;-Used gloves lay on a wheelchair pedal beside a trash can;-Used gloves lay on a shower chair;-A sign on the inside of the door read, Please clean shower stall room after use. 8. During interviews on 05/11/26 at 3:45 P.M. and on 05/13/26 at 12:57 P.M., Resident #68 said the following:-He/She went to the Administrator at least three times complaining of odors;-The facility smelled of odors and it was totally disgusting;-The body odor and urine odors are so offensive he/she sprayed cologne to mask the odor; -The shower room had hair balls, feces, and standing water in it and it smelled like a sewer; -Staff didn't clean or sanitize the shower rooms or equipment in between residents. During an interview on 05/13/26 at 9:05 A.M., the Assistant Director of Nursing (ADON) said staff should clean the shower rooms after each use. During an interview on 05/19/26 at 7:26 P.M., the Administrator said the following: -He expected all equipment and furniture to be in good working order;-If something needed fixed or addressed, staff filled out a work order in the electronic maintenance system. This was the preferred alert system for requests as it went directly to the maintenance department;-He expected staff to conduct routine cleaning to control the odors in the facility, but this could be a challenge, because the incontinent episodes were unpredictable;-He expected staff to clean the shower rooms after each resident;-Housekeeping also cleaned the shower rooms every shift;-Staff should not leave soiled linens in any resident areas. 2973690

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility employees and service providers failed to provide services to a resident (Resident #79) that were necessary to avoid physical harm. Facility staff failed to follow facility policy and procedures, and physician orders for monitoring upon admission and when the resident, who had cardiac-related diagnosis, experienced a change in condition. Staff failed to follow physician's order to check the resident's blood pressure prior to administering blood pressure medication and failed to initiate orders for a muscle relaxer. The facility failed to use nursing judgement and knowledge to advocate for further medical evaluation when the resident expressed possible cardiac-related symptoms, including a feeling of something sitting on their chest on [DATE] and [DATE]. Staff failed to notify the resident's power of attorney, per facility policy, when the resident had a change in condition. The resident's power of attorney reported he/she would have wanted the resident evaluated at the hospital if made aware of the resident's condition on [DATE] and [DATE]. On [DATE], staff found the resident unresponsive and without respirations. The facility failed to ensure the resident's preferred code status, Do Not Resuscitate, was accurately reflected in the resident's medical record. Staff initiated life-saving measures when the resident was found without a pulse and respirations, which was against the resident's wishes. The facility census was 72.The administrator was notified of the Immediate Jeopardy (IJ) on [DATE] at 04:31 P.M. which began on [DATE]. The IJ was removed on [DATE] as confirmed by the surveyor onsite verification. Review of the facility policy, Abuse, Prevention and Prohibition, dated 11/2025, showed the facility defined neglect as a failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the facility policy, Significant Condition Change and Notification, dated 12/2024, showed the following:-Purpose: To ensure the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: -An accident or incident, with or without injury, that has the potential for needed medical practitioner intervention; -A significant change in the resident's physical, mental or psychosocial status (see below for examples):Chest pain;-Procedure: When any of the above situations exist, the licensed nurse will contact the resident's representative and their medical practitioner. Prior to calling the medical practitioner, the nurse will complete the SBAR (situation, background, assessment, recommendation) assessment (a structured communication to quickly and safely convey critical resident information);-Calls will be made to the resident's representative until they are reached;-The medical practitioner will be contacted;-Each attempt will be charted as to the time the call was made, who was spoken to and what information was given;-Documentation: -All significant changes will be recorded in the residents electronic health record; -Charting will include an assessment of the resident's current status as it relates to the change in condition; -Charting will be done each shift for 72 hours for residents with change of condition; -Change of condition is reviewed by the Director of Nursing or designee for the continued need for additional documentation. Review of the facility policy, Advanced Directive, dated 12/2024, showed the following:Procedure:-Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her representative, about the existence of any written advance directives;-Information about whether or not the resident has executed an advance directive shall be placed in the medical record;-The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive;-The resident has the right to refuse treatment, whether or not he or she has an advance directive. A resident will not be treated against his or her own wishes;-In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to:-Advance Directive - a written instruction, such as a living will or durable power of attorney for (continued on next page)

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health care, recognized by State law, relating to the provisions of health care when the individual is incapacitated;-Durable Power of Attorney for Health Care (i.e., Medical Power of Attorney) - a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated;-Do Not Resuscitate - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used;-Life-Sustaining Treatment - treatment that, based on reasonable medical judgment, sustains an individual's life and without it the individual will die. This includes medications and interventions that are considered life-sustaining, but not those that are considered palliative or comfort measures;-The Interdisciplinary Team will review for changes to the resident's cognitive status and communicate significant changes to the resident's representative. Such changes will be documented in the care plan and medical record;-The Interdisciplinary Team will review at regular intervals with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Staff will assist the resident or representative to make changes to advanced directives in accordance with state law. Changes and/or revocations will be added to the clinical record. The care plan will be updated to reflect the change. Review of the facility policy, Cardiopulmonary Resuscitation, dated 03/2025, showed the following:Policy: Cardiac arrest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness). The goal of early delivery of CPR is to try to maintain life until the emergency response team arrives to deliver Advanced Life Support (ALS);-Policy interpretation and implementation:-If a resident is found unresponsive and not breathing normally, a clinical staff member will verify code status using the medical record;-If the resident is full code, per the medical record, a staff member that is certified in CPR will initiate CPR until the emergency response team arrives;-If the resident is a DNR, per the medical record, notify the attending provider. Review of the American Heart Association website showed a sensation of something sitting on the chest is classic symptom of chest pain/discomfort and the action needed advised to call 911 immediately as it may be a medical emergency. 1. During an interview on [DATE] at 2:55 P.M., the Assistant Director of Nursing (ADON) said the following:-The facility did not have a policy specific to new admissions or the admission process, but expected staff to complete an admission assessment, monitoring each shift (nurses worked 12 hour shifts), including documentation of nursing assessments and vital signs (VS) for 72 hours for newly admitted residents;-The Nurse Communication Book at each nursing station detailed these procedures. Review of a Nurse Communication Book showed the following:-The binder contained a page titled, What to do if I get an admission/re-admit. The form instructed staff to obtain VS, enter in all orders, including code status, and to complete nursing admission/re-admission data collection;-The binder contained a page titled, What to do if a resident has a change in condition. The form instructed staff to complete an SBAR, make family/POA notification, call Director of Nursing (DON)/ADON on call. If non-emergency, please send text. On day one, two and three, in the electronic health record, write a short progress note description of the resident's mood/behavior during your shift. A change in condition included pain of any kind. During an interview on [DATE] at 4:00 P.M., the DON said the facility administration was to conduct a 24-hour record review of all residents. Administration completed the review Monday through Friday during clinical meetings. Administration completed the Saturday and Sunday reviews on Monday during the clinical meeting. The review consisted of a review of various things, including new admits/readmits, residents with a change of condition and any new orders. 2. Review of Resident #79's face sheet showed the following:-admitted to the facility on [DATE];-His/Her family member was listed as his/her responsible party and emergency contact;-He/She was a full code, indicating the resident wanted full life-saving measures. Review of the resident's admission agreement showed the following:-An active Power of Attorney (POA) document, uploaded into the resident's medical record on [DATE];-The resident's elected Authorized Representative was his/her family member;-The Durable Power of Attorney for Health (continued on next page)

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Care and/or Health Care Directive showed if the resident was persistently unconscious or there was no reasonable expectation of his/her recovery from a seriously incapacitating or terminal illness or condition, he/she directed that all of the life-prolonging procedures, including heart-lung resuscitation (CPR) be withheld or withdrawn. The resident initialed the selection;-The resident signed the document on [DATE]. Review of the resident's diagnoses page from his/her electronic medical record showed he/she was admitted with known cardiovascular diagnoses of complete AV block (irregular heart beat/rhythm), cardiac pacemaker (an medically implanted device to keep the heart beating at a normal rate), congestive heart failure (impaired heart function), and hypertension (high blood pressure), as well as pulmonary diagnoses of chronic obstructive pulmonary disease (lung disease) and history of respiratory failure with hypoxia (low level of oxygen in blood stream), and he/she was a full code status. Review of the resident's progress notes, dated [DATE] at 5:21 P.M. (documented as a late entry), showed the resident arrived at the facility, was alert and oriented, and able to make his/her needs known. Review of the resident's electronic health record. showed the following:-Staff took the resident's VS on [DATE];-Staff began data collection for the Nursing admission on [DATE] at 7:45 P.M. and data collection was still in progress (not complete). (Review on [DATE] at 10:00 A.M., showed the data collection was still in progress.) Review of the resident's care plan, dated [DATE], showed the following:-Advanced Directive/End of Life Care Plan: the resident is not at or approaching end of life at this time. The resident elected a full code status and his/her wishes would be honored (initiated by the Minimum Data Set (MDS) Coordinator);-The resident had a pacemaker. Monitor VS as ordered/per facility protocol and record. Monitor/Document/Report to provider any signs and symptoms of lower than baseline blood pressure. During an interview on [DATE] at 2:00 P.M., the MDS Coordinator said the following:-She thought she uploaded the resident's admission paperwork, including his/her health care directive, in the resident's electronic medical record, but she wasn't sure;-She completed the resident's care plan and would have entered the information related to code status based off the record review and what she saw as the resident's elected code status;-To her knowledge, she entered the resident's code status correctly. Review of the resident's [DATE] physician order sheet (POS) showed the following:-The resident was a full code;-The resident was prescribed midodrine HCl (medication to treat orthostatic hypotension (a sudden drop in blood pressure upon standing)) 10 milligrams three times daily; hold for systolic pressure (the top number of a blood pressure) over 130 (normal is less than 120). Review of the resident's electronic health record for [DATE] showed the following:-No documentation staff completed nursing assessments for the day shift (6:00 A.M. to 6:30 P.M.) and the night shift (6:00 P.M. to 6:30 A.M.) on [DATE], as directed in facility procedure for 72 hours following admission;-No documentation staff checked the resident's blood pressure as ordered before administering his/her scheduled midodrine at 4:00 P.M. on [DATE]. Review of the resident's electronic health record for [DATE] showed the following:-No documentation staff completed nursing assessments or VS for the day shift and the night shift on [DATE], as directed in facility procedure for 72 hours following admission;-No documentation staff checked the resident's blood pressure before administering his/her scheduled midodrine at 8:00 A.M., 12:00 P.M., and 4:00 P.M. on [DATE]. Review of the resident's progress notes, dated [DATE] at 7:00 A.M., showed Nurse Practitioner (NP) #1 conducted a routine round assessment of the resident. The resident required close monitoring to prevent respiratory or cardiac decompensation. At that time, the resident denied chest pain and was negative for anxiety. The NP documented the resident remained medically complex, requiring ongoing monitoring due to risk of respiratory compromise and cardiac instability. The plan was to continue cardiac monitoring and assess for arrhythmia (heart palpitations, chest pain, dizziness, shortness of breath and fatigue) symptoms and continue blood pressure monitoring. Review of the resident's electronic health record for [DATE] showed the following:-No documentation staff completed nursing assessments or VS for day shift on [DATE], as directed in facility procedure for 72 hours following admission;-No documentation staff checked the resident's blood pressure as ordered before (continued on next page)

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administering his/her scheduled midodrine on [DATE] at 8:00 A.M., 12:00 P.M. or 4:00 P.M. Review of the resident's progress note, dated [DATE] at 7:00 A.M., showed NP #2 conducted a telehealth visit where the resident reported anxiety and a feeling of something sitting on his/her chest. The resident was ordered and administered hydroxyzine (a medication for itching and anxiety) 25 milligrams (mg) with instructions to follow up in 30 - 60 minutes if symptoms persist or sooner if needed. Review of the resident's progress notes, dated [DATE], showed no documentation who contacted NP #2 for the telehealth visit, the reason for the visit and the information provided to NP #2, per the facility's change in condition and notification policy. Review of the resident's electronic health record showed no documentation staff checked the resident's blood pressure before administering his/her scheduled midodrine at 8:00 A.M. or 12:00 P.M. on [DATE]. Review of the resident's [DATE] medication administration record (MAR) showed Licensed Practical Nurse (LPN) OO administered the resident the hydroxyzine 25 mg on [DATE] at 2:54 P.M. (approximately eight hours after the order was received). (Review showed no documentation staff followed up on the resident's condition as NP #2 directed following administration of the hydroxyzine.) Review of the resident's electronic health record showed the following:-No documentation staff completed an SBAR; no documentation staff notified the resident's POA, the DON, or ADON of the resident's change in condition; and no documentation staff completed a short progress note of the resident's condition during the shift on [DATE] when the resident had a change in condition, as directed in the Nursing Communication Book;-No documentation to show staff checked the resident's blood pressure before administering his/her scheduled midodrine at 4:00 P.M. on [DATE]. During an interview on [DATE] at 5:18 P.M., Licensed Practical Nurse (LPN) OO, the resident's charge nurse on [DATE] during the day shift, said the following:-He/She could not really recall the resident;-He/She could not recall how the telehealth visit on [DATE] came about;-He/She could not recall completing any assessments on the resident or administering him/her any medications;-If a resident required a physician or provider visit, the charge nurse was responsible to notify the family of any concerns or changes; he/she could not recall doing any of that. During an interview on [DATE] at 1:30 P.M., the contact with the medical group confirmed LPN OO called with the resident's concern of a feeling of something sitting on his/her chest. This was the reason for the telehealth visit on [DATE]. During an interview on [DATE] at 3:44 P.M., NP #2 said the following:-She could not speak to the resident and the specific visit at that time;-If a resident had a known cardiac history and was complaining of something sitting on his/her chest, it could indicate a cardiac event and possible evaluation in an emergency room;-She thought the system prompted her to order hydroxyzine due to anxiety, but could not recall. Review of the resident's electronic health record showed the following:-No documentation staff documented on the resident's condition during the night shift on [DATE] through the night shift on [DATE]. (The facility's change in condition policy directed staff to document on the resident for 72 hours following a change in condition.)-No documentation staff checked the resident's blood pressure before administering his/her scheduled midodrine at 8:00 A.M., 12:00 P.M., and 4:00 P.M. on [DATE]. (The facility did not provide evidence of a 24-hour record review for [DATE]. The facility did not provide documentation to show the DON or designee reviewed the resident's change of condition for the continued need for additional documentation as directed in the facility's policy for change in condition.) Review of the resident's electronic health record showed the following:-No documentation staff documented on the resident's condition during the day and night shifts on [DATE], per the facility's change in condition policy; -No documentation to show staff checked the resident's blood pressure before administering his/her scheduled midodrine at 8:00 A.M. and 12:00 P.M. on [DATE]. Review of the resident's [DATE] MAR showed staff did not administer the resident's scheduled midodrine on [DATE] at 4:00 P.M. Review of the resident's progress note, dated [DATE], showed staff did not administer the 4:00 P.M. dose of midodrine as the medication was not available. Review of the resident's electronic health record showed no documentation staff checked the resident's blood pressure at 4:00 P.M. on [DATE] and no documentation staff notified the resident's physician when staff did not administer the (continued on next page)

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's midodrine. (The facility did not provide evidence of a 24-hour record review for [DATE]. The facility did not provide documentation to show the DON or designee reviewed the resident's change of condition on [DATE] for the continued need for additional documentation as the facility policy for change of condition instructed.) Review of the resident's progress note, dated [DATE] at 7:00 A.M., showed NP #1 conducted a visit with the resident and documented the chief complaint as anxiety episode with chest pressure sensation in a resident with chronic respiratory failure and advanced cardiopulmonary disease requiring evaluation and medication adjustment. The resident was evaluated for anxiety and complaint of a sensation described as something sitting on his/her chest. Nursing reports VS stable. The hydroxyzine administered to the resident resulted with only partial relief of symptoms. Due to underlying respiratory disease and cardiac co-morbidity, symptoms required careful evaluation to differentiate anxiety from cardiopulmonary decompensation. The resident was on a monitoring plan. Medication adjustment was initiated with tizanidine (a muscle relaxer) for muscle tension and discomfort with blood pressure precautions. Nursing staff were educated to monitor respiratory status, anxiety symptoms, blood pressure parameters, and sedation risk related to the new medication. Review of the resident's progress notes, dated [DATE], showed no documentation who contacted NP #1 for the telehealth visit, the reason for the visit and the information provided to NP #1, per the facility's change in condition and notification policy. During an interview on [DATE] at 11:15 A.M., NP #1 said the following:-She believed her visit on [DATE] was a follow up to the telehealth visit of [DATE];-She did not realize the visit was for a complaint of something sitting on the resident's chest for a second time in three days;-She could only go with what was documented and could not recall specifics about the resident;-If she instructed staff to complete careful monitoring. The resident was on a monitoring plan, which should have included monitoring the resident's VS per the facility policy and/or as ordered. Staff were to monitor and follow up on any voiced concerns and new medication orders;-She wasn't aware the facility was not monitoring the resident's VS.-She could not recall ordering the tizanidine, but if she did, she would have expected staff to administer it;-A resident with cardiac history who reports a feeling of something sitting on their chest could require further evaluation. During an interview on [DATE] at 5:00 P.M., the DON said a resident reporting a feeling of something sitting on their chest would be considered a cardiac symptom. She spoke with NP #1 who said anxiety can mimic cardiac symptoms. She did not agree with NP #1, but did nothing further to question her. She was not aware of the resident's cardiac history. If she had been, she would have sent the resident out for evaluation. Review of the resident's electronic health record for [DATE] through [DATE] showed the following:-No evidence the DON conducted an assessment or directed staff to conduct on-going monitoring of the resident after she became aware of the resident's reported possible cardiac symptoms and potential cardiac emergency;-No documentation of a physician order for tizanidine with a dose to be given or how often;-No documentation of blood pressure precautions or documentation staff monitored the resident's blood pressure before the administration of his/her midodrine at 8:00 A.M., 12:00 P.M. and 4:00 P.M. on [DATE];-No documentation to support staff monitored the resident's respiratory status, anxiety symptoms, and blood pressure parameters as NP #1 directed in his/her progress note, dated [DATE]. Review of the resident's progress note, dated [DATE] at 7:37 P.M. (documented as a late entry), showed staff alerted LPN I the resident was not breathing. The resident was in his/her room in severe respiratory distress with labored breathing and unresponsiveness. Staff assessed the resident immediately; no spontaneous respirations and no palpable pulse detected. Staff initiated emergency response and started CPR/compressions per facility protocol. Staff assisted and notified emergency medical services (EMS). Chest compressions continued as indicated. Despite resuscitation efforts, the resident remained unresponsive with no pulse and no respirations. EMS announced the resident's time of death at 8:57 A.M. The family was at the resident's bedside. Review of the EMS ticket of [DATE] showed nursing staff on scene reported the resident having shortness of breath in which he/she was denying oxygen or nebulizer treatments in which they called the family (continued on next page)

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	05/19/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	who was in route to the facility. On arrival, the resident was found unresponsive, apneic (a person has stopped breathing) and without a pulse with nursing staff standing around the bed not performing compressions. Nursing staff reports they did chest compressions for approximately one to two minutes prior to the EMS crew's arrival. Nursing staff reported the resident was a full code, therefore, compressions were initiated, and the paramedic took over before family member, who has power of attorney over the resident's medical decisions, asked for resuscitation measures be stopped. During an interview on [DATE] at 10:02 A.M., LPN OO, who worked on the day shift on [DATE], said the following:-He/She could recall assisting LPN I when staff found the resident in cardiac arrest;-Upon entering the room, LPN I was doing chest compressions on the resident;-He/She took over compressions at some point;-He/She did not look for the resident's code status and figured LPN I had;-He/She usually checked for a resident's code status on a report sheet and the electronic health record, specifically the physician's orders or face sheet, to determine a resident's code status;-He/She could not recall any facility staff checking the resident's vital signs. During an interview on [DATE] at 12:44 P.M., the resident's power of attorney (POA) said the following:-Staff did not make him/her aware of the resident's complaints of something sitting on his/her chest on [DATE] and [DATE] or of any medication adjustments;-He/She would have wanted the resident evaluated at the hospital.-He/She told the facility at the resident's admission the resident was a DNR (do not resuscitate, no CPR is to be initiated);-When he/she arrived at the facility on [DATE] and found staff and EMS performing CPR on the resident, he/she demanded they stop. During an interview on [DATE] at 4:18 P.M., Certified Medication Technician (CMT) BB said the following:-He/She really couldn't recall the resident, but could see his/her initials on the MAR showing he/she administered the resident's midodrine during his/her shifts;-The instructions with the medication order were to take the resident's blood pressure before administering the medication;-He/She could not see where he/she took the resident's blood pressure before administering the medication;-If he/she had taken the blood pressure, he/she would have documented it under the VS tab in the electronic medical record since there was no specific place to document it on the MAR. During an interview on [DATE] at 3:00 P.M., the ADON said she expected staff to monitor and document assessments of the resident per facility procedure and as ordered or directed by the medical provider. Nursing staff were to use their nursing judgement and knowledge. She would consider a resident reporting something sitting on their chest as cardiac related and would have sent the resident to the hospital for evaluation. She was not previously aware of the resident's complaint and had only just now become aware. During an interview on [DATE] at 2:00 P.M., the Administrator said the following:-Staff were to follow all facility policies and procedures and physician orders;-Staff should meet all residents' needs, through assessment and care. Staff should not neglect the residents;-The care the facility provided should reflect the resident's wishes and this information should be accurate throughout the resident's medical record. NOTE: At the time of the recertification survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). 2973690

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	05/19/2026

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders for three residents (Residents #81, #36, and #42), in a review of 28 sampled residents. Staff failed to administer medications as ordered on admission for Resident #81 and failed to obtain blood tests as ordered for Residents #36 and #42. The facility census was 72. Review of the facility's policy, Medication Administration, dated May 2019, showed the following: -Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis;-If medication is ordered but not present, call the pharmacy or supervisor to obtain the medication. During an interview on 05/13/26 at 2:55 P.M., the Assistant Director of Nursing (ADON) said a check list in the nursing communication book gave directions to staff on what to do when a resident was admitted . The facility did not have a specific policy related to the process to follow for new admissions. Review of the undated nursing communication book, What to do if I get an admission/re-admit, showed the following:-Call physician to verify medications;-Enter all orders. During an interview on 05/15/26 at 12:40 P.M., the Administrator said the facility did not have a specific policy for following physician's orders or obtaining blood tests. 1. Review of Resident #81's face sheet showed the following: -admitted to the facility on [DATE];-Diagnoses include anxiety disorder (a mental health condition that causes fear and dread), hypertension (high blood pressure), hyperlipidemia (high cholesterol), stroke, gastroesophageal reflux disease (GERD/stomach contents leak backwards into the esophagus), depression (a mental health condition that includes a persistent feeling of sadness and loss of interest), glaucoma (a group of eye diseases that damage the optic nerve causing increased pressure inside the eye) and seizure disorder. Review of the resident's progress note, dated 05/11/26 at 7:47 P.M., showed the resident was admitted to the facility from a local hospital via emergency medical services. Review of the resident's hospital transfer/discharge paperwork, dated 05/11/26, showed physician orders for the following:-Cosopt (glaucoma eye drops) ophthalmic solution 2-0.5 percent (%), instill one drop in left eye two times a day for ocular hypertension (last administered at the hospital on [DATE] at 8:51 A.M.);-Depakote delayed release 125 mg, give three tablets, three times a day for seizures (last administered at the hospital on [DATE] at 8:47 A.M. and 2:09 P.M.);-Latanoprost ophthalmic solution (glaucoma eye drops) 0.005 percent (%), instill one drop in left eye at bedtime for ocular hypertension (no record this was administered at the hospital);-Trazodone hydrochloride/HCL (antidepressant) 100 mg, two tablets at bedtime for depression (no record this was administered at the hospital);-Potassium chloride (supplement) extended release (ER) 20 milliequivalents (meq) one time a day for minerals and electrolytes (no record this was administered at the hospital);-Amlodipine besylate (heart medication) 10 milligrams (mg) one time a day for elevated blood pressure. (last administered at the hospital on [DATE] at 8:46 A.M.);-Vitamin D-3 (supplement) oral table 25 mcg one time a day for vitamin deficiency (last administered at the hospital on [DATE] at 8:46 A.M.);-Acetaminophen (pain reliever) 325 mg, give two times a day for pain (no record this was administered at the hospital). Review of the resident's pharmacy electronic transmission report showed on 05/12/26 between 7:54 A.M. and 7:56 A.M., the resident's orders for potassium chloride, amlodipine besylate, Depakote, Cosopt ophthalmic solution, Latanoprost ophthalmic solution, Lipitor, vitamin D-3 and trazodone HCL were created and processed. During an interview on 05/12/26 at 9:53 A.M., the resident said he/she did not think he/she received any medications last night and was not sure if he/she received any medications yet today. Review of the resident's pharmacy electronic transmission report showed the following: -On 05/12/26 at 11:31 A.M, the resident's order for acetaminophen was created and processed;-On 05/12/25 at 5:22 P.M., the resident's order for Depakote was created and processed. Review of the resident's May 2026 medication administration record showed the following:-Cosopt ophthalmic solution 2-0.5% instill one drop in left eye two times a (continued on next page)

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	05/19/2026

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 - Some	day for ocular hypertension. Staff first administered the medication in the evening on 05/12/26. (The resident did not receive the medication as ordered in the evening on 05/11/26 and in the morning on 5/12/26); -Depakote delayed release 125 mg, give three tablets, three times a day for seizures. Staff first administered the medication on 05/12/26 at 4:00 P.M. (The resident did not receive the medication as ordered in the evening on 05/11/26 and for the morning and noon dose on 05/12/26); -Latanoprost ophthalmic solution 0.005 %, instill one drop in left eye at bedtime for ocular hypertension. Staff first administered the medication in the evening on 05/12/26. (The resident did not receive the medication as ordered in the evening on 05/11/26;-Trazodone hydrochloride/HCL 100 mg, two tablets at bedtime for depression. Staff first administered the medication as ordered in the evening on 05/12/26. (The resident did not receive the medication as ordered in the evening on 05/11/26); -Potassium chloride ER 20 meq one time a day for minerals and electrolytes. Staff first administered the medication as ordered in the morning on 05/13/26. (The resident did not receive the medication as ordered on 05/12/26); -Amlodipine besylate 10 mg one time a day for elevated blood pressure. Staff first administered the medication as ordered in the morning on 05/13/26. (The resident did not receive the medication as ordered on 05/12/26); -Vitamin D-3 oral table 25 mcg one time a day for vitamin deficiency. Staff first administered the medication as ordered in the morning on 05/13/26. (The resident did not receive the medication as ordered on 05/12/26); -Acetaminophen 325 mg, give two times a day for pain. Staff first administered the medication as ordered in the evening on 05/12/26. (The resident did not receive the medication as ordered on 05/11/26 and in the morning on 05/12/26). Review of the facility provided medication list for the emergency medication kit showed the following medications were available:-Amlodipine besylate 5 mg;-Potassium chloride 10 meq;-Trazodone 50 mg,-Divalproex sodium (Depakote) 125 mg;-Acetaminophen 325 mg;-Vitamin D-3 25 mcg. During an interview on 06/03/26 at 2:58 P.M., Licensed Practical Nurse (LPN) PP said the following:-Resident #81 was admitted to the facility at the same time as another resident, toward the end of his/her shift;-He/She completed the resident's admission assessment and let the ADON know he/she still had medications to administer to other residents and had to administer a tube feeding for another resident. He/She asked the ADON if she could help since there were two admissions at the same time;-The ADON said she did not have time to help. The ADON said he/she (LPN PP) could pass it on to the next shift to complete the physician orders for the resident;-He/She was unsure who the staff member was who took over the next shift, but he/she shared the only thing he/she completed for the resident was the admission assessment and he/she had not had time to get to the physician orders. During an interview on 05/15/26, at 3:33 P.M., the Director of Nursing (DON), said the following: -She expected staff to administer medications as ordered;-Staff should enter orders for newly admitted residents as soon as possible, so staff could order the medications from the pharmacy as soon as possible;-Staff should not take 24 to 36 hours to enter physician orders for newly admitted residents.-She expected staff to check the emergency medication kit to check if any of the ordered medications were available to administer before the facility received the resident's medication supply from the pharmacy. During an interview on 05/12/26, at 2:30 P.M., the Medical Director said the following: -He expected staff to enter physician orders for new admissions in a timely manner. A resident should not miss 24 to 36 hours of medication;-Staff should contact the pharmacy for direction if a medication was unavailable in the emergency stock. 2. Review of Resident #36's April 2026 POS showed the resident had orders for a complete blood count (CBC; a blood test that determines general health status and screens for and monitors for a variety of disorders, including anemia), comprehensive metabolic panel (CMP; a blood test that measures blood sugar, electrolytes, fluid balance, kidney and liver function), A1C (a blood test to screen, diagnose or monitor diabetes) to be drawn every three months for chronic obstructive pulmonary disease (lung disease), type II diabetes (metabolic disease) with hyperglycemia (elevated amount of sugar in the blood) and hypertension (high blood pressure), starting on the last day of the month, starting 01/30/26. Review of the resident's electronic medical record showed results for a CMP and A1C dated 04/17/26. (continued on next page)

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	05/19/2026

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 - Some	(Review showed no documentation a CBC was obtained. Review showed no documentation staff reviewed the blood test results.) Review of the resident's April 2026 treatment administration record (TAR) showed staff documented a code of 6 in the blood test administration box for 04/30/26. Review of the code definitions showed a code of 6 instructed to see progress notes. Review of the resident's progress note, dated 04/30/26 at 12:21 P.M., showed the only documentation was a copy of the order for the blood tests, including the CBC. Review of the resident's electronic medical record showed no evidence a CBC was obtained in April 2026 through the review date of 05/19/26. During an interview on 05/19/26 at 2:26 P.M., the DON said the following:-An outside lab company drew all ordered blood tests;-Staff were to document on the TAR to acknowledge the blood tests were obtained;-When staff received the blood test results, staff should document on the result form or at least in the progress notes that staff received and reviewed the results and made the physician aware. Part of that review would be to ensure all ordered blood tests were obtained and a result received; -There was no official tracking to ensure blood tests orders were obtained as ordered;-She did not see results of a CBC in the resident's medical record;-A CBC was not drawn as ordered. 3. Review of Resident #42's April 2026 POS showed the resident had orders for a CBC, CMP, thyroid stimulating hormone (TSH; a blood test to monitor treatment of hypothyroidism), lipids (laboratory test that measures cholesterol level in the blood) and vitamin-D every six months, starting on the first Monday of April/October, order date of 09/26/24. Review of the resident's April 2026 TAR showed a checkmark documented in the blood test administration box of 04/01/26. Review of the code definitions showed a checkmark indicated administered. LPN N's identifier was noted in the administration box with the checkmark. Review of the resident's electronic medical record showed blood tests results for a CMP, CBC, TSH and vitamin-D dated 04/02/26. (Review showed no documentation lipid blood test was obtained. Review showed no documentation staff reviewed the blood test results.) Review of the resident's electronic medical record showed no evidence a lipid blood test was obtained in April 2026 through the review date of 5/19/26. During an interview on 05/19/26 at 11:00 A.M., LPN N said the following:-A laboratory company drew the blood tests as ordered; -He/She documented in the administration box on the TAR that he/she knew the laboratory company was on-site to draw the blood, but did not confirm what they drew. During an interview on 05/19/26 at 2:26 P.M., the DON said the following:-She did not see results of a lipid blood test in the resident's record;-A lipid blood test was not drawn as ordered. 3007792

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	05/19/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide eight residents (Residents #2, #9, #18, #29, #42, #45, #52, and #64), who required staff assistance for activities of daily living (ADLs), in a review of 28 sampled residents, the necessary care to maintain good personal hygiene. The facility census was 72. Review of the facility's policy, Activities of Daily Living,(ADLs), dated 09/24/25, showed the facility provided each resident with care, treatment, and services according to the resident's individualized care plan. The facility did not provide a policy related to oral care. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 03/16/26, showed the resident was dependent on staff for oral hygiene. Review of the resident's care plan, revised 04/06/26, showed the following:-Diagnoses included need for assistance with personal cares;-The resident had a feeding tube;-The resident had a swallowing problem and was to have nothing by mouth (NPO; instruction that restricts a resident from consuming any food, beverages or oral medications);-The resident had an ADL self-care performance deficit;-The resident required one staff to assist with his/her oral care. Observation on 05/11/26 at 4:40 P.M., showed the following:-The resident had debris on his/her teeth;-The resident had debris on his/her lips, and his/her lips were dry; Observation on 05/12/26 at 10:00 A.M., showed the following:-The resident had debris on his/her lips, and his/her lips were dry;-His/Her teeth were coated with white-colored debris. Observation on 05/13/26 at 8:19 A.M., showed the following:-The resident sat in his/her wheelchair in the common area;-The resident had thick, discolored secretions flowing out of his/her mouth and onto his/her shirt; -The resident had debris on his/her lips;-His/Her teeth were coated with white-colored debris. During an interview on 05/13/26 at 8:13 A.M., the resident shook his/her head side to side when asked if any staff brushed his/her teeth. During an interview on 05/13/26 at 3:03 P.M., Certified Nurse Assistant (CNA) K said the following:-He/She was responsible for the resident's care on 05/13/26;-He/She washed the resident's face with a washcloth during morning cares; -He/She did not perform oral care for the resident during his/her shift. During an interview on 05/15/26 at 9:40 A.M., Licensed Practical Nurse (LPN) J said the following:-The resident required staff to perform oral care;-Staff should perform oral care once per day for the resident. 2. Review of Resident #9's care plan, dated 02/14/25, showed the resident required one staff to assist him/her with personal hygiene and oral care. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognition intact;-Required partial to moderate assistance with oral hygiene. Observation on 05/11/26 at 12:30 P.M., showed the resident had a significant tremor, (unintentional, rhythmic muscle contraction causing shaking movements) in both of his/her hands. Observation on 05/12/26 at 9:30 A.M., showed the following:-The resident had debris on his/her teeth;-He/She had supplies needed for oral care in his/her room. During an interview on 05/12/26 at 9:10 A.M., the resident said the following:-He/She had his/her natural teeth;-He/She was unable to perform oral care without assistance due to his/her hands shaking;-Staff did not provide him/her with oral care on a regular basis. Observation on 05/13/26 at 9:13 A.M., showed the following:-The resident was in bed;-He/She had debris on his/her teeth;-Staff assisted the resident to eat his/her breakfast. Staff did not offer to provide oral care after the resident finished eating and before leaving the resident's room. Observation on 05/13/26 at 2:10 P.M., showed the resident had debris on his/her teeth. During interviews on 05/13/26 at 9:30 A.M. and 2:10 P.M., the resident said staff did not provide him/her with oral care today. Observation on 05/14/26 at 3:12 P.M., showed the resident had debris on his/her teeth. During an interview on 05/14/26 at 3:13 P.M., the resident said staff did not provide oral care for him/her today. Review of the resident's electronic health record, task section, showed no documentation staff provided oral care for the resident from 05/11/26 through 05/15/26. 3. Review of Resident #52's MDS, dated [DATE], showed the following:-Cognition intact;-Required supervision or touch assistance with oral care. Review of the (continued on next page)

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	05/19/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's care plan showed the resident required assistance for personal hygiene and oral care. During an interview on 05/11/26 at 2:40 P.M., the resident said the following:-He/She had his/her natural teeth;-He/She was able to brush his/her own teeth if staff assisted him/her with set-up of the supplies;-He/She asked staff for assistance with oral care, but they did not assist him/her with oral care. Observation on 05/11/26 at 2:40 P.M., showed an emesis basin containing oral care supplies, including toothpaste and a toothbrush, on a shelf in the resident's room, out of the resident's reach. Observation on 05/12/26 at 9:51 A.M., showed the resident had debris on his/her teeth. Observation on 05/13/26 at 2:21 P.M., showed the resident had debris on his/her teeth. Observation on 05/14/26 at 3:13 P.M., showed the resident had debris on his/her teeth. During interviews on 05/12/26 at 9:50 A.M., 05/13/26 at 2:20 P.M. and 05/14/26 at 3:12 P.M., the resident said staff did not give him/her oral care supplies and did not assist him/her with oral care since he/she returned from the hospital on [DATE]. Review of the resident's electronic health record, task section, showed no documentation staff provided oral care for the resident from 05/11/26 through 05/15/26. 4. Review of Resident #42's care plan, dated 09/13/24, showed he/she required staff assistance for personal hygiene and oral care. Review of the resident's MDS, dated [DATE], showed the following:-Cognitively impaired;-Required partial to moderate assistance with oral care. Observation on 5/12/26 at 9:00 A.M., showed the following:-The resident sat in the common area in his/her wheelchair;-He/She had debris on his/her teeth. Observation on 05/13/26 from 5:10 A.M. through 5:50 A.M., showed the following:-Staff assisted the resident to dress and transferred the resident from the bed to the wheelchair;-An electric toothbrush and toothpaste sat on a shelf in the resident's room;-Staff did not provide oral care for the resident; -Staff took the resident to the common area in his/her wheelchair. Observation on 05/13/26 at 8:35 A.M., showed staff assisted the resident to the common area after the resident ate breakfast. Staff did not offer or provide oral care for the resident after breakfast. During interview on 05/13/26 at 9:50 A.M., Resident #52, the resident's roommate said the following:-He/She had not left his/her room since he/she returned from the hospital on [DATE];-He/She had not witnessed staff provide Resident #42 assistance with oral care at any time during the past two days. Review of the resident's electronic health record, task section, showed no documentation staff provided oral care for the resident from 05/11/26 through 05/15/26. 5. During an interview on 05/13/26 at 2:42 P.M., Certified Nursing Assistant (CNA) M said the following:-Staff should provide residents with oral care in the morning and after meals;-He/She was responsible for Residents #9, #42, and #52's care that day;-He/She did not assist Residents #9, #42, or #52 with oral care. During an interview on 05/13/26 at 2:57 P.M., CNA Q said the following:-Staff should provide residents with oral care at least one time per day;-He/She was responsible for Residents #9, #42, and #52's care that day and did not provide oral care for the residents;-Staff documented in the electronic health record when they provided oral care. During an interview on 05/13/26 at 4:45 P.M., LPN C said staff should provide oral care for dependent residents at least daily. During an interview on 05/14/26 at 7:32 P.M., LPN S said CNA staff should perform oral care for the residents. During an interview on 05/13/26 at 5:05 P.M., the Assistant Director of Nursing (ADON) said the following:-Staff should provide oral care at least in the morning and at bedtime during routine cares;-Staff should provide set-up assistance for oral care for residents who were able to perform the task independently after set-up;-Staff should document in the resident's electronic medical record when staff provide oral care for the resident. During an interview on 05/13/26 at 5:06 P.M., the Director of Nursing (DON) said the following:-Staff should provide oral care every day as part of routine morning and bedtime care; -Staff should provide set-up assistance with oral care for residents who require set-up assistance. 6. Review of Resident #29's care plan, revised on 09/17/24, showed the following:-Encourage the resident to ask for assistance prior to toileting;-He/She had bladder incontinence;-Check the resident as required for incontinence; wash, rinse, and dry perineum. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Intact cognition;-Frequently incontinent of bladder and always incontinent of bowel;-Required partial to moderate assistance for toileting hygiene. Observation on (continued on next page)

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	05/19/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/13/26 at 6:10 A.M. showed the following:-CNA A removed the resident's urine-saturated incontinence brief and the urine-saturated incontinence pad underneath the resident;-CNA A provided perineal care for the resident;-The resident's buttocks was red. During an interview on 05/13/26 at 1:20 P.M., the resident said the following:-Staff didn't change him/her all night;-Staff let him/her lay wet all night and had to change his/her bedding, because he/she was soaked all the way through;-He/She used his/her call light, but no one came in, or they came in and turned it off, and didn't come back;-He/She was supposed to call for assistance because he/she loses his/her balance;-He/She has asked staff to take him/her to the bathroom and they wouldn't help, so he/she asked his/her roommate to help him/her get to the bathroom or to get staff when needed. During an interview on 05/13/26 at 1:20 P.M., Resident #68, the resident's roommate, said the following:-Staff left Resident #29 wet all night every night;-He/She assisted Resident #29 to go to the bathroom and got staff's attention when staff didn't respond to the resident's call light. 8. Review of Resident #45's care plan, revised on 06/29/25, showed the following:-He/She had potential impairment to skin integrity related to decreased mobility, cognition impairment and occasional incontinence; redness to left buttock;-He/She had an ADL self-care performance deficit and required assistance from one staff for bed mobility, toilet use and personal hygiene. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Intact cognition;-Frequently incontinent of bladder and always incontinent of bowel;-Required substantial to maximum assistance for toileting hygiene. Observation on 05/13/26 at 5:30 A.M., showed the following:-CNA A entered the resident's room and turned on the overhead light above the bed;-The resident asked CNA A for the time. CNA A told the resident it was 5:30 in the morning; -The resident said, Can you please help me? I'm wet and it's been a while. You see I need help. Please help me. It's been a long wait since 10:00 P.M.-CNA A pulled down the resident's blanket. The resident's incontinence brief was heavily saturated with urine. The skin on the resident's genitalia and buttocks was red. CNA A provided incontinence care for the resident. -The resident said, Thank you for the help I am receiving. I'm thankful now. During an interview on 05/13/26 at 5:30 A.M., the resident said the following:-Staff did not check or change him/her since 10:00 P.M.;-That was a long time to wait and to be left wet. 9. Review of Resident #64's care plan, revised on 06/29/25, showed the following:-He/She was totally dependent on staff for personal hygiene and toilet use; -He/She was incontinent of bladder; -Check the resident frequently and as required for incontinence;-Wash, rinse, and dry perineum. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severely impaired cognition;-Occasionally incontinent of bladder and always incontinent of bowel;-Required substantial/maximum assistance from staff for personal hygiene. Observation on 05/13/26 at 5:45 A.M., showed the following:-CNA A entered the resident's room and began performing morning cares;-The room had a very strong urine odor that permeated into the hallway;-CNA A pulled down the resident's heavily urine-saturated incontinence brief, -CNA A provided incontinence care for the resident;-The resident's buttocks were white and heavily wrinkled from moisture. During an interview on 05/13/26 at 5:20 A.M., CNA A said the following: -He/She worked on the night shift;-He/She was to check and change Resident #45 every two hours. The other residents on his/her assigned hall (Residents #29 and #64) were independent and used their call light if they needed assistance;-Staff gave him/her this information in report. 10. During an interview on 05/19/26 at 7:26 P.M., the DON said the following:-Staff should check and change the residents every two hours and as needed;-Residents should not have to depend on their roommate to get staff's attention to provide care. 29797883001665

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	05/19/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reorder an antianxiety medication timely for one resident (Resident #62), in a review of 28 sampled residents, to ensure the medication was available for administration. Resident #62 missed six doses of antianxiety medication. The resident had a panic attack (a sudden surge of overwhelming fear and physical discomfort), experienced withdrawal symptoms, and expressed feelings of hopelessness and not wanting to live. The facility census was 72. Upon request, the facility did not provide a policy regarding re-ordering controlled medications.Review of Resident #62's care plan, revised on 11/04/23, showed the following:-Diagnoses included anxiety disorder;-The resident had mood problems due to major depressive disorder, anxiety, and insomnia; -Give anti-anxiety medications as ordered. Monitor/document side effects and effectiveness. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/01/26, showed the following:-Cognitively intact;-Mood: minimal depression;-The resident had been feeling down, depressed or hopeless for several days;-Diagnosis of anxiety disorder;-He/She took antianxiety medication.Review of the resident's April 2026 physician order sheet showed the resident had an order for alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M. Review of the resident's controlled drug record/disposition form for alprazolam showed staff administered the last dose from the resident's supply on 04/05/26 at 8:00 A.M. Review of the facility's automated medication dispensing system showed the machine contained alprazolam 0.25 mg tablets available for emergency use. Review of the resident's April 2026 treatment administration record (TAR) showed the following: -Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On 04/05/26 at 12:00 P.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/05/26 at 11:40 A.M., showed staff documented they reordered the resident's alprazolam 1 mg.Review of the resident's April 2026 TAR showed the following:-Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On 04/05/26 at 9:00 P.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/05/26 at 10:49 P.M., showed the following:-Alprazolam oral tablet 1 mg, give one tablet three times a day for anxiety;-Medication out at this time.(Review showed no documentation staff notified the resident's physician or the pharmacy regarding the resident's medication.)Review of the resident's April 2026 TAR showed the following:-Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On 04/06/26 at 8:00 A.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/06/26 at 8:53 A.M., showed the following:-Alprazolam oral tablet 1 mg, give one tablet three times a day for anxiety;-Medication on order and was not available.(Review showed no documentation staff notified the resident's physician or the pharmacy regarding the resident's medication.)Review of the resident's April 2026 TAR showed the following:-Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On 04/06/26 at 12:00 P.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/06/26 for approximately 12:00 P.M.,showed no progress note related to the resident's alprazolam 1 mg tablet. Review of the resident's April 2026 TAR showed the following:-Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On 04/06/26 at 9:00 P.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/06/26 at 9:47 P.M., showed no documentation why staff did not administer the resident's alprazolam, and no documentation staff notified the resident's physician or the pharmacy about the resident's medication. Review of the resident's April 2026 TAR showed the following:-Alprazolam 1 mg tablet, give one tablet three times a day for anxiety, scheduled for 8:00 A.M., 12:00 P.M., and 9:00 P.M.;-On (continued on next page)

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	05/19/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	04/07/26 at 8:00 A.M., staff did not administer the medication. Review of the resident's progress notes, dated 04/07/26 at 8:34 A.M., showed the following:-Alprazolam oral tablet 1 mg, give one tablet three times a day for anxiety;-Medication unavailable; awaiting signed script from physician. During an interview on 05/21/26 at 1:43 P.M., the pharmacist said the following:-The resident had a future fill prescription on file for alprazolam, and 120 pills were available on 04/05/26; -The facility did not notify the pharmacy they needed the resident's alprazolam until 04/07/26;-The pharmacy did not automatically refill prescriptions for controlled medications. The facility had to refill the medications by calling, faxing, or requesting the medication from the pharmacy through the facility's electronic health management system; -Staff could contact the pharmacy for access to the medication in the facility's automated medication dispensing system.During an interview on 05/11/26 at 2:05 P.M., the resident said he/she ran out of his/her medication, and he/she had withdrawals which led him/her to have a panic attack while at a scheduled appointment (on 04/07/26). His/Her physician sent him/her to the hospital.During an interview on 05/20/26 at 3:10 P.M., the registered medical assistant at the resident's physician's office said the following:-The resident attended a scheduled cardiology appointment on 04/07/26 at 1:10 P.M.-The resident was upset he/she had not received his/her scheduled medications (alprazolam) because he/she was awaiting the prescription refill;-The resident was having some withdrawal symptoms including being red, sweating and shaking before his/her appointment;-The resident said he/she felt off and was tearful;-The physician thought the resident was having withdrawals and was visibly withdrawing from his/her medication;-The resident said he/she did not want to live anymore, and the physician wanted the resident to be sent to the hospital.Review of the resident's hospital admission record, dated 04/07/26 at 1:14 P.M., showed the chief complaint was panic attack (from physician's office). The resident did not have alprazolam for three days.Review of the resident's ambulance patient care report, dated 04/07/26 at 6:22 P.M., showed the following:-Non-emergent transport from the hospital to the facility;-Chief concern: anxiety;-History: The resident presented to the hospital for a panic attack. The registered nurse (RN) reported the resident was at the physician's office today when he/she expressed feelings of hopelessness and felt like he/she did not have a reason to go on. The RN reported the resident had been out of his/her prescribed alprazolam and was given some in the hospital until the resident was able to have his/her prescribed alprazolam refilled. The resident denied any thoughts of suicidal ideations (SI) or homicidal ideations (HI). The resident was cleared for discharge. Review of the resident's mental status exam, dated 04/27/26, showed the following:-Problem list: anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable fear or worry);-The resident said he/she had been on alprazolam for 10 years.During an interview on 05/11/26 at 9:40 A.M., Licensed Practical Nurse (LPN) J said the following:-Staff were to reorder a controlled medications when the resident had approximately 10 doses remaining;-If a resident ran out of a medication, the facility had an automated medication dispensing machine they could use;-Staff should call the pharmacy to check on the availability of the medication in the automated medication dispensing system, and the pharmacy could open up the drawer where the medication was located;-Staff may have to contact the physician for a new prescription order.During an interview on 05/21/26 at 5:09 P.M., the Assistant Director of Nursing (ADON) said she did not know the resident did not receive his/her alprazolam.During an interview on 05/19/26 at 6:12 P.M., the Director of Nursing (DON) said the following:-Nursing staff should re-order controlled medications when the medication card was half empty;-She did not know the resident did not receive his/her alprazolam from 04/05/26 through 04/07/26;-She did not know the resident went to the emergency room on [DATE];-The resident should have received his/her alprazolam;-Nursing staff were responsible to ensure the resident received his/her controlled medications;-Staff did not report the resident was out of alprazolam to her.During an interview on 05/19/26 at 6:56 P.M., the Administrator said he expected residents to receive their medications as ordered.2979788

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	05/19/2026

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 - 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** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible, when the facility staff failed to follow facility policy during a manual transfer for one resident (Resident #51), in a review of 28 sampled residents, when staff failed to use a gait belt (device used to transfer residents from one position to another) and lock the resident's wheelchair brakes when assisting the resident to transfer from his/her wheelchair to the common area couch. The facility failed to propel one resident (Resident #18) safely when staff transported the resident in his/her wheelchairs without foot pedals. The resident's right foot was bent backwards and dragged against the floor underneath the wheelchair. The facility failed to utilize a sit-to-stand lift (a transfer device that helps partially-weight bearing individuals transition between sitting and standing positions) per the owner's manual for one resident (Resident #9), when staff used the lift as a transport device to transport the resident from his/her bed to the bathroom. The facility census was 72. Review of the facility's policy, Safe Lifting and Movement of Residents, dated 12/2024, showed the following:-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.(The facility policy did not address when to use a gait belt and did not address locking wheelchair wheels during a transfer.) Review of an on-line source from Medline Plus (.gov), Moving a Resident, showed the standard of practice is to lock both wheelchair wheels before any transfer. Never assume the chair will stay in place due to body weight or a short pivot. 1. Review of Resident #18's undated diagnosis sheet showed his/her diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side. Review of the resident's care plan, revised on 01/19/26, showed the resident was at risk for falls: staff educated on gait belts, transfers, and pivoting. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/16/26, showed the following:-No documented cognitive status;-Impairment in one of his/her lower extremities;-Used a wheelchair for mobility;-Required substantial to maximum assistance from staff wheeling 50 feet. Observation on 05/11/26 at 12:20 P.M., showed the following:-The Staffing Coordinator pushed the resident down the 300 hall to the main living area. The resident's right foot was bent backwards and dragged against the floor underneath the wheelchair; -The wheelchair did not have food pedals attached;-The Staffing Coordinator left the resident to assist other residents on the hall; -The resident sat in his/her wheelchair and was crying;-The MDS Coordinator asked the resident what was wrong. The resident said, I don't know;-The MDS Coordinator asked the resident if he/she was in pain. The resident said, Yes;-The MDS Coordinator asked the resident where he/she was hurting. The resident said, I don't know; -The MDS Coordinator pushed the resident closer to the nurse's station. The resident's right foot was bent backwards and dragged on the floor; -The resident was still crying;-The MDS Coordinator pushed the resident back down the 300 hall. The resident's right foot dragged on the floor. During an interview on 05/19/26 at 6:25 P.M., the Staffing Coordinator said the following:-She should not push the resident without foot pedals;-Pushing the resident without food pedals could cause an accident or injury. 2. Review of Resident #51's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment;-Limited range of motion upper extremity, one side only;-Required substantial/maximum assistance for transfers from sitting to standing position.-Has had two or more non-injury falls and one fall with injury since last assessment. (continued on next page)

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	05/19/2026

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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, updated on 05/05/26, showed the following: -Encourage the resident to ask for assistance with transfers while in the common area;-Staff education on gait belts, transfers, and pivoting. Observation on 05/11/26 at 12:30 P.M., showed the following: -The resident sat in his/her wheelchair in the common area near a couch. The resident scooted his/her bottom in the wheelchair closer to the front part of the wheelchair seat, placed his/her hands on the wheelchair arm rests and attempted to stand up from the wheelchair. The resident was partially standing; -Licensed Practical Nurse (LPN) N placed both of his/her arms up under the resident's arms, lifted under the resident's armpits/shoulders, and pivot transferred the resident from his/her wheelchair to the couch in the common area; -LPN N did not use a gait belt during the transfer and did not lock the wheels on the wheelchair prior to the transfer. During an interview on 05/19/26 at 11:00 A.M., LPN N said the following:-The resident began to transfer himself/herself, and he/she quickly went to assist him/her;-The resident had a history of falls and was unsteady when standing. He/She should have sent someone to get a gait belt before he/she transferred the resident; -He/She could have asked the resident to sit back down, and he/she then obtained and used a gait belt to transfer the resident; then the gait belt could have been obtained and used. During an interview on 05/19/26 at 3:03 P.M., the Director of Nursing (DON) said the following:-Staff should not manually lift residents under the arm/shoulder; -Staff should use a gait belt with all manual transfers. 3. Review of the owner's manual for the facility's sit-to-stand lift, showed the following:-The manufacturer strictly states the device is not a transport device;-The lift should be used solely for transferring a resident from one utility (e.g., bed, chair, wheelchair, or toilet) to another;-No room-to-room transport: It is not designed or intended to be used for transporting or moving residents across rooms or over longer distances;-Transfer proximity: Transfers should normally take place within the same resident room or bathroom. Review of the operating parameters for the sit-to-stand lift device showed the following:-Stand-up lifts (stand assists) are not transport devices. They are designed strictly to assist a resident from one resting surface to another (e.g., bed to wheelchair, or wheelchair to commode);-Safety Warnings & Use Cases: -Not for Room-to-Room Transport: You should not use a standing lift to wheel a resident over long distances, down hallways, or in lieu of a wheelchair or gurney; -Safe Transfer Limit: They should solely be used for short, direct transfers to a commode, shower chair, or wheelchair; -Patient Requirements: To use the lift, the resident must have partial weight-bearing capacity, be able to sit up, and have the upper-body strength to hold onto the lift's handles. 4. Review of Resident #9's face sheet showed the resident's diagnoses included muscle weakness, lack of coordination, Parkinson's disease (brain disorder causing unintended or uncontrolled movements) with dyskinesia (a category of movement disorders characterized by involuntary, erratic, and uncontrollable muscle movements), abnormalities of gait and mobility, unsteadiness on feet, and foot drop (inability to lift the front part of the foot due to weakness or paralysis) of the left foot. Review of the resident's care plan, dated 01/08/25, showed the following:-The resident was at risk for falls;-The resident required partial to moderate assistance with transfers. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Uses wheelchair for locomotion;-Required partial to moderate assistance to transfer from bed to chair and to the toilet and to walk. Observation on 05/13/26 from 9:13 A.M through 10:10 A.M., showed the following:-Certified Nurse Assistant (CNA) M and CNA Q assisted the resident to sit on the side of his/her bed;-CNA M and CNA Q assisted the resident to a standing position using the sit-to-stand lift; -The CNAs transported the resident across the room, approximately 15 to 20 feet, to the bathroom, using the sit-to-stand lift as a transport device while the resident stood suspended and attached to the lift with the sling; -After the resident finished using the toilet, staff transported the resident from the bathroom across the room to his/her bedside, using the sit-to-stand lift as a transport device; -Staff lowered the resident to a sitting position in his/her wheelchair using the sit-to-stand lift. During interviews on 05/12/26 at 9:30 A.M., 05/13/26 at 10:10 A.M., and 10:35 A.M., the resident said the following:-Staff usually transported him/her to the bathroom using the sit-to-stand lift if he/she was not already in his/her wheelchair. -He/She (continued on next page)

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	05/19/2026

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 - Minimal harm or potential for actual harm Residents Affected - Some	preferred for staff to transport him/her from his/her bed to the bathroom in the sit-to-stand lift; -CNA M and CNA Q had cared for him/her before 5/13/26 and were aware of what he/she liked. During an interview on 05/13/26 at 10:20 A.M., CNA M said the following:-He/She did not know how staff usually transported the resident to the bathroom because he/she worked for an agency and it was his/her first day at this facility;-He/She should not transport residents any distance further than required to move from bed to chair, chair to bed, or chair to chair; -He/She used the sit-to-stand lift to transport the resident to the bathroom because it was the resident's preference. During an interview on 05/13/26 at 10:28 A.M., CNA Q said the following:-He/She did not know how staff usually transported the resident to the bathroom because he/she worked for an agency and it was his/her first day at this facility; -He/She should not transport residents any distance further than required to move from bed to chair, chair to bed, or chair to chair; -He/She used the sit-to-stand lift to transport the resident to the bathroom because it was the resident's preference;-He/She should have transported the resident to the bathroom using the resident's wheelchair. During an interview on 05/13/26 at 4:45 P.M., LPN C said staff should not transport residents to the bathroom using a sit-to-stand lift. 5. During interviews on 05/13/26 at 5:05 P.M. and 05/19/26 at 3:03 P.M., the DON said the following:-CNA M and CNA Q have worked shifts at that facility many times prior to 05/13/26;-Staff should not transport residents to the bathroom using any mechanical lifting device;-Staff should not push a resident in a wheelchair without foot pedals;-Staff pushing a resident without foot pedals could cause injuries. 3001665