STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE: 2150 West Randolph Street Saint Charles, MO 63301	

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interviews, record review, and policy review, the facility failed to ensure a resident that had nasal medication and two inhaler medications on the resident's bedside had a self-administration of medication assessment, a physician's order, and care plan completed for one of one resident (Resident (R) 3) reviewed for self-administration of medications. Failure to assess and care plan residents for self-administration of medications increases the potential of medication errors for residents. Findings include: Review of facility's policy titled, Self-Administration of Medications by Residents, dated 05/19, revealed Self-administration medications will be encouraged if it is desired by the resident, safe for the resident and other residents of the facility, ordered by the attending physician, and approved by the Interdisciplinary team (IDT). Procedure: 1. Each resident is offered the opportunity to self-administer his or her medications during the routine assessment by the facility IDT. 2. If the resident indicates no desire to self-administrate medications, this is documented on the appropriate form in accordance with facility policy and procedures. This form becomes part of the resident's medical record, and the resident is deemed to have deferred this right to the facility. If the resident desires to self-administer medications, an assessment is conducted by an IDT. This assessment includes the resident's cognitive, physical, and visual ability to carry out this responsibility. 3. An IDT determines the resident's ability to self-administer medications by means of a skill assessment . 4. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted. c. The medications provided to the resident for bedside storage are kept in containers dispensed by UnitedRx. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 West Randolph Street Saint Charles, MO 63301	

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. The facility nurse is responsible to account for every dose of medication the resident has taken. 5. A physician order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the IDT. The order is recorded on the medication administration record (MAR) . Review of R3's Face Sheet located under 'Profile' tab in the electronic medical record (EMR) revealed that R3 was readmitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). During observation and interview with R3 on 03/18/24 at 4:08 PM, Astepro nasal solution, Albuterol sulfate hydro fluoroalkane (HFA) inhalation aerosol solution and Trilogy inhaler were observed at the resident's bedside. R3 said that she used the Albuterol sulfate hydro fluoroalkane (HFA) inhalation aerosol solution when needed, the Astepro nasal solution and Trilogy inhaler once a day. Review of quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/16/24 indicated that R3 had a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated R3 was cognitively intact. Review of Assessments located under the Assessment tab in the EMR revealed no self-administration assessment. Review of R3's (facility provided) Order Summary Report, dated 03/16/24, revealed Astepro Nasal Solution, one puff in both nostrils one time a day for allergies with start date of 02/07/24. There was no evidence R3 could self-administer this medication. Review of R3's (facility provided) Order Summary Report dated 03/16/24 revealed Albuterol sulfate hydro fluoroalkane (HFA) inhalation aerosol solution 108 (90 Base) MCG/ACT (microgram/asthma control test), two puffs inhaled orally every four hours as needed for shortness of breath (SOB) with start date 06/29/23. There was no evidence that R3 could self-administer this medication. Review of R3's (facility provided) Order Summary Report dated 03/16/24 revealed Trilogy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT, one puff inhaled orally one time a day for COPD, rinse mouth after use with start date of 06/29/23. There was no physician order for R3 to self-administer this medications. Review of R3's Care Plan located under Care Plan tab in the EMR revised 09/29/23, revealed no evidence that R3 could self-administer the nasal spray or inhaler medications. During interview on 03/18/24 at 4:25 PM, Certified Medication Tech (CMT) 1 indicated that there were no residents on the hall that R3 resided that were allowed to self-administer medications. Interview with Director of Nursing (DON) on 03/19/24 at 08:30 AM, the DON stated that she removed the medications until R3 could be assessed for self-administration of nasal spray and inhaler medication and that she could speak with the physician about whether R3 could self-administer her medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview and policy review, the facility failed to ensure an allegation of injury of unknown origin was reported to the State of Missouri Department of Health and Senior Services State Agency (SA) timely for one or one (Resident (R) 21) reviewed for abuse in the sample of 19. Findings include: Review of R21's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 03/18/24 with diagnoses of Alzheimer's disease, cerebral infarction, and repeated falls. Review of R21's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/26/23, revealed the Brief Interview for Mental Status (BIMS), was unable to be completed due to the resident was rarely understood. Review of the facility's Reportable Event revealed that R21's injury of unknown origin was found on 03/12/24 at 8:49 AM. However, the incident was not reported until 03/18/24 at 3:11 PM. Review of a Nurse's Note, in the EMR, under the Notes tab by Registered Nurse (RN) 3 dated 03/12/24 at 9:22 AM indicated, R21 observed guarding left knee and wincing in pain, left knee noted to be swollen and discolored purple and green. During an interview on 03/21/24 at 12:35 PM, RN3 stated that a Certified Nurse Aide (CNA) told that R21 was in pain and the CNA observed the resident's left leg appeared swollen through the clothing. RN3 stated that when she pulled back the resident's clothing the left leg was very swollen, dark purple but not red in color. RN3 stated that when she touched the left knee, R21 experienced discomfort. RN3 stated that she did not report it to the Administrator or Director of Nursing (DON) but notified the facility's on call physician and obtained an order for an X-ray. During an interview on 03/21/24 at 2:13 PM, the DON said she first heard about R21's left knee on 03/18/24 when she learned R21 had a fracture. The DON stated that she knew it was an injury of unknown origin and reported it to the SA that day. She confirmed that R21's injury of unknown origin should have been reported to the SA on 03/12/24, the day it was found. Review of the facility's policy titled ABUSE, PREVENTION AND PROHIBITION POLICY revised 01/24 revealed, .nursing staff is responsible for reporting the appearance of injuries of unknown origin. An Occurrence Report must be completed .Law enforcement and your state agency (SA) must be notified within two hours of the discovery of the injury .Notify your Regional Nurse of notification that will be made to the State (SA) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 West Randolph Street Saint Charles, MO 63301	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview and policy review, the facility failed to ensure an investigation was immediately initiated when an allegation of injury of unknown origin was found for one of one resident (Resident (R) 21) reviewed for abuse in the sample of 19. Findings include: Review of R21's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 03/18/24 with diagnoses of Alzheimer's disease, cerebral infarction, and repeated falls. Review of R21's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/26/23, revealed the Brief Interview for Mental Status (BIMS), was unable to be completed due to resident was rarely understood. Review of the facility's Reportable Event revealed R21's injury of unknown origin was found on 03/12/24 at 8:49 AM. However, the investigation was not initiated until 03/18/24. Review of a Nurse's Note, in the EMR, under the Notes tab by Registered Nurse (RN) 3 dated 03/12/24 at 9:22 AM indicated, R21 was observed guarding left knee and wincing in pain, left knee noted to be swollen and discolored purple and green. RN 3 called the on-call physician and obtained an order for an X-ray of left knee. During an interview on 03/21/24 at 12:35 PM, RN3 stated that Certified Nurse Aide (CNA) told her R21 was in pain and she observed that R21's left leg appeared swollen. RN3 stated that when she pulled back the resident's clothing, R21's left leg was very swollen, and the resident was in pain when RN3 touched the knee. RN3 stated that she did not report it to the Administrator or Director of Nursing (DON). During an interview on 03/21/24 at 2:13 PM, the DON confirmed that she first learned of R21's left knee was on 03/18/24 when she learned that R21 had a fracture and that she knew it was an injury of unknown origin. The DON stated that she initiated her investigation on 03/18/24. The DON confirmed that the investigation should be initiated immediately when the injury of unknown origin was found on 03/12/24. Review of the facility's policy titled ABUSE, PREVENTION AND PROHIBITION POLICY revised 01/24 revealed that nursing staff is responsible for reporting the appearance of injuries of unknown origin if the sources of the injuries are unknown, an Occurrence Report must be completed, and an investigation initiated. Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, and interview, the facility failed to update the resident's care plan with new interventions for one of three residents (R)21) care plans reviewed in the sample of 19. Specifically, R21, who had wandering behaviors, left the skilled nursing unit without staff knowledge or supervision and was found in the portion of the building identified as the independent living Bistro on 09/03/23 and then again found missing for over two hours on 10/05/23 in the portion of the building identified as the chapel which was located past two closed double doors at the end of the hall. Findings include: Review of R21's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 03/18/24 with diagnoses of Alzheimer's disease, cerebral infarction, and repeated falls. Review of R21's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/26/23, revealed the Brief Interview for Mental Status (BIMS), was unable to be completed due to resident was rarely understood. Review of R21's Care Plan, located under the Care Plan tab of the EMR dated 07/12/23, revealed The resident was a wanderer and will occasionally wander into other rooms. Interventions in place were to distract the resident from wandering by offering pleasant diversions, structured activities, food conversation and redirection. Further review revealed no additional updates to interventions after the 09/02/23 and 10/05/23 incidents in which R21 was missing from the unit. Review of R21 Incident report dated 10/05/23 provided by the Director of Nursing (DON) revealed R21 was at the end of her hallway in the chapel, sitting in a wheelchair sleeping. Further review of incident reports and confirmed by the DON on 03/21/24 at 2:13 PM that there was no incident report for 09/03/23 incident. Review of a Nurse's Note, in the EMR, under the Notes tab written by Registered Nurse (RN)2 dated 09/03/23 at 12:34 PM indicated, received a call from the Bistro-resident was there. Retrieved by this nurse and taken to the assist dining room for lunch. No change/update to the plan of care. Review of a Nurse's Note, in the EMR, under the Notes tab written by Licensed Practical Nurse (LPN3) dated 10/05/23 at 10:47 PM indicated, resident was at the end of her hallway in the chapel, sitting in wheelchair sleeping . No change/update to the plan of care. During an interview on 03/21/24 at 2:13 PM, the Director of Nursing (DON) stated staff would need to try and figure out the root cause of what was going on, look for patterns and put new care plan interventions in place. The DON stated the facility did not have a policy related to updating care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, interview and policy review, the facility failed to prevent a resident with wandering behaviors from leaving the skilled nursing unit without staff's knowledge or supervision for one of three residents (R)21) reviewed for accidents in the sample of 19. Specifically, R21 left the skilled nursing unit and was found in the portion of the building identified as the independent living Bistro on 09/03/23 and then again found missing for over two hours on 10/05/23 in the portion of the building identified as the chapel which was located past two closed double doors at the end of the hall. Findings include: Review of R21's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and readmission was on 03/18/24 with diagnoses of Alzheimer's disease, cerebral infarction, and repeated falls. Review of R21's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/26/23, revealed the Brief Interview for Mental Status (BIMS), was unable to be completed due to resident was rarely understood. Review of R21's Care Plan, located under the Care Plan tab of the EMR dated 07/12/23, revealed The resident was a wanderer and will occasionally wander into other rooms. Interventions in place were to distract the resident from wandering by offering pleasant diversions, structured activities, food conversation and redirection. Further review revealed no additional updates to interventions after the 09/03/23 incident and the 10/05/23 incident. In addition, R21's Care Plan dated 03/20/23 indicated, The resident has impaired cognitive function or impaired through process. Interventions in place were keep the resident's routine and caregivers consistent to try and reduce confusion. Review of R21 Incident report dated 10/05/23 provided by the Director of Nursing (DON) revealed R21 was at the end of her hallway in the chapel, sitting in a wheelchair sleeping. Further review of incident reports and confirmed by the DON on 03/21/24 at 2:13 PM that there was no incident report for 09/03/23 incident. Review of a Nurse's Note, in the EMR, under the Notes tab by Registered Nurse (RN2) dated 09/03/23 at 12:34 PM indicated, received a call from the Bistro-resident was there. During an interview on 03/20/24 at 12:17 PM, RN1 stated that R21 was a wanderer, and that staff are supposed to try and keep an eye on her. When she is missing staff will look in other resident rooms. RN1 stated that on 09/03/23, R21 would have had to go through the Assisted and Independent living areas portions of the building to get to the Bistro. Review of a Nurse's Note, in the EMR, under the Notes tab by Licensed Practical Nurse (LPN)3 dated 10/05/23 at 10:47 PM indicated, resident was at the end of her hallway in the chapel, sitting in wheelchair sleeping. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/24 at 12:39 PM, Certified Nurse Aide (CNA)/Certified Medication Technician (CMT)7 stated that on 10/05/23, she remembered seeing R21 roll past her in the resident's wheelchair heading towards the double doors at the end of the 100 hall around 7:30 PM and thought she was going towards her room. Sometime after that staff told her R21 was missing but she was unaware there was anything behind the double doors because the doors were always kept shut. During an interview on 03/20/24 at 1:06 PM, LPN1 stated that she became aware on 10/05/23 between 8:30 PM to 8:45 PM that R21 was missing, and she assisted with searching the entire facility complex to try and locate her. She said it was at least a good hour or more before she was found. LPN1 stated that she was aware that R21 was a wanderer, but she was unsure of what interventions were in place to provide R21 supervision. During an interview on 03/20/24 at 1:17 PM, LPN2 stated that she knew that R21 was a wanderer, but she was unsure of any interventions in place to supervise R21 other than staff try to keep an eye on her. On 10/05/23 around 8:00 PM, LPN2 stated that staff were going to assist R21 get ready for bed when they determined that they were unable to locate her. LPN2 stated that staff came to 200 hall and asked her if she had seen R21. LPN2 stated that she had not seen R21. LPN2 stated that she did search the 200 unit but was unable to locate R21. LPN2 thinks that after they found her, they were doing 15-minute checks on her, but she did not know if that was documented. She said the double doors that led to the chapel were always kept shut and it did not alarm when it was opened. Residents were not allowed to go to the chapel without staff present. During an interview on 03/20/24 at 1:29 PM, LPN3 stated that she knew R21 wandered, and that staff were to keep an eye on her and redirect her if she was going towards somewhere she was not supposed to go. She remembered on 10/05/23 staff looked all over the facility and R21 was found in the chapel. The doors at the end of the 100 hall that led to the chapel were always kept shut and there was a chime sound when they were opened but it did not an alarm. LPN3 stated that there was no delay on the doors at the end of the 100 hall and that anyone could just push the doors to open. LPN3 stated that she and the night shift CNA were checking on R21 every hour after she was found until 6:30 AM the next day, however, there was no documentation of the hourly monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 West Randolph Street Saint Charles, MO 63301	

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 - Few	Interview and observations on 03/20/24 at 11:20 AM, the Maintenance Director stated that there were 41 exits from the whole complex building to the outside and that you can walk the whole building without going outside. The Maintenance Director stated that since demolition of the residential care facility (RCF) in January 2024, you would have to exit the building and re-enter through another door to finish the tour of the whole building. The Maintenance Director stated that the independent living area was demolished in March 2024. The Maintenance Director stated that there were three ways to exit the skilled nursing facility and to get to another part of the building. One way was at the end of hall 200 in the activity area. Another way was at the end of 100 hall which goes directly into the RCF. This door has an alarm. Observation on 03/20/24 at 11:29 AM revealed a small white doorbell box observed in the middle of the double doors. The door alarm was tested and made a very faint ding [NAME] sound. After opening these doors, there was thick white plastic with red zippers which have been placed up for construction in the RCF area. Also, on these doors there were two signs that indicated emergency exit only. He said if there was an emergency, staff and residents would go through these doors, unzip the thick plastic and exit the double doors to the to the outside parking lot. The third exit was from the skilled nursing portion of the facility to another portion of the building without going outside through the door to the assisted living area (AL). The door going out of the skilled facility had a small white doorbell in the middle of the doors, which made a ding-[NAME] sound when opened. When these doors were open, you entered the entrance into the AL. There was a small black box on top of the right-side door, inside of the metal frame, which made a ding [NAME] sound when opened. He said there were other exits from the skilled nursing facility that could be used to exit the area. One would be the front door which has a magnetic lock on it with a coded keypad. One would be to the left of the end of 300 hall. It has a magnetic lock with a coded keypad. One is to the right of the end of 300-hall, through the dining room. The door to the outside of the main dining room has a red round stop panic alarm on the upper right side of the door. When tested the panic alarm went off faintly for around five seconds. At the end of the 200-hall, there was an activity room, with a door that has a magnetic lock with a coded keypad. The other door, which was unlocked, goes into a courtyard, which is between the buildings and has no exit to any parking lots. During an interview on 03/21/24 at 2:13 PM, the DON confirmed that she was unable to find an elopement assessment for R21 prior to the two elopement incidents and after the incidents and that she was unable to find a root cause analysis or investigation into how R21 exited the unit on 09/03/23 or the 10/05/23 incidents. The DON stated that she was unable to find documentation of staff's 15-minute checks intervention that was implemented after R21 was found on the 10/05/23 incident. Review of the facility's policy titled Elopements revised 05/2023, revealed it is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents identified will have these issues addressed in their individual care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Windsor Estates of St Charles		STREET ADDRESS, CITY, STATE, ZIP CODE 2150 West Randolph Street Saint Charles, MO 63301	

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on interviews and record review, the facility failed to employee a Food Service Director (FSD) with credentials that were not expired. This failure had the potential to affect 55 of 55 residents as there were no enteral feeding residents at the facility. Findings include: Interview on [DATE] at 8:05 AM the Director of Nursing (DON) stated the facility has a Registered Dietician (RD) who was at the facility two days a week. The DON stated that the FSD does not have a certification at this time. The DON stated the FSD started in October of 2023 and the Administrator (ADM)2 was going to pay and enroll the FSD in the certification course, however, this did not occur. Interview on [DATE] at 11:35 AM, the FSD confirmed that he started [DATE] and that he has started the certification course but has not completed it. Interview on [DATE] at 11:25 AM, the Regional Director of Operations (RDO) stated the FSD did not have his certification for food and safety management. Review of facility's job description titled, 6001 Dietary Supervisor Position Description supplied by the facility revealed the FSD must have certification in food safety. Review of FDS's employee file revealed a certification that expired on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that the Certified Nurse Aide (CNA)changed gloves and performed hand hygiene when going from a contaminated area to a clean area for one of one resident (Resident (R) 18) observed for catheter care from a total of 18 residents sampled, to prevent possible cross contamination. Findings include: Review of the facility's policy titled, Prevention of Catheter-Associated Urinary Tract Infections, dated 2019, revealed .Standard Precautions .2. Hand hygiene is performed immediately after any manipulation of or contact with the catheter site, catheter, tubing, drainage bag, or emptying container, even when gloves were worn. Review of facility policy titled, Standard Precautions, dated 2019, revealed Gloves . Policy .3. Sterile gloves and examination gloves are removed .d. before touching uncontaminated surfaces or other areas of the same resident's body that may be uncontaminated. Review of R18's (facility provided) Face Sheet revealed that R18 was readmitted to the facility on [DATE], with a diagnosis of neuromuscular dysfunction of the bladder. Review of (facility provided) Lab Report dated 05/26/23 revealed R18 had a urinalysis with mixed pathogen growth. Observation during R18's catheter care on 03/18/24 at 4:44 PM, revealed CNA 2 and CNA1 rolled R18 over to his right side, CNA2 reached for the wipes and removed bowel movement from R18's bottom. CNA2 stuffed the soiled linen, and soiled incontinent brief under R18's right hip. While wearing the same gloves, CNA2 gathered another blanket from the end of R18's bed, and placed a new incontinence brief on the blanket, and stuffed it under the soiled linens under R18. CNA1 assisted CNA to roll R18 over to his left side, and CNA1 pulled the soiled linen from under R18, along with the clean linen. CNA1 placed soiled linen into a bag and without CNA1 changing her gloves, she assisted CNA2 in rolling R18 to his back. At this point, CNA1 went out of the room, wearing the same gloves. CNA1 returned to the room wearing gloves, took several wipes out of the package and placed them on the side of R18's bed, and placed the package of wipes on the ledge of the window. CNA2 took two wipes, and wiped R18's pubic area in a triangle motion, moving down his right leg, and up his left leg. While wearing the same gloves, CNA2 assisted R18 in removing his shirt, adjusting his top bed sheet, and placing two bath towels on R18's stomach over R18's suprapubic catheter tubing, and fastening R18's new incontinent brief. CNA2 went into R18's closet and obtained a clean shirt and assisted R18 to put the shirt on. At this point, CNA2 removed her gloves, however, did not perform hand hygiene after removing her gloves. Interview with CNA2 on 03/20/24 at 6:17 PM, she indicates that gloves should be changed when going from dirty to clean. Interview with Director of Nursing (DON) on 03/20/24 at 6:25 PM, the DON indicated that gloves should be changed when going from a dirty area to a clean area.