STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265805	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Senior Services at Meramec Bluffs	50 Meramec Trails Drive Ballwin, MO 63021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, the facility failed to notify Next of Kin (NOK) of a resident fall for one resident (Resident #1). The sample size was three. The census was 67. Review of the facility's Event Reporting Policy, revised 7/29/21, showed: -Policy statement: Event reporting is essential to providing resident and client care. Events involving a resident, visitor, or other person (non-employee) that are outside of usual or normal happenings and present a potential liability, and events that are not in keeping with standards, policies, procedures or practices and may have an adverse outcome will be documented. The documentation of an event and its investigation, outside of what is documented in the medical chart, is confidential. Applicable authorities will be notified as appropriate. -A fall is an unintentional coming to rest on the ground, floor, or other lower level but not the result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention. Is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a patient or resident is found on the floor, and there is no witness to account for the event. -Procedures: Resident's physician shall be informed of any event concerning the physical care and wellbeing of the resident. Family or power of attorney (POA) shall be informed of all events defined in this policy. Review of Resident #1's electronic medical record (EMR), showed diagnoses included late onset Alzheimer's dementia with other behavior disturbances, short term memory loss, status post right femur fracture surgery 12/17/25, weight bearing as tolerated, fall, and muscle weakness. Review of a video tape, dated 12/21/25 at 10:34 P.M., showed Resident #1 sat on the floor next to bed, with his/her left arm resting on top of the bed. Certified Nursing Assistant (CNA) A approached resident and said, Oh he/she is on the floor. Did you hit your head? How did you fall out. Review of the resident's progress notes, showed no documentation of a fall on 12/21/25 and not documentation the physician and NOK were notified. During an interview on 12/23/25 at 1:48 P.M., CNA A said, he/she discovered the resident with their elbows resting on the bed and buttocks off the floor. He/She told the resident to sit down onto the floor so he/she can get him/her up. He/she does not consider it a fall and did not report it as a fall. During an interview on 12/23/25 at 2:01 P.M., CNA B said CNA A followed him/her into the resident's room and discovered the resident sitting on the floor next to their bed. The resident denied falling. CNA B said he/she does not consider this a fall, just a slide off the bed. He/she does not know if a report was completed. During an interview on 12/23/25 at 3:15 P.M., the Director of Nursing (DON) and Executive Director (ED) said they would consider a resident sliding off the bed onto the floor and a resident holding themselves up by their elbows off the floor as a fall and should be reported. When a fall/incident happens, the physician is notified along with the NOK, and the DON or Administrator. 2698306

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265805	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Senior Services at Meramec Bluffs	50 Meramec Trails Drive Ballwin, MO 63021

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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to provide services per acceptable standards of practice for one resident (Resident #1), when facility staff failed to use a gait belt when transferring the resident from the floor to the wheelchair. The sample size was 3. The census was 67.Review of the facility's Event Reporting Policy, revised 7/29/21, showed: -Policy statement: Event reporting is essential to providing resident and client care. Events involving a resident, visitor, or other person (non-employee) that are outside of usual or normal happenings and present a potential liability, and events that are not in keeping with standards, policies, procedures or practices and may have an adverse outcome will be documented. The documentation of an event and its investigation, outside of what is documented in the medical chart, is confidential. Applicable authorities will be notified as appropriate. -A fall is an unintentional coming to rest on the ground, floor, or other lower level but not the result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention. Is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a patient or resident is found on the floor, and there is no witness to account for the event. -Procedures: Resident's physician shall be informed of any event concerning the physical care and wellbeing of the resident. Family or power of attorney (POA) shall be informed of all events defined in this policy. Review of the facility's Safe Lifting and Movement of Residents Policy, revised 10/14/19, showed: -Policy statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this community uses appropriate techniques and devices to lift and move residents;-Manual lifting of residents will be eliminated when feasible;-Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, slide boards), and mechanical lifting devices. Review of Resident #1's electronic medical record (EMR), showed diagnoses included late onset Alzheimer's dementia with other behavior disturbances, short term memory loss, status post right femur fracture surgery 12/17/25, weight bearing as tolerated, fall, and muscle weakness. Review of a video tape, dated 12/21/25 at 10:34 P.M., showed Resident #1 sat on the floor next to bed, with his/her left arm resting on top of the bed. Certified Nursing Assistant (CNA) A approached resident and said, oh he/she is on the floor. Did you hit your head? How did you fall out. Review of a video tape dated 12/21/25 at 10:35 P.M., showed the resident sat on the floor next to the bed. CNA A stood in front of the resident. CNA B entered the room and said to get him/her up and put him/her in the chair. The resident raised up both arms, as to reach for the staff. CNA A stood on the left side of the resident with his/her left arm under resident's left armpit and CNA B stood on the right side of the resident with his/her right arm under resident's right armpit and together they lifted the resident off the floor by pulling on his/her arms and transferred the resident into the wheelchair. No gait belt was used to transfer the resident from the floor to the wheelchair. Review of Resident #1 progress notes, showed the fall on 12/21/25 not documented. No fall assessment documented, and no post fall follow-up documented. During an interview on 12/23/25 at 1:48 P.M. CNA A said he/she and CNA B got on each side of Resident #1 and transferred the resident up with his/her good leg from the floor to the wheelchair. He/she does not remember if they used a gait belt for the transfer. CNA A said a gait belt should be used for transfers. During an interview on 12/23/25 at 2:01 P.M. CNA B said he/she and CNA A got on each side of the resident and transferred the resident up with his/her good leg from the floor to the wheelchair. They did not use a gait belt to transfer the resident from the floor to the wheelchair. A gait belt should have been used. During an interview on 12/23/25 at 3:15 P.M., the Director of Nursing (DON) and Executive Director (ED) said they would expect staff to use a gait belt when transferring a resident from the floor to the wheelchair after a fall. 2698306