

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/26/2025
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CHESTNUT GLENN-ASSISTED LIVING BY AME **121 KLONDIKE CROSSING**
SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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A4777

19 CSR 30-86.047(36) Proper Care Per Individual Service Plan

Residents shall receive proper care as defined in the individualized service plan. I/II

This regulation is not met as evidenced by:
Class II

Based on interview and record review, the facility failed to ensure one resident (Resident #3), of seven sampled residents, received proper care as defined in the Individualized Service Plan (ISP) when staff failed to assess the resident following a fall and failed to assess a bruise of unknown origin. The facility census was 35.

Review of the facility undated policy Incident/Accident Report Guidelines showed the following:

- All resident incidents should be reported and documented as soon as possible on the Incident/Accident Report form. The Director of Nursing (DON) conducts a post fall assessment;
- When a resident has sustained an injury or is found on the floor presumably from a fall, staff members immediately evaluates the resident for severity of injury;
- The DON should be notified;
- The DON should direct staff to assure that the resident has appropriate and safe follow up medical care;
- The resident's primary care physician should be notified by fax or phone, dependent on the status of the resident;
- Family/Power of Attorney should be notified;
- The Incident/Accident report form should be thoroughly and legibly completed by the staff member who was first on the scene;
- A description of the occurrence should be noted in the resident's record;

A4777

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Colleen Hammel

Executive Director

7/17/25

Missouri Department of Health and Senior Services

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A4777	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Resident who sustained a confirmed fall should have narrative charting each shift along with vital signs for 72 hours post fall; -A completed report form should be forwarded to the DON; -A post fall assessment should be initiated by the staff member filling out the incident report and then forwarded to the DON for follow up and completion. This assessment form should be placed in the resident's chart. <p>Review of the facility policy Change of Condition dated October 2015 showed the following:</p> <ul style="list-style-type: none"> -The DON is responsible for completing an evaluation and recognizing and responding to changes in the residents' condition that may indicate illness or a decline in functional status; -A significant change of status is a decline in a resident's status, physical, emotional or psychosocial condition that does not normally resolve itself without intervention by staff; -Evaluation should be conducted and documented by licensed nursing staff. Observations and concerns should be addressed as needed; -The resident's physician and legal representative should be notified of the condition change. <p>1. Review of Resident #3's Physician Order Sheet dated 5/8/25 showed the following:</p> <ul style="list-style-type: none"> -Admitted 5/7/25; -Diagnoses of dementia, chronic obstructive pulmonary disease (COPD, a progressive lung disease which caused increased shortness of breath and typically worsened over time with chronic cough, wheezing and difficulty breathing), and Parkinson's Disease (a progressive disease of the nervous system that affected movement and mobility). 	A4777		

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A4777	<p>Continued From page 2</p> <p>Review of the resident's Individual Service Plan (ISP), dated 5/8/25, showed the following: -Alert to person with long term memory loss; -Walked with a walker; -No recent history of falls; -No wounds or bruises; -Special medication awareness included anticoagulant medication (blood thinning medication); -Totally dependent on staff for personal care (bathing, oral care, hair care, shaving, and nail care).</p> <p>Review of the resident's fall risk evaluation, dated 5/12/25, showed the following: -One to two falls in the previous six months; -Cognitive impairment, mental status varied over the course of the day; -Ambulated with a walker; -One to two prescribed medications which potentially affected mobility (antidepressant, antipsychotic and high blood pressure medications); -Fall risk score of 4 indicating low fall risk.</p> <p>Review of the resident's Monthly summary, dated 6/9/25, showed the following: -No change in the resident's functional status; -Ambulated with a walker, with abnormal and unsteady gait; -Skin tear to left elbow on 6/5/25 when staff found the resident on the floor; -No falls.</p> <p>Review of the resident's medical record showed no documentation regarding the resident's fall on 6/5/25 including staff assessment of the resident including the resident's skin tear on the left elbow.</p> <p>Review of the resident's nurses' notes dated</p>	A4777		

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A4777	<p>Continued From page 3</p> <p>6/13/25 showed staff documented the following: -At 1:59 P.M. the Memory Care Director of Nursing (DON) documented a late entry which occurred on 6/8/25. The DON arrived at the facility on 6/8/25 at approximately 8:30 A.M. The resident sat in his/her chair and was talkative. The DON palpated (touched) the resident's right and left sides without any complaints of pain. Staff informed the DON on 6/7/25 the resident had a bruise to his/her side.</p> <p>During an interview on 6/26/25 at 9:40 A.M. Level One Medication Aide (LIMA) A said on 6/8/25 staff noted a large purple bruise on the resident's left upper side below the arm pit area the size of his/her hand with fingers spread open. A raised lump was noted in the bruised area. The resident fell prior to 6/8/25 (unsure of the date but within the three days prior to hospital admission on 6/8/25) in another resident's room, crawled on the floor and staff assisted the resident off the floor. No assessment following the earlier fall was completed and he/she did not document the fall in the resident's medical record or complete a fall incident report. He/She did not notify the DON, family or physician of the earlier fall. LIMA A thought LIMA C completed the assessment and documentation. Staff should assess a resident after a fall for injuries, obtain treatment and notify the DON of the fall. Staff should document the fall in the resident's medical record and complete a fall incident report.</p> <p>During an interview on 6/26/25 at 1:15 P.M. LIMA C said the resident fell on 6/5/25. LIMA C found the resident on the floor crawling with a skin tear to the left elbow. Later the resident said his/her back hurt. LIMA C did not see a bruise on the resident's left chest wall on 6/5/25, the bruise showed up later. LIMA C and LIMA A got the</p>	A4777		

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A4777	<p>Continued From page 4</p> <p>resident off the floor following the 6/5/25 fall. LIMA C did not complete an incident report or document the 6/5/25 fall. The only injury was a skin tear to the left elbow.</p> <p>During an interview on 6/26/25 at 12:30 P.M. Caregiver B said on 6/6/25 the resident had a C-shaped skin tear on his/her left elbow. Caregiver B notified either the administrator or Memory Care DON of the skin tear.</p> <p>During interviews on 6/26/25 at 9:15 A.M. and 11:30 A.M. the Memory Care DON said the following:</p> <ul style="list-style-type: none"> -She was not aware of any prior falls; -The resident had a bruise to the left side, under the left arm for a couple of days prior to transport to the ER on 6/8/25. The bruise was about the size of a person's hand with unknown cause. She was aware of the bruise and completed no investigation or assessment to determine the cause and no follow up assessments were completed; -Staff must have marked no falls in error on the resident's monthly summary, dated 6/9/25, as the resident had experienced falls; -Staff should assess a resident's condition following a fall, obtain medical treatment as indicated, document the fall in the resident's medical record, complete a fall incident report and notify the DON, family and physician. Staff should assess a bruise or injury of unknown origin immediately and attempt to determine the cause. The DON and staff should have ongoing assessments of any injury and document the assessments in the resident's medical record. <p>During an interview on 6/26/25 at 11:30 A.M. the Administrator said the following:</p> <ul style="list-style-type: none"> -Staff notified her, on an unknown date, the 	A4777		

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A4777	<p>Continued From page 5</p> <p>resident was on the floor on his/her knees prior to the 6/8/25 fall. She asked staff if the resident had use of his/her legs and arms and instructed staff to help the resident up, check vital signs and completed an incident report. She instructed staff to notify the resident's family and physician; -Staff did not assess and document the resident's fall and skin tear and did not assess and document the resident's left chest wall bruise. Staff completed no follow up assessments or incident reports regarding either fall or the bruise; -Staff should have assessed the resident after each fall, assessed the resident's condition and obtained medical treatment. Staff should have documented the assessments and completed incident reports following each fall and following identification of a bruise of unknown origin. Staff should have notified the physician and the family of the resident's falls and left chest wall bruise.</p> <p>During an interview on 7/7/25 at 12:55 P.M. the resident's physician said she was not aware the resident fell 6/5/25 and was not aware the resident had a open hand size bruise on the left chest wall two days prior to the 6/8/25 fall and hospitalization. Staff had not notified her of the fall on 6/5/25 or the left chest wall bruise. She expected staff to monitor a bruise and notify her of the bruise and if the bruise became worse or larger. Staff should notify her of any change in the resident's condition and notify her of any falls or bruise or injury. Staff should assess and monitor the resident following a fall or injury and document the assessments in the resident's medical record.</p> <p>MO 00255520</p>	A4777		

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A4778	Continued From page 6	A4778		
A4778	<p>19 CSR 30-86.047(37) Appropriate Action & Notification</p> <p>In case of behaviors that present a reasonable likelihood of serious harm to himself or herself or others, serious illness, significant change in condition, injury or death, staff shall take appropriate action and shall promptly attempt to contact the person listed in the resident ' s record as the legally authorized representative, designee or placement authority. The facility shall contact the attending physician or designee and notify the local coroner or medical examiner immediately upon the death of any resident of the facility prior to transferring the deceased resident to a funeral home. I/II</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on interview and record review, the facility failed to notify one resident's (Resident #3's) physician and family in a review of four residents, when the resident sustained a fall with a skin tear to the left elbow and failed to notify the physician and family when staff identified a bruise of unknown origin on the resident's left chest wall. The facility census was 35.</p> <p>Review of the facility undated policy Incident/Accident Report Guidelines showed the following: -All resident incidents should be reported and documented as soon as possible on the Incident/Accident Report form; -The DON should be notified; -The resident's primary care physician should be notified by fax or phone, dependent on the status of the resident;</p>	A4778		

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A4778	<p>Continued From page 7</p> <p>-Family/Power of Attorney should be notified.</p> <p>Review of the facility policy Change of Condition dated October 2015 showed the following: -A significant change of status is a decline in a resident's status, physical, emotional or psychosocial condition that does not normally resolve itself without intervention by staff; -The resident's physician and legal representative should be notified of the condition change.</p> <p>1. Review of Resident #3's Physician Order Sheet, dated 5/8/25, showed the following: -Admitted 5/7/25; -Diagnoses of dementia, chronic obstructive pulmonary disease (COPD, a progressive lung disease which caused increased shortness of breath and typically worsened over time with chronic cough, wheezing and difficulty breathing), and Parkinson's Disease (a progressive disease of the nervous system that affected movement and mobility).</p> <p>Review of the resident's Monthly summary dated 6/9/25 showed the following: -No change in the resident's functional status; -Ambulated with a walker, with abnormal and unsteady gait; -Skin tear to left elbow on 6/5/25 when staff found the resident on the floor.</p> <p>Review of the resident's medical record showed no documentation the resident fell and no documentation staff notified the resident's physician and family of the resident's fall and skin tear on 6/5/25.</p> <p>Review of the resident's nurses' notes dated 6/13/25 showed at 1:59 P.M. the Memory Care Director of Nursing (DON) documented a late</p>	A4778		

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A4778	<p>Continued From page 8</p> <p>entry which occurred on 6/8/25. The DON arrived at the facility on 6/8/25 at approximately 8:30 A.M. The resident sat in his/her chair and was talkative. The DON palpated (touched) the resident's right and left sides without any complaints of pain. Staff informed the DON on 6/7/25 the resident had a bruise to his/her side.</p> <p>Review of the resident's medical record showed no documentation staff identified a bruise to the resident's left side, assessed the cause of the bruise or notified the resident's physician or family of the resident's bruise.</p> <p>During an interview on 6/26/25 at 9:40 A.M. Level One Medication Aide (LIMA) A said the resident fell prior to 6/8/25 (unsure of the date but within the three days prior to hospital admission on 6/8/25) in another resident's room, crawled on the floor and staff assisted the resident off the floor. He/She did not notify the DON, family or physician of the earlier fall. Staff should notify the physician and the resident's family of a fall or injury.</p> <p>During an interview on 6/26/25 at 1:15 P.M. LIMA C said the resident fell on 6/5/25. LIMA C found the resident on the floor crawling with a skin tear to the left elbow. Later the resident said his/her back hurt. LIMA C did not see a bruise on the resident's left chest wall on 6/5/25, the bruise showed up later. LIMA C and LIMA A got the resident off the floor following the 6/5/25 fall. Staff should notify the resident's physician and family of a fall or injury. LIMA C thought the Memory Care DON notified the physician and family of falls and injuries.</p> <p>During interviews on 6/26/25 at 9:15 A.M. and 11:30 A.M. the Memory Care DON said the</p>	A4778		

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A4778	<p>Continued From page 9</p> <p>following:</p> <ul style="list-style-type: none"> -The resident had a bruise to the left side, under the left arm for a couple of days prior to transport to the ER. The bruise was about the size of a person's hand with unknown cause. She did not notify the resident's physician or family of the left chest wall bruise; -Staff should complete a fall incident report and notify the DON, family and physician. Staff should notify the resident's physician and family of any injury or bruise of unknown origin. <p>During an interview on 6/26/25 at 11:30 A.M. the Administrator said the following:</p> <ul style="list-style-type: none"> -Staff notified her, on unknown date, the resident was on the floor on his/her knees prior to the 6/8/25 fall. She asked staff if the resident had use of his/her legs and arms and instructed staff to help the resident up, check vital signs and complete an incident report. She instructed staff to notify the resident's family and physician; -Staff did not notify the resident's physician or family of the fall, the skin tear or the left chest wall bruise; -Staff should have notified the physician and the family of the resident's falls, skin tear and left chest wall bruise. <p>During an interview on 7/7/25 at 12:55 P.M. the resident's physician said she was not aware the resident fell 6/5/25 and was not aware the resident had a hand print size bruise on the left chest wall two days prior to the 6/8/25 fall and hospitalization. Staff had not notified her of the fall on 6/5/25 or the left chest wall bruise. She expected staff to monitor a bruise and notify her of the bruise and if the bruise became worse or larger. Staff should notify her of any change in the resident's condition and notify her of any falls or bruise or injury.</p>	A4778		

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A4778	Continued From page 10 MO0025520	A4778		

PLAN OF CORRECTION

Provider/Supplier Name:	Chestnut Glen -Assisted Living by Americare	
Street Address, City, Zip:	121 Klondike Crossing, St. Peters MO 63376	
Date of Survey:	06/26/2025	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		25446
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A4777	<p>In response to 19 CSR 30-86.047(36) Proper Care Per Individual Service Plan</p> <p><u>Immediate Action:</u></p> <p>Regional Nurse Consultant will be provided training on or before 8/01/25 to Memory Care and Director of Nurses, Administrator on the following:</p> <ol style="list-style-type: none"> 1.) Incident & Accident Reporting Guidelines <ol style="list-style-type: none"> a. Completing Incident Report b. Types of Incident including Injury of unknown Origin c. Notification to responsible party & Physician d. Updating ISP to include interventions to decrease future risk e. Review and or update of Fall Risk Evaluation f. Follow up assessments and documentation 2.) Change of Condition Guidelines <ol style="list-style-type: none"> a. What constitutes a change in condition b. Notification to responsible party & Physician c. Completing Community Based Assessment with Change of Condition d. Updating ISP to include interventions to decrease future risk/decline e. Review and or update to Risk evaluations f. Follow up assessments and documentation <p>Director of Nursing will provide staff education in-servicing on or before 8/01/2025 on the following items:</p> <ol style="list-style-type: none"> 1.) Incident & Accident Reporting Guidelines 2.) Entering all Incident Reports in Point Click Care 3.) Documentation on incident in resident progress notes 4) Initial Service Plan & Plan of Care/ISP policy and procedure 5.) Fall Follow Up Protocol 6.) Fall Follow Up-Checkoff Sheet 7.) Change of Condition policy and procedure 	08/01/2025

	<p>All resident Monthly Summaries reviewed and updated to reflect resident status and needs, Community Based assessment completed on any resident with identified change in condition.</p> <p>All resident ISP reviewed and updated to reflect needs and services required including appropriate interventions to decrease the risk of falls.</p> <p>All residents Fall Risk evaluations reviewed and updated if indicated to reflect residents' risk for falls.</p> <p><u>Ongoing Compliance:</u></p> <p>Director of Nursing will ensure ongoing compliance through reviewing 24-hour communication log during or prior to morning meeting and providing follow up on any and all incidents, accidents and or change in condition. Follow up will include but is not limited to:</p> <ol style="list-style-type: none"> 1. Physical Assessment of resident is completed when indicated 2. Assuring that all documentation, evaluations, assessments incident report and progress notes are complete 3. Assuring physician was/is notified 4. Notification to responsible party and or legal representative & Physician 5. ISP is updated with appropriate interventions to decrease future risks or decline 6. Review of Community Based Assessment and updated if resident has experienced a change in condition 7. Capturing all incident accidents and or change of condition in Monthly Summary <p><u>Completion Date:</u> 08/01/2025</p>	
A4778	<p>In response to 19 CSR 30-86.047(37) Appropriate Action</p> <p><u>Immediate Action:</u></p> <p>Regional Nurse Consultant will be provided training on or before 8/01/25 to Memory Care and Director of Nurses, Administrator on the following:</p> <ol style="list-style-type: none"> 1.) Incident & Accident Reporting Guidelines <ol style="list-style-type: none"> a. Completing Incident Report b. Types of Incident including Injury of unknown Origin c. Notification to responsible party and or legal representative & Physician d. Updating ISP to include interventions to decrease future risk e. Review and or update of Fall Risk Evaluation f. Follow up assessments and documentation 2.) Change of Condition Guidelines <ol style="list-style-type: none"> a. What constitutes a change in condition 	08/01/2025

