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	25446	A. BUILDING: _____ B. WING _____	C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GLENN ASSISTED LIVING	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
A4775	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident's estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to follow the facility's policy and procedures for two residents (Resident #3 and #4), who experienced falls, in a review of five sampled residents. Staff failed to update Resident #3's Individualized Service Plan (ISP) to identify the resident's fall risk, failed to document risk factors that may have attributed to falls, failed to develop safeguards needed to prevent falls, and failed to effectively communicate information regarding the resident's falls to staff. Staff failed to document when Resident #4 fell and failed to updated the resident's ISP with safeguards to prevent falls after the resident fell. The facility census was 36. Review of the facility policy, Fall Follow up Protocol, dated 6/9/19, showed the following: -Unwitnessed fall; -If bleeding profusely or there was a loss of consciousness, call 911 immediately. Obtain a copy of the transfer packet to send with the resident. Notify the nurse on call, responsible party and physician; -If not transferred out, take the resident's vital signs. Ask the resident if they were experiencing pain or discomfort anywhere, if the resident denies pain, ask them if they can move their arms	A4775		

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and legs on their own, notify the on call staff for further instructions before moving the resident;
-If the resident is unable to accomplish the above and they are not transferred out, check the resident for bumps, bruises, cuts, abrasions, limb misalignment, confusion, and/or change in the level of consciousness, take vital signs and notify on the on call staff;
-Complete the incident report in the electronic record;
-Communicate information to the next shift via communication book and verbally;
-Review falls in the daily stand-up meeting.

Review of the facility policy, Fall Risk Evaluation, dated 6/19/26 showed the following:
-A tool used to evaluate the resident on a regularly scheduled basis to determine risk factors which may be attributed to falls;
-The fall risk evaluation should be completed on move in and every six months or with a significant change in condition. The cumulative score is used as a tool for monitoring the resident's safety factors and to determine what additional safe guards need to be put in place. Appropriate care plan goals and interventions should be in the ISP/care plan to identify and assist staff, residents, and family to find cause and help manage the risks related to falls.

1. Review of Resident #3's undated face sheet showed the resident was admitted on 4/17/26.

Review of the resident's Individualized Service Plan (ISP), dated 4/17/26, showed the following:
-Mobility devices: wheelchair and walker;
-The resident did not have a history of falls. The section for fall interventions was blank;
-Alert, oriented with short-term memory loss;
-Staff to check the resident every two hours.

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A4775	Continued From page 2 Review of the resident's fall risk evaluation, dated 4/23/26, showed the following: -The resident was at high risk for falls; -The resident had one to two falls within the last six months and was currently on physical therapy; -Toileting schedule while awake and remind to use assistive devices; -Independent and incontinent. Encourage to call for help with toileting. (Review showed no documentation staff updated the resident's ISP to address the resident's fall risk and interventions to prevent falls after staff identified the resident was at high risk for falls on 4/23/26.) Review of the resident's Community Based Assessment, dated 4/23/26, showed the following: -Well oriented, no confusion, memory/recall and judgement, some memory lapse; -The resident was able to express information and able to understand others; -Ambulatory, able to get around independently, able to transfer to and from bed, transfer to and from the chair, and transfer to and from wheelchair independently; -Assistive devices used were a walker and wheelchair. Review of the resident's progress note, dated 4/23/26 at 4:56 P.M., showed the following: -The resident was found on the floor of the closet with a brief around his/her ankles and nothing else on. The resident was experiencing loose stools that morning and was attempting to get up without asking for assistance; -The resident had loose stools for several days and was weak. The resident said, "I was just trying to get dressed,. My legs are so weak."	A4775		

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A4775	Continued From page 3 Pendent provided for resident to use for calling staff. Review of the resident's ISP showed no documentation staff updated the plan to address the resident was at risk for falls and fell on 4/23/26 and did not include any safeguards/interventions needed to prevent falls. Review of the resident's progress note, dated 5/21/26 at 4:45 P.M., showed the following: -Staff was pushing the cleaning cart when staff heard the resident calling for help. Staff walked to the door and observed the resident in front of the chair with his/her feet under the over-the-bed table. When asked what happened, the resident said he/she slid off the chair; the foot rest was out a little bit; -Called the Director of Nursing (DON) and completed range of motion with no complaints of pain, vitals obtained, and the resident was assisted back to his/her chair. Texted the resident's family member and the nurse practitioner (NP). Review of the resident's ISP showed no documentation staff updated the plan to address the resident was at risk for falls and fell on 4/23/26 and did not include any safeguards/interventions needed to prevent falls. Review of the resident's progress note, dated 5/25/26 at 7:27 A.M., showed the following: -Staff went to give the resident's his/her early morning medications and complete last round of every two hour check. Staff found the resident in the floor sideways. The resident's head was laying over the bottom metal bar of the resident's bedside table on wheels. It appeared this resident rolled out of bed from how the sheets, blankets	A4775		

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and pads were still half on the bed and wrapped around the resident;
-Staff questioned the resident on what had happened. The resident said he/she did not know. No redness or bruising was noted. Staff asked the resident if he/she was hurt anywhere and to try to bend or lift his/her legs. The resident tried but yelled out in pain. The level I medication aide (LIMA) found another co-worker to help and called the Director of Nursing (DON). The DON said to call an ambulance.

Review of the Emergency Medical Services (EMS) patient care report, dated 5/25/26 at 7:39 A.M., showed the following:
-On arrival, the resident was found with chief concerns of a fall. A staff member said the resident was found on the floor. When asked how long the resident had been on the floor, staff said the night nurse said he/she checked on him/her two hours ago. When the night nurse was asked how long the resident had been on the floor, the night nurse asked what the day nurse had told EMS;
-The resident said he/she was on the floor for a few hours and fell out of bed when getting out of bed in the middle of the night. The resident said he/she hit his/her head and had pain in both hips but had more pain in his/her left hip;
-The resident requested to go to the hospital. No further information was received from staff;
-Hospital diagnoses showed pain in unspecified hip and sepsis (extreme, life-threatening response to an infection).

During an interview on 5/27/26 at 8:50 A.M. Patient Care Aide (PCA) D said the following:
-He/She had worked with the resident routinely since the resident was admitted;
-On 5/25/26, the resident fell and was sent to the

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A4775	Continued From page 5 hospital. He/She was unaware the resident had any previous falls. During an interview on 5/27/26 at 9:00 A.M., PCA E said the following: -He/She worked routinely with the resident; -He/She worked the day shift on 5/25/26 when the resident fell. The night shift had already called EMS before he/she arrived. He/She helped another staff member get the resident up off the floor; -He/She heard the resident might have fallen previously, but was not sure. He/She was not aware of any interventions in place for falls. The resident required assistance of one to two staff members with transfers. During an interview on 5/26/26 at 10:40 A.M., Head Certified Medication Aide (CMA) said the following: -On 5/25/26 at 10:40 A.M., he/she worked on the day shift, and his/her shift started at 7:00 A.M. -The resident fell in his/her room. The resident had pain in his/her legs. The resident had not been at the facility very long, but this was the resident's fourth fall in two weeks. During an interview on 5/26/26 at 10:25 A.M., the Life Enrichment Coordinator said the resident was admitted to the facility about a month ago. He/She was not aware of any falls prior to the resident's fall 5/25/26. During an interview on 5/26/26 at 5:20 P.M. and 5/27/26 at 1:10 P.M., the Health and Wellness Director/Director of Nursing said the following: -The resident fell more than a couple of times; -The ISP should be updated after each fall. She had not updated the resident's ISP with any new fall interventions.	A4775		

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A4775	Continued From page 6 2. Review of Resident #4's undated face sheet showed the following: -Admission date was 12/10/25; -Diagnoses included Alzheimer's disease and dementia. Review of the resident's Community Based Assessment, dated 12/10/25, showed the following: -The resident was ambulatory, and the resident was independent with transfers; -The resident had confusion and some memory lapse with memory and recall, judgement and following instructions; -Assistive devices used showed walker, cane, or crutch; -The resident was able to express information and was able to understand others; -Current or recent problems/risk showed the resident was hard of hearing. (Falls were not checked as a problem); -The resident had memory loss and dementia. Review of the resident's Fall Risk Evaluation, dated 01/02/26, showed the following: -The resident was at low risk for falls; -History of one to two falls in the last six months; -Cognitive impairment; mental status varies over the course of the day; -Impairment: dementia; -Mobility: ambulates with steady gait and no appliance. Review of the resident's Individualized Service Plan (ISP), dated 3/25/36, showed the following: -The resident used a walker; -The resident was not at risk for falls; -The fall risk assessment score was blank.	A4775		

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Review of the resident's monthly summary, dated 4/29/26, showed the following:
-No change in functional status. The resident could complete activities of daily living with reminders and cues;
-No assistive device;
-The resident was alert to person and recognized family. The resident was able to make his/her needs known verbally and was easy to understand;
-No falls since the last review.

Review of the resident's Medication Administration Record (MAR), dated 5/12/26 and 5/13/26, showed staff documented medications were not administered. The resident was hospitalized.

Review of the resident's Hospital After Visit Summary, dated 5/12/26 through 5/19/26, showed the following:
-Fall prevention discharge care;
-Hyperkalemia (high potassium level in the blood).
(Review of the resident's medical record showed no documentation regarding a fall prior to the resident's hospitalization.)

Review of the resident's progress note, dated 5/19/26 at 3:06 P.M., showed the resident returned from the hospital via wheelchair van transport. Alert and oriented to person and ambulating with a walker. Hospice nurse here to complete Hospice admission.

Review of the resident's ISP, updated on 5/19/26, showed the following:
-The resident started hospice services;
-The resident was not at risk for falls;
-The ISP showed no updated fall interventions

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A4775	Continued From page 8 following the fall and resulting hospitalization on 5/11/26. Review of the resident's assessments showed no evidence staff completed an event report regarding a fall on 5/11/26. During an interview on 5/26/26 at 12:55 P.M., LIMA G said the resident fell recently and was hospitalized. He/She was not at the facility when the resident fell. The resident was on hospice care after he/she returned from the hospital. During an interview on 5/26/26 at 5:20 P.M. and 5/27/26 at 1:10 P.M., the Health and Wellness Director/Director of Nursing (DON) said the following: -She expected staff to follow the fall policy protocol after each fall; -She was not responsible for updating the ISP following a fall with any new interventions on the memory care unit where Resident #4 resided; -Resident #4 had a fall a couple weeks ago and was now on hospice; -Staff were notified of a resident's fall through shift-to-shift report, usually a verbal notification; -Staff should update the ISP after each fall. She had not updated the resident's ISP with any new fall interventions. During an interview on 5/27/26 at 1:05 P.M. and by email correspondence on 6/4/26 at 8:37 A.M., the Administrator said the following: -Staff should notify administration of any falls, complete an incident report, and notify the family and the physician of the fall; -The only documentation regarding falls would be in the progress notes; -Staff should follow the fall policy protocol, determine the root cause of the fall, determine	A4775		

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A4775	Continued From page 9 what needs may need to be addressed, and tailor the interventions to each resident; -Staff should communicate recent falls and any new interventions through report or the communication book. MO262538 MO262285	A4775		

PLAN OF CORRECTION

Provider/ Supplier Name:	Chestnut Glen Assisted Living
Street Address, City, Zip:	121 Klondike Crossing St. Peters, MO 63376
Date of Survey:	5/27/2026

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	25446

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4775	In response to 19 CSR 30-86.047(35) Protective Oversight **Immediate Action:** Administrator will provide education in-servicing to Health & Wellness Director on or before 07/22/2026 on the following items: • Fall Follow Up Policy & Procedure • Updating ISP to include interventions to decrease future risk, developing safeguards for fall prevention • Fall Risk Evaluation Policy • Utilization of 24-hour Communication Book to include recent falls and any new interventions Health & Wellness Director will provide staff education in-servicing on or before 7/22/2026 on the following items: • ISP policy and procedure • Fall Follow Up Protocol • Utilization of 24-hour Communication Book Resident #3 is no longer a resident of the community. Resident #4 Fall Risk Assessment completed, ISP updated to include interventions and safeguards for fall prevention by Administrator. All resident ISPs reviewed and updated by Administrator and Health & Wellness Director to reflect needs and services required including appropriate interventions to decrease future risk, developing safeguards for fall prevention. All residents Fall Risk evaluations reviewed and updated by Administrator and Health & Wellness Director if indicated to reflect residents' risk for falls. **Ongoing Compliance:**	07/22/2026

	Health and Wellness Director or designee in absence of will ensure ongoing compliance through reviewing the 24-hour communication log during or prior to morning meeting and providing follow up on any incidents, accidents, or change in condition. Follow up will include completion of documentation, risk evaluations, post fall follow up if indicated, ISP updated with interventions to decrease future risk, developing safeguards for fall prevention. **Completion Date: 07/22/2026+**	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.