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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrew's at Francis Place	400 Summerville Blvd Eureka, MO 63025

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 0561 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) D, an agency CNA, respected Resident #24's right to remain in bed. On 10/2/25, the CNA transferred the resident out of bed for a shower after the resident told the CNA he/she did not want to get out of bed. The resident said he/she was upset about being made to get up, the transfer was rough and felt like a tussle. During the transfer, the resident sustained a large skin tear, approximately ten centimeters (cm) long, to the left lower leg. The resident was sent to the hospital where five sutures were required to close the skin tear. The facility investigated the incident and in-serviced some nursing staff on transfer training. The facility investigation failed to identify the resident's right to self-determination had been violated, and no interventions regarding resident's rights were implemented. The census was 90. Review of the facility Resident Rights Policy, dated 9/19/24, showed:-Policy Statement: The facility will protect and promote the rights of each resident to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The requirements concerning resident rights are guaranteed to them under Federal and State law;-Procedure:-Information regarding resident rights and facility rules will be posted in a conspicuous location in the facility and copies will be provided to anyone requesting this information;-Staff Competencies in Resident Rights information will include the following: Understanding of abuse, neglect, misappropriation of resident property, and exploitation. Demonstrate respect for residents through actions and interactions. Plan and provide individualized care and services as the resident prefers. Ability to provide residents with quality care and services with respect. Follows resident preferences in care decisions and choices;-Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality;-Right to Self Determination: Choices of activities, schedules, health care, and providers, including attending physician. Reasonable accommodation of needs and preferences. Request, refuse, and/or discontinue treatment.Review of the facility Resident Handbook, revised 6/22, showed:-Our goal is not to maintain but enrich lives. We respect personal dignity and promote independence;-Our Mission: Empower elders and their caregivers through choices and options that foster a vital life;-We believe that you have the right to make decisions about your medical care, including the right to refuse care;-Resident Responsibilities (includes): Assist in planning your own care;-Nursing Home Residents' Rights (include): -Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality. Quality of life is maintained or improved;-Right to Self-Determination (includes): Choice of activities, schedules, health care, and providers, including attending physician. Reasonable accommodation of needs and preferences. Request, refuse, and/or discontinue treatment.Review of Resident #24's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 8/11/25, and located in the electronic medical record (EMR), showed:-Hearing: Minimal difficulty;-Speech (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 0561 Level of Harm - Actual harm Residents Affected - Few	Clarity: Clear speech - distinct intelligible words;-Makes Self Understood: Understood;-Ability To Understand Others: Understands;-Chair/bed-to-chair/transfer: Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort;-Diagnoses of high blood pressure, arthritis, weakness and chronic pain.Review of the resident's care plan, dated 10/2/25, and located in the EMR, showed:-8/11/25, Focus: ADL (activities of daily living) self-care performance deficit. Goal: Resident will maintain current level in ADLs. Interventions: Transfers - partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort;-8/11/25, Focus: Communication problem. Goal: Will be able to make basic needs known on a daily basis. Intervention: Allow adequate time to respond. Repeat as necessary. Do not rush. Request clarification from the resident to ensure understanding. Ask yes/no questions if appropriate.Review of the resident's physician's order sheet (POS), located in the EMR, showed:-9/8/25: Shower/Bath every Monday and Thursday.Review of the resident's progress note, located in the EMR, showed:-10/2/25 (Thursday) at 9:52 A.M., Licensed Practical Nurse (LPN) B documented: This nurse made aware that the resident had a skin tear to the left leg. Upon assessment, resident was observed with a deep laceration to the lower part of left leg. Pressure was applied. Physician was called and wants resident to go get stitches. Director of Nursing (DON) and Administrator notified.Review of the Executive Director's/Administrator's initial report to the Department of Health and Senior Services (DHSS) on 10/2/25 at 7:35 P.M., showed:-Resident #24 was transferred today from his/her bed to his/her wheelchair. During the transfer, resident hit his/her leg on his/her wheelchair resulting in a skin tear. Resident was sent to the hospital for stitches. Upon return, resident was interviewed. He/She said the CNA who transferred him/her was kind of rough. He/She said the CNA was coming to get him/her up for the day and they were talking about a shower. When asked what he/she meant by rough, he/she said it felt like they were wrestling. Resident did not feel like the CNA was intentionally trying to harm him/her;-The CNA was interviewed. He/She said he/she hugged the resident to transfer him/her and then he/she took a couple of steps to the wheelchair. He/She noticed the resident's leg almost immediately and went to get the nurse for assessment. The CNA said he/she was trying to encourage the resident to get up for the day because in report he/she was told the resident does not get up until later and he/she needs a lot of encouragement, or the resident will stay in bed all day;-The resident is moderate assistance for transfers and can bear weight but needs support to take steps. At this time, the facility does not suspect abuse or neglect. Transfer in-servicing will be completed with staff.Review of the resident's progress note, dated 10/2/25 at 10:30 P.M., showed the resident returned from the hospital with a new order for Keflex (an antibiotic) 500 milligrams three times a day for seven days. Resident has five nylon sutures in his/her left lower extremity.Review of the facility Final Investigation Incident 10/2/25, completed by the DON, showed the following statements:-CNA D: I was getting resident up and told him/her today was his/her shower day. Resident said he/she did not want to have a shower. Nurse told me to get resident up and resident will change his/her mind once out of bed. I got resident on the side of the bed and put the resident's wheelchair at an angle so that when we stood resident could go to the side and sit in the wheelchair. I put my arms around resident's chest, like a bear hug, and together we turned towards the wheelchair, resident was standing up. When almost in the wheelchair, resident kicked with his/her left leg at the same time I was helping him/her sit. He/She hit the left footrest on the wheelchair when he/she kicked and got the skin tear; -Certified Medication Technician (CMT) A: This morning I heard from resident's room an aide (CNA D) getting loud with one of the residents. I informed LPN B he/she might want to check on the situation;-LPN B: At approximately (continued on next page)

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F 0561 Level of Harm - Actual harm Residents Affected - Few	the resident's POS, showed:-10/2/25: Suture/staple removal on left lower extremity in 14 days. Review of the facility Transfer Training, conducted by the Physical Therapist on 10/3/25, showed twenty nursing staff (a combination of facility staff and agency staff) received transfer training. Review of the resident's POS, showed:-10/6/25: Monitor steri-strips to make sure they remain clean, dry and intact;-10/6/25: Wound Care Company to evaluate and treat for left lower front leg.Review of the wound care company progress note dated 10/7/25, located in the EMR, showed:-Location: Left Distal (situated away from the center of the body or point of attachment), Lower Leg;-Measurements: Length (L): 0.00 cm by Width (W): 12.50 cm by Depth (D): 0.00 cm by Area (A): 0.00 cm;-Etiology: Laceration;-Stage/Severity: Full Thickness;-Wound Status: New;-Wound Edges: Sutured;-Periwound (skin around the wound): No erythema (redness), no fever, no signs of infection;-Exudate (drainage) Amount: None;-Treatment: Leave open to air;-Location: Left Lower, Proximal (situated nearer to the center of the body or point of attachment) Leg;-Measurements: 4.0 cm by 3.50 cm by 0.00 cm by 14.00 cm;-Etiology: Laceration;-Stage/Severity: Full Thickness;-Wound Status: New;-Wound Edges: Surgically glued or bonded. Edges well approximated;-Periwound: Ecchymosis (a discoloration of the skin typically caused by bruising);-Exudate Amount: None;-Treatment: Leave open to air.Review of the resident's POS, showed:-11/7/25: Left distal wound - cleanse with wound cleanser and apply xeroform (occlusive gauze designed to maintain a moist environment for healing wounds) to wound bed and cover every Tuesday and Friday;-11/7/25: Left Proximal Leg: Betadine (an antiseptic solution), daily and leave open to air.Review of the resident's Brief Interview for Mental Status (BIMS, a cognitive assessment) dated 11/7/25 and completed by the Social Service director (SSD), showed a score of 11, indicating moderate cognitive impairment. Review of the wound care company progress note dated 11/11/25, showed:-Location: Left Distal, Lower Leg;-Measurements: 5.80 cm by 2.60 cm by 0.20 cm by 5.08 cm;-Etiology: Laceration;-Stage/Severity: Full Thickness;-Wound Status: Improving;-Wound Edges: Unattached;-Periwound: No erythema, no fever, no signs of infection;-Exudate Amount: Moderate;-Exudate Description: Serosanguineous (thin watery fluid with a pink hue);-Dressing Change Frequency: Tuesday and Friday;-Treatment: Xeroform;-Location: Left Lower, Proximal Leg;-Measurements: 3.90 cm by 3.30 cm by 0.00 cm by 12.87 cm; -Etiology: Laceration;-Stage/Severity: Full Thickness;-Wound Status: Improving;-Wound Edges: Surgically glued or bonded. Edges well approximated;-Periwound: Ecchymosis;-Exudate Amount: None;-Treatment: Betadine daily. Leave open to air.Review of the resident's care plan showed on 11/13/25, the facility added the following intervention/task: Transfer with a Hoyer lift and assistance of two staff until left lower leg laceration is resolved.During an interview on 11/18/25 at 8:13 A.M., CNA E (agency staff) said he/she started coming to the facility about a month ago. He/She had taken care of the resident before. He/She had not been in-serviced on transfer training or resident rights since starting at the facility. If a resident does not want to get up, they should not be forced to get up. They have a right to refuse. If a nurse told him/her to get a resident up that did not want to get up, he/she would not get the resident up and would tell the DON. During an interview on 11/18/25 at 8:35 A.M., CMT F (agency staff) said he/she had been coming to the facility prior to 10/2/25. He/She did not recall taking care of the resident in the past. If a resident does not want to get up, the resident has a right to refuse and stay in bed. He/She would tell the nurse a resident does not want to get up and if the nurse said the resident had to get up, he/she would get the resident up. That has not happened since she has been here. He/She did not attend the transfer training and has not been in-serviced on resident rights since 10/2/25.During an interview on 11/18/25 at 8:58 A.M., CMT G (agency staff) said he/she had been coming to the facility on a steady pace since 7/2/25. He/She has taken care of the resident before. The resident can make his/her needs known. If the resident did not want (continued on next page)

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