STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265842	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ssm Health Depaul Hospital - Anna House	12284 Depaul Drive Bridgeton, MO 63044

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(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 - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure staff provided adequate supervision and assistance to prevent accidents for one of three sampled residents (Resident #1) when Certified Nursing Assistant (CNA) C used a Sara lift (also known as a sit to stand, designed to assist individuals with limited mobility in transitioning from a sitting to a standing position) instead of a Hoyer lift (full body lift, used for residents who are unable to move themselves), alone to transfer the resident. CNA C yelled for help. Registered Nurse (RN) A and CNA B responded to the resident's room. The resident was hanging from the Sara lift with his/her legs twisted underneath his/her body, on the platform. A mobile x-ray was ordered. The x-ray confirmed an acute impacted fracture to the left distal femur (a sudden, traumatic break of the lower part of the left thigh bone just above the knee joint). The resident was sent to the hospital. The census was 90. Review of the facility's Sara lift policy, dated September 2017, showed two nursing personnel must be used for a Sara lift transfer. Review of the facility's undated Hoyer/Patient transfer policy, showed:-Purpose: Ensure safe, consistent use of patient lifts to protect residents and staff, meet regulatory requirements, and support a zero-manual-lift environment;-Scope: Applies to all staff using or assisting with mechanical lifts and slings;-Two trained staff members are required for every lift/transfer;-Operator: Runs lift, checks sling attachments;-Assistant: Positions/reassures resident, clears obstacles, helps guide transfer. Review of Resident #1's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 7/30/25, showed:-Adequate vision and hearing;-Clear speech;-Understands others and is understood;-Cognitively intact;-Rejection of care exhibited;-No upper or lower extremity impairments;-Required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for toileting and upper/lower body dressing;-Required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for showers/baths;-Resident required substantial/maximal assistance with sit to stand, chair to bed/chair, toilet and tub/shower transfers;-Diagnoses included unspecified dementia, history of stroke, osteoporosis (a bone disease that weakens bones and makes them more prone to fractures), artificial knee joint, spondylosis (a degenerative condition of the spine that affects the intervertebral discs and vertebrae) and muscle weakness. Review of the resident's care plan, in use during the survey, showed:-Need: The resident had an Activities of Daily Living (ADL) self-care performance deficit;--Intervention: The resident needed one person assistance for transfers. On 08/01/24 physical therapist recommended use of sit to stand lift for transfers as the resident allowed;-Need: The resident was resistive to care during ADLs;--Interventions: Staff allowed the resident to make decisions about treatment regime. Encouraged participation/interaction during care activities. If the resident resisted, staff reassured him/her, left and returned ten minutes later and tried again;-Need: The resident was at risk for falls;--Interventions: Physical therapy evaluated/screened due to weakness and appropriate transfer;-No documented update to show the resident was a two person assist, or when his/her transfer status changed to a Hoyer lift. Review of the resident's progress notes, showed:-On 9/10/25 at 2:30 P.M., the care partner said the resident did not fall. He/She lowered the resident to the floor when he/she slid out of the sit to stand. Staff assisted the resident to bed using the Hoyer lift. The resident's Responsible Party (RP) and Nurse Practitioner (NP) were notified. A new order for x-ray of left knee and right shoulder due to pain and swelling. At 2:33 P.M., (late entry) the nurse noted at approximately 12:45 P.M., staff heard screaming from down the hall. The care partner went to the resident's room to see what happened. The care partner asked the nurse to come to the resident's room. The nurse entered the room. The resident was hanging from sit to stand with knee and leg twisted on the sit to stand. The nurse lowered resident to floor with Hoyer pad and assisted him/her to the bed. The NP, RP, supervisor and Assistant Director of Nursing (ADON) were notified. The resident complained of pain. He/she was administered pain medication at 2:00 P.M. and 6:30 P.M. The NP made aware and ordered an x-ray of the resident's shoulder and knee. X-ray tech will come out this evening or tomorrow. At 10:39 P.M., the x-ray tech obtained x-rays. The resident denied any pain. Review of the resident's x-ray results dated 9/10/25, showed acute impacted fracture of distal femur just above knee prosthesis. Review of the resident's progress notes dated 9/11/25, showed at 8:11 A.M., the nurse called the NP and RP. New order received to send resident to emergency room (ER). The supervisors were notified. At 8:30 A.M. (late entry), the NP was notified of x-ray results. At 8:40 A.M., the resident was transported to the emergency room (ER). At 6:59 P.M., the resident was sent to the hospital