STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265160	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewis & Clark Gardens	1221 Boones Lick Road Saint Charles, MO 63301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of abuse immediately and no later than two hours to the state survey agency after an allegation was made of physical abuse towards one resident (Resident #1) in a review of seven sampled residents. The facility census was 85. Review of the undated facility policy for Abuse and Neglect showed the following:-It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion-All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property by facility employees, contract employees, volunteers, contract services, consultants, physician, visitors, family members or other individuals will be reported immediately but no later than the following timeframes. If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made;-Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator;-The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal Requirements. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 1/6/26 showed the following:-Able to make self-understood and able to understand others;-BIMS (Brief Interview for Mental Status, a quick cognitive screening tool used in long-term care to assess orientation, memory, and recall) with a score of 13 (indicates a cognitively intact or normal mental status, meaning the individual has good orientation and memory);-Dependent upon staff for Activities of Daily Living (ADL's);-No behaviors;-Diagnoses of hemiparesis, (weakness on one entire side of the body, affecting the arm, leg, and sometimes the face, often resulting from a stroke or brain injury, causing difficulty with movement, coordination, balance, and grasping objects), respiratory failure and Traumatic Spinal Cord Dysfunction (damage to the spinal cord from an external force, like car accidents or falls, causing loss of motor, sensory, or autonomic function below the injury level, leading to paralysis, impaired sensation, bowel/bladder issues, and other systemic complications). Review of the resident's care plan for behaviors dated 04/16/2025 showed the following:-Problem: I'm followed by a mental health professional as I become very easily angered, yell at staff, yell at my family. I cause for the other residents to be disturbed especially at night;Goal: I will be able to express myself without yelling at staff and loved ones.Interventions: My family member who is my Emergency Contact is aware of my behavior and can at times help me de-escalate, I call him/her regardless of the time, another family member is also helpful. With encouragement from staff, help from mental health provider, and if needed medication as last resort I will be able to express myself clearly without yelling at staff/family. Review of the resident's care plan for Behavioral Symptoms dated 10/12/23 showed the following:-Problem: I have impaired mobility, cannot bear weight on my legs, can really use my right (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arm and require for staff to preform my mobility/turning ADL's, I also push against the staff, scream at them and demand they pull on me in unsafe ways.-Goal: I will relax and allow for staff to take care of me, stop pushing against them and becoming angry/verbal loud outburst/telling staff how to do my mobility/movements/turning in inappropriate way.-Interventions: Please attempt to re-direct me when I start to scream out loud and demand you re-position me the way I want you to do (pulling on my arms/shoulders), remind me this is not a safe manner and that it could lead to physical concerns for myself as well as for potential injuries for both me and the staff. When I requested to be re-positioned, please remind me that pulling on me (which I request to have my arms pulled) is not good for myself or for the provider. Since I'm in bed a lot more due to my wound I require little more re-positioning than if I were up out of bed for a while. During an interview on 1/14/26 at 9:00 A.M. the Administrator said the following:-Last week or possibly Monday, January 12th, Resident #1 told Certified Nurse Aide (CNA) B a staff member who the resident called Firehead was rude to him/her;-CNA B had reported this to the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) either on Friday last week or Monday, January 12, 2026, she could not remember the exact date;-After talking with the resident and describing several staff members, the resident identified CNA A as the identified staff;-The resident told CNA B that CNA A had squeezed her face and told him/her to shut up;-At first she thought this could be abuse, but when she interviewed the resident with CNA A in the room, the resident denied the allegation; -She could not remember the exact date on when this was reported to her;-She did not report this to the state agency or complete an investigation as the resident denied the allegation. During an interview on 1/14/26 at 10:37 A.M. CNA B said the following:-On Friday, January 9th, he/she and the Activity Director were in the resident's room providing care and the resident told them that a staff member he/she called Firehead told him/her to shut up and squeezed his/her cheeks;-He/She reported this to the DON. During an interview on 1/14/26 at 11:15 A.M. the Activity Director (AD) said the following:-He/She and CNA B went to Resident #1's room to provide care;-He/She thinks this was Monday, January 12th, but could have been last week;-The resident told them that he/she felt like he/she was falling out of bed and began to scream when a staff member the resident called Firehead came into his/her room and squeezed his/her cheeks;-He/She and CNA B reported this to the Administrator;-On Monday, the 12th, the Administrator said the DON and ADON had talked with the resident and the resident denied CNA A had squeezed his/her cheeks. During an interview on 1/14/26 at 1:10 P.M. Resident #1 said the following:-Last week, Firehead, he/she did not know the staff member's real name, came into his/her room and squeezed his/her face; it really hurt;-He/she felt like he/she was falling out of the bed, and he/she began yelling for help;-A staff member he/she calls Firehead came into the room and yelled at him/her to shut up, it scared him/her. The then staff member came over and put his/her hands on his/her face and squeezed his/her cheeks real hard and told him/her to be quiet. During an interview on 1/14/26 at 1:20 P.M. and again at 3:00 P.M. the ADON said the following:-Upon interview at 1:20 P.M. the ADON said that the incident between Resident #1 and CNA A was reported on 1/12/26, then after thinking about the days and reviewing the schedule, he/she stated that the incident was reported to him/her and the Administrator on 1/9/26 by CNA A and the AD;-The resident told him/her and the DON that he/she felt like he/she was falling out of the bed and was yelling when CNA A came into his/her room and told him/her to be quiet and squeezed his/her cheeks and it hurt;-After reporting this to the Administrator, the Administrator walked CNA A in front of the resident's door and the resident identified CNA A as the staff member who yelled at him/her;-The administrator then brought CNA A into the residents' room and in front of the resident asked the resident if this was the staff member who yelled at him/her. The resident said yes, it (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the staff member who yelled at him/her. During an interview on 1/14/26 at 1:45 P.M. the DON said the following:-She was at the nurses' station when CNA B and the AD came to her and said they wanted to report potential abuse;-She took CNA B and the AD to the Administrator's office;-She heard CNA B, and the AD tell the Administrator that Resident #1 reported to them that a staff member who he/she calls Firehead yelled at him/her and grabbed his/her face;-She left the office to get the schedules to see who had worked and inform the ADON of the allegations;-She and the ADON went to the resident's room and the Administrator walked CNA A by the resident's door and the resident identified CNA A as Firehead;-The administrator brought CNA A into the resident's room and began asking the resident and CNA A questions about the allegations;-She left the room and did not hear all the questions or answers;-Upon initial interview the DON said this was reported on 1/12/26, but then stated it was reported on 1/9/26. During a telephone interview on 1/15/26 at 10:30 A.M. the Administrator said the following:-The incident was reported to her on Friday, January 9th, not 1/12/26 as initially said;-She did not report the allegation, as the resident denied staff yelled at him/her;-She did interview and asked questions with CNA A in the room with the resident;-She did not feel any abuse occurred or that the allegations needed to be reported since the resident denied the allegations. 2719121

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to conduct a timely and thorough investigation of an allegation of abuse involving one resident (Resident #1), in a review of seven sampled residents. Resident #1 made an allegation of verbal and physical abuse on 1/9/26, involving a staff identified by the resident as Certified Nurse Aide (CNA) A. The facility census was 85.Review of the undated facility policy for Abuse and Neglect showed the following:-It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion;-It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated;-The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately;-The investigation will include who is involved, resident statements, resident roommate statements (if applicable), interviews from residents who received care from the alleged staff, interviews from different department staff, involved staff and witness statements of events;-Steps taken to protect residents-Immediate assessment of the alleged victim and provision of medical treatment if necessary; evaluation of whether the alleged victim feels and safe and if he/she does not feel safe, taking immediate steps to protect the resident; if the alleged perpetrator is a facility staff member, removal of the alleged perpetrator's access to the alleged victim and other residents and assurance that ongoing safety and protection is provided to the alleged victim and other residents. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 1/6/26 showed the following:-Able to make self-understood and able to understand others;-BIMS (Brief Interview for Mental Status, a quick cognitive screening tool used in long-term care to assess orientation, memory, and recall) with a score of 13 (indicates a cognitively intact or normal mental status, meaning the individual has good orientation and memory);-Dependent upon staff for Activities of Daily Living (ADL's);-No behaviors;-Diagnoses of hemiparesis)weakness on one entire side of the body, affecting the arm, leg, and sometimes the face, often resulting from a stroke or brain injury, causing difficulty with movement, coordination, balance, and grasping objects), respiratory failure and Traumatic Spinal Cord Dysfunction (damage to the spinal cord from an external force, like car accidents or falls, causing loss of motor, sensory, or autonomic function below the injury level, leading to paralysis, impaired sensation, bowel/bladder issues, and other systemic complications). During an interview on 1/14/26 at 9:00 A.M. the Administrator said the following:-Last week or possibly Monday, January 12th, Resident #1 told Certified Nurse Aide (CNA) B that a staff member who the resident calls Firehead was being rude to him/her;-CNA B had reported this to the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) either on Friday last week or Monday, January 12, 2026, she could not remember the exact date;-After talking with the resident and describing several staff members, the resident identified CNA A as Firehead;-The resident told CNA B that CNA A squeezed his/her face and told him/her to shut up;-At first she thought this could be abuse, but when she interviewed the resident with CNA A in the room, the resident denied the allegation;-She could not remember the exact date on when this was reported to her;-She did not report this to the state agency or complete an investigation as the resident denied this allegation. During an interview on 1/14/26 at 1:10 P.M. Resident #1 said the following:-Last week, Firehead (CNA A), came into his/her room and squeezed his/her face, it really hurt; /she began yelling for help;-CNA A came into the room and yelled at him/her to shut up, it scared him/her. The staff member then came over and put his/her hands on his/her face and squeezed his/her cheeks real hard and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told him/her to be quiet. Review of the facility documentation showed there were no interviews or statements from the alleged perpetrator or any other witnesses, residents or staff members. There was no evidence the facility completed a thorough investigation. During a telephone interview on 1/15/26 at 10:30 A.M. the Administrator said the following:-The incident was reported to her on Friday, January 9th, not 1/12/26 as initially said;-She had not completed an investigation and will complete one and sent to the state agency. 2719121