STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the safety of one resident (Resident #1), of seven sampled residents. While assisting the resident to transfer from the toilet to his/her new motorized chair, staff ran the motorized chair over the resident's left foot. The resident sustained a fractured toe. The facility census was 66. Review of the facility policy for Accidents and Supervision dated 07/2024 showed the following:-The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devises to prevent accidents. This includes identifying hazards(s) and risk(s); evaluating and analyzing hazards(s) and risk(s); implementing interventions to reduce hazards(s) and risk(s); monitoring for effectiveness and modifying interventions when necessary;-The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents;-All staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident;-Use specific interventions to try to reduce a resident's risks from hazards in the environment. This process includes in part: providing training as needed;-Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. 1.Review of Resident #1's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses of end stage renal disease (ESRD, a disease in which the kidneys do not function), with dialysis, type 1 diabetes, atrial fibrillation (irregular heartbeat) and Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement). Review of the resident's care plan for Activities of Daily Living (ADL) dated 6/23/25 showed the following:-The resident has alterations in ADL function secondary to ESRD, decreased mobility and decreased strength.-Assist in completing ADL tasks each day. Review of the resident's Care Plan showed no direction related to use of the resident's new motorized chair. Review of the resident's nurses note dated 6/25/25 at 10:23 A.M. signed by Assistant Director of Nursing (ADON)/Registered Nurse (RN) showed the certified nurse aide (CNA) reported the resident's right foot was accidently rolled over by resident's power chair. Nurse Practitioner (NP) notified and assessed resident. No signs of injury currently. Resident denies pain, no changes in range of motion (ROM) to Right foot or ankle. X-rays order and set up for 4:00 P.M. when resident returned from dialysis. During an interview on 7/15/25 at 3:55 P.M. Certified Nurse Aide (CNA) B said the following:-He/She and CNA C were transferring the resident from the electric wheelchair to the toilet on 6/25/25 in the morning;-CNA C moved the electric wheelchair out of the way, as he/she dressed the resident's lower body, then CNA C began to move the electric wheelchair closer to the resident when the resident said ouch and said the electric chair was on his/her foot. He/She and CNA C looked down and saw the electric chair was on top of the resident's toes; CNA C backed the chair off the resident's foot;-He/She reported this to the nurse and there was a nurse practitioner in the facility at the time;-The resident complained of pain in the foot, but could still move the foot;-They took the resident to the front lobby as he/she had to go to dialysis. During an interview on 7/28/25 at 2:40 P.M. CNA C said the following:-He/She did not receive any training on how to use this electric wheelchair;-CNA B helped him/her transfer the resident into the electric wheelchair, took the resident into the bathroom and transferred him/her out of the electric wheelchair onto the toilet;-He/She did not remember running over the resident's foot;-He/She reported what the resident said to the ADON and the Nurse Practitioner (NP). During an interview on 7/17/25 at 8:50 A.M. Resident #1 said the following:-The staff seemed like they were in a hurry when they came to get her up and take her to the bathroom;-When the CNA's stood him/her up off the toilet, one CNA moved the electric wheelchair over towards him/her and it rolled onto his/her left foot;-The aides left the electric wheelchair on top of his/her foot; he/she told them the chair was on his/her foot;-The aids moved the wheelchair, so it wasn't sitting on his/her foot, then helped him/her into the chair and took him/her to the front lobby to go to dialysis;-No one looked at his/her foot before he/she went to dialysis;-When he/she got to dialysis, he/she could not stand to transfer, his/her foot hurt bad;-Dialysis staff were unable to transfer the resident to the dialysis chair due to his/her painful right foot, so they sent him/her to the hospital;-Once he/she was at the hospital, they x-rayed the left foot and the toes and top on his/her foot was broken so they put a walking boot on the foot. Review of the resident's progress note dated 6/25/25 signed by NP A showed the following:-In the process of getting to the toilet from the motorized wheelchair, the resident's foot was hit by the wheel of the chair;-The resident denies pain, he/she is moving the foot. Order X-Ray to the right foot