STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265767	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Senior Services at Breeze Park	600 Breeze Park Drive Saint Charles, MO 63304

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure ice and beverage dispensing units in three of three dining rooms/satellite kitchens were free of an accumulation of debris. The facility census was 47. 1. Observation on 3/30/26 at 11:20 A.M. and on 3/31/26 at 10:14 A.M., inside the Lindenwood dining room, showed the following:-A combination ice/water dispensing unit had two separate dispensing spouts. The ice dispensing spout had a buildup of white crusty debris on the exterior of the spout and dark-colored debris inside the spout. The water dispensing spout had a buildup of white crusty debris inside the spout. The exterior of the ice/water dispensing unit had vents on either side with a buildup of fuzzy debris;-A beverage dispensing unit had four dispensing nozzles for orange juice, grape cocktail, lemonade and cranberry cocktail. The nozzles and areas around the nozzles had a buildup of multi-colored liquid and debris. The metal backsplash behind the nozzles had numerous splatters and splashes of purple liquid. Observation on 3/30/26 at 11:30 A.M. and on 3/31/26 at 10:14 A.M., inside the Sycamore dining room, showed the following:-A combination ice/water dispensing unit had two separate dispensing spouts. The ice dispensing spout had a buildup of dark-colored debris inside the spout. The water dispensing spout had a buildup of dark-colored debris inside the spout. The exterior of the ice/water dispensing unit had vents on either side with a buildup of fuzzy debris;-A beverage dispensing unit had four dispensing nozzles for orange juice, grape cocktail, lemonade and cranberry cocktail. The nozzles and areas around the nozzles had a buildup of multi-colored liquid and debris. Observation on 3/31/26 at 8:42 A.M., inside the Cherry Blossom dining room, showed the following:-A combination ice/water dispensing unit had two separate dispensing spouts. The ice dispensing spout had a buildup of white crusty debris on the exterior of the spout and dark-colored debris inside the spout. The exterior of the ice/water dispensing unit had vents on either side with a buildup of fuzzy debris. During an interview on 3/31/26 at 10:20 A.M., the Dietary Manager said the following:-Dietary staff cleaned the ice/beverage dispensing units daily in the evening;-Maintenance staff did not perform any cleaning of the ice/beverage dispensing units;-The facility did not have a policy regarding cleaning the beverage station equipment;-Maintenance staff was responsible for contacting the ice machine vendor for deep cleaning. During an interview on 4/1/26 at 2:32 P.M., the Maintenance Director said the following:-The vendor cleaned the ice/water dispensing units quarterly;-Dietary staff were responsible for cleaning the beverage dispensing units on a regular basis;-Maintenance staff cleaned the exterior vents on the machines quarterly.

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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(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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a system to monitor the facility's water supply, including assessment of cold and hot water temperatures, to ensure specific control parameters to prevent growth of Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease) in accordance with the Centers for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The facility failed to ensure staff performed hand hygiene when providing incontinence care to two residents (Residents #48 and #6), in a review of 12 sampled residents, and for one additional resident (Resident #35). The facility census was 47.1. Review of the facility policy, Water Management Plan, revised May 2025, showed the following:-The policy is specifically to reduce Legionella risk in healthcare facility water systems to prevent cases and outbreaks of Legionnaires' disease (LD);-Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospital and long-term care facilities;-Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs and decorative fountains;-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;d. Infection Control;-Identify and describe the potable and non-potable systems within the building and develop system schematics;-Determine locations where control measure must be applied and establish control limits;-Establish procedures for monitoring whether control measures are operating within established limits and if not, take corrective actions. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical and epidemiological considerations for healthcare facilities are described in this toolkit;-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;-Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the ASHRAE guidelines, dated December 2020, showed information and recommendations in this section apply to every portion of the hot and coldpotable water systems, including all components and branches, from intake to taps. Methodsfor limiting Legionella growth in potable water systems include the following:-Keeping the system clean and free of sediment;-Controlling hot-water and cold-water temperatures;-Minimizing water age (the residence time of the water in the system);-Maintaining a disinfectant residual. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's weekly water temperature log, dated 12/01/25-03/26/26, showed hot water temperatures were monitored in the following locations:-Hot water supply and hot water supply mixing valve on the Long-Term Care (LTC) and REACH units;-Two resident rooms (#960 and #972);-T-hall office.(Reviewed showed no documentation staff checked the water temperature in any other rooms of the facility.) The facility provided no documentation showing monitoring of cold water temperatures. Observation on 04/01/26 at 11:42 A.M., showed the following:-In room [ROOM NUMBER], the temperature of the hot water was 107 degrees F; -In the spa on Sycamore hall, the temperature of the hot water at the faucet eye wash station was 105 degrees F and the hot water temperature at the handheld shower head was 102 degrees F;-In room [ROOM NUMBER], the temperature of the hot water at the sink was 100 degrees F and the hot water temperature at the handheld shower head was 100 degrees F. During an interview on 04/01/26 at 5:25 P.M., the Maintenance Director said the following:-Staff monitored the hot water temperatures in the hot water heaters, boilers and the mixing valves;-Staff monitored the temperature of the hot water monthly at the beginning of the loop and end of the loop. Staff did not check water temperatures in the middle of the loop; -The range for monitoring hot water temperatures was between 110 degrees F and 120 degrees F;-He did not monitor the temperature of the cold water;-The facility did not have a procedure for monitoring for corrosion buildup and biofilm. During an interview on 04/02/26 at 2:24 P.M., the Administrator said the water management plan followed the state regulations for hot water temperature monitoring. 3. Review of the facility policy, Hand Hygiene, revised September 2022, showed the following:-All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors;-Wash hand with soap and water when hands are visibly soiled;-Use an alcohol-based hand rub containing at least 60 percent (%) alcohol; or alternatively, soap and water for the following situations: -Before and after direct contact with residents; -Before moving from a contaminated body site to a clean body site during resident care; -After contact with blood or bodily fluids; -After removing gloves;-Hand hygiene is the final step after removing and disposing of personal protective equipment;-The use of gloves does not replace hand washing/hand hygiene. 4. Review of Resident #48's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument), dated 01/28/26, showed the following:-Severe cognitive impairment;-Required substantial/maximal assistance from staff for personal hygiene and to roll left and right,-Dependent on staff for toileting hygiene, lower body dressing, and chair/bed-to-chair transfer, Review of the resident's current Care Plan, dated March 2026, showed the resident had an activity of daily living self-care deficit related to decreased mobility and muscle weakness. Staff staff were to transfer the resident with a mechanical lift and to provide incontinence care after incontinence. Observation on 03/31/26 at 7:25 P.M., showed the following:-The resident sat in his/her Broda chair (reclining padded chair on wheels) in his/her room;-Licensed Practical Nurse (LPN) B and Certified Nurse Assistant (CAN) D entered the room, did not perform hand hygiene, and put on gloves;-LPN B and CNA D transferred the resident with a mechanical lift into his/her bed;-CNA D removed the resident's urine-soiled incontinence brief; -CNA D cleaned the resident's frontal and back perineal areas with disposable wipes;-CNA D removed his/her gloves, reached into his/her pocket, and pulled out new gloves;-Without performing hand hygiene, CNA D put on the new gloves, and assisted LPN B to roll the resident back and forth to remove the mechanical lift sling and soiled linens and placed a new incontinence brief on the resident. CNA D touched the resident's clean skin, clothing, brief, sheets and pillow;-CNA D removed the soiled linens from the bed;-CNA D removed his/her gloves, pulled new gloves from his/her pocket, and without performing hand hygiene, put on the new gloves;-LPN B, wearing the same gloves used to roll the resident in bed and off the dirty linens, picked up the resident's water pitcher, and held the straw while the resident took a drink;-CNA D and LPN B placed dirty linens in a bag and trash in a bag, removed their gloves and left the room without washing their hands. During an interview on 03/31/26 at 8:40 P.M., CNA D said staff was to wash their hands before and after providing care to a resident. Staff put on gloves before possible (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contact with a resident's body fluids and changed gloves between dirty and clean tasks. Staff was to perform hand hygiene between glove changes. He/She did not wash his/her hands or use alcohol-based hand rub when he/she changed his/her gloves because he/she forgot. His/Her gloves could become contaminated when he/she reached into his/her pocket for gloves. During an interview on 03/31/26 at 8:21 P.M., LPN B said staff was to wash their hands before and after physical contact with a resident, especially if body fluids were involved. Staff was to change their gloves and wash their hands when they moved from a contaminated area to a clean area, like after providing perineal care and before touching clean supplies. 5. Review of Resident #6's quarterly MDS, dated [DATE], showed the following:-Partial/moderate assistance required for personal hygiene;-Always incontinent of bladder and bowel. Review of the resident's care plan, dated 12/22/25 to 04/01/26, showed the following:-The resident was always incontinent;-Provide incontinence care after incontinence episodes. Observation on 04/01/26 at 10:15 A.M., showed the following:-CNA G put on gloves and removed the resident's feces-soiled incontinence brief;-CNA G provided peri care to the resident's buttocks with wet wipes;-He/She removed his/her gloves, did not perform hand hygiene, and put on clean gloves;-CNA G placed a clean incontinence brief on the resident;-He/She removed his/her gloves, did not perform hand hygiene, put on clean gloves, and then assisted the resident to put on pants and shoes. During an interview on 04/01/26 at 10:37 A.M., CNA G said the following:-He/She was to wash his/her hands before he/she put on gloves and after he/she removed his/her gloves;-He/She should have washed his/her hands after he/she removed his/her gloves when providing peri care to the resident. 6. Review of Resident #35's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting;-Partial/moderate assistance required for personal hygiene;-Always incontinent of bladder and occasionally incontinent of bowel. Review of the resident's care plan, dated 12/22/25 to 04/01/26, showed the following:-The resident was always incontinent;-Provide incontinence care after incontinence episodes;-Provide peri-care as needed (PRN) for incontinent episodes;-Change resident if wet/soiled. Observation on 03/31/26 at 8:07 P.M., showed the following:-CNA F put on gloves and removed the resident's urine-soaked incontinence brief;-CNA F performed peri care to the resident's frontal area with wet wipes;-CNA F removed his/her gloves, did not perform hand hygiene, put on new gloves, and put a clean incontinence brief on the resident. During an interview on 03/31/26 at 8:52 P.M., CNA F said the following:-He/She was to change his/her gloves, wash his/her hands and put on new gloves when moving from a dirty to clean task;-He/She should have washed his/her hands after he/she removed his/her gloves. 7. During an interview on 04/01/26 at 4:18 P.M., the Infection Preventionist (IP) said the following:-Staff was to wash their hands when hands were visibly soiled, when going from resident to resident, and when going from a clean to dirty task;-Staff should wash their hands when removing gloves after performing pericare and prior to touching a resident's ice water or clean supplies;-Staff was to clean their hands every time they changed their gloves;-Staff should not place a handful of gloves in their pocket to utilize for resident care because they could become contaminated in their pocket. During an interview on 04/02/26 at 5:13 P.M., the Director of Nursing (DON) said the following: -Staff should wash their hands or use a hand sanitizer before and after providing personal care and between glove changes;-It was not appropriate for staff to carry disposable gloves in their pockets; -The facility educator, management and the infection preventionist educated staff on hand hygiene;

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative nursing services to assist two residents (Resident #3 and #4), in a review of 12 sampled residents, and one additional resident (Resident #45), to attain or maintain his/her highest level of functioning. The facility census was 47.Review of the facility policy, Restorative Nursing, dated 04/26/19, showed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence;-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies);-Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care;-The resident or representative will be included in determining goals and the plan of care;-Restorative goals may include, but are not limited to supporting and assisting the resident in: -Adjusting or adapting to changing abilities; -Developing,maintaining or strengthening their physiological and psychological resources; -Maintaining their dignity, independence and self-esteem; and -Participating in the development and implementation of their plan of care;-The staff will monitor and discuss the residents' progress with the interdisciplinary team;- Progress notes will be made by the restorative nurse or designee on a monthly basis;-A quarterly evaluation will be completed by the restorative nurse or designee; -An evaluation will be conducted with a significant change;-Upon completion of restorative nursing services, a discharge summary will be completed by the restorative nurse or designee. Review of the facility policy, Range of Motion Exercises, dated 09/16/22, showed the following:-The purpose of this procedure is to exercise the resident's joints and muscles;-Verify there is a nursing restorative care plan for this procedure;-Review the resident's care plan to assess for any special needs of the resident;-Assemble the equipment and supplies as needed;-If the resident becomes weak, or complains of pain, cease the exercise and summon the staff/charge nurse;-Support the extremity at the joint as it is being exercised;-Move each joint through its range of motion three (3) times unless otherwise instructed.-Move each joint gently, smoothly and slowly through its range of motion;-Remember to stop an exercise before the point of pain. 1. Review of the facility's Restorative Aide (RA)'s attendance and assignments for March 2026 showed the RA was pulled from providing restorative nursing services to work as a certified nurse assistant (CNA) on 03/03/26, 03/04/26, 03/13/26, 03/20/26, 03/23/26, 03/25/26, 03/26/26, 03/27/26, and 03/30/26. During an interview on 04/02/26 at 2:00 P.M., the Director of Nursing said there was no one to provide the restorative nursing services if the RA was pulled to the floor or was off work. 2. Review Resident #3's physician's order sheet, dated 01/21/25, showed the following:-Apply left hand splint;-Resident to wear left hand orthotic splint during bedtime hours as tolerated. Encourage 8-10 hours of wear. Review of the resident's significant change in status Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 02/04/26, showed the following:-Severe cognitive impairment;-Impairment in functional range of motion to one upper extremity and both lower extremities;-Dependent on staff for upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, chair/bed-to-chair transfer;-No therapy or restorative nursing services;-No range of motion (active or passive). Review of the resident's Restorative Nursing Program Evaluation, dated 03/24/26, showed the following:-Date of referral 02/04/26, date of evaluation 03/24/26;-Assist the resident with the following passive range of motion restorative program;-Bilateral upper extremity passive range of motion in all planes;-Tell the resident he/she is dancing and he/she tolerates the activity well;-Bilateral lower extremity passive range of motion all planes for 15 reps with maximum cues;-Focus on bilateral lower extremity hamstring stretches and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stretching every 24 hours;-Assist the resident with splint/brace assistance restorative program: ensure hand splint is on and provide passive stretch to all digits in direction and extension every 24 hours. Review of the resident's Care Plan, updated 03/24/26, showed the following:-Restorative - Resident is at risk for decrease in function as evidenced by decreased strength in range of motion;-The resident will not have a decline in function by participating in restorativeprograms: passive range of motion and splint/brace assistance;-Bilateral upper extremity passive range of motion in all planes;-Tell the resident he/she is dancing, and he/she tolerates the activity well;-Bilateral lower extremity passive range of motion all planes for 15 reps with maximum cues;-Focus on bilateral lower extremity hamstring stretches and stretching every 24 hours;-Assist the resident with splint/brace assistance restorative program: ensure hand splint is on and provide passive stretch to all digits in direction and extension every 24 hours. Review of the resident's March 2026 clinical flow sheet (documentation for restorative services) showed the resident did not receive any restorative nursing services from 03/24/26 to 03/31/26. Observation on 03/31/26 at 12:06 P.M. showed the resident sat in a Broda chair (specialized reclining chair on wheels) at the dining room table. The resident had contractures (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement) to his/her left hand. Observations on 03/31/26 at 7:25 P.M. and 8:12 P.M. showed the resident lay in bed. He/She did not have a splint or brace on his/her left hand. During an interview on 03/31/26 at 8:25 P.M., Licensed Practical Nurse (LPN) B said he/she did not know why the resident was not wearing his/her brace. 3. Review of Resident #45's undated face sheet showed the resident's diagnoses included stroke. Review of the resident's Restorative Nursing Program Evaluation, dated 06/17/25, showed the following:-Assist the resident with the following active range of motion restorative program;-Bilateral upper extremity passive range of motion exercises 10 repetitions as tolerated two to three times per week;-Bilateral lower extremity passive range of as tolerated two to three times per week. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Required supervision/touching assistance to roll left and right, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet;-Requires partial/moderate assistance from staff for sit to lying, lying to sitting on side of bed,-Requires substantial/maximal assistance from staff for tub/shower transfer;-No therapy services;-No restorative nursing services or range of motion (passive or active). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Requires supervision/touching assistance to roll left and right, sit to lying, and lying to sitting on side of bed;-Required partial/moderate assistance from staff for chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Required substantial/maximal assistance from staff for sit to stand ant to walk 10 feet;-Dependent on staff to walk 50 feet with two turns;-Unable to walk 150 feet;-No therapy services;-No restorative nursing services, or range of motion (passive or active).(The assessment showed worsening of the resident's ADL self-performance.) Review of the resident's active care plan, undated, showed the resident is at risk for activity of daily living (ADL) decline related to decreased mobility, muscle weakness, and cognitive deficits. The goal was for the resident to maintain ADL self-performance levels as evidence of no decline in stated levels. Provide restorative programs to help maintain ADL self-performance (see restorative plan of care for specific interventions). Review of the resident's March 2026 clinical flow sheet for restorative nursing services showed the following:-Program A - Assist the resident with the following active range of motion restorative program: Bilateral upper extremity passive range of motion exercises 10 repetitions as tolerated two to three times per week;-Program B - Bilateral lower extremity passive range of as tolerated two to three times per week;-No documentation the resident was offered, received or refused Program A and/or Program B restorative services two to three times during the week of 03/08/26 through 03/14/26;-On 03/19/26, the resident completed 15 minutes of upper extremity passive range of motion, with 15 reps, and the resident tolerated well. The resident completed 15 minutes of lower extremity passive range of motion with 15 reps and tolerated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	well. The resident did not receive restorative services on any other day during the week of 03/16/26 through 03/21/26;-No documentation the resident was offered, received or refused Program A and/or Program B restorative services two to three times during the week of 03/22/26 through 03/28/26. 4. Review of Resident #4's undated face sheet showed the resident's diagnoses included presence of other bone and tendon implants. Review of the resident's Restorative Nursing Program Evaluation, dated 02/14/25, showed the following:-Program A: Assist the resident with the following active range of motion restorative program, bilateral upper extremity active/assistive range of motion exercises in all planes as tolerated two to three times per week;-Program B: Assist the resident with the following active range of motion restorative program, bilateral lower extremity active/assistive range of as tolerated, 20 repetitions two to three times per week;-Program C: Assist the resident with transfer restorative program, standing to grab bar in hallway, bathroom or on sit to stand lift standing for as long as tolerated two to three times per week. Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Impairment of one lower extremity functional range of motion;-Independent with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand,-Set up or clean up assistance from staff for oral hygiene, toilet transfer,-Requires supervision/touching assistance from staff members for upper body dressing, chair/bed-to-chair transfer, -Requires partial/moderate assistance from staff for toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene,-Dependent on staff for shower/bathe;-Did not receive physical, or occupational therapy;-No restorative nursing, or range of motion. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Impairment of one lower extremity functional range of motion;-Required supervision/touching assistance from staff members for roll left and right (worsened), sit to lying (worsened), chair/bed-to-chair transfer, and toilet transfer; -Required partial/moderate assistance from staff for lying to sitting on side of bed (worsened) and to sit to stand (worsened);-Required substantial/maximal assistance from staff for personal hygiene (worsened),-Dependent on staff for oral hygiene (worsened), toileting hygiene (worsened), shower/bathe, upper body dressing (worsened), lower body dressing (worsened), and putting on/taking off footwear (worsened);-Did not receive physical, or occupational therapy;-No restorative nursing or range of motion.(The assessment showed worsening in the resident's ADL self-performance.) Review of the resident's March 2026 Flow sheet showed the following:-Program A: Assist the residents with the following active range of motion restorative program, bilateral upper extremity active/assistive range of motion exercises in all planes as tolerated two to three times per week;-Program B: Assist the resident with the following active range of motion restorative program, bilateral lower extremity active/assistive range of as tolerated, 20 repetitions two to three times per week;-Program C: Assist the resident with transfer restorative program, standing to grab bar in hallway, bathroom or on sit to stand lift standing for as long as tolerated two to three times per week;-On 03/19/26, the resident completed 15 minutes of active range of motion in his/her upper extremities, with 15 reps, and the resident tolerated well. The resident also completed 15 minutes of active range of motion in his/her lower extremities with 15 reps, and the resident tolerated well. The resident completed 15 minutes of Part C restorative services with 15 reps, and the resident tolerated well. The resident did not receive restorative services on any other day during the week of 03/16/26 through 03/21/26;-No documentation the resident was offered, received or refused Program A, Program B and/or Part C restorative services two to three times during the week of 03/22/26 through 03/28/26. 5. During an interview on 03/31/26 at 2:04 P.M., the Restorative Aide (RA) said the following:-She worked during the week days;-Today, she worked as the RA. Yesterday (03/30/26), she worked as a CNA on the floor;-The facility tried to keep her as the RA, but if staff called in or there were issues, she was pulled from RA to work as a CNA on the floor;-She was pulled from RA often;-If she was the RA every day, she would be able to get all the restorative nursing services completed. When she was pulled to work as a CNA, she did what she could get done. During an interview on 04/01/26 at 12:43 P.M., the Registered Nurse (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Senior Services at Breeze Park	600 Breeze Park Drive Saint Charles, MO 63304

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RN)/MDS Coordinator said the following:-She oversaw the restorative nursing program until recently; the Director of Nursing was taking over the oversight;-She reviewed the restorative documentation to ensure the restorative nursing programs were getting done and to see if adjustments needed to be made to the program; -She reviewed the restorative documentation and was aware the restorative nursing services were not completed. This is why the DON took over the restorative program so she could review and monitor the program; -There were times when the RA was pulled to work as a CNA which made it more difficult to complete the restorative nursing services. During an interview on 04/01/26 at 5:15 P.M., the Director of Nursing said the following:-She recently took over as the person responsible for providing oversight of the restorative program; -The RA program was tp keep residents at their current ADL levels as much as possible and to prevent decline; -Residents with contractures or at risk for contractures needed a restorative program which included range of motion and some may have splints. -The current RA had some absences from work and was pulled to work as a CNA at times, which made it a challenge to complete the restorative nursing services.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain documentation to show staff accurately assessed the risk of entrapment from bed rails and failed to maintain documentation staff obtained informed consent from the residents' representatives prior to bed rail use for four residents (Residents #48, #3, #29, an #12) with bed rails, in a review of 12 sampled resident. The facility census was 47.Review of the facility policy, Proper Use of Bed Assistive Devises, dated 05/19/26, showed the following:-The purposes of these guidelines are to ensure the safe use of bed assistive devices as resident mobility aids and to prohibit the use of bed assistive devices as restraints unless necessary to treat a resident's medical symptoms;-Bed assistive devices include side rails, assist rails, and other bed positioning devices;-An assessment will be made to determine the resident's symptoms or reason for using the bed assistive device upon initiation, quarterly, and as needed;-The use of bed assistive devices will be addressed in the resident's care plan;-Consent for using bed assistive devices will be obtained from the resident or representative and documented per community protocol;-The risk and benefits should be considered for each resident. 1. Review of Resident #48's face sheet showed the resident's diagnoses included dementia, weakness and physical debilitation. The resident had a power of attorney for health care decisions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/28/26, showed the following:-Severe cognitive impairment;-Impaired functional range of motion both upper extremities and one lower extremity;-Required substantial/maximal assistance from staff to roll left and right and to roll side to side in bed;-Dependent on staff for chair/bed-to-chair transfer. Review of the resident's March 2026 physician order sheet showed an order for assist side rail for mobility (original order date 05/15/24). Review of the resident's quarterly Bed Assistive Device Assessment, dated 03/02/26, showed staff marked the resident did not use a bed assistive device. The entrapment risk assessment was not completed. Review of the resident's current care plan showed the resident used an enabler side rail to assist with transfers and bed mobility: half side rails, grab bars. Observation on 03/31/26 at 7:25 P.M., showed the following:-Licensed Practical Nurse (LPN) B and Certified Nurse Assistant (CNA) D transferred the resident with a mechanical lift into his/her bed;-The resident had 1/8 bed rails on both sides of his/her bed in the raised position;-CNA D assisted the resident to roll onto his/her right side. LPN B guided the resident as he/she rolled toward LPN B;-The resident held the bed rail. When CNA D released the pressure to the resident's back side to keep in a turned position, the resident's hand slid off the rail and the resident rolled to his/her back;-The resident held the rail at times as staff provided care but could not pull his/her body weight or maintain a side lying position while using the bed rail. Review of the resident's electronic medical record showed no documentation staff completed an assessment to identify if the resident was at risk for entrapment and no documentation staff obtained informed consent for the bed rails from the resident's representative. During an interview on 03/31/26 at 8:40 P.M., CNA D said the resident could hold the bed rail but could not hold up his/her body weight. The resident could not move himself/herself with the bed rails. If the resident was caught in the bed rails, he/she would not be able to get out by himself/herself. 2. Review of Resident #3's face sheet showed the resident had a power of attorney for healthcare decisions. Review of the resident's significant change in status MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Diagnoses of Alzheimer's disease;-Impairment in functional range of motion to one upper extremity and both lower extremities;-Dependent on staff for roll left and right and for chair/bed-to-chair transfer. Review of the resident's quarterly Bed Assistive Device Assessment, dated 02/07/26, showed staff marked the resident did not use a bed assistive device. The entrapment risk assessment was not completed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's current care plan showed the resident used the right assist grab bar for bed mobility. Review of the resident's March 2026 Physician's Orders Sheet showed no order for bed rails. Review of the resident's electronic medical record showed no documentation staff completed an assessment to identify if the resident was at risk for entrapment and no documentation staff obtained informed consent for the bed rails from the resident's representative. Observation on 03/31/26 at 7:25 P.M. and 8:12 P.M. showed the resident lay in bed. He/She had a 1/8 bed rail in the raised position on the right side of his/her bed. The resident had a bolstered mattress (a mattress with raised edges along the sides of the mattress). During an interview on 03/31/26 at 8:40 P.M., CNA D said the resident did not use his/her bed rail for mobility. 3. Review of Resident #29's face sheet showed the resident had a power of attorney for health care decisions. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Required partial/moderate assistance from staff for sit-to-stand; -Required substantial/maximal assistance from staff to roll left and right, sit to lying, and chair/bed-to-chair transfer;-Dependent on staff for lying to sitting on side of bed. Review of the resident's quarterly Bed Assistive Device Assessment, dated 02/07/26, showed staff marked the resident did not use a bed assistive device. The entrapment risk assessment was not completed. Review of the resident's current care plan showed the resident was at risk for falls related to history of falls, cognitive status, incontinence and impaired safety and risk for loss of balance. An intervention listed to decrease falls was bed rails to assist as an enabler with transfers and bed mobility: half bed rails, grab bars. Review of the resident's March 2026 physician orders sheet showed no order for bed rails. Review of the resident's electronic medical record showed no documentation staff completed an assessment to identify if the resident was at risk for entrapment and no documentation staff obtained informed consent for the bed rails from the resident's representative. Observation on 03/31/26 at 8:30 P.M., showed the resident lay in a low bed. The resident had 1/8 bed rails in the raised position on both sides of his/her bed. During an interview on 03/31/26 at 8:40 P.M., CNA D said the resident used his/her bed rails for mobility. 4. Review of Resident #12's comprehensive MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Upper and lower extremity impairment on one side;-Partial/moderate assistance by staff for rolling left and right in bed;-Dependent on staff for chair/bed-to-chair transfer. Review of resident's care plan, dated 1/29/25, showed the following:-Side rails as an enabler to assist with transfers and bed mobility- half side rails, grab bars;-Encourage use of assist rails to assist turning in bed. Review of the resident's bed assistive device assessment and bed rail safety recommendations, dated 02/04/26, showed the resident did not have bed rails and no consent was needed due to resident not using a bed assistive device. Review of the resident's physician order sheet showed an order, dated 03/11/25, for assist (side) rail/grab bar for mobility. Observation on 03/31/26 at 9:30 A.M., showed the resident sat awake in his/her bed. The resident had a half side rail in the raised position on the right side of the bed. Observation on 04/01/26 at 10:41 A.M., showed the resident lay asleep in his/her bed. The resident had a half side rail in the raised position on the right side of the bed. Observation on 04/02/26 at 9:55 A.M., showed the resident lay asleep in his/her bed. The resident had a half side rail in the raised position on the right side of the bed. 5. During an interview on 04/02/26 at 10:05 A.M., LPN A said the following:-He/She was a charge nurse;-Charge nurses or the nurse managers completed risk assessments, including Bed Assistive Device Assessments, on admission, quarterly and if there was a significant change; -If a resident had a grab bar or bed rail when staff completed the Bed Assistive Device Assessment, the assessment opened another section that reviewed the resident's physical abilities;-Almost all of the residents' beds had bed rails;-When he/she completed the assessment, he/she documented what the resident used to the best of his/her knowledge. If a resident did not use bed rails, he/she marked the resident did not have rails on the assessment;-He/She did not know if anyone reviewed the assessments, orders, consents, and care plans to ensure they all matched and were consistent. During interviews on 04/02/26 at 2:36 P.M. and 5:12 P.M., the Director of Nursing (DON) said the following:-Staff was to complete the Bed Assistive (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Device Assessment on admission and quarterly; -If the staff picked bed rails are not used, the assessment did not have the staff complete the entrapment assessment;-Staff should fully complete the Bed Assistive Device Assessment for any resident who had bed rails in order to trigger the entrapment risk assessment;-A charge nurse or nurse manager should complete an entrapment risk assessment with any change of condition or decline in physical or mental status;-The assessment should be accurate;-Staff was to obtain informed consent for every resident with bed rails;-Bed rails and risk for entrapment should be listed on the care plan with any interventions needed for the resident; -She recently started a book with the bed rail information and was gathering all of the bed rail assessments, but this was not completed.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to evaluate Broda chairs (a padded reclining chair on wheels) as a physical restraint and failed to ensure the chairs were the least restrictive device while maintaining safety for two residents (Resident #9 and #45), in a review of 12 sampled residents. Staff identified the Broda chairs were utilized to keep the residents in their chair and prevented the residents from standing or propelling without staff assistance. The facility census was 47. Review of the facility's policy, Restraints, last reviewed 03/03/25, showed the following:-The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medication symptoms;-Restraints should only be used when there is no other option for treating a medical symptom;-Restraints will not be used to control resident behavior or as a punishment;-Restraints will only be used when it has been determined that less restrictive interventions are not effective;-An assessment will be completed by the interdisciplinary team (IDT) team in collaboration with the physician to evaluate the need for the use of a restraint;-A physician order will be obtained prior to initiation of the restraint, and the order will specify the period of time to use the restraint;-A care plan will be developed including interventions to minimize or eliminate the medical symptom underlying the restraint use;-The resident and representative will be fully informed on the use of the restraint including but not limited to the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use;-The community will obtain informed consent from the resident or in the case of a resident who is incapable of making a decision, the resident's representative may give informed consent;-The continued use of restraints will be evaluated with each reassessment to determine if the continued use is appropriate or that less restrictive interventions would achieve the same goal;-The use of restraints will be discontinued as soon as it is determined an alternative would be as effective, or the resident's level of functioning has improved and that the risk factors necessitating restraints have been mediated. Review of the Resident Assessment Instrument (RAI) manual, updated October 2025, showed the following:-Physical restraint is any manual method, physical or mechanical device, material or equipment, attached or adjacent to the resident's body, that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body;-The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms;- Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) the restraint is being employed to address;-If a physical restraint is needed to treat the resident's medical symptom(s), the nursing home is responsible for assessing the appropriateness of that restraint;-Chairs that prevent rising include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers for example;- For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual and should be coded as -Chair Prevents Rising. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 11/01/25, showed the following:-Severe cognitive impairment;-Used a manual wheelchair;-Required partial/moderate assistance from staff to move from a lying position to a sitting position on the side of the bed, to sit to stand, to transfer to chair and bed-to-chair transfers, and to wheel 50 feet and two turns; -Two or more falls with no injury and two or more falls with injury;-Did not use a chair that prevented rising. Review of the resident's care plan, revised 12/11/25, showed the following:-May (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use Broda chair (a padded reclining chair on wheels); -At risk for falls/injury as evidenced by history of falls, cognitive status/expressions, vision status, continence, mobility, and balance;-On 12/11/25, the resident was found lying on the floor after attempting to self-transfer from Broda chair. The resident fell forward landing face forward. The resident had an injury. Staff cleaned with wound cleanser and applied antibiotic ointment. Nursing staff ordered the Broda chair from hospice to assist the resident with positioning while up in a chair. Review of the resident's significant change in status MDS, dated [DATE], showed the following:-Diagnoses include Alzheimer's disease, non-Alzheimer's dementia, seizure disorder, and repeated falls, -Severe cognitive impairment;-No wheelchair was used;-Independent with sitting to lying,-Required substantial/maximal assistance from staff for roll left and right, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer;-Had two or more falls without injury and two or more falls with injury since last assessment;-Did not have a chair that prevented rising. Review of the resident's care plan, revised 01/13/26, showed the resident was found on the floor on his/her right side, halfway on the fall mat in his/her room. The resident was in his/her Broda chair before the fall. Review of the resident's Physician Order Sheet, dated March 2026, showed the resident had an order for pedal Broda chair (a type of Broda chair with wheels similar to a wheelchair that allowed for mobility). Review of the resident's quarterly MDS, dated [DATE], showed the following:-One no injury fall ;-Required substantial/maximal assistance from staff for roll left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and sit to lying; -Did not use a chair that prevented rising. Review of the resident's medical record showed no documentation staff evaluated or assessed the restraining properties of a Broda chair for the resident. Observation on 03/31/26 at 7:21 P.M., showed the resident sat in his/her Broda chair in the common television area. The resident's Broda chair sat high in the air, in a reclined position, with a fixed solid footrest that was approximately 10-12 inches off the floor. The resident's Broda chair had caster-style wheels and was not a pedal Broda chair as ordered. The resident lifted his/her body from the chair by pushing up on the arm rest of the chair. The resident moved his/her buttocks to the edge of the seat of the Broda chair. Observation on 03/31/26 at 8:05 P.M. showed the following:-The resident sat in his/her Broda chair in the common television area;-The resident put his/her legs over the right side of his/her footrest and scooted to the edge of the seat of his/her Broda chair;-The resident moved his/her foot around as if to try to touch the ground, while pushing up on his/her armrest attempting to lift his/her body from the chair. Observation on 03/31/26 of the common television area showed the following:-At 8:08 P.M., the resident put his/her leg over the right side of the footrest of the Broda chair and pushed off the armrest of the Broda chair. -At 8:12 P.M., the resident tried to lean over the right side of the Broda chair; -At 8:40 P.M., the resident tried to stand up out of the Broda chair; -At 8:46 P.M., the resident remained in his/her Broda chair. His/Her legs, from the knee down, were off to the right side of the footrest of the chair; -At 8:51 P.M., the resident continued to try to put his/her feet over the right side of the Broda chair footrest. Certified Nurse Assistant (CAN) D told the resident he/she did not want him/her to try to get up out of the chair. During an interview on 03/31/26 at 8:55 P.M., CNA D said the following:-The facility used the Broda chairs to make the residents more comfortable and for safety;-The resident could not get out of the Broda chairs safely without staff's help;-The resident sometimes tried to climb out of his/her Broda chair.-The resident could take a few steps with staff's help to steady himself/herself;-The resident fell from the Broda chair trying to get up on his/her own. 2. Review of Resident #45's care plan, updated 08/05/25, showed the following:-Diagnoses of Alzheimer's dementia and history of a stroke;-At risk for falls as evidenced by history of falls, cognitive status, poor vision, mobility, balance and psychotropic medications;-The resident had a fall 08/05/25. Staff to transfer the resident to the Broda chair as ordered and monitor for comfort, positioning, and safety while seated once the chair arrives;-The resident's Broda chair was added as an intervention to prevent falling. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Diagnosis of Alzheimer's disease;-Required supervision/touching assistance from staff members for roll left and right, sit to stand, (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chair/bed-to-chair transfer, walk 10 feet, walk 50 feet with two turns, and walk 150 feet-Required partial/moderate assistance from staff for sit to lying, lying to sitting on side of bed,-One non-injury falls since last assessment;-Two or more injury falls since last assessment;-Did not use a chair that prevented rising;-No restraint used. Review of the resident's care plan, updated 01/13/26, showed the following:-The resident sat on the foot of his/her Broda chair and then sat on the floor;-Nursing staff to monitor the resident and his/her positioning while he/she is in the Broda chair. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Requires supervision/touching assistance from staff members for roll left and right, sit to lying, lying to sitting on side of bed,-Requires partial/moderate assistance from staff for chair/bed-to-chair transfer (worsen), toilet transfer (worsen), tub/shower transfer,-Requires substantial/maximal assistance from staff for sit to stand (worsen), walk 10 feet (worsen);-Dependent on staff to walk 50 feet with two turns (worsen);-Unable to walk 150 feet (worsen);-Two or more non-injury falls since last assessment;-Two or more injury falls since last assessment;-Chair that prevents rising was not used;-Frequently incontinent (worsen).-No restraint used;-Chair that prevents rising is not used. Review of the resident's medical record showed no documentation staff evaluated or assessed the restraining properties of a Broda chair for the resident. Observation on 03/31/26 from 7:21 P.M. to 8:04 P.M., of the common television area, showed the resident sat in his/her Broda chair, in a reclined position, at an approximate 70-degree angle. The resident's Broda chair had caster-style wheels. The resident's Broda chair sat higher off the ground than a standard chair, with the footrest approximately 12 inches or more off the ground with the leg rest extended out. Observation on 03/31/26 of the common television area showed the following: -From 8:01 P.M. to 8:06 P.M., the resident sat in his/her Broda chair. The resident was fidgety and put his/her leg over the right side of his/her footrest and raised himself/herself up where his/her body lifted off the seat; -At 8:51 P.M., the resident said he/she was trying to go to the house. Observation showed the resident threw his/her leg over the side of the foot rest and pushed off the arm rest to raise his/her body. The resident could not reach the floor with his/her feet and sat back in the chair. During an interview on 03/31/26 at 8:55 P.M., CNA D said the resident sometimes tried to climb out of his/her Broda chair. The resident could take a few steps with staff's help to steady himself/herself. The resident fell from the Broda chair trying to get up on his/her own. 3. During an interview on 04/02/26 at 2:53 P.M., CNA I said the following:-The residents were in Broda chairs for comfort, and the chairs kept them in the chair;-Resident #45 can walk. His/Her family wanted the resident in the Broda chair and not to walk because he/she was falling;-The residents fell from the Broda chairs. -He/She didn't think Broda chairs were a restraint. During an interview on 04/01/26 at 4:00 P.M., Licensed Practical Nurse (LPN)/Infection Preventionist (IP) said the following:-She worked at 11:00 P.M. on 03/31/26 to 6:00 A.M. on 04/01/26 (this morning);-Resident #9 and Resident #45 tried to climb out of the Broda chairs most of the night during his/her shift; -The facility utilized the Broda chairs for Resident #9 and Resident #45 to keep the residents in their chairs;-He/She didn't think Broda chairs were a restraint. During an interview on 04/01/26 at 9:18 A.M., the Director of Nursing (DON) said the following:-The facility utilized the Broda chairs for Resident #9 and Resident #45 to keep them in their chairs;-The facility did not have an assessment to determine if a Broda chair was a restraint;-The residents could not stand from the Broda chairs unassisted because the chairs were higher off the ground and had fixed foot rests. The residents could not propel the Broda chair to move around without help; -Staff had to propel the Broda chair and assist the residents to transfer out of the Broda chairs;-She didn't think Broda chairs were a restraint.