

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/31/2024
NAME OF PROVIDER OR SUPPLIER  McKnight Place Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  Two McKnight Place Saint Louis, MO 63124	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>46967</p> <p>Based on observation, interview and record review, the facility failed to ensure staff provided care to one resident, (Resident #1) in a manner which maintained his/her dignity when Licensed Practical Nurse (LPN) A berated the resident for pressing his/her call light several times, removing his/her brief, and asking for a soda. Additionally, LPN A, Certified Nurse Assistant (CNA) B and CNA C, yelled at the resident after he/she had an unwitnessed fall. The census was 54.</p> <p>Review of the facility policy titled, Quality of Life Dignity Policy, revised August 2009, showed:</p> <ul style="list-style-type: none"> <li>-Each resident shall be cared for in a manner which promotes and enhances quality of life, dignity, respect, and individuality;</li> <li>-Residents shall be treated with dignity and respect at all times;</li> <li>-Treated with dignity means the resident will be assisted in maintaining and enhancing his/her self-esteem and self-worth;</li> <li>-Staff shall speak respectfully to residents at all times;</li> <li>-Staff shall keep the resident informed and oriented to their environment;</li> <li>-Procedures shall be explained before they are performed;</li> <li>-Demeaning practices and standards of care that compromise dignity are prohibited;</li> <li>-Staff shall promote dignity and assist residents as needed by: <ul style="list-style-type: none"> <li>-Promptly responding to the resident's request for toileting assistance;</li> <li>-Allowing residents unrestricted access to common areas;</li> </ul> </li> <li>-Staff shall treat cognitively impaired residents with dignity and sensitivity by: <ul style="list-style-type: none"> <li>-Addressing the underlying motives or root causes for behavior;</li> </ul> </li> </ul> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Not challenging or contradicting the resident's beliefs or statements.</p> <p>Review of the facility's Answering the Call Light Policy, revised October 2010, showed:</p> <p>-Turn off the signal light;</p> <p>-Identify yourself and call the resident by his/her name;</p> <p>-Listen to the resident's request;</p> <p>-Do what the resident asks of you, if permitted. If you are uncertain as to whether a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.</p> <p>Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/7/23, showed the following:</p> <p>-The resident had clear speech, was always understood by others and always understood others;</p> <p>-Moderate cognitive impairment;</p> <p>-It was very important for the resident to have snacks in between meals and choose his/her bedtime;</p> <p>-The resident required substantial to maximum assistance with activities of daily living (ADLs), ambulating, transfers, and mobility;</p> <p>-The resident was dependent on staff for toileting and was always incontinent of bowel and bladder;</p> <p>-Diagnoses included stroke, muscle weakness (generalized), unsteadiness on feet, cognitive communication deficit, dysphagia and pain in hip.</p> <p>Review of the resident's care plan, dated 7/7/23, showed:</p> <p>-Focus: The resident had a monitoring device in his/her room;</p> <p>-Goal: The resident's rights and dignity would be always preserved;</p> <p>-Focus: The resident had an ADL performance deficit;</p> <p>-Intervention: Staff assisted resident to turn and reposition in bed, monitored bumpers on bed, lowered bed to floor with mats on floor and placed call light in reach. Resident on low concentrated sweets diet with mildly, thick consistency;</p> <p>-Focus: The resident had acute pain in lower back and hip;</p> <p>-Intervention: Administer pain reliever per orders. Anticipate the resident's need for pain relief and respond immediately to any pain complaint.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress notes, dated 7/24/23 at 4:01 A.M., showed LPN A documented the resident was awake most of the night with his/her call light on. When staff entered his/her room, he/she only wanted to talk. LPN A told the resident staff could not sit and talk to him/her. They had to help other residents. The resident said he/she understood, then pressed the call light again. Staff answered his/her call light and he/she just wanted to talk or not speak at all. Staff checked on the resident several times during the night. He/She had not slept since 2:00 A.M. LPN A spoke to the resident at 3:45 A.M. and told him/her to go to sleep because it was 4:00 in the morning. The resident responded, Oh, I didn't know it was that time of the morning.</p> <p>Observation of video camera footage of the resident's room on 7/24/23 (time unknown), showed a housekeeper entered the resident's room, and the resident told him/her, he/she needed his/her left leg massaged. The housekeeper told the resident he/she would tell the nurse. LPN A entered the resident's room and said, Honey you need to quit calling your family members to shut off the light. The resident said Wait, let me explain. LPN A said No, I'm not waiting. LPN A turned off the resident's light and exited his/her room.</p> <p>Review of the resident's progress notes on 7/31/23 at 2:00 A.M., showed LPN A documented the resident was awake and in bed. He/She pressed the call light several times for small things. He/She asked staff to pull his/her sleeve up and down and fix his/her covers and call light. LPN A documented Most of these things (he/she) could have done for (him/herself), (he/she) just wanted someone to be in the room with (him/her) giving (him/her) their undivided attention. LPN A told the resident there were other residents in need of care. Staff did not have time to sit in with him/her to just talk and do the little things he/she could do for him/herself. The resident said he/she understood, then pressed his/her call light again. He/She was incontinent of bowel and bladder, ripped off his/her brief and liners, and threw them onto the floor in little pieces. The resident did not understand what happened.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of video camera footage of the resident's room on 7/31/23 (time unknown), showed LPN A entered the resident's room and said, What do you need. The resident tried to respond, and LPN A cut him/her off. LPN A asked the resident what was on his/her floor. LPN A picked up a brief off the floor, next to the resident's bed, then dropped it back on the floor. The resident said the brief came off and LPN A said it does not just come off, you have to pull it off. LPN A asked the resident why he/she pressed the call light. The resident asked LPN A why he/she was challenging him/her. LPN A said, Don't tell me I am challenging you. I asked you a direct question. The resident said he/she wanted a 7 Up (soda). LPN A said they did not have any 7 Up. The resident asked what kind of soda was available and LPN A said we do not have any soda. The resident asked LPN A to look in his/her refrigerator and get a 7 Up. LPN A said Look (sir/madam), it is 3:00 in the morning we are not doing 7 Up. I am not playing these games. It is 3:00 in the morning and you are playing games. This is ridiculous. LPN A opened the refrigerator, removed a soda, slammed the refrigerator door, and slammed the soda on the resident's bedside table. LPN A told the resident he/she could not have a straw. The resident asked for a cup. LPN A said use the cup on your table. The resident said the cup was full of water. LPN A said, Well I do not know what to say (sir/madam). I am tired of this. LPN A grabbed the cup, went in the resident's bathroom, came out and sat the cup on the bedside table. LPN A asked the resident if he/she had to have thickeners in his/her liquids. The resident said, No. Why are you so mad. LPN A walked around to the left side of the resident's bed and said Because it is 3:00 in the morning and we are playing around. You have been awake all night with your call light. Pull my sleeve down, do this, do that. The resident said he/she was sorry. LPN A said, I would like to know why. You should not call us in here for things you can do yourself. If you pulled your sleeve up, you can pull it down. The resident said he/she was sorry for bothering LPN A. LPN A said, Well you did and now I have to have someone come in and change you, because you pulled your liner out. LPN A exited the resident's room. The resident attempted to open the soda. LPN A returned to the resident's room and snatched the soda out of his/her hand. LPN A said Oh no (sir/madam), do not drink that. You lied to me. You are supposed to have thickened liquids. The resident said he/she did not like thickened liquids. LPN A told the resident he/she had to have them, or he/she would choke. LPN A sat the soda on the dresser, answered his/her phone and walked out of the resident's room.</p> <p>Review of the resident's progress notes, dated 10/3/23 at 6:00 A.M., showed LPN A documented the resident was found on floor next to his/her bed with buttocks on floor, feet on foot of bed. Top of body on floor as well. Resident unable to say how this happened.</p> <p>Review of video footage of the resident's room on 10/3/23 (time unknown), showed:</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff transferred the resident from the floor to his/her bed. The resident asked CNA B to remove his/her wet shirt. CNA B said Look, let us focus on getting you up (sir/madam). CNA B snatched the liner and sheet from under the resident. The resident said Oh. CNA B said This (man/woman) here. LPN A said (he/she) fell the other day. The resident continued to say his/her shirt was wet. CNA C pointed at the resident and said, We heard you. The resident asked CNA B if he/she would take his/her shirt off. CNA C leaned towards the resident's face and yelled, Can you give her a chance. Give her a chance. The resident said give me a dry shirt with long sleeves. CNA C said No. The resident said a dry shirt was all he/she asked for. CNA C got in the resident's face and yelled Stay in the bed is all we ask. CNA C started removing the resident's shirt and he/she said Good. CNA C yelled Thank you. You do not say good, you say thank you. The resident said, I thank you in my heart. CNA C said, No thank you, I want to hear it. The resident said you are not wrong. LPN A entered the resident's room and said, Are you kidding me? LPN A walked over to the resident's bedside and yelled, What is wrong with you, why can't you just stay in the bed? The resident said, you want me to stay in the bed. LPN A yelled Yes, stay in the bed. The resident said, I am in the bed. LPN A said, What is wrong with you. When you are in the bed you are supposed to stay in the bed and not get out by yourself. The resident asked LPN A to pull his/her shirt down. CNA C yelled (He/She) is not done yet. (He/She) will pull your shirt down when (he/she) puts your underwear on. You be worried about the wrong stuff. The resident said okay. CNA C told CNA B the resident wanted his/her shirt pulled down, but that was not important. LPN A said please do not get out of bed again. The resident told LPN A he/she thinks he/she met him/her before. LPN A said, Yeah you met me before when you were worried about a juice bottle on the floor instead of going to sleep. The staff laughed and exited the resident's room.</p> <p>During an interview on 5/31/24 at 11:58 A.M., LPN A said he/she could not recall a video monitoring device in the resident's room. He/She did not remember telling the resident to stop calling his/her family to ask staff to turn off his/her light. He/She was shown the video of the 7 Up incident. He/She said he/she should have known the resident was on thickened liquids and should not have given him/her the soda before checking. He/She thought it was appropriate to tell the resident to stop pressing the call light for things he/she could do for him/herself. His/Her behavior was unacceptable. He/She did not remember the conversation after the resident's fall.</p> <p>During an interview on 5/29/24 at 3:17 P.M., the Director of Nursing (DON) said the resident's family member sent two videos to his/her cell phone. She watched them with the Administrator then deleted them. LPN A spoke in a loud tone, but it was not demeaning. She talked to LPN A about the videos. LPN A was upset he/she was accused of treating the resident with a lack of dignity and respect. LPN A and the CNAs were allowed to continue providing care to the resident.</p> <p>During an interview on 5/31/24 at 9:45 A.M., the Administrator and DON reviewed the videos with the Department of Health and Senior Services, Senior Regulatory Auditor. They identified LPN A as the nurse in the videos. They could not identify the CNAs. The Administrator said they did not receive the videos. When told there was documentation the DON received the videos, the DON said she could not get the videos to play. LPN A should have known the resident was on thickened liquids. This behavior is not tolerated by staff.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46967</p> <p>Based on observation, interview and record review, the facility failed to assess a resident, (Resident #1) and properly transfer the resident from the floor to the bed, after an unwitnessed fall. The census was 54.</p> <p>Review of the facility's Answering the Call Light Policy, revised October 2010, showed:</p> <ul style="list-style-type: none"> <li>-Turn off the signal light;</li> <li>-Identify yourself and call the resident by his/her name;</li> <li>-Listen to the resident's request;</li> <li>-Do what the resident asks of you, if permitted. If you are uncertain as to whether a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance;</li> <li>-If assistance is needed when you enter the room, summon help by using the call signal.</li> </ul> <p>Review of the facility's Fall Protocol Policy, revised September 2012, showed:</p> <ul style="list-style-type: none"> <li>-The nurse shall assess and document/report the following:</li> <li>-Vital signs;</li> <li>-Recent injury, especially fracture or head injury;</li> <li>-Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.;</li> <li>-Change in cognition or level of consciousness;</li> <li>-Neurological status;</li> <li>-Pain;</li> <li>-Frequency and number of falls since last physician visit;</li> <li>-Precipitating factors, details on how fall occurred.</li> </ul> <p>Review of the facility's Low Lifting Policy dated 2/18/97 and revised 5/1/24, showed:</p> <ul style="list-style-type: none"> <li>-To comply with the Occupational Safety and Health Administration (OSHA) regulations, the facility purchased a quantity of resident transfer devices to reduce the physical lifting of residents;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The equipment was designed to help make the transfers easier to perform and safer for both the staff and the residents;</p> <p>-The nurse with the assistance of therapy if needed, will evaluate the residents transfer technique on admission and as needed. This will be documented on the aide assignment sheet;</p> <p>-From this point forward, any employee found to be manually lifting any resident, except with the permission of their supervisor, failure to comply will result in violation of policy;</p> <p>- Any employee in violation of this policy will be subject to disciplinary action, which could conclude to immediate termination.</p> <p>Review of the Resident #1's care plan, dated 7/7/23, showed:</p> <p>-Focus: The resident had an activities of daily living (ADL) performance deficit;</p> <p>-Intervention: Staff assisted resident to turn and reposition in bed, monitored bumpers on bed, lowered bed to floor with mats on floor and placed call light in reach;</p> <p>-Focus: The resident had acute pain in lower back and hip;</p> <p>-Intervention: Administer pain reliever per orders. Anticipate the resident's need for pain relief and respond immediately to any pain complaint;</p> <p>-Focus: The resident was high risk for falls;</p> <p>-Intervention: Anticipate and meet the resident's needs. The resident needed prompt response to call for assistance. Follow facility fall protocol;</p> <p>-Focus: The resident was incontinent of bowel and bladder;</p> <p>-Intervention: Check resident every two hours and assist with toileting as needed. Provide bedpan/bedside commode transfer with two assist and Hoyer lift. Provide loose fitting, easy to remove clothing. Provide peri care after each incontinent episode.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/1/23, showed the following:</p> <p>-The resident had clear speech, was always understood by others, and always understood others;</p> <p>-Moderate cognitive impairment;</p> <p>-The resident did not have any behaviors;</p> <p>-The resident did not reject care;</p> <p>-It was very important for the resident to choose his/her bedtime;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident required substantial to maximum assistance with ADLs, ambulating, transfers, and mobility;</p> <p>-The resident was dependent on staff for toileting and was always incontinent of bowel and bladder;</p> <p>-Diagnoses included stroke, muscle weakness (generalized), unsteadiness on feet, cognitive communication deficit, dysphagia, and pain in hip.</p> <p>Review of the resident's progress notes, dated 10/3/23 at 6:00 A.M., showed Licensed Practical Nurse (LPN) A documented the resident was found on floor next to his/her bed with buttocks on floor, feet on foot of bed. Top of body on floor as well. Resident unable to say how this happened. He/She was assessed for injuries, none noted. Neuro checks initiated. Vitals taken, with in limits. He/She was assisted into bed with assist of two staff members and gait belt.</p> <p>Review of video footage of the resident's room, dated 10/3/23 (time unknown), showed:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident on the floor. His/Her back was on the floor and his/her legs and feet were on the bed. The resident's sheets were wrapped around his/her body and the bedside table metal bar was across his/her neck (not touching). The resident could not move. The resident was wearing a t-shirt, no brief, and socks. Certified Nurse Aide (CNA) B entered the resident's room. The resident said help. CNA B looked at the resident on the floor, sighed and said, Oh God, then exited the resident's room. The resident continued to yell help, please help. CNA B returned to the resident's room and said, wait a minute. He/She picked the bedside table up. He/She said, Something told me you were going to fall when you kept leaning over to the side. The resident said he/she could not get up. CNA B said, I know you can't. CNA B put the resident's pillows on his/her bed and picked up a sheet. CNA B said he/she had to go get help, stepped over the resident, and left the room. CNA B returned a few seconds later with CNA C. CNA B put his/her hands under the resident's neck. CNA C stood on the resident's bed and grabbed his/her legs. CNA B said 1, 2, 3 and lifted the resident off the floor by his/her neck, while CNA C lifted his/her legs. The resident's buttocks were on the bed and his/her legs were hanging off the left side of the bed. CNA B turned the resident's torso and CNA C forcefully swung the resident's legs onto the bed. The resident said, Oh shit. CNA C said That is how we feel. That is how we feel. Ouch. LPN A entered the room and asked the resident what he/she was trying to do when he/she got out of bed. The resident said he/she was trying to get up. LPN A said, So you were trying to get out of bed to get back in the bed. CNA B and CNA C laughed. The resident said he/she did not realize he/she was out of the bed. He/She knew he/she needed help. CNA B put a sheet on top of a liner and rolled them together. CNA pulled the resident by his/her right shoulder and LPN A grabbed the resident's legs. The resident said, wait. LPN A said, No we are not waiting. We have been waiting. The resident's legs were hanging off the left side of the bed. The resident yelled My legs, my legs. CNA C said You did that. Stop, I got you. Don't worry about your legs. The resident asked CNA C to pick up his/her legs. CNA C yelled, In a minute! You worried about falling, you should have thought about that a couple of minutes ago. CNA B pushed the liner and sheet under the resident's buttocks. LPN A grabbed the resident's legs and put them on the bed. CNA C and LPN A aggressively pushed the resident on his/her right side. The resident said Ouch, that hurts. That hurt my hip. LPN A said, You should have thought about that before you climbed out of bed in the first place. CNA B and CNA C put a brief on the resident without performing peri care. CNA B and CNA C turned the resident on his/her right side and placed a pillow under his/her back. The resident said, not so rough. LPN A said, When you do not help, they say you are rough. The resident said, you are being too rough. CNA C got in the resident's face and yelled If you would stay in bed, you would not have to worry about this. So let this be a lesson learned for the hundredth time. The resident said okay.</p> <p>During an interview on 5/31/24 at 11:51 A.M., CNA B said he/she entered the resident's room, saw the resident on the floor, left the room and called LPN A for assistance. LPN A was assisting another resident. CNA C helped him/her get the resident off the floor. CNA B could not remember what position the bedside table was in. CNA B said they got the resident up the best way they could. He/She denied lifting the resident off the floor by his/her neck. CNA B started yelling during the interview and terminated the call.</p> <p>During an interview on 5/31/24 at 11:58 A.M., LPN A said CNA B and CNA C should not have moved the resident. They should have removed the table from over the resident's neck, then waited for him/her to assess the resident. CNA B and CNA C should have used a Hoyer lift to transfer the resident. LPN A said he/she should have assessed the resident for injuries, took his/her vitals and started neuro checks. The DON and Administrator did not show him/her the video. He/She received a written warning for unprofessional behavior on 10/5/23.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN A, CNA B and CNA C employee files, showed:</p> <p>-LPN A received a counseling notice for unprofessional behavior on 10/5/23. The notice was signed by the Administrator and DON;</p> <p>-CNA B received a counseling notice for unprofessional behavior on 10/5/23. The notice was signed by the Administrator and DON;</p> <p>-CNA C received a counseling notice for unprofessional behavior on 10/5/23. The notice was signed by the Administrator and DON;</p> <p>During interviews on 5/29/24 at 3:17 P.M. and 5/31/24 at 9:45 A.M., the DON said the CNA walked into the room and saw the resident on the floor mat. The over the bed table was on the resident, but not on his/her neck. She could not identify the CNAs. The two CNAs lifted the resident on to the bed. The bed was low, and the CNA did stand on it. One had the upper body and the other had the lower body. They did not drag the resident. When the video was reviewed with the DON on 5/31/24, she said she did not see all the video previously. When informed there was documentation she received all the videos, she said they could not get the videos to play. When a resident has an unwitnessed fall, staff should complete an incident report and start neuro checks. The nurse is supposed to assess the resident. The CNAs should not have moved the resident until the nurse assessed him/her. The transfer was improper. The resident required a Hoyer lift for transfers, and they should have used one.</p> <p>During interviews on 5/30/24 at 8:54 A.M. and 5/31/24 at 9:45 A.M., the Administrator said they received the video of the resident's fall. She could not remember the date. There was no sound on the video. The table was over the resident, but it was not touching him/her. The CNA went to the door and called for help. Another staff member came in to assist the CNA. The resident's positioning was weird. One of the CNAs stood on the bed so he/she could get the resident's shoulders. The other CNA moved the resident's feet onto the bed. The CNAs did not drag the resident. She did not see anything in the video which would warrant an investigation. During review of the video on 5/31/24, the Administrator said they did not get the entire video. LPN A's, CNA B's and CNA C's behavior was unacceptable. If they would have seen the entire video, they would have terminated all of them.</p> <p>MO00236005</p>		