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	06/29/2026

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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement procedures to accurately acquire and administer prescribed medications for one resident (Resident #1) upon admission, in a review of seven sampled residents. On admission, the facility involved a third-party provider, a group of physicians and nurse practitioners who review and issue orders after hours, to review the resident's medications listed on the resident's hospital discharge orders. The third-party provider placed medications to treat the resident's pain, anxiety, migraine headaches, and attention deficit hyperactivity disorder (ADHD, a disorder causing persistent patterns of inattention, hyperactivity, and impulsivity) on hold until the resident's physician reviewed and approved the orders. The facility failed to ensure the resident's physician was aware the third-party provider placed the resident's medications on hold. The resident, who was recovering from a fractured leg, did not receive as needed (PRN) pain medication for approximately 22 hours and complained of throbbing pain that affected his/her sleep. The resident did not receive prescribed medications to treat ADHD, anxiety and headaches for six days following admission to the facility. The resident reported headaches, anxiety, depression symptoms and difficulty focusing as a result of not receiving the medications. The facility census was 75.Review of the facility policy, Admission, dated 12/2024, showed prior to or at the time of the admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering medication orders, including (as necessary) a medical condition or problem associated with each medication. The facility did not provide a policy addressing the third-party provider system and the services they were expected to provide the facility. Review of Resident #1's undated Face Sheet showed the resident was admitted to the facility on [DATE]. The resident's diagnoses included fractured upper left tibia (larger bone in the lower leg), anxiety, and major depressive disorder (a severe mental health condition causing persistent sadness, hopelessness, and loss of interest in life). Review of the resident's hospital physician's discharge orders, dated 06/09/26, showed the following:-Oxycodone-acetaminophen (Percocet, a narcotic pain medication used to treat severe pain) 10 milligrams (mg)-325 mg every four hours as needed (PRN) for pain. The medication was circled and a note on hold was handwritten next to the medication;-Alprazolam (an antianxiety medication) 0.25 mg two times a day as needed (PRN) for anxiety. The medication was circled and a note on hold was handwritten next to the medication;-Butalbital-acetaminophen-caffeine (a medication used to treat migraine headaches) 50-325-40 mg every six hours PRN. The medication was circled and a note on hold was handwritten next to the medication;-Mydayis (a stimulant medication) 37.5 mg daily for ADHD. The medication was circled and a note on hold was handwritten next to the medication. Review of the resident's progress note, written by a facility contracted physician and nurse practitioner third-party provider, dated 06/09/26 at 5:55 P.M., showed the following:-Available documentation reviewed;-Orders and medications approved until resident is evaluated by primary team;-Obtain and review current/relevant hospital documentation and orders with primary team when available;-Notify a clinician of any change in condition; -Hold pending primary provider review - controlled substances. The following (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Actual harm Residents Affected - Few	medications are held pending provider rounds or contact with authorizing/primary provider: 1. Oxycodone-acetaminophen (Percocet)10-325 mg one tablet by mouth (PO) every four hours as needed (PRN) for pain HOLD; 2. Alprazolam 0.25 mg one tablet two times a day (BID) PRN for anxiety HOLD; 3. Mydayis 37.5 mg ER (extended release) 24 hour one capsule PO daily HOLD; 4. Butalbital-acetaminophen caffeine 50-325-40 mg one tablet PO every six hours PRN for headache/migraine HOLD. -All other transfer orders received and noted. Provider notification pending. During a telephone interview on 06/29/26 at 5:30 P.M., a representative of the third-party provider said the following:-The facility contracted them to review medications and issue orders when the primary provider was not available;-They communicated with facility nurses via a computer and video conference if needed. They did not actually see the residents;-The resident's medical record was integrated through their system, so when Resident #1 was admitted to the facility after hours, they reviewed his/her medications. Due to the number of medications containing acetaminophen, the Percocet and butalbital-acetaminophen-caffeine were placed on hold for the physician to review before a prescription could be issued;-The Mydayis and alprazolam were narcotic medications. The physician should review before issuing a prescription;-The nurse with the third-party provider, who reviewed the resident's medications, communicated this with the facility nurse, Registered Nurse (RN) D, and documented it in a progress note; -The third-party provider did not follow up to see if physician orders were obtained; that was the facility's responsibility. During an interview on 07/06/26 at 2:05 P.M., RN D said the following:-Since the resident was admitted after hours (on 06/09/26), the third-party provider reviewed the resident's medications;-The third-party provider put Percocet, alprazolam, Mydayis and butalbital-acetaminophen-caffeine on hold since the resident's physician needed to review the orders for these medications; -He/She passed this information on to the night shift nurse (Licensed Practical Nurse (LPN) E). During an interview on 07/06/26 at 2:30 P.M., LPN E said the following:-He/She worked the night shift the day the resident was admitted (06/09/26). He/She remembered being told the third-party provider placed the pain medication (Percocet) and the alprazolam on hold pending the nurse practitioner's or physician's review;-He/She documented for the next shift to inform the NP or the physician; If the -The resident was very upset he/she did not have any pain medication;-The resident's family member got a prescription for the Percocet from the hospital, but the facility could not use it since the third-party provider placed the medication on hold. During an interview on 06/26/26 at 2:32 P.M., the resident said the following:-He/She fell and fractured his/her lower left leg and was in extreme pain;-The pain was a throbbing pain and woke him/her at night;-Upon admission [DATE]), the hospital did not send the handwritten prescription for the Percocet, so his/her family member went to the hospital to get the prescription;-When his/her family member brought the prescription to the facility, staff told them an NP reviewed the medication, and they could not give the Percocet until a physician reviewed the medication the next day;-He/She took acetaminophen for the pain every four hours, but it did not help. Review of the resident's progress note, dated 06/10/26 at 7:00 A.M., signed by Nurse Practitioner (NP) A showed the resident was seen for post-admission follow-up for fracture of upper end of left tibia. The resident reported significant pain in both legs and stated his/her pain was not adequately controlled with Tylenol. The resident reported he/she did not sleep well due to the pain. The resident and family reported concerns the pain medication was placed on hold or not available despite prior order and prescription. The resident reported the last pain medication dose was around 1:30 P.M. on 06/09/26. The Director of Nursing (DON) and pharmacy follow-up was discussed to clarify pain medication availability and status of medications. The resident reported anxiety and depression. (NP A's progress note did not address the resident's medications, alprazolam, butalbital-acetaminophen caffeine or Mydayis, which the third-party provider placed on hold on 06/09/26 awaiting the resident's physician's review.) During an interview on 06/29/26 at 10:47 A.M., NP A said she had not been made aware the third-party provider placed the orders for the resident's Percocet, alprazolam, Mydayis or the butalbital-acetaminophen-caffeine on hold. She assessed the resident who reported (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	he/she had not had any pain medication since admission and said he/she was in extreme pain. She reviewed the chart on 06/10/26 and found the order for the Percocet and notified the physician and received an order for the Percocet. The resident did not mention he/she had not received any other medications. During an interview on 06/26/26 at 3:00 P.M., the Director of Nursing (DON) said the resident's physician could not issue a prescription for narcotic medications without seeing a resident and utilized NP A to screen the resident for the narcotic use and communicate with the physician. She did not know if NP A made the physician aware the medications were placed on hold. On 06/10/26, she made the physician aware of the prescription for the Percocet from the hospital and received permission to have the medication be given, the first dose was administered from the facility emergency kit on 06/10/26. The pharmacy then sent a medication card containing nine tablets of Percocet. Review of the resident's Physician Order Sheet (POS), dated 06/2026, showed a new order, dated 06/10/26, for Percocet (oxycodone with acetaminophen) 10-325 mg, give one tablet every four hours PRN. (The resident did not have active orders for alprazolam, butalbital-acetaminophen caffeine or Mydayis.) Review of the resident's Medication Administration Record (MAR), dated June 2026, showed staff administered Percocet on 06/10/26 at 11:29 A.M. for a pain level of six out of 10 (pain level of 0 being no pain and a pain level of 10 being extreme pain). During an interview on 06/29/26 at 11:25 A.M., LPN B said the following:-He/She received an order for the resident's Percocet on 06/10/26 and pulled the medication from the facility emergency kit. Percocet was delivered from the pharmacy later that day;-The third-party provider, who reviewed the medications, reviewed any orders received after hours when the NP or the physician is was not available;-The third-party provider did not actually see the resident; the nurses communicated with them via a computer;-When the third-party provider made a recommendation to put a medication on hold, staff should communicate this to the resident's NP or the physician. Review of the resident's progress note, dated 06/11/26 at 8:00 A.M., signed by NP A, showed the resident was assessed for post-admission fracture follow-up, pain management concern, chronic pain, anxiety and depression. (NP A's progress note did not address the resident's medications, alprazolam, butalbital-acetaminophen caffeine or Mydayis, which the third-party provider placed on hold on 06/09/26 awaiting the resident's physician's review.) Review of the resident's progress note, dated 06/12/26, signed by NP A, showed follow-up for a headache yesterday, chronic pain and orthopedic recovery, anxiety, depression history and medication review. The resident said he/she had a headache throughout the day and slept much of the day. The resident reported an anxiety level rated five out 10 (0 being none and 10 being severe) and denied feeling very depressed. Review of the medication orders did not show any orders for alprazolam, butalbital-acetaminophen-caffeine or Mydayis ordered or reviewed from admission. Review of the resident's Controlled Drug Receive/Record/Disposition Form for Percocet 10-325 mg showed the resident received the last dose (the last of the nine tablets received on 6/10/26) on 6/14/26 at 3:50 P.M. During an interview on 06/26/26 at 3:00 P.M., the Director of Nursing (DON) said staff administered the last dose (the last of the nine tablets received on 6/10/26) of the resident's Percocet on 06/14/26 and a new physician script needed to be obtained. The physician was scheduled to come to the facility to see the resident on 06/15/26, however the resident continued to complain of pain. She did not know anything about the resident's orders for alprazolam, Mydayis or the butalbital-acetaminophen-caffeine medications. During an interview on 06/26/26 at 3:00 P.M., Family Member (FM) A said the following:-After a couple of days at the facility, the resident ran out of pain medication (Percocet), and staff told the resident he/she would have to wait until a physician wrote another prescription for the Percocet;-It was at that point, he/she and the resident realized the facility had not given the resident any anxiety medication or medication for ADHD;-No one reviewed the medications after they were placed on hold on 06/09/26. During an interview on 06/26/26 at 2:32 P.M., the resident said the following:-A couple of days after admission, he/she had difficulty focusing and became depressed and had a lot of anxiety due to the pain;-He/She asked for a medication list and realized he/she had not received Mydayis for ADHD or alprazolam for anxiety. He/She also did (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	not have an order for his/her migraine medication;-When he/she asked about this, staff said the physician had not reviewed the medication, so they had not been ordered. During an interview on 07/06/26 at 2:33 P.M., LPN F said the following:-He/She took care of the resident for the first time on 06/15/26;-On 06/15/26, the resident was in a lot of pain and did not have any pain medication;-The resident said he/she had not received any of the medication for ADHD, anxiety or headaches;-He/She reviewed the resident's medical record and found the medications were put on hold at admission;-He/She called the pharmacy to get a prescription. The DON told him/her the medications were put on hold and were waiting for the physician to review; -The resident and his/her family member were so upset the resident had not received the medication, they discharged the resident from the facility (on 06/15/26). Review of the resident's medical record, dated 06/09/26 through 06/14/26, showed no documentation the resident's physician reviewed the resident's medications that were on hold to ensure the resident received prescribed medications to treat anxiety, ADHD, and headaches. Review of the resident's progress note, dated 06/15/26 at 7:30 A.M., signed by NP A, showed the resident was seen on 06/15/26 for follow-up regarding medication concerns and post-admission orthopedic recovery. The resident reported he/she has been without pain medication since yesterday afternoon. The resident reported chronic pain related to left tibia fracture. The resident requested follow up with the attending physician for pain medication script and when it would be available from pharmacy. The resident also reported his/her long-standing ADHD treatment had not been given. The resident reported feeling less focused and questioned why he/she had not received the medication. During an interview on 06/29/26 at 10:47 A.M., NP A said on 06/15/26, when the resident told her about the ADHD and anxiety medications, she was told the DON was aware those medications had not been ordered. She notified the physician the medications were on hold for review. The physician said he would be in to see the resident later that day to review those medications. If she had been made aware those medications were on hold she would have communicated with the physician to get the medications approved and ordered. During an interview on 06/29/26 at 1:44 P.M., Physician C said the following:-He was the Medical Director for the facility and the resident's attending physician; -He was not aware the third-party provider placed the resident's Percocet, alprazolam, Mydayis, and the butalbital-acetaminophen-caffeine on hold until 06/15/26, when NP A contacted him for a prescription for the Percocet;-He expected staff to notify him/her the day after the medications were placed on hold. During an interview on 6/29/26 at 3:30 P.M., the DON said NP A was responsible for communicating the orders that were placed on hold to the resident's physician. NP A was made aware the medications were placed on hold the day after the resident was admitted . She expected NP A to communicate the resident's medications were on hold to the physician;She did not think the nursing staff should have had to call the physician regarding the resident not receiving his/her medications because the NP was the go to person for the physician and had access to the medical record. She thought it should have been the NPs responsibility. During an interview on 06/29/26 at 3:30 P.M., the Administrator said he expected the nurses and the nurse practitioner to communicate with the physicians to ensure the residents had the medications as ordered. 3045508