STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident's needs and preferences were accommodated when staff rearranged two resident's rooms which prevented one resident access to some of his/her personal belongings (Resident #64) and hindered one resident from freely maneuvering his/her wheelchair in between his/her side of the bed and the other bed in the room (Resident #46). In addition, after removing all side rails in the facility, the facility failed to provide alternative options for four residents who requested the use of siderails for mobility and repositioning (Residents #13, #46, #12 and #14). The sample was 18. The census was 73. Review of the facility's Resident Rights policy, dated 9/19/24, showed: -Procedure: staff competencies in resident rights information will include the following: -Plan and provide individualized care and services as the resident prefers; -Follow resident preferences in care decisions and choices; -Right to self-determination: -Reasonable accommodation of needs and preferences; -Personal and cultural preferences.	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtney West — TITLE: Executive Director — (X6) DATE: 03/03/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 1	F 558		

Review of the facility's Adaptative/Assistive Device and Potential Restraints Policy, revised 11/30/24, showed:
-Policy statement: to ensure that physical restraints and adaptive/assistive devices will be used only when it has been determined through an evaluation process that it is necessary to treat a resident's medical condition or as a therapeutic intervention to enhance the resident's functional abilities to promote the resident's highest level of wellbeing and after evaluation of risks;
-Procedure:
- Other adaptive/assistive devices such as Geri-chairs (large padded chair), Broda chairs (tilt chair), siderails and assist bars, low air loss mattresses (air mattress), lap buddys (device used to support upper body), canoe/scoop mattresses (mattress with raised edges or contoured sides), alarms and other devices and/or combination of devices that are not assessed as a restraint will be evaluated for necessity and risk prior to being placed, quarterly, upon significant change of condition, and when a mattress is changed;
-Siderail(s) and assist bars will be evaluated in combination with the mattress prior to placement of a mattress or siderail(s) upon admission, quarterly, upon significant change of condition, and each time the mattress is changed;
-Consent will be obtained from the resident (where appropriate) or responsible family member/legal guardian/Durable Power of Attorney (DPOA) for adaptive devices such as Geri-chairs, broad chairs, siderails and assist bars, low air loss mattresses, lap buddy, canoe/scoop mattresses, alarms and other devices and/or combination of devices placed near, next to, or in contact with the resident's body prior to placement if the device assesses to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 2	F 558		

be a restraint. Phone consent/verbal consent will suffice until written consent can be obtained provided that the evaluation is read to the consenting party. A copy of the evaluation will be presented with the consent for signature as soon as practicable.

1. During a group interview on 2/5/25 at approximately 10:30 A.M., six residents, whom the facility identified as alert and oriented, attended the meeting. Residents #46, #12, #64 and #14 were among the residents who voiced concerns during the meeting. Residents #46 and #64 said they wanted their beds to be placed against the wall. Resident #64 said he/she could not reach his/her things from the nightstand which was placed in the far corner of the room because his/her wheelchair could not go around the bed. He/She said the bed used to be placed against the wall and the nightstand was on the other side of bed, but staff had rearranged the furniture. He/She had informed the staff, but nobody fixed the issue. Resident #46 said he/she was in the same situation and was told staff had to move the bed away from the wall with at least a three foot gap due to "state regulations". He/She said the siderails were also removed for the same reason. He/She said having the bed against the wall and siderails helped him/her with repositioning and made him/her feel safer. The bed against the wall, also provided extra space in between the two residents. Especially when moving around with a wide wheelchair when the roommate used a stand lift. The roommate (Resident #12) agreed with Resident #46 and added that he/she also preferred to have siderails on his/her bed to assist with repositioning. Resident #14 said he/she needed the siderails for repositioning as well. Both residents said the siderails helped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 3	F 558		

them turn side to side instead of being fully dependent to the staff. They felt safer having the siderails in place. They said staff removed their siderails due to regulations. All four residents said the facility did not provide any siderail and bed positioning assessments.

2. Review of Resident #64's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/2/25, showed:
-Cognitively intact;
-No behaviors;
-No impairment in functional range of motion (ROM);
-Used a manual wheelchair/scooter;
-Once seated in wheelchair/scooter, the ability to wheel at least 50 feet make two turns: Independent;
-Diagnoses included: heart failure, anxiety disorder, depression, and chronic lung disease.

Review of the care plan, in use at the time of survey, showed:
-Need: The resident has an Activities of Daily Living (ADL) self-care performance deficit;
-Goal: Resident will show an improvement in ADL performance;
-Interventions included: transfer: the resident required moderate assistance by one staff to move between surfaces;
-Need: The resident had limited physical mobility;
-Goal: The resident will demonstrate the appropriate use of wheelchair to increase mobility;
-Interventions: locomotion: the resident can self-propel in wheelchair for locomotion.

Observation and interview on 2/3/25 at 6:59 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 4	F 558		

showed the resident sat in his/her wheelchair in his/her room. On the right side of the bed, there was a nightstand against the wall. A two foot isle was between the wall and the bed. There was approximately 12 inches from the head of the bed to the wall. On the left side of the bed, there was a three drawer container with a telephone on top of it. Approximately six inches from the container was a recliner chair in the corner. The resident said he/she could not reach the items on his/her nightstand. "State" came in and told the facility they had to have 20 inches between the bed and the wall. The facility moved his/her bed away from wall, and now he/she could not reach his/her items.

Observation and interview on 2/7/25 at 10:05 A.M., showed the resident in his/her wheelchair, in his/her room. The resident tried to propel from the foot of the bed and turn to go down the aisle between the bed and the wall where the nightstand was. The resident's wheelchair got caught on the foot of the bed and he/she was unable to make the turn. The resident said he/she preferred the bed against the wall and the nightstand on the other side of the bed, so he/she could reach his/her items and the telephone. The way the room was arranged now, when the phone rang, whomever called had hung up by the time he/she could get to the telephone. The resident said he/she had talked to staff about this, and they had a care plan meeting, but he/she was told they could not grant his/her request.

During an interview on 2/7/25 at 10:05 A.M., Certified Nurse Aide (CNA) O said today was the first time he/she was made aware of the situation with the room arrangement. It had been some time since he/she worked with the resident, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 5	F 558		

the last time he/she worked with the resident, the nightstand was on the other side of the room.

During an interview on 2/7/25 at 11:46 A.M., Physical Therapist (PT) L said therapy could do an evaluation for residents who had concerns with reaching items in their rooms. Therapy could assess the resident's mobility and the way the rooms were set up to ensure residents were able to move around safely. The resident was seen by PT and Occupational Therapy (OT) for several months. Documentation on 1/17/25, showed the resident required contact guard to minimum assist for bed mobility and minimum assistance with wheelchair mobility.

During an interview on 2/7/25 at 1:15 P.M., Licensed Practical Nurse (LPN) K said residents should be able to decide how their rooms were arranged. The beds must be three feet from the wall. LPN K was not aware the resident could not reach items in his/her room.

During an interview on 2/7/25 at 2:55 P.M. CNA E said, the resident had voiced concerns about his/her bed not being against the wall. CNA E reported the resident's concerns to the nurse.

During an interview on 2/7/25 at 5:06 P.M., the Administrator said she was not aware the resident could not reach items in his/her room. She would check on the resident to make sure he/she was able to reach his/her nightstand and telephone. They had to move the resident's bed to comply to the regulation.

3. Review of Resident #46's quarterly MDS, dated 8/22/24, showed:
-Cognitively intact;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 6	F 558		

-Used wheelchair as mobility device;
-Independent with mobility and self-care, and supervision with shower or bath;
-Occasional urinary incontinence;
-Diagnoses included cancer, heart disease, high blood pressure, and high cholesterol.

Review of the resident's care plan, in use at the time of survey, showed:
-Need: The resident has an ADL self-care performance deficit;
-Goal: Resident will maintain current level in ADL performance;
-Interventions/Tasks: Bed Mobility, the resident is independent for repositioning and turning in bed, chooses to keep his/her bed next to the wall;
-Need: The resident has limited physical mobility;
-Goal: The resident will maintain current level of mobility, such as able to propel self;
-Interventions/Tasks: The resident is independent to walk, usually will only walk short distances in room, related to pain in left hip. The resident used a wheeled walker for walking. The resident is independent of locomotion. Used a wheelchair for long distances, may ask for assistance when tired.

Observation and interview on 2/7/25 at 9:55 A.M., showed the resident's bed was positioned approximately two feet from the wall. There were boxes of personal belongings in between the bed and wall. There were no siderails observed attached to the bed. The resident said he/she used to have U-shaped rails that he/she could grab onto when he/she turned/repositioned. Now, he/she reaches down under the side of bed to reposition. He/She preferred to have the bed against the wall because he/she relied on the wall for repositioning independently and his/her wide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 7	F 558		

wheelchair made it difficult to get in and out with the tighter space in between the two residents' beds. He/She was very upset when the facility moved the bed and removed the siderails. The resident said there was no proper education or explanation of the reasons why these changes were made. The resident was informed today, that therapy will do an evaluation for bed mobility and safety next week.

During an interview on 2/7/25 at 11:46 A.M., Physical Therapist (PT) L said the facility entered a physician order for an OT evaluation for bed safety and bed positioning, which would be completed on 2/10/25. The resident had no previous therapy records.

During an interview on 2/7/25 at 1:15 P.M., LPN K said the resident never had siderails but he/she wanted siderails. The resident talked to the old DON about how this would benefit his/her mobility, but the corporation said no.

4. Review of Resident #13's quarterly MDS, dated 9/19/24, showed:
-Cognitively intact;
-No behaviors;
-No rejection of care;
-No functional limitation in ROM;
-Roll left to right: partial/moderate assistance (helper does less than half the effort);
-Diagnoses included: high blood pressure, diabetes, depression, chronic lung disease;
-Moisture Associated Skin Damage (MASD, skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat or wound drainage).

Review of the care plan, in use at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 8	F 558		

survey, showed:
-Need: impaired physical mobility;
-Goal: resident will be able to perform activity within physical limits:
-Interventions: encourage use of prescribed assistive devices; had tried trapeze on his/her bed to aid in bed mobility but decided to have it removed; monitor for environmental barriers to mobility; needs staff assistance to turn and reposition in bed. Use pillows and wedges to aid in positioning; occupational therapy to treat to assist with bed mobility;
-Need: the resident has an ADL self-care performance deficit;
-Goal: resident will maintain current level in ADL performance;
-Interventions included: bed mobility: the resident is able to turn in bed with maximum assistance; resident to be turned side to side while in bed;
-Need: Is at risk for MASD and yeast infection related to moisture to mid back, skin folds and groin 1/29/25- mid back to mid-thigh MASD resolved, still has MASD to groin, abdominal folds and under breasts;
-Goal: the resident will have intact skin, free of redness, blisters, or discoloration by/through review date;
-Intervention included: two staff assist for care when in the bed for incontinence care and turning and repositioning.

Review of the OT treatment encounter notes, dated completed on 11/11/24, showed: Summary of skill: patient continues to have right shoulder issues (chronic from old rotator cuff injury); patient continues to use bed rails for assist with positioning and for hygiene purposes.

Review of the annual MDS dated 12/20/24,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 9	F 558		

showed:
-Cognitively intact;
-No behaviors;
-No rejection of care;
-No functional limitation in Range of Motion (ROM) in upper extremities; impairment of lower extremities on both sides;
-Roll left to right: substantial/maximal assistance (helper does more than half the effort);
-MASD.

Observation and interview on 2/2/25 at approximately 11:30 A.M. and on 2/7/25 at 9:30 A.M., showed the resident lay in bed on an air loss mattress, with no siderails up. The resident said he/she had a U shaped siderails on his/her bed after "fighting" for them. He/She could not stand up but could pull himself/herself over with the rails. Also, he/she tended to lean to the right while sitting up and with the siderails up he/she was able to readjust himself/herself. A few weeks ago, the siderails were removed from the bed. He/She was told, once "state" came in, the facility would put the siderails back on the bed. A couple of weeks ago the Director of Nursing (DON) and the Nurse Practitioner (NP) came in and told the resident not to ask for the siderails anymore. The corporation had decided this building would not use siderails because they were a restraint, and it would not matter if he/she had a doctor's order.

During an interview on 2/7/25 at 11:46 A.M., PT L said the resident was evaluated upon admission and was noted to be appropriate for an air mattress and bedrails.

During an interview on 2/7/25 at 1:15 P.M., LPN K said, the facility used to use U shaped siderails. They were removed from the residents' beds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 10	F 558		

sometime between September 1st and December 30th, 2024. He/She was not given a clear reason why the siderails were removed from the beds. The old DON fought to get the residents siderails. The siderails really helped the resident turn and reposition his/herself. Last week the new DON and NP went in to talk with the resident. Later the resident told LPN K the corporation said he/she could not have the siderails. The resident's bed mobility had declined since he/she did not have the siderails because he/she was unable turn and reposition himself/herself.

During an interview on 2/7/25 at 2:55 P.M. CNA E said the resident had siderails when he/she first came to the facility and he/she was able to reposition him/herself. After the siderails were removed, the resident was not able to do that anymore. This was not an improvement for him/her. No residents in the facility currently used siderails. Some residents used siderails in the past. He/She did not know why the siderails were removed from the beds.

5. Review of Resident #12's quarterly MDS, dated 12/20/24, showed:
-Cognitively intact;
-No hallucinations and delusions behaviors;
-Used wheelchair as mobility device;
-Impairment on one side of the upper extremities, and impairment on both sides of lower extremities;
-Frequent urinary incontinence, and occasional bowel incontinence;
-Diagnoses included anemia, heart failure, high blood pressure, kidney disease, high cholesterol, anxiety, asthma, and respiratory failure.

Review of the resident's care plan, in use at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 11	F 558		

time of survey, showed:
-Need: The resident has an ADL self-care performance deficit due to history of CVA (cardiovascular accident, or stroke), with left hemiplegia (weakness), impaired balance, difficulty using his/her hands, especially right hand;
-Goal: Resident will maintain current level in ADL performance;
-Interventions/Tasks: Bed Mobility, the resident required maximum assistance by one staff to turn and reposition in bed, requires maximum assistance by one staff to dress upper body, and dependent on staff for lower body.

During an interview on 2/7/25 at 10:21 A.M., the resident said his/her U-shaped siderails were removed a couple of weeks ago and he/she was unhappy about the facility's decision. He/She was informed the siderails had to be removed because there was no approval from the "state". The siderails helped him/her turn side to side during care and he/she felt more comfortable and safer with the siderails up. The facility did not provide the resident a siderail assessment.

During an interview on 2/7/25 at 11:46 A.M., PT L said the resident had been on the PT and OT caseload since 1/28/25, due to a decline in mobility. PT L said the documentation showed the resident required moderate assist for rolling side to side. There was no documentation showing the resident required bed adaptive equipment. However, the resident could potentially have bed adaptive equipment following an assessment.

During an interview on 2/7/25 at 1:15 P.M., LPN K said the resident used to have siderails and they were taken away. He/She did not know why the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 12	F 558		

siderails were removed.

6. Review of Resident #14's MDS, dated 11/26/24, showed:
-Cognitively intact;
-No behaviors;
-Mobility devices: wheelchair (manual or electrical);
-Roll left to right: independent;
-Chair/bed-to-chair transfer-the ability to transfer to and from a bed to chair (or wheelchair): Supervision or touching assistance (helper provides verbal cues or touching/steadying and/or contact guard assistance as resident completes activity);
-Diagnoses included: heart failure, high blood pressure, diabetes, dementia, anxiety, depression, and psychotic disease (a mental illness that causes a person to lose touch with reality).

Review of the care plan in use at the time of survey, showed:
-Need: has an ADL self-care performance deficit;
-Goal: Resident will show an improvement in ADL performance;
-Interventions included: bed mobility: the resident is needing touching assist/supervision to turn and reposition herself in bed; transfer: can self-transfer in/out of bed to her wheelchair.

During an interview on 2/03/25 at 7:49 A.M. the resident said about a year ago the facility took his/her siderails off the bed. He/She wished the siderails were back on because they helped him/her reposition while in bed and it gave him/her something to hang on to when he/she transferred in/out of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 558	Continued From page 13 During an interview on 2/7/25 at 2:55 P.M. CNA E said the resident used to have siderails. Since his/her siderails were removed the resident had not had a decline in his/her mobility. He/She just did better with the siderails. 7. During an interview on 2/7/25 at 11:46 A.M., PT L said the therapy department assessed residents who had mobility concerns including getting in and out of bed. Currently no residents required any adaptive bed equipment. Typically, if therapy recommended side rails for a resident therapy would work with the resident in therapy and simulate the bed with siderails to assess for safety. If the therapy department determined a resident needed adaptive equipment, therapy would bring it up to the Interdisciplinary Team (IDT), but it would depend on the facility's decisions. PT L did not know who was responsible for completing the siderail assessments. 8. During an interview on 2/7/25 at 5:06 P.M., the Administrator said the facility did not use siderails. The facility was in the process of evaluating the usage of siderails, and their policy and procedures. During this process, the facility has removed all siderails. While in the process of developing their new policy and procedures, the residents' care plans were updated to reflect their needs and provide appropriate care to assure residents' safety without the use of siderails. The Administrator expected the staff to follow the residents' updated care plan. She said the beds were moved to have three feet clearance according to state regulation.	F 558		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v)	F 569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 569	Continued From page 14	F 569		

§483.10(f)(10)(iv) Notice of certain balances.
The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and
(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

§483.10(f)(10)(v) Conveyance upon discharge, eviction, or death.
Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were followed up on for the final accounting within 30 days for a resident who expired. This affected one of five residents who expired and had money in their resident trust account (Residents #240). The census was 73.

Review of Resident #240's resident fund account, showed the following:
-Resident expired on 8/31/24;
-A balance of $481.39;
-TPL completed 9/15/24;
-As of 2/7/25, the resident's account remained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 569	Continued From page 15 open with a balance of $481.39. During an interview on 2/7/25 at 11:10 A.M., the Corporate Business Office Manager (BOM) said the resident expired on 8/31/24. The balance report was submitted on 9/15/24. The balance was $481.39. She was still awaiting a letter to close account. She would contact someone at the TPL unit today to see when they would send the letter to advise how much of the resident's funds needed to be submitted. Normally, if she hadn't heard from anyone in the TPL unit, within 30 days she would have followed up before now. She should have followed up before now. During an interview on 2/7/25 at 5:06 P.M., the Administrator said when a resident expired and had money left in their account, she expected for the BOM to complete a TPL form and submit it within 30 days. It was her expectation that follow up would be made on the TPL forms for the final accounting for expired residents to ensure that there would be a zero balance in the resident's account.	F 569		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 16 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a consistent and updated code status (a medical directive that specifies the type of resuscitation and medical interventions a resident wishes to receive in the event of a cardiac or respiratory arrest) in the residents' medical records for four out of 18 sampled residents (Residents #18, # 14, #17 and #62). The census was 73.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 17	F 578		

Review of the facility's Therapeutic Support Level/Resuscitation Plan Policy, dated revised 2/2010, showed:
-In order to facilitate timely intervention in those situations which require immediate action, and to support the resident's wishes related to health care directives, the resident or their legally appointed representative or healthcare agent, upon admission to the facility, will be asked to complete a therapeutic support level/resuscitation plan. The therapeutic support level (TSL)/resuscitation plan will assist the facility staff in obtaining physician orders supporting the resident's wishes related to the level of intervention to be initiated in the event of a life threatening emergency;
-In the event of a medical emergency, facility staff will provide care based on documented physician orders and supported by the resident's advanced directive and/or TSL/resuscitation plan. Care will be provided in accordance with the level of training of facility staff and following basic principles of first aid and under the direction of a licensed nurse;
-In the event of a cardiopulmonary arrest (sudden, unexpected loss of heart function, breathing, and consciousness), when vital signs (pulse and respiration) are not present, facility staff will provide care based on documented physician orders and supported by the resident's advanced directive and/or therapeutic support level/resuscitation plan. Cardiopulmonary resuscitation (CPR, a lifesaving technique useful in which someone's breathing or heartbeat has stopped) will be provided by licensed nursing staff. (Note: CPR will be provided only for residents with TSL 1 (Provide aggressive medical management, this includes all treatments to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 18	F 578		

reduce advancement of disease and/or death. Including Resuscitation/CPR));
-The resident's advanced directive and/or resident's TSL/ resuscitation plan will be reviewed annually;
-If a resident brings an "Outside the hospital Do Not Resuscitate" (DNR, instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating) form (OHDNR) to the facility, the resident's wishes will be honored and the information will be transferred, to the TSL/resuscitation plan which will be approved and signed by the resident and/or resident's designee and the physician.

1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/19/24, showed:
-Severe cognitive impairment;
-No hallucinations and delusions behaviors
-Diagnoses included anemia, heart failure, high blood pressure, multidrug-resistant organism (MDRO), pneumonia, diabetes, high cholesterol, Alzheimer's disease, stroke, hemiplegia or hemiparesis (weakness or paralysis on one side of the body), anxiety and depression.

Review of the resident's care plan, in use at the time of survey, showed:
Need: The resident is at the end stage of life and is utilizing hospice care services;
Goals: Resident will receive palliative care directed by hospice interdisciplinary team and provided by nursing facility and hospice staff through next review period;
Interventions/Tasks: Facility staff and hospice staff will coordinate care, supplies, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 19	F 578		

equipment to meet the resident's needs.

Review of the resident's electronic medical records (EMR) showed:
-Admitted on 11/1/24;
-A scanned DNR form, with hospital letterhead, signed by representative and physician on 11/1/24;
-A scanned TSL/Resuscitation Plan sheet, TSL 1 was checked (signed by representative and physician) on 11/8/24, and by the physician on 11/12/24.

Review of the resident's hospice binder showed an original purple OHDNR form signed by the resident and spouse on 11/18/24. The physician signed on 11/20/24.

During an interview on 2/6/25 at 3:25 P.M., Licensed Practical Nurse (LPN) M said residents' code statuses were found in the EMR, and in the nurse's report sheet. LPN M showed the current nurses' report sheet which contained daily columns for a full week. The first column of the sheets contained the resident's information which included their name, their physician and their code status.

Review of the Nurse's Report Sheet, showed the resident's code status as TSL 1 Full Code.

2. Review of Resident #14's MDS, dated 11/26/24, showed:
-Cognitively intact;
-Diagnoses included: heart failure, high blood pressure, diabetes, dementia, anxiety, depression, and psychotic disease (a mental illness that causes a person to lose touch with reality).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 20	F 578		

Review of the resident's care plan, in use at the time of survey, showed:
-Need: Resident had an advance directive;
-Goal: The resident's advance directive will be honored through next review date;
-Interventions/Tasks: Code status will be reviewed quarterly and as needed; has a signed full code TSL form; has a TSL 1 form.

Review of the resident's EMR, showed:
-An order summary report, with an order dated 2/2/25, for TSL 1;
-The Advanced Directive tab, showed the resident had a DNR, with an effective date of 8/22/23.

During an interview on 2/4/25 at 3:00 P.M., the Administrator said the resident wanted to remain a full code and a new TSL form was completed today. Residents' code status should be reviewed annually, after a year the code status expired. A new form should be completed each year.

3. Review of Resident #17's quarterly MDS, dated 1/8/25, showed:
-Admitted to the facility on 9/26/14;
-Re-admitted to the facility on 5/21/14;
-Severe cognitive impairment;
-Diagnoses included: heart disease, high blood pressure, high cholesterol, dementia, Alzheimer's disease, dementia, anemia, and psychotic disorder.

Review of the care plan, in use at the time of survey, showed:
-Need: Resident had an advance directive;
-Goal: Resident's advance directive will be honored;
-Interventions/Tasks: Code status will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 21	F 578		

reviewed quarterly and as needed. Resident is a TSL 3 (Provide non-aggressive individualized or comfort care. All care will be directed toward providing comfort measures only throughout the advancement of disease and/or dying process. No Resuscitation/No CPR). Resident had a signed DNR ordered.

Review of the TSL/resuscitate plan, showed, the form was last updated on 9/26/14.

4. Review of Resident #62's quarterly MDS, dated 12/18/24, showed:
-Severe cognitive impairment;
-Diagnoses included: high blood pressure, diabetes, dementia, anxiety, and depression.

Review of the care plan, in use at the time of survey, showed:
-Need: Resident had an advanced directive;
-Goal: Resident's advanced directive will be honored;
-Interventions/Tasks: Code status will be reviewed quarterly and as needed. Resident had a signed DNR ordered; A signed TSL 3.

Review of the TSL/resuscitate plan, showed, the form was last updated on 9/25/23.

5. During an interview on 2/6/25 at 4:43 P.M., the Director of Nursing (DON) said the residents' code status information should be obtained and should be part of the admission process. The nurses and the clinical support nurse were responsible for obtaining the code status information. During the resident's arrival or admission to the facility, the charge nurse should obtain the current code status information. If there was no documentation, the nurse should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 578	Continued From page 22 verify with the resident or responsible party then notify the physician to receive an order. Physician's orders should be documented in the EMR. The DON said all residents should have a code status order. The nurses had a reference shift report that they used daily or every shift. The charge nurses were responsible for updating the shift report sheets. The DON said Resident #18's code status will be updated to DNR immediately. 6. During an interview on 2/7/24 at 5:06 P.M., the Administrator said she expected the staff to obtain the residents' code statuses during admission. They are to be updated annually at the expiration date. If the resident or the responsible party requested a change in code status, a new form should be filled out and a physician's order should be obtained.	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 657	Continued From page 23	F 657		

and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to revise care plans to address a recent fall and hospice status for two of 18 sampled residents (Residents #26 and #56). The census was 73.

Review of the facility's Care Plan policy dated January 2011 and reviewed January 2023 showed:
-Policy: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, nutritional, emotional, spiritual, and psychological needs.
-Procedures:
-An interdisciplinary team, in coordination with the resident and his/her responsible party, develops and maintains a comprehensive care plan for each resident;
-The comprehensive care plan has been designed to:
-Incorporate identified problem's areas;
-Incorporate risk factors associated with identified problems;
-Build on the resident's strengths;
-Reflect treatment goals and objectives in measurable outcomes;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 657	Continued From page 24	F 657		

-Identify the professional services that are responsible for each element of care;
-Ensure that all relevant areas of the federal and state guidelines, outlined in the facility corporate compliance program manual, are upheld with respect to resident care;
-Prevent declines in the resident's functional status and/or functional levels; and;
-Enhance the optimal functioning of the resident by focusing on a rehabilitative program.

Review of the facility's Fall Risk Reduction policy, dated revised 11/2024, showed:
-Purpose: To identify residents at risk for falls and implement interventions to reduce risks;
-Actions steps following a fall: Update a new fall risk assessment, immediately update the care plan, and implement interventions to further reduce the risk of reoccurrence.

1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/10/25, showed:
-Moderately impaired cognition;
-Diagnoses included: cancer, heart failure, neurogenic bladder (the bladder does not empty properly due to a neurological condition), diabetes and paraplegia (impairment in motor or sensory function of the lower extremities).

Review of the progress notes dated 11/22/2024 at 7:24 AM, showed a fall was not witnessed. Fall occurred in the resident's room.

Review of the care plan in use at the time of survey, showed staff did not include the resident was at risk for falling and what interventions were put into place to prevent the resident from falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 657	Continued From page 25	F 657		

2. Review of Resident #56's significant change MDS, dated 2/5/25, showed the following:
-Admitted to the facility: 5/20/24;
-Moderate impaired cognition;
-Prognosis: Condition or chronic disease that may result in a life expectancy of less than 6 months: Yes;
-Special treatments and programs: Hospice care while a resident;
-Diagnoses included atrial fibrillation (A-Fib, irregular heart rhythm), heart failure, diabetes mellitus (DM, metabolic disease), hypertension (high blood pressure), hyperlipidemia (high cholesterol), dementia, depression, chronic obstruction pulmonary disease (COPD, lung disease), and respiratory disease.

Review of the resident's physician orders, showed an order dated 1/29/25, for hospice consult to evaluate and treat.

Review of the resident's care plan, used during the survey showed the care plan not revised to reflect his/her hospice diagnosis, goals, and/or interventions.

3. During an interview on 2/7/25 at 4:37 P.M., the MDS Coordinator said care plans should be updated when there had been a change in the resident's condition or after a resident fell. Care plans could be updated by the nurse or by the MDS Coordinator. The MDS Coordinator was made aware of changes in a resident's condition during the facility's clinical meetings. She expected for the care plans to be updated and accurate so the Certified Nurse Aide (CNA) could follow the care plan to know what care to provide to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 657	Continued From page 26 4. During an interview on 2/7/25 at 5:06 P.M., the Administrator said care plans should be updated as needed. If anything needed to be changed both the nurse and the MDS Coordinator could update them. If a resident fell, the care plan should be updated, as needed. She would expect for the care plan to be complete and accurate because they are individualized for each resident to show what care the resident needed.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure care was provided in accordance with professional standards of practice by not following the physician orders for daily and weekly weights for one resident (Resident #78), and not obtaining physician's order for hospice care for one resident (Resident #18). The sample was 18. The census was 73. Review of the facility's Physicians' Orders policy, dated 1/2011, showed: -Policy: All treatments and medications must be ordered by the resident's attending physician; -Procedure: All physicians' orders shall be recorded on the Physician's Order Form for each resident and must be signed or initialed by the attending/prescribing physician as per state and/or federal regulations and as outlined in the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 658	Continued From page 27	F 658		

facility's Management Services Corporate Compliance Manual;
-Physician orders include all medications, treatments, diets, restorative measures (long-term and short-term), special medical procedures required for the safety and well-being of the resident, limitation of activities, others as necessary and appropriate;
-The original physician orders must remain in the resident's chart at all times;
-Physicians' orders are rewritten every thirty days;
-Medications, diets, therapy, or any treatment may not be administered to the resident without a written order from the attending physician;
-The policy did not provide instructions for procedures in following the physicians' orders.

Review of the facility's undated Hospice Policy and Procedure, showed:
-Policy: The facility staff will provide and arrange for hospice services for all patients deemed eligible and interested in hospice services. When a resident has elected hospice services, the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers. The coordinated plan of care must identify the care and services which the nursing home and hospice will provide to be responsive to the unique needs of the resident. Nursing home and hospice are responsible for performing each of their perspective functions that have been agreed upon and will be included in the plan of care. Hospice retains overall professional management for directing the implementation of the plan of care related to the terminal illness and related conditions;
-Procedure: The facility staff will discuss the availability of hospice services for all residents deemed by his/her physician to have a condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 658	Continued From page 28	F 658		

where the resident is given a terminal diagnosis and who may meet hospice criteria, with patients and/or family. Social Services or designee will notify nursing of need for physician's order for hospice.

1. Review of Resident #78's medical record, showed:
-Admitted on 11/14/24;
-Expired on 11/24/24;
-Intact Cognition;
-Understood/Understand;
-Clear speech distinct intelligible words;
-Diagnoses included anemia (low levels of healthy red blood cells to carry oxygen throughout the body), malnutrition, hypertension (high blood pressure), heart disease and heart failure.

Review of the resident's Physician Order Sheet (POS), showed:
-Order dated 11/14/24, start date: 11/19/24, to take weights every day shift every Tuesday;
-Order dated 11/14/24, start date: 11/15/24, to take weights for three days; admission/weekly weights times three, then monthly.

Review of the resident's baseline care plan, undated, showed:
-Dietary Nutritional Status:
    -Resident's dietary goal:
        -Maintain weight;
        -Prevent weight loss.

Review of the resident's weight report, showed his/her weight of 204.5 pounds (lbs) on 11/14/24. No other weights were recorded.

During an interview on 2/7/25 at 5:06 P.M., the Administrator and Director of Nursing (DON) said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 658	Continued From page 29 they expected staff to follow the physician's order. 2. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/19/24, showed: -Re-admitted on 11/1/24; -Severe cognitive impairment; -Diagnoses included anemia, heart failure, high blood pressure, multidrug-resistant organism (MDRO), pneumonia, diabetes, high cholesterol, Alzheimer's disease, stroke, dementia, hemiplegia or hemiparesis (weakness or paralysis on one side of the body), anxiety and depression; -On hospice care. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident is at the end stage of life and is utilizing hospice care services; -Goal: Resident will receive palliative care directed by hospice interdisciplinary team and provided by nursing facility and hospice staff; -Interventions/Tasks: Facility staff and hospice staff will coordinate care, supplies, and equipment to meet the resident's needs. Review of the resident's medical records, showed no order for hospice care was documented. During an interview on 2/6/25 at 4:43 P.M., the DON said there should be a physician's order for hospice care.	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 758	Continued From page 30	F 758		

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 758	Continued From page 31	F 758		

indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to implement a 14-day stop date for the PRN (as needed) use of psychotropic medications or provide a rationale for the continued use of the medication for two residents (Residents #18 and #15). The facility census was 73.

Review of the facility's undated Psychotropic Medication Use policy, showed:
-Policy: Based upon each resident's comprehensive assessment, the facility will ensure that residents who have not used psychotropic drugs are not given them unless the medication is necessary to treat a specific condition that is diagnosed and documented in the clinical record. Residents will not receive psychotropic medications unless behavioral programming and/or environmental changes or other non-pharmacological interventions have failed to sufficiently address the resident's target behavioral goals;
-The facility will monitor psychotropic medications for proper dose, including duplicate therapy, duration, evidence of adequate monitoring for efficacy and adverse consequences and to prevent, identify and respond to adverse consequences. Residents who receive psychotropic medications will receive gradual dose reductions and behavioral interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 758	Continued From page 32	F 758		

unless clinically contraindicated with the intention to decrease or discontinue the use of the psychotropic medication whenever safe and possible;
-PRN orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN anti-psychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication. When selecting medications and non-pharmacological approaches, members of the interdisciplinary team and the resident and resident representative, if applicable, will participate in the care process to identify, assess, advocate for, monitor and communicate the resident's needs and changes of condition.

1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/19/24, showed:
-Re-admitted on 11/1/24;
-Severe cognitive impairment;
-No hallucinations and delusions behaviors;
-Diagnoses included Alzheimer's disease, stroke, anxiety and depression.

Review of the resident's care plan, in use at the time of survey, showed:
-Need: The resident uses antidepressant medication;
-Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy;
-Interventions/Tasks: Administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 758	Continued From page 33	F 758		

shift; monitor/document/report PRN adverse reactions to antidepressant therapy;
-The resident uses anti-anxiety medications;
-Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy;
-Interventions/Tasks: Administer anti-anxiety medications as ordered by physician, monitor and document side effects and effectiveness every shift; monitor/document/report PRN adverse reactions to anti-anxiety therapy.

Review of the resident's physician order, dated 11/13/24, showed an order of Lorazepam Intensol Oral Concentrate (medication used to treat anxiety) 2 milligrams per milliliter (mg/ml), give 0.25 ml by mouth every 4 hours as needed for pain. No stop date documented.

2. Review of Resident #15's quarterly MDS, dated 12/18/24, showed:
-Admitted on 6/11/24;
-Severe cognitive impairment;
-No hallucinations and delusions behaviors;
-Diagnoses included dementia and depression.

Review of the resident's care plan, in use at the time of survey, showed:
-Need: The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits;
-Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired;
-Interventions/Tasks: Invite the resident to scheduled activities; the resident needs assistance/escort to activity functions;
-No mentioned of resident using psychotropic medication.

Review of the resident's physician order, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 758	Continued From page 34 11/13/24, showed an order of Quetiapine Fumarate Tablet (an atypical antipsychotic used to treat schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and social interactions), bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and activity levels) and depression), give 25 mg by mouth at bedtime as needed for agitation. No stop date documented. 3. During an interview on 2/7/25 at 3:57 P.M., Licensed Practical Nurse (LPN) K said all PRN psychotropic medications required a consent signed by the resident or their responsible party. These medications should have an order for 14 days. The pharmacy reviewed and sent a recommendation to the physician to review and renew the order for another 14 days if needed or have an indefinite stop date ordered. 4. During an interview 2/7/25 at 5:06 P.M., the Administrator and the Director of Nursing (DON) said they expected all PRN psychotropic medications to have a 14-day stop date, and a new order should be obtained if needed.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 812	Continued From page 35	F 812		

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that kitchen equipment was kept clean during five of six days of observation. In addition, the facility failed to ensure expired thickened milk was discarded. This had the potential to affect all residents who consumed food from the facility kitchen. The census was 73.

Review of the kitchen's cleaning schedules, showed:
-November 2024's schedule:
-Steamer cleaned: 11/11/24;
-Stove (trays) cleaned: 11/3/24, 11/14/24 and 11/20/24;
-Flat grill cleaned: Not listed on cleaning schedule;
-Deep fryer cleaned: 11/6/24, 11/11/24 and 11/22/24;
-January 2025's schedule:
-Steamer cleaned: no days initialed;
-Stove (trays) cleaned: 1/9/25 and 1/22/25;
-Flat grill cleaned: Not listed on cleaning schedule;
-Deep fryer cleaned: 1/2/25 and 1/14/25;
-No cleaning schedule for December 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 812	Continued From page 36	F 812		

1. Observation on 2/2/25 at 9:35 A.M., 2/3/25 at 10:35 A.M., 2/4/25 at 12:09 P.M., 2/5/25 at approximately 3:00 P.M., and 2/7/25 at approximately 3:15 P.M., of the kitchen, showed the following:
-The stove: heavy caked-on stains along the front and sides of the of the stove;
-Steamer: Heavy caked-on stains along the front;
-Flat grill: heavy caked-on stains along the front and sides;

2. Observation on 2/2/25 at 9:35 A.M., 2/3/25 at 10:35 A.M., 2/4/25 at 12:09 P.M., 2/5/25 at approximately 3:00 P.M., of the the deep fryer inside the kitchen, showed:
-Heavy caked-on stains along the front and sides of the fryer;
-Old grease in the fryer.
-Heavy caked on grease and batter along the inside of the fryer.

3. Observation on 2/4/25 at 12:09 P.M., 2/5/25 at approximately 3:00 P.M. and on 2/7/25 at approximately 3:15 P.M., in the cooler inside the kitchen, showed a box that contained several cartons of 2% milk, expired on 2/2/25.

Observation on 2/4/25 at 12:09 P.M. and on 2/5/25 at approximately 3:00 P.M., in the cooler inside the kitchen showed an opened full box that contained cartons of 2% milk, expired on 2/3/25.

4. During an interview on 2/7/25 at approximately 3:15 P.M., with the Dietary Manager (DM) and the Kitchen Manager (KM), the DM said the expired milk should have been discarded. He expected for all items to be properly labeled, dated, stored and for any expired items to be discarded. The KM said everyone is responsible for properly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 812	Continued From page 37 labeling, dating, storing, and discarding expired food. The DM said the general cleaning is done daily. They have some items that are cleaned every Tuesday, then other items are cleaned the other Tuesday. This process is rotated. He has a staff person who is responsible for cleaning the hood.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 38	F 842		

operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure resident records were complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 39	F 842		

and accurately documented when staff failed to document one resident's treatments (Residents #26). In addition, the facility failed to have the certification of terminal illness for one resident (resident #56) who was receiving hospice services. The sample was 18. The census was 73.

Review of the facility's Administration Procedures for all Medications policy, dated May 2018, showed:
-After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the Medication Administration Record (MAR) or the Treatment Administration Record (TAR);
-If resident refuses medication, document refusal on MAR or TAR;
-Notification of physician/prescriber for persistent refusals.

1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/10/25, showed:
-Moderately impaired cognition;
-No behaviors;
-No rejection of care;
-Number of stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling): One;
-Number of stage four pressure ulcers that were present on admission: 0;
-Received pressure ulcer care: applications of ointments/medications other than to feet;
-Diagnoses included: cancer, heart failure, neurogenic bladder (the bladder does not empty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 40	F 842		

properly due to a neurological condition), diabetes and paraplegia (impairment in motor or sensory function of the lower extremities).

Review of the care plan in use at the time of survey, showed:
-Need: The resident has pressure ulcers, is at risk for impaired skin Integrity related to incontinence of stool and decreased mobility. Was admitted with a Deep Tissue Injury (DTI, damage to the soft tissue beneath the skin caused by pressure or shear forces) to his/her sacrum (triangular bone located above the coccyx (tailbone), is now a stage four. On 1/21/25, continues with stage four pressure injury to sacrum;
-Goal: The resident's pressure ulcer will show signs of healing and remain free from infection;
-Interventions included: resident was being seen by the wound team, see the TAR for treatment.

Review of the TAR, dated 12/5/24 through 12/31/24, showed:
-An order for coccyx: cleanse wound bed for mechanical debridement (physical force to remove dead or damaged tissue) and cleanse Peri-wound (area around the wound) with normal saline and gauze. Apply Santyl (sterile enzymatic debriding ointment) and gentamicin ointment (antibiotic) to the wound bed, and cover with superabsorber adhesive dressing. Change daily or as needed (PRN) based on saturation every day shift for wound management, start date: 12/11/2024;
-Documentation showed five out of 20 opportunities left blank;
-An order for: gentamicin sulfate ointment 0.1 %, apply to coccyx every day shift for unstageable tissue loss (UTD, wounds where the depth is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 41 obscured by tissue breakdown, such as slough, eschar, or necrosis.), start date: 12/11/2024; -Documentation showed five out of 20 opportunities were blank; -An order for: Santyl ointment 250 unit/gram (GM) apply to coccyx every day shift for wound care; -Documentation showed six out of 26 opportunities left blank. Review of the resident's progress notes dated 12/5/24 through 12/31/24 showed: -No documentation the resident refused his/her treatment, the treatment was placed on hold or the treatment should not have been completed per physician orders; -No documentation the physician was notified. Review of the TAR dated 1/1/25 through 1/31/25, showed: -An order for coccyx: cleanse wound bed for mechanical debridement and cleanse peri-wound with normal saline and gauze. Apply Santyl and gentamicin ointment to the wound bed, and cover with superabsorber adhesive dressing. Change daily shift OR PRN based on saturation every day shift for wound management. The order was discontinued on 1/8/25; -Documentation showed three out of eight opportunities left blank; -An order for coccyx: cleanse wound bed for mechanical debridement and cleanse peri-wound with normal saline and gauze. Apply Santyl, pack with aquacel (Wound drainage absorbent product) and cover surrounding area with aquacel, cover with sacral foam dressing. Change three times weekly or PRN based on saturation every day shift every three days for wound management, start date 1/9/25 and discontinue date 1/16/25;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 42 -Documentation showed: one out of three opportunities left blank; -An order for coccyx: cleanse wound bed for mechanical debridement and cleanse peri-wound with Dakin's 1/4 strength (antiseptic) and gauze. Apply Santyl, pack with calcium alginate (provides a moist environment for wound healing) and cover surrounding area with calcium alginate, cover with sacral foam dressing. Change daily or PRN based on saturation every day shift for wound management, start date 1/17/25; -Documentation showed: six out of 15 opportunities left blank; -An order for: gentamicin ointment 0.1 % apply to coccyx every day shift for UTD; -Documentation showed: 10 out of 31 opportunities left blank; -An order for Santyl Ointment 250 unit/GM, apply to coccyx every day shift for wound care; -Documentation showed 11 out of 31 opportunities left blank. Review of the progress notes dated 1/1/25 to 1/31/25, showed: there was no documentation showing the resident refused his/her treatment or the treatment was placed on hold, or the treatment should not be completed per physician orders and no documentation showing the physician was notified. Review of the TAR dated 2/1/25 through 2/5/25, showed: -An order for coccyx: cleanse wound bed for mechanical debridement and cleanse peri-wound with Dakin's 1/4 strength and gauze. Apply Santyl, pack with calcium alginate and cover surrounding area with calcium alginate, cover with sacral foam dressing. Change daily or PRN based on saturation every day shift for wound	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 43	F 842		

management;
-Documentation showed two out of five opportunities were blank;
-An order for: gentamicin ointment 0.1 % apply to coccyx topically every day shift for UTD;
-Documentation showed two out of five opportunities were blank;
-An order for: Santyl ointment 250 unit/GM apply to coccyx every day shift for wound care;
-Documentation showed two out of five opportunities were blank;

Review of the progress notes dated 2/1/25 through 2/5/25, showed:
-No documentation the resident refused his/her treatment, the treatment was placed on hold or the treatment should not have been completed per physician orders;
-No documentation the physician was notified.

During an interview on 2/7/25 at 1:15 P.M., Licensed Practical Nurse (LPN) K said the facility's clinical support nurse completed the treatments when she was in the building. When she was off or if she could not complete the treatment, the charge nurse on the floor would be responsible for completing the treatments. The treatment should be documented on the TAR after they were completed. If a treatment was not documented, it would be assumed it was not done. One possible consequence of a treatments not being completed as ordered would be the wound could decline.

During an interview on 2/7/24 at 5:06 P.M., the Administrator said she expected for staff to follow the physician orders and document after the treatment was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 842	Continued From page 44	F 842		

2. Review of Resident #56's significant change MDS, dated 2/5/25, showed the following:
-Admitted to the facility: 5/20/24;
-Moderate impaired cognition;
-Prognosis: Condition or chronic disease that may result in a life expectancy of less than 6 months: Yes;
-Special treatments and programs; Hospice care while a resident;
-Diagnoses included atrial fibrillation (A-Fib, irregular heart rhythm), heart failure, diabetes mellitus (DM, metabolic disease), hypertension (high blood pressure), hyperlipidemia (high cholesterol), dementia, depression, chronic obstruction pulmonary disease (COPD, lung disease), and respiratory disease.

Review of the resident's physician's order sheet dated 2/6/25 showed an order dated: 1/29/25, for hospice consult to evaluate and treat senile degeneration of the brain (dementia), congestive heart failure, and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues).

Review of the resident's medical record and hospice binder, showed no documentation of the resident's certification of terminal illness form.

During interviews on 2/5/25 at 5:28 P.M. and 2/7/25 at 5:07 P.M., the Administrator said the resident's certification of terminal illness form was not in the building at the time. The hospice provider was sending it over. The resident had just signed started hospice about a week ago on 1/30/25 or 1/31/25. She expected for the certification of terminal illness form to have been in the facility with the resident's medical records and/or hospice binder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 46	F 880		

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow acceptable infection control standards when staff failed to wear appropriate Personal Protective Equipment (PPE) for two residents (Resident #26 and #20) and failed to post signage for one resident (Resident #18) who required Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 47	F 880		

contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS). In addition, the facility failed to position the urinary catheter (a sterile tube inserted into the bladder to drain urine) release valve (tap-like feature on the bag that is manually open to allow urine to flow out) drain from touching the floor and failed to clean the release valve drain prior to placing it back in the drain holder (holds the tip of the release valve drain) for one resident (Resident #26). The sample was 18. The census was 73.

Review of the Enhanced Barrier Precautions Policy, dated 4/24, showed:
- Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions when other Transmission-Based precautions do not apply, when facility identifies any resident with: wounds or skin openings that require dressings;
-Any indwelling medical device, regardless of MDRO colonization status, for example: urinary catheter;
-Post clear signage on the door/wall outside resident room:
-Personal Protective Equipment is required for all staff providing high-contact resident care activities to include gown and gloves with:
- Providing hygiene;
-Changing linens;
-Changing briefs or assisting with toileting;
-Device care or use: urinary catheter.

Review of the facility's Catheter Care policy dated reviewed 2/2019, showed:
-Emptying drainage bag (collects urine):
-Wipe release valve on drain bag with alcohol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 48	F 880		

prep;
-Re-clasp release valve;
-Policy failed to show what staff should do if the release valve drain was touching the floor.

1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/10/25, showed:
-Moderately impaired cognition;
-Diagnoses included: Cancer, heart failure, neurogenic bladder (the bladder does not empty properly due to a neurological condition), diabetes and paraplegia (impairment in motor or sensory function of the lower extremities);
-Number of stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling): One;
-Indwelling catheter.

Review of the care plan in use at the time of survey, showed:
-Need: Risk for infection;
-Goal: Resident will show no signs/symptoms of infection;
-Interventions included: manage indwelling catheters to minimize risk of infection;
-Need: The resident has a urinary catheter, is on EBP;
-Goal: The resident will be/remain free from catheter-related trauma through review date;
-Interventions: Staff to follow EBP during catheter care and close personal care.

Observation on 2/4/25 at 6:00 P.M., there was an EBP sign posted on the resident's door. The resident was lying in bed. The catheter drainage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 49	F 880		

bag was attached to the bed frame and was draining to gravity. The release valve drain tube was clamped closed, but the tip of the drain was touching the floor. Certified Nurse Aide (CNA) O brought the resident's dinner tray into the room and sat it on the over the bed table. The resident asked the CNA to straighten his/her legs out. The CNA left the room to get help. CNA O returned with Certified Medication Technician (CMT) N. CMT N placed the drain tube into the drain holder without cleaning it. CNA O and CMT N repositioned the resident in bed by rolling him/her from side to side and pulling him/her up in bed. Neither staff member wore a gown. After the resident was repositioned, CMT N emptied 500 milliliters of yellow urine from the drainage bag without wearing a gown.

During an interview on 2/6/25 at 3:01 P.M., CNA S said if a piece of the catheter drain was on the floor, it would need to be sanitized. He/She would let the nurse know. The nurse would change it, but that piece of the catheter should never be on the floor.

During an interview on 2/6/25 at approximately 3:13 P.M., CMT T said if a piece of the catheter drain was on the floor, it would need to be sanitized. He/She would let the nurse know because that would be a hazard for infection. The nurse would change it, but that piece of the catheter should never be on the floor.

During an interview on 2/6/25 at 2:34 P.M., Registered Nurse (RN) P said if the catheter drain touched the floor staff should change the appliance.

During an interview on 2/6/25 at approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 50	F 880		

3:35 P.M., Licensed Practical Nurse (LPN) U said if there was a piece of the catheter on the floor, he/she would just change it because of contamination.

During an interview on 2/7/25 at 1:15 P.M. LPN K, said if a catheter drain touched the floor it would be considered contaminated and it would need to be changed because there would be a risk for infection.

During an interview on 2/7/25 at 5:06 P.M., the Director of Nursing (DON) said if the catheter drain touched the floor, staff should sanitize the drain before placing it in the drain holder. The DON did not know what staff should sanitize the drain with, but she would expect for staff to follow the facility's policy. Changing the appliance may be a good option if it was in the policy.

2. Review of Resident #20's admission MDS, dated 11/7/24, showed the following:
-Admitted to the facility: 10/9/24;
-Readmitted to the facility: 11/1/24
-Moderately impaired cognition;
-Section K- Nutrition Approach; tube feeding while a resident;
-Diagnoses included cancer, anemia, benign prostatic hyperplasia (enlarged prostate), diabetes, high blood pressure, dementia, depression, and malnutrition.

Review of the resident's care plan, used during the survey showed:
-Problem: The resident has a G-tube (tube feeding for nutrition), he/she had been getting intermittent feedings, now only flushing the G-tube to keep patent. He/She has a swallowing problem related to esophageal cancer. He/she is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 51	F 880		

on hospice;
-Goal: The resident's insertion site will be free of signs and symptoms (s/sx) of infection through the review date. He/She will maintain adequate nutrition and hydration status as evidenced by (aeb) weight stable, no s/sx of malnutrition or dehydration through review date.
-Interventions included: The resident needs total assist with tube feeding and water flushes. See physician orders for current orders. Check for tube placement and gastric contents/residual volume per facility protocol and record. Monitor/document/report as needed (PRN) any s/sx of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site. Provide local care to G-tube site as ordered and monitor for s/sx of infection. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders.

Review of the resident's physician's order sheet dated 2/6/25 showed:
-An order dated 11/1/24, for EBP during high contact care activities;
-An order dated 11/27/24, to cleanse G-tube site with wound cleanser, apply dressing daily and as needed, every day shift for G-tube care.

Observations of the resident's room on 2/5/25 showed:
-At 2:37 P.M., CNA Q came out of the resident's bathroom with the resident. CNA Q did not have on gloves or a gown. He/She asked the Surveyor if he/she needed Resident #20 and said the resident was in the bathroom, and then CNA Q exited out the room;
-At approximately 2:38 P.M., CNA Q returned to the resident's room. He/she opened the bathroom door. CMT R was in the bathroom with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 52	F 880		

the resident. CMT R did not have on gloves or a gown.
-At 2:40 P.M., the resident, CNA Q and CMT R came out the bathroom and exited out of the resident's room.

During an interview on 2/5/25 at 2:42 P.M., CNA Q and CMT R, both initially said the resident was not on EBP. Both CNA Q and CMT R then looked at the resident's door and noticed the EBP signage on the door to be hanging down via tape and flipped over onto the back side. They then said the resident was on EBP, and the sign was hanging down and turned over. CNA Q said the resident was probably on EBP because he/she was eating regular meals and had a feeding tube. CMT R said he/she wasn't aware the resident on EBP because the resident ate food. Both CNA Q and CMT R said PPE should be worn while providing care for a resident on EBP. Normally they would have had on the gear. CMT R said this was a mishap, and CNA Q agreed. CMT R said they usually knew if someone was on EBP because there would be signage on the door, and they would be made aware during report. CMT R heard the resident yelling for assistance to get out of the bed. He/She went in to help the resident and then the resident had to use the bathroom. Both CMT R and CNA Q said PPE should have been worn while they were assisting the resident in the bathroom. They should have worn a gown and gloves, and the mask was optional.

3. Review of Resident #18's admission MDS, dated 11/19/24, showed:
-Severe cognitive impairment;
- Indwelling catheter;
-Diagnoses included anemia, heart failure, high blood pressure, MDRO, pneumonia, diabetes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 53	F 880		

Alzheimer's disease, stroke, hemiplegia, or hemiparesis (weakness or paralysis on one side of the body), anxiety and depression.

Review of the resident's care plan, in use at the time of survey, showed:
Need: The resident has a suprapubic urinary catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine), on EBP;
Goal: The resident will show no signs and symptoms of urinary infection (UTI);
Interventions/Tasks: Staff to wear a gown and gloves during close personal care with resident. Monitor, record, or report to physician for signs and symptoms of UTI.

Observation on 2/2/25 at 11:41 A.M., showed PPE supplies , stored in a plastic storage drawers, placed in the hallway approximately 4 doors down from the nurses' station. No EBP door signage observed on any rooms in the hall. Resident #18 resided in the same hall.

Observation and interview on 2/3/25 at 7:24 A.M., showed an EBP sign on Resident #18's door, but no PPE supplies located near the door. The resident was not in the room. At 7:25 A.M., a female staff propelled the roommate from having breakfast to the room and said the PPE supplies were stored in the bottom shelf of the linen carts. The linen cart was about four doors down from the resident's room. Resident #18's roommate said he/she has been a resident for two years and had never seen that EBP sign. He/She said it was something really new and was not even up that morning prior to breakfast. He/She asked the Surveyor if there was something going on with the roommate and if he/she needed to be transferred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 54	F 880		

The roommate said no staff explained to him/her the purpose of the door signage.

4. During an interview on 2/6/25 at 3:01 P.M., CNA S said residents are placed on EBP due to wounds and if they had an infection going on. He/She would know which residents were on EBP by the signage on the door, and the nurse would tell them during their rounds. While working with a resident who was on EBP, staff should wear gloves, gowns, and masks. This applies to anyone who was providing care to the resident. There usually is a cart that sat outside the door of a resident on EBP, but they moved it, now the are supplies on the linen cart.

5. During an interview on 2/6/25 at approximately 3:13 P.M., CMT T said residents are placed on EBP due to wounds and an infections going on. He/She knew which residents were on EBP due to the signage on the door, and the nurse would tell them during their rounds. While working with a resident who was on EBP, staff should wear gloves, gowns, and masks. This applies to anyone who was providing care to the resident. There usually was a cart that sat outside the door of a resident who is on EBP, but they moved it, now there are supplies on the linen cart.

6. During an interview on 2/6/25 at 2:34 P.M., RN P said residents who require EBP, should have a sign on the door. The sign should show which resident required EBP. Medical records staff place the signs on the doors. Staff should wear gown and gloves while providing direct resident care such as personal care, toileting, turning and repositioning and while performing catheter care/emptying the drainage bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 880	Continued From page 55 7. During an interview on 2/6/25 at approximately 3:35 P.M., LPN U said he/she just normally knew which residents were on EBP. There was a list at the nurses' station. When residents are first placed on EBP, they let the staff know. LPN U thought it was the nurse supervisor who would let the staff know. When there is signage on the door, he/she was not sure if there was a way to tell which resident in the room was on EBP, but he/she would just go by what the requirements are. Residents who are placed on EBP normally would have a G-tube, catheter, wounds, or something like that. When providing care to a resident, the staff member should have on a gown, gloves, and a mask. That's it. It depends on if the staff person was providing care to the resident or not. If you're not doing care, the staff person just needs to wash their hands and put on gloves before attending to the resident. The PPE should be outside the resident's door. She didn't see any at this time, but usually it is outside the door in a plastic cart. 8. During an interview on 2/7/25 at 1:15 P.M., LPN K, said staff knew which residents require EBP because they get a verbal report at the beginning of each shift and there would be a sign on the resident's door. Staff should wear gown and gloves while proving high care activities. 9. During an interview on 2/7/25 at 5:06 P.M., the Administrator said staff knew which residents required EBP by the sign on their door. Staff should wear gown and gloves while providing direct resident care such as toileting, repositioning residents in bed, and emptying catheters.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 947	Continued From page 56 CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure they had a system in place to track the required Certified Nurse Aide (CNA) 12 hours annual education (in-services). The facility identified 12 CNAs who worked for the facility for at least one year. Six CNAs (CNA #B, #D, #E, #G, #H, and #I) and Four Certified Medication Technician (CMT)s (CMT #A, #C, #F and #J) were sampled. The facility failed to document the length of time the training was provided for all sampled staff . The census was 73. 1. Review of CNA B's employee file showed: -Date of hire: 10/17/22; -Three in-services were completed;	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 947	Continued From page 57	F 947		

-The in-services failed to show the length of time the training was provided.

2. Review of CNA D's employee file, showed:
-Date of hire: 10/10/22;
-10 in-services were completed;
-The in-services failed to show the length of time the training was provided.

3. Review of CNA E's employee file showed:
-Date of hire: 7/25/18;
-11 in-services were completed;
-The in-services failed to show the length of time the training was provided.

4. Review of CNA G's employee file showed:
-Date of hire: 4/15/2010;
-Eight in-services were completed;
-The in-services failed to show the length of time the training was provided.

5. Review of CNA H's employee file showed:
-Date of hire: 7/1/15;
-Nine in-services were completed;
- The in-services failed to show the length of time the training was provided.

6. Review of CNA I's employee file showed:
-Date of hire: 3/9/16;
-One in-service was completed;
-The in-services failed to show the length of time the training was provided.

7. Review of CMT A's employee file, showed:
-Date of hire: 5/18/11;
-12 in-services were completed;
-The in-services failed to show the length of time the training was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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) COMPLETION DATE
F 947	Continued From page 58 8. Review of CMT C's employee file showed: -Date of hire: 8/1/22; -13 in-services were completed; -The in-services failed to show the length of time the training was provided. 9. Review of CMT F's employee file showed: -Date of hire: 9/2/22; -16 in-services were completed; - The in-services failed to show the length of time the training was provided. 10. Review of CMT J's employee file showed: -Date of hire: 4/22/15; -20 in-services were completed; -The in-services failed to show the length of time the training was provided. During an interview on 2/4/25 at 2:35 P.M., the Administrator said the facility did not track the time for the in-services and they would not be able to tell if the CNAs or CMTs had received the required 12 hours of education or not. She would expect for staff to have the required education and for the hours to be tracked.	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06430	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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
A4054	19 CSR 30-85.042(45) Written Orders; Restraints No medication, treatment, or diet shall be given without a written order from a person lawfully authorized to prescribe such and the order shall be followed. No restraint shall be applied except as provided in 13 CSR 15-18.010, Resident Rights. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F658.	A4054		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F880.	A4086		
A4116	19 CSR 30-85.042(102) Clinical Records Accurate/Accessible The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately	A4116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06430	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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
A4116	Continued From page 1 documented, readily accessible on each nursing unit, and systematically organized. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F842.	A4116		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III See the deficeincy cited at F812.	A7015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06430	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning Surfaces of equipment not intended for contact with food, but which are exposed to splash or food debris or which otherwise require frequent cleaning, shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections or crevices, and readily accessible for cleaning, and shall be of such material and in a repair as to be easily maintained in a clean and sanitary condition. III This regulation is not met as evidenced by: See the deficiency cited at F812.	A7056		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined	A8010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06430	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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
A8010	Continued From page 3 incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F578.	A8010		
A8042	19 CSR 30-88.010(41) Resident Lives Not Regulated/Controlled Residents shall not have their personal lives regulated or controlled beyond reasonable adherence to meal schedules and other written policies which may be necessary for the orderly management of the facility and the personal safety of the residents. II This regulation is not met as evidenced by: See the deficiency cited at F558.	A8042		
A9011	19 CSR 30-88.020(11) Death of Resident, Contact DSS Upon the death of a resident, the operator shall contact the Department of Social Services (DSS), MO HealthNet Division, Third Party Liability Unit, to determine if the deceased resident is a MO HealthNet participant or has been a recipient of aid, assistance, care, services, or if the resident has had moneys expended on his/her behalf by DSS. The facility shall document the contact(s) with and response(s) from DSS. II/III	A9011		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06430	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S AT FRANCIS PLACE	400 SUMMERVILLE BLVD EUREKA, MO 63025

(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
A9011	Continued From page 4 This regulation is not met as evidenced by: Class III See the deficiency cited at F569.	A9011		

PLAN OF CORRECTION

Provider/Supplier Name:	St. Andrew's at Francis Place
Street Address, City, Zip:	400 Summerville Blvd Eureka, MO 63025
Date of Survey:	02/07/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Please accept this Plan of Correction as Credible Allegation of Compliance. Submission of this Response and Plan of Correction is not a legal admission that a deficiency was correctly cited and is also not to be construed as admission against interest by St. Andrew's at Francis Place Administration or any employee, agents or other individuals who may draft or who may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by St. Andrew's at Francis Place of the truth of any facts alleged or correctness of any conclusion set forth in this allegation by the Survey Agency.	

F558	**Reasonable Accommodations Needs/Preferences** **CFR(s): 483.10(e)(3)** Resident #64 was evaluated by Occupational Therapy and PTA to determine if resident can safely reach items in room. Resident's room was arranged to accommodate needs. Resident #46 will be evaluated by therapy and nursing in accordance with the *Adaptive/Assistive Device and Potential Restraints Policy* to determine appropriateness for adaptive device/bed placement for mobility. If appropriate, devices will be placed according to policy. Resident #13 no longer resides in the community. Resident #12 will be evaluated by therapy and nursing in accordance with the *Adaptive/Assistive Device and Potential Restraints Policy* to determine appropriateness for adaptive device/bed placement for mobility. If appropriate, devices will be placed according to policy. Resident #14 will be evaluated by therapy and nursing in accordance with the *Adaptive/Assistive Device and Potential Restraints Policy* to determine appropriateness for adaptive device/bed placement for mobility. If appropriate, devices will be placed according to policy. Residents who use adaptive/assistive devices and potential restraints have the potential to be affected. Residents will be screened upon admission, during quarterly therapy screen, or by physician order for adaptive/assistive devices and potential restraints. If appropriate devices will be placed according to policy. Monthly the Therapy Director will report to the QAPI committee the results of their quarterly screens.	03/19/2025

F569	**Notice and Conveyance of Personal Funds** **CFR(s): 483.10 (f)(10)(iv)(v)** Resident #240's refund check was issued on 02/10/2025. All residents utilizing the resident trust have potential to be affected. The Business Office Manager will issue funds within 30 days of discharge, eviction, or death. The Business Office Manager will follow up with the TPL unit if no response is received from initial report. The Executive Director will ensure the Manager of Revenue & Disbursements audits the resident trust monthly with the Business Office Manager to ensure compliance. Monthly the Manager of Revenue & Disbursements will submit a report to the Executive Director to present at the QAPI meeting with results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audit.	03/19/2025

F578	**Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v)** Resident #18's TSL was updated on 02/07/2025. Resident no longer resides in the community. Resident #14's TSL was updated on 02/04/2025. Resident #17's TSL was updated on 02/10/2025. Resident #62's TSL was updated on 02/18/2025. All residents have the potential to be affected. A community wide TSL audit was completed. The community began updating Residents' TSL forms, orders, and care plans. The community is awaiting a response from one resident representative. Will continue to contact. Nursing staff or designee will obtain initial TSL at admission to the community. Social Services will review TSLs annually with resident or representative. TSLs will be updated upon request of resident or representative. Social Services or designee will in-service Nurses on obtaining TSL status upon admission to the community. Social Services will complete a monthly TSL audit to maintain compliance. The Social Services Coordinator will report results of the audit monthly to the QAPI committee. When 100% compliance has been reached for 3 consecutive months, the QAPI committee will determine whether to continue to monitor, process, or discontinue.	03/19/2025

F657	**Care Plan Timing and Revision** **CFR(s): 483.21 (b)(2)(i)-(iii)** An ad-hock fall risk meeting was held on 02/28/2025 to discuss Resident #26's fall interventions. Resident care plan was updated accordingly. Resident #56's care plan was updated to reflect his/her hospice diagnosis, goals, and/or interventions. All residents have the potential to be affected. The Clinical IDT will discuss resident specific care plan interventions daily during the clinical IDT meeting. Care plans will be updated accordingly to meet the resident's medical, nursing, nutritional, emotional, spiritual, and psychological needs. The Director of Nursing or designee will in-service nurses on updating care plan post fall. The Director of Nursing or designee will audit resident falls daily for care plan updates in the IDT meeting. The MDS Coordinator will update care plans at significant change of condition to reflect resident's individualized care needs. The Executive Director will audit significant change of condition care plans monthly. Monthly the Executive Director and Director of Nursing will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F658	**Services Provided Meet Professional Standards** **CFR(s): 483.21 (b)(3)(i)** Resident #78 did not reside in the community at the time of the survey. A hospice order was obtained for Resident #18 on 02/11/2025. Resident no longer resides in the community. All residents have the potential to be affected. The Director of Nursing or designee will in-service nursing staff on following physician's orders. The Director of Nursing or designee will audit physician's orders daily at clinical IDT meeting. Monthly the Director of Nursing will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F758	**Free from Unnec Psychotropic Meds/PRN Use** **CFR(s): 483.45 (c)(3)(e)(1)-(5)** Resident #18 no longer resides in the community. Resident #15's order for Quetiapine Fumarate was updated to have a 14 day stop date on 02/28/2025. All residents with PRN orders for antipsychotics have the potential to be affected. An audit was completed of all residents who have PRN orders for antipsychotics to ensure there is a 14 day stop date. The Director of Nursing and/or Consultant Pharmacist will in-service nurses on the Psychotropic Medication use policy. The Director of Nursing or Designee will audit new antipsychotic drug orders weekly to ensure sustained compliance. Monthly the Director of Nursing will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F812	**Food Procurement Store/Prepare/Serve-Sanitary** **CFR(s): 483.60 (i)(1)(2)** The stove, steamer, and flat grill were cleaned on 02/27/2025. The deep fryer was cleaned and the grease replaced on 02/06/2025. The expired milk was thrown away on 02/06/2025. A full audit of the cooler/freezer was completed to ensure no items were expired. The cleaning schedule for the kitchen was updated to include the flat grill. Frequency of cleaning was also added. Director of Dining Services or designee will in-service dining staff on proper labeling and discarding of expired items. The Director of Dining Services or designee will audit the kitchen cleaning schedule weekly. The Director of Dining Services or designee will audit the cooler for expired items weekly. Monthly the Director of Dining Services will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F842	**Resident Records- Identifiable Information** **CFR(s) 483.20 (f)(5), 483.70 (h)(1)-(5)** Resident #26's TAR will be reviewed daily to ensure documentation of treatments are completed. All residents have the potential to be affected. The Director of Nursing or designee will audit the TAR dashboard daily for documentation. The Director of Nursing or Designee will in-service Nurses on documentation in the TAR. Monthly the Director of Nursing will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits. Resident #56's certificate of illness is documented in the hospice binder. An audit will be completed on all hospice residents for an updated certificate of illness. Medical Records will track certificates of illness upon admission and recertification to ensure documentation is in resident's hospice binder. Medical Records will audit certificates of illness monthly to ensure sustained compliance. Monthly Medical Records will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F880	**Infection Prevention & Control** **CFR(s): 483.80 (a)(1)(2)(4)(e)(f)** Staff began wearing appropriate PPE when caring for Resident #26. Staff began wearing appropriate PPE when caring for Resident #20. Resident #20 no longer resides in the community. Staff began wearing appropriate PPE when caring for Resident #18. Resident #18 no longer resides in the community. All residents requiring Enhance Barrier Precautions (EBP) have the potential to be affected. An audit will be completed on all residents requiring EBP to ensure orders are in place and proper signage is posted, and care plan updated. The Director of Nursing or Designee will in-service staff on EBP precautions. The Director of Nursing or designee will audit 3 staff weekly to ensure proper PPE is being worn in EBP rooms. Resident #26's catheter was changed on 02/16/2025. The Director of Nursing or designee will in-service nursing staff on catheter care. The Director of Nursing or designee will audit 3 staff weekly to ensure providing proper catheter care. Monthly the Director of Nursing will present at the QAPI meeting results of the audits. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

F947	**Required In-Service Training for Nurse Aides** **CFR(s): 483.95 (g)(1)-(4)** In-service sheets were updated to include length of in-service. A document was created to track annual CNA in-service hours. CNAs will be offered regular in-servicing monthly. The Director of Nursing or designee will audit CNA education hours monthly to ensure CNAs stay on track for their annual education. Monthly the Director of Nursing will present at the QAPI meeting results of the audit. When 100% compliance has been reached for 3 consecutive months the QAPI committee will determine whether to continue to monitor, process, or discontinue audits.	03/19/2025

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.

PLAN OF CORRECTION

Provider/Supplier Name:	St. Andrew's at Francis Place
Street Address, City, Zip:	400 Summerville Blvd Eureka, MO 63025
Date of Survey:	02/07/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Please accept this Plan of Correction as Credible Allegation of Compliance. Submission of this Response and Plan of Correction is not a legal admission that a deficiency was correctly cited and is also not to be construed as admission against interest by St. Andrew's at Francis Place Administration or any employee, agents or other individuals who may draft or who may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by St. Andrew's at Francis Place of the truth of any facts alleged or correctness of any conclusion set forth in this allegation by the Survey Agency.	

A4054	**19 CSR 30-85.042(45) Written Orders; Restraints** See POC for F658.	03/19/2025
A4086	**19 CSR 30-85.042 (77) Infection Control/Communicable Disease** See POC for F880.	03/19/2025
A4116	**19 CSR 30-85.042(102) Clinical Records Accurate/Accessible** See POC F842.	03/19/2025
A7015	**19 CSR 30-87.030 (13) Food-Protected, Temp, Need to Contact DHSS** See POC F812.	03/19/2025
A7056	**19 CSR30-87.030(54) Nonfood Contact Surfaces, Cleaning** See POC F812.	03/19/2025
A8010	**19 CSR 30-88.0101 (10) Advance Directive Requirements** See POC F578.	03/19/2025
A8042	**19 CSR 30-88.010 (41) Resident Lives Not Regulated/Controlled** See POC F558.	03/19/2025
A9011	**19 CSR 30-88.020 (11) Death of Resident, Contact DSS** See POC F569	03/19/2025

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.