STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 - Minimal harm or potential for 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 interview and record review, the facility failed to ensure residents received treatment in accordance with acceptable standards of practice when facility staff failed to complete and document neurological assessments (neuro checks) following falls for two residents (Residents #1 and #2). The facility failed to complete and document a fall evaluation and fall risk evaluation for one resident (Resident #1) and failed to complete and document incident follow up (IFU) monitoring on each shift for 72 hours post-fall for three residents (Residents #1, #2, and #3). The sample was 3. The census was 79.Review of the facility's Falls Clinical Protocol policy, revised 12/25, showed:-Assessment and Recognition:-The nurse shall assess and document/report the following:--Vital signs;--Recent injury, especially fracture or head injury;-- Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.;--Change in cognition or level of consciousness;--Neurological (neuro) status;--Pain;--Frequency and number of falls since last physician visit;--Precipitating factors, details on how fall occurred;--All current medications, especially those associated with dizziness or lethargy, and;--All active diagnoses;-Falls should also be identified as witnessed or unwitnessed events. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/15/26, showed:-Cognitively intact; -Dependent on staff for assistance with all transfers;-No falls since admission or prior assessment;-Diagnoses included high blood pressure, depression, hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, and wedge compression fracture of T7-T8 (bones in the middle of the thoracic spine (mid-back)), subsequent encounter for fracture with routine healing. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident has activities of daily living (ADL) self-care performance deficit related to activity intolerance, fatigue, hemiplegia, impaired physical mobility, impaired functional ability and generalized weakness; -Goal: Resident will maintain current level of function/mobility with his/her ADLs without significant decline through next review date;-Interventions included resident requires dependent assist from staff for dressing, bed mobility, transfer, bathing, personal hygiene, toileting;-Focus: Resident is at risk for potential falls related to impaired physical mobility, receiving antidepressants and generalized weakness;-Goals: Resident will be free of minor injury from possible fall through the review date. Resident will not sustain serious injury from possible fall through the review date. Resident's ultimate goal will be free of falls through the review date;-Interventions included follow facility fall protocol. Review of the resident's incident report, dated 3/9/26 at 9:30 P.M., showed Certified Nurse Aide (CNA) was assisting resident into bed. Resident was sitting on the edge of the bed and fell hitting his/her head on the floor. The resident had a large amount of blood with a hematoma (localized collection of clotted blood that has leaked from damaged blood vessels under the skin) and laceration on the right side of his/her forehead. Resident alert and orientated to self, place, and year (A&O times (x) three). 911 called and emergency medical services (EMS) arrived shortly after and transported the resident to the hospital. Review of the resident's progress notes, dated 3/9/26 through 3/12/26, showed:-On 3/10/26 at 10:59 A.M., resident returned from hospital with two stitches noted to forehead laceration;-On 3/11/26, day shift (7:00 (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: 265627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Garden View Care Center of Chesterfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 Chesterfield Pointe Parkway Chesterfield, MO 63017	

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 - Minimal harm or potential for actual harm Residents Affected - Few	A.M. to 3:00 P.M.), no IFU note;-On 3/11/26, evening shift (3:00 P.M. to 11:00 P.M.), no IFU note;-On 3/11/26, night shift (11:00 P.M. to 7:00 A.M.), no IFU note;-On 3/12/26, evening shift, no IFU note. Review of the resident's neurological flow sheet, dated 3/10/26, showed:-On 3/12/26, day shift entries were blank;-On 3/12/26, evening shift entries were blank. Review of the resident's incident report, dated 3/27/26 at 4:00 P.M., showed resident on his/her left side on the floor beside his/her bed with staff around him/her assisting with care. The resident stated he/she fell from the Broda chair (specialized reclining chair propelled by staff). Review of the resident's progress note, dated 3/27/26 at 4:00 P.M., showed nurse called to resident's room. Resident noted lying on his/her left side on the floor beside his/her bed with CNA. Resident stated that he/she fell out of his/her chair. CNA stated resident was leaning to the left side when the resident fell. Range of motion (ROM) performed. Resident had hematoma to left side of forehead, area was raised with no discoloration noted at that time. Resident denied any other complaints of pain or discomfort. No other injuries noted. Ice pack applied. Neuro checks within normal limits (WNL). Review of resident's medical record, showed:-No skin evaluation completed on 3/27/26 after fall;-No fall risk evaluation completed on 3/27/26 after fall;-No neuro checks completed after the fall on 3/27/26. Review of the resident's progress notes, dated 3/27/26 through 3/30/26, showed:-On 3/27/26, night shift, no IFU note;-On 3/28/26, day shift, no IFU note;-On 3/28/26, evening shift, no IFU note;-On 3/28/26, night shift, no IFU note;-On 3/29/26, day shift, no IFU note;-On 3/29/26, evening shift, no IFU note;-On 3/29/26, night shift, no IFU note;-On 3/30/26, day shift, no IFU note;-On 3/30/26, evening shift, no IFU note. During an interview on 4/13/26 at 2:36 P.M., the Administrator and Director of Nurses (DON) said following the resident's fall on 3/9/26, the resident was cleared at the hospital for any head injuries and then returned to the facility. Once the resident returned to the facility, staff initiated neuro checks. They expected neuros to be completed after they were started upon the resident's return to the facility. The DON said following the resident's fall on 3/27/26, neuro checks, a fall risk assessment, and a skin evaluation were not completed for the resident. The resident fell on a Friday and the DON was not aware the fall assessments were not completed until Monday. The DON expected the neuro checks, skin evaluation, fall risk assessment and 72-hour monitoring to have been completed. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on assistance for all transfers;-One fall with no injury since admission/prior assessment;-Diagnoses included multiple sclerosis (disease of central nervous system that disrupts communication between the brain and body), altered mental status, high blood pressure, and dementia. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident requires staff assistance with ADLs related to his/her impaired functional abilities, impaired physical mobility, impaired bed mobility and overall generalized weakness;-Focus: Resident is high risk for falls related to impaired functional abilities, decreased physical mobility, decreased body strength/endurance, activity intolerance, unsteady balance/gait, periods of confusion, impaired safety awareness and overall generalized weakness. Resident continues to be at risk for potential for falls related to his/her antidepressant medications, impaired functional abilities, impaired physical mobility and overall generalized weakness;-Goals: Resident will not sustain serious/major injury from possible fall through the review date. Resident will be free of minor injury from possible fall through the review date;-Interventions included follow facility fall protocol. Review of the resident's incident report, dated 1/22/26 at 1:30 P.M., showed nurse went into the resident's room and observed the resident lying on the floor next to his/her bed. Resident stated he/she was reaching for something on the bedside table and he/she fell out of the bed. Review of the resident progress notes, dated 1/22/26 through 1/23/26, showed:-On 1/22/26, night shift, no IFU note;-On 1/23/26, day shift, no IFU note;-On 1/23/26, evening shift, no IFU note;-On 1/23/26, night shift, no IFU note;-On 1/24/26, day shift, no IFU note;-On 1/24/26, evening shift, no IFU note;-On 1/25/26, day shift, no IFU note. Review of resident's medical record, showed, no neuro checks completed for the fall on 1/22/26. 3. Review of Resident #3's medical record, showed:-Severe cognitive impairment;-Diagnoses included dementia, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Garden View Care Center of Chesterfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 Chesterfield Pointe Parkway Chesterfield, MO 63017	

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 - Minimal harm or potential for actual harm Residents Affected - Few	high blood pressure, diabetes, kidney disease, and depression. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident has an ADL self-care performance deficit related to Alzheimer's disease, confusion, dementia, and disease processes including diabetes, obesity, and dependence on staff for all cares;-Focus: Resident is at high risk for falls related to confusion and gait/balance problems. Resident is dependent on staff for transfers;-Goal: Resident will be free of falls through the review date;-Interventions included follow facility fall protocol. Review of the resident's incident report, dated 3/15/26 at 7:00 P.M., showed:-Incident description: Resident's brief was being changed and the resident pushed against the wall causing the bed to move and resident rolled forward onto the floor. Resident noted to have multiple skin tears to bilateral (both sides) upper extremities and laceration to left forehead;-Resident description: Rolled off the bed;-Immediate action taken: Pressure held to left forehead until bleeding stopped three minutes. EMS called due to head laceration and bruising starting to forehead and nose area. Review of the resident's progress notes, dated 3/15/26 through 3/18/26, showed:-On 3/16/26 at 6:49 A.M., resident returned to the facility around 1:00 A.M., with a nasal fracture, sutures to medial (middle) aspect of eye brows and has skin tears to bilateral arms with foam dressings noted;-On 3/16/26, day shift, no IFU note;-On 3/16/26, night shift, no IFU note;-On 3/17/26, evening shift, no IFU note;-On 3/18/26, day shift, no IFU note;-On 3/18/26, evening shift, no IFU note. 4. During an interview on 4/13/26 at 10:34 A.M., Registered Nurse (RN) A said when a resident falls, the nurse assesses the resident for any injuries. A head-to-toe assessment is completed and vital signs are taken. If the fall is unwitnessed or if the resident hit their head, neuro checks are initiated. The incident report, skin evaluation, and fall risk assessment are completed after the fall. Neuros start and continue for 72 hours along with IFU documentation in a progress note each shift monitoring the residents for any changes for 72 hours. 5. During an interview on 4/13/26 at 2:36 P.M., the Administrator and DON said they expected the nurse to assess the resident when a fall occurs. If the fall was unwitnessed or if the resident hit their head, neuro checks were to be completed and documented for 72 hours. Incident monitoring was to be completed during each shift for 72 hours post fall and documented in the progress notes showing that the resident was being monitored. They expected the nurse to document and complete an incident report regarding the fall, a skin evaluation to determine if the resident had any injuries, and a fall risk assessment after each fall. They expected staff to be knowledgeable of and to follow the facility policies regarding falls. 2807911