STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265136	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village Sunset Hills	12651 Village Circle Drive Saint Louis, MO 63127

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity, in a manner and in an environment that promoted maintenance or enhancement of his/her quality of life when staff failed to serve a requested alternate meal and told the resident to wait until the next meal (Resident #91), failed to serve a resident timely after the tablemates were served (Resident #109). The facility staff also failed to answer a resident after asking staff several times (Resident #44) and staff entered the resident rooms without knocking on the door (Residents #67, #102 and #110). The sample was 26. The census was 132. Review of the facility's Resident Rights: Accommodation of Needs and Preferences and Homelike Environment policy, dated August 2019, showed: -It is the policy of the facility to identify and provide reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents. Residents have the right to retain and use personal possessions to promote a home like environment and to support each resident in maintaining their independence. The facility will provide a safe, clean, comfortable and home-like environment allowing the resident to use his or her personal belongings to the extent possible. Review of the facility's Quality of Life-Dignity policy, dated 8/19, showed: -It is the policy of the facility to ensure that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents' private space and property will be respected at all times. Staff will knock and request permission before entering resident rooms. 1. Review of Resident #91's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/23/24, showed: -Moderate cognitive impairment; -Upper body impairment one side; -Uses walker and wheelchair for mobility; (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Supervision for eating and personal hygiene; -Diagnoses include cancer, malnutrition, osteoporosis (bones become extremely porous and are subject to fracture and slow healing), high blood pressure and depression. Review of the resident's current care plan, showed: -Problem: Resident has nutritional problem. Inadequate oral intake related to cognitive impairment; -Goal: Resident will have increased oral intake to meet estimated nutrition and hydration needs and weight will remain stable; -Interventions: Provide diet per physician order, provide nutrition supplement per physician orders, and monitor weights per physician orders. Review of the resident's electronic Physician's Orders Sheet (ePOS), showed: -An order, dated 1/24/25, regular diet. Review of the resident's meal ticket, dated 1/24/25, showed: -Diet: Regular; -Texture: Regular; -Allergies: Eggplant; Other-Lobster. Observation on 1/22/25 at 11:50 A.M., showed the resident sat in the dining room with two other residents. At the time of the resident's request, none of the residents at the table had been served food. The resident told Dietary Aide S he/she would like a bacon, lettuce and tomato (BLT) sandwich for lunch. The dietary aide said he/she could have it tonight with dinner and asked the resident if he/she wants chips or french fries as a side. Dietary Aide S told the resident he/she will put it on the dinner ticket. Observation on 1/22/25 at 12:07 P.M., showed the resident served with a plate of the lunch choice, pasta con broccoli. The two other residents seated at the table were served BLT sandwiches and french fries. During an observation and interview on 1/22/25 at 12:15 P.M., showed the resident ate approximately 25% of the food on his/her plate. The resident pushed the food away from him/her. The two residents at the table were still eating their BLT sandwiches. The resident said he/she was not sure why Dietary Aide S told him/her to wait for dinner to get a BLT. The resident guessed it was because he/she already had ordered this option. During an interview on 1/23/25 at 12:58 P.M., Food Service Manager T contacted the staff member who passed out hall trays on 1/22/25 evening shift. The resident received a half peanut butter and jelly sandwich and a half cordon bleu with mashed potatoes for dinner. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/27 at 11:40 A.M., Dietary Supervisor U said the residents can get anything on the a la carte menu until the kitchen closes, which is around 6:30 P.M. There would be no reason to make them wait. If they asked for something else at lunch, they should get it at lunch. Dietary Supervisor U said he/she is not sure why a resident would be told to wait for the next meal to get a requested alternate food item. During an interview on 1/28/25 at 10:15 A.M., the Director of Nursing (DON) and Administrator said the residents can have something else whenever they want, even after they order something. They should not be told to wait. That is not dignified. 2. Review of Resident #109's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses wheelchair for mobility; -Supervision or touching assistance for eating (Helper provides cues or touching/steadying assistance as resident completes activity); -Diagnoses include acid reflux, diabetes, malnutrition, dementia and depression. Review of the resident's current care plan, showed: -Problem: Resident has potential for cognitive impairment; -Goal: Resident's nutritional status will remain stable as evidenced by adequate oral intake to meet estimated nutrition and hydration needs and no significant weight change through next review. Review of the resident's ePOS, showed: -An order, dated 11/04/24, regular diet. Review of the resident's lunch meal ticket, dated 1/24/25, showed: -Diet: Regular; -Texture: Regular; -Beverages: [NAME] (chocolate nutritional milk) milk-4 full ounces (oz) -Food Adds: Fresh fruit-1 serving, Yogurt-1 each. Observation in the dining room on 1/22/25, showed: -At 11:33 A.M., staff in the dining room brought out plates of food to different residents at different tables. Resident #109 sat at a table with two other residents. The resident had a cup of water, a cup of juice, and a cup of chocolate milk in front of him/her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:37 A.M., one of the residents at the table had food brought to him/her. Resident #109 and the other resident sat without food. -At 11:52 A.M., a dietary staff member at the table with Resident #109 and other resident to get food order. The resident who was served ate all of his/her food and has his/her head down with his/her eyes closed. -At 11:58 A.M., dietary staff passed out cookies and ice cream to residents at other tables. Resident #109 and the other resident at table still did not have food. -At 12:01 P.M., dietary staff brought the other resident at the table his/her food. The resident ordered the lunch choice of pasta con broccoli. Resident #109 still without food. -At 12:01 P.M., dietary staff brought Resident #109's lunch plate and set it in front of the him/her, but out of reach of the resident. The resident was not served fruit. The dietary aide cut the meatloaf on the resident's plate and walked away with the plate out of the resident's reach. -At 12:06 P.M., staff member went to the resident and straightens out his/her chair and put the resident's food in front of him/her. The resident began to eat. During an interview on 1/28/25 at 10:15 A.M., the DON and Administrator said the residents at the same table should be served at approximately the same time, unless one resident got there later than someone else at the table. It is not dignified for a resident to have to wait more than thirty minutes after someone at their table received their food at their table to get their food. They expected everyone to be served as close together as possible and their order should be taken at approximately the same time. 3. Review of Resident #44's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included heart disease, high blood pressure, hip fracture, peripheral vascular disease and benign prostatic hyperplasia; -Impairment to one side of the lower extremity; -Uses wheelchair. Review of the resident's care plan, in use during survey, showed: -Problem: Resident has slightly impaired cognition presumably related to post hospitalization . Alert and oriented x 2-3 with some forgetfulness; -Goal: Resident will maintain or improve level of cognitive functioning over the next 90 days; -Intervention: Use a calm, slow approach; -Explain all procedures before beginning and repeat during procedure as necessary; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Encourage activity programs for added stimulation; assist as necessary; -Provide activity calendar and newsletter; -Provide reorientation and redirection as needed; -Problem: Resident has impaired communication-receptive related to very hard of hearing. He/She has cochlear implant to left ear and wears hearing aide to right ear. Able to communicate with speaker increased volume; -Goal: Resident will correctly interpret conversation during visits and will ask to repeat or speak louder when conversation is not heard or understood; -Interventions: When conversing with him/her allow adequate time; do not rush or supply words; -Resident to wear hearing aides to ears; -Speak slowly and enunciate clearly; -Use different words to say the same thing if not understood; -Establish eye contact and face him/her prior to communication; -Reduce environmental distractions, turn off T.V., close door, low noise; -Use step by step instructions. Segment tasks as needed to slow pace; -Speak slowly and clearly using short and simple phrases; -Repeat/rephrase questions as needed. Observation on 1/22/25 at 5:56 P.M., showed the resident sat at a dining room table after dinner was served. Several residents remained in the dining room waited to be transported back to their room. The resident called out to staff nearby, when are you taking me back to my room. Staff did not speak to the resident. A Certified Nurse Aide (CNA) entered the dining room and began to transport a resident out of the dining room. The resident said, are you taking me back to my room. The CNA continued to transport the other resident in the wheelchair without speaking to Resident #44. The resident continued to ask staff who entered and exited the dining room if they were taking him/her back to their room. Staff did not speak to the resident. During an interview on 1/28/24 at 10:15 A.M., the Administrator said it would not be dignified to ignore a resident when they ask a question. 4. Review of Resident #67's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis include high blood pressure, kidney failure, high cholesterol, Alzheimer's disease, anxiety and depression. Observation on 1/23/25 at 6:40 A.M., showed CNA A entered the resident's room and did not knock on the door or introduce himself/herself. 5. Review of Resident #102's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnosis include anemia (low iron in the blood), seizure, anxiety and depression. Observation on 1/23/25 at 6:47 A.M., showed CNA A entered the resident's room and did not knock on the door or introduce himself/herself. 6. Review of Resident #110's admission MDS, dated [DATE], showed: -Slurred speech; -Rarely or never understood; -Sometimes understand direct communication; -Diagnoses included kidney failure, aphasia (loss of speech), dementia, anxiety and depression. Observation on 1/27/25 at 8:49 A.M., showed CNA B and CNA C entered the resident's room. The roommate was present in the shared room. CNA B and CNA C did not knock on the door or introduce themselves. During an interview on 1/28/25 at 8:19 A.M., CNA D said when entering a resident's room, staff should knock on the resident's door and introduce themselves. It does not matter if the resident is cognitive or not, staff should still provide dignity and privacy. During an interview on 1/28/25 at 8:24 A.M., Licensed Practical Nurse (LPN) E said all staff should knock before entering a resident's room and say their name. Knocking on the door shows respect for the resident's privacy. During an interview on 1/28/25 at 10:12 A.M., the DON said staff are trained at the time of hire and randomly about residents' rights and dignity. Staff should knock before entering a resident's room. During an interview on 1/28/25 at 10:26 A.M., the Administrator said she expected staff to follow the facility's policy on resident rights and dignity. 44950 49992

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to ensure resident care plans were updated and accurate to reflect resident needs. This failure affected three of four sampled residents, whose care plan did not identify self-harm (Resident #96) sexual behaviors (Resident #109) and hospice services (Resident #29). The sample was 26. The census was 132. Review of the facility's Care Planning policy, dated [DATE], showed: -Policy: It is the policy of the facility for the Care Planning/Interdisciplinary Team to develop and to implement a person-centered comprehensive care plan for each resident to meet the resident's preferences and goals, and to address medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment; -A comprehensive care plan for each resident is developed within seven days of completion of the comprehensive resident assessment; -The resident's care plan must be reviewed after each Omnibus Budget Reconciliation Act (OBRA) assessment, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions; -Using the policy: It is the policy of the facility for care plans to be used in developing the resident's daily care routines and will be available to staff who have responsibility for providing care or services to the resident; -Completed care plans are placed in the resident's electronic medical chart; -Certified Nursing Assistants (CNAs) are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved; -Other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the Minimum Data Set ((MDS), a federally mandated assessment instrument completed by facility staff) Assessment Coordinator; -Changes in the resident's condition must be reported to the MDS Assessment Coordinator so a review of the resident's assessment and care plan can be made; -Documentation in the medical record must address the resident's subjective statements as well as the staff's objective assessments and observations of the resident's physical, mental, and psychosocial functioning. 1. Review of Resident #96's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Occasionally incontinent of bladder, always incontinent of bowel; -Diagnoses include Alzheimer's, stroke, anxiety, depression, and malnutrition. Review of the resident's progress notes showed: -A progress note, dated [DATE] at 10:14 A.M., Continued slurred speech as reported by staff. Strong bilateral hand grips. Independent with transfers and ambulation using walker; -10:00 A.M. family present, informed of assessment. Family has declined for resident to be sent to emergency room . States I think it is behaviors related to needing medication adjustments, you know he/she has a long psych history. Message left for psychiatrist and Nurse Practitioner (NP) regarding this matter. Awaiting return calls; -2:20 P.M. Resident noted standing in doorway with no pants on holding pink scissors in right hand. Two cuts noted across left writs and several scratches noted to right wrist (Resident has dug nails in his/her wrist scratching up his/her arm). Call placed to family informing of situation and that resident will be sent out. (Family said) The resident has been to the hospital before for this, also asked have they discontinued his/her valium (sedative medication used to treat anxiety). Family informed at this time; it is beyond this nursing home's care. Physician present, resident assessed and stated twice I want to kill myself; -3:00 P.M. routine Seroquel (antipsychotic medication used to treat schizophrenia (chronic mental illness characterized by significant disruptions in thought processes, perceptions, emotions, and behaviors), bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and activity levels), and depression), Zyprexa (antipsychotic medication, used to treat schizophrenia and bipolar disorder) and PRN (as needed) Trazadone (used to treat depression) administered. Resident 1 to 1 at this time. Vital signs obtained. Emergency Medical Services (EMS) called for transport; -3:13 P.M. Wander guard removed; -3:19 P.M. Report called to hospital triage; -3:40 P.M. EMS present for transport to hospital; -A progress note, dated [DATE] at 4:05 P.M., Resident's son/daughter called and asked what can be done to keep resident from going to the hospital. Advised son/daughter that it is out of my control and resident has to go to the hospital. The Medical Director is here and states he/she needs to be hospitalized . Son/Daughter asked if they found 24 hour ,d+[DATE] care could the resident be discharged from the hospital and return to the facility. Son/Daughter advised that no decision like that could be made at this time, any decision regarding the resident's readmission cannot be made at this time, it will depend on his/her treatment plan and behaviors. Family voiced understanding and will be meeting the resident at the hospital; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note, dated [DATE] at 8:16 P.M., Resident was initially sent and admitted to the hospital on [DATE] after an attempted suicide (cut his/her wrist with scissors) for psychiatry stabilization. CT (computerized tomography scan) head suggestive of subacute infarction (stroke). Urinalysis was suggestive of urinary tract infection (UTI) and completed five days of ceftriaxone (antibiotic). Resident was transferred to behavioral health center on [DATE] as he/she remained actively suicidal. After medication adjustments and agreed upon 24-hour private duty caregivers, resident was discharged . Resident's son/daughter plans to follow up with hospice care once resident gets resettled into the facility; -1:10 P.M. Transferred via EMS. Accompanied by private duty caregiver. Resident was readmitted to facility from behavioral health center but transferred to 2nd floor. Alert and oriented ,d+[DATE] (not to place or time, only to self and situation) with soft speech. Asking about location of spouse who has been deceased approximately [AGE] years and has been the source of depression. Denies pain. Denies suicidal ideations; -A progress note, dated [DATE] at 6:19 A.M., Resident lying down in bed, resting comfortably. Sitter in room. No signs of suicidal ideations. Poor appetite. No nausea/vomiting/diarrhea. Review of the resident's Psychiatric Consultations showed: -A follow up evaluation, dated [DATE], Resident seen for dementia with depression, anxiety, and a history of psychosis. Significant anxiety documented [DATE] throughout the day shift but improved since then. Supervisor reports patient frequently approaches the desk with various concerns and he/she has been very anxious, complains of constipation, and then he/she has diarrhea. Resident knows his/her son/daughter has been very busy with his/her house and resident wishes his/her son/daughter would visit. Resident knows her month and day of birth but not the year. Next visit ,d+[DATE] weeks; -A follow up evaluation, dated [DATE], Resident seen for dementia with depression, anxiety, and a history of psychosis. Resident was seen in the presence of his/her private duty nurse who reports resident has been resting and awakened shortly before I entered. Resident was anxious and obsessed with his/her clothes being twisted. I adjusted his/her t-shirt and blouse and resident continued to complain of this. Review of the resident's care plan, in use during the survey, showed: -Problem: Resident has impaired cognition related to Alzheimer's. Resident is alert and oriented ,d+[DATE] (time and place) with memory loss, forgetful, confusion, and anxiety. Has companions provided by family, that comes to sit with him/her at times. Can become tearful at times. Enjoys going for walks, playing bingo, and going outside; -Goal: Resident will maintain current level of cognitive functioning; -Action: Identify baseline cognition, use a calm, slow approach, provide reorientation and redirection as needed; -The resident's suicide attempt was not mentioned in the care plan; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Resident is at risk for elopement related to wandering and episodes of increased anxiety. Resident is able to walk independently with his/her walker around facility. Also, up in wheelchair propelled by feet at times, and by staff/companion at times. History of verbalizing suicidal ideation. Followed by psych. Also encouraged to speak with psychotherapist. Resident has been noted to voice accusations critical of staff related to his/her impaired cognition and dementia. Wander guard in place; -Goal: Resident will not leave facility unescorted; -Action: Monitor behaviors to determine causes and patterns, staff to make frequents checks of resident to ensure his/her safety, companions frequently during the week, Interdisciplinary Team (IDT) to assign risk level after assessment and determine plan of care; -The resident's suicide attempt was not mentioned in the care plan. During an interview on [DATE] at 11:22 A.M., Licensed Practical Nurse (LPN) V said the resident has a private caregiver that the family hired. The CNAs still go in and check on the resident. The resident gets very anxious and upset especially if alone and has a history of self-harm. The resident was sent out last month because he/she was at his/her room door with pair of scissors in his/her hands and had cuts on the other arm. During an interview on [DATE] 9:20 A.M., CNA H said the resident has not had any behaviors toward staff. The resident tells staff he/she hears voices. Staff tell the resident, he/she is ok and staff redirect. CNA H believes the resident has all plastic silverware now after he/she returned from the hospital. The resident has not tried to hurt himself/herself since he/she came to this unit after readmission from hospital. The resident has a sitter but the aides still do rounds. During an interview on [DATE] at 10:05 A.M., LPN X said to his/her knowledge the resident does not have any restrictions as far as silverware or other sharp items. The resident has 24 hour sitters. The sitters are aware of the resident's self-harm behavior. LPN X said there a note of self-harm under the skin tab for the resident that the CNAs can see. They will chart behaviors. During an interview on [DATE] at 10:15 A.M., the Director of Nursing (DON) and Administrator said if the resident has known behaviors such as a history of self-harm those behaviors should be on the care plan. The DON said if the resident has a family hired sitter, that should also be on the care plan. They would expect the staff to communicate with the sitter and update them with any new information on the resident. If something is on the care plan then it would be on the CNA care guide and vice versa. 2. Review of Resident #109's MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses wheelchair for mobility; -Incontinent of bowel and bladder; -Diagnoses include acid reflux, diabetes, malnutrition, dementia, and depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 9:20 A.M., showed CNA G entered the resident's room to provide care. When CNA G informed the resident that he/she was there to take the resident to the bathroom, the resident was overheard saying to CNA G, Oh, I have a pretty one to grab onto today. CNA G did not respond and propelled the resident into the bathroom. During an interview on [DATE] at 9:20 A.M., CNA H said the resident has a lot of behaviors. The resident fights, kicks, and wants to be touchy, like rub on staff. CNA H said he/she was informed when the resident was admitted that the resident acts like that. The resident makes comments like the one that was just made to CNA G. He/She thinks the resident got kicked out of his/her previous facility for being touchy. Sometimes the resident will try to grab the staff's bottom area during care. When the resident starts to kick, there will have to be two staff in there because the resident is so tall. CNA H said this morning the resident was playing with his/her private area when CNA H and CNA G were trying to provide incontinence care. Then the resident began to kick when they tried to redirect the resident. The resident is able to be redirected and normally stops the behavior. The nurses and management are aware. They tell aides to chart the behavior and to redirect the resident. During an interview on [DATE] at 9:22 A.M., CNA G said the resident says inappropriate stuff and in a sexual nature when staff provide incontinence care. Sometimes staff use two staff; it depends on the morning. Sometimes staff can just propel the wheelchair in the bathroom and he/she will use the urinal. Some days the resident is combative. The resident had to have two aides this morning. Staff chart the behaviors in the medical record and tell the nurse. Staff redirect. The resident is not that aggressive and is easy to redirect. This morning the resident had his/her hand on his/her genitals during incontinence care, so CNA G said he/she just politely removed the resident's arm. CNA G said sometimes reminding the resident of his/her spouse gets the behavior to stop. The resident has not been physically aggressive just verbally aggressive. During an interview on [DATE] at 10:05 A.M., LPN X states the resident has sexual behaviors sometimes. The resident is a nice person. The CNAs do report the resident is grabby. They did not report that any words were said to them today. The behaviors have been since he/she was admitted . The resident was like this before the resident got here. There have been multiple care plan meetings with his/her wife. The first one he/she did not remember so had another one a couple weeks later with the resident's wife and daughter. The CNAs redirect the resident. LPN X would expect behaviors to be on the care plan. At the time of the last care plan meeting, the resident had not had the behaviors a lot but they have increased since the last meeting. LPN X said care plans are done by the MDS coordinator. The care plan meeting includes the nurse manager, therapy, and dietary. The MDS coordinator does not attend. The nurse manager give the MDS coordinator any updates. The nurse will also update the plan of care for the CNAs to be aware of any behaviors. Care plan meetings are done upon admission and quarterly. The family calls to schedule the meeting. Review of the resident's care plan, in use during the survey, showed: -Problem: Impaired cognition related to overall decline in cognition; As evidenced by being alert and oriented to self. Resident is pleasant and cooperative; -Goal: Will be able to express needs and wants through facilitated communication at resident's level of cognitive function; (continued on next page)

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	265136	A. Building B. Wing	01/28/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Intervention: Bring out to area of activity to enhance socialization, identify self upon entering room, explain all procedures prior to beginning in simple direct terms. -No problems noted on the care plan related to the resident's sexually inappropriate behaviors. Review of the resident's medical record showed: -A progress note, dated [DATE] at 10:49 A.M., Resident voiced sexually explicit comment to CNAs while touching himself/herself. CNAs attempted to redirect resident but then he/she became resistive towards care. CNAs were able to divert behaviors with music and drink prior to pericare. After care, resident attended activities. During an interview on [DATE] at 10:15 A.M., the DON and Administrator said if the resident has known behaviors such as sexual behaviors with comments and grabbing at staff, those behaviors should be on the care plan especially if they have been occurring since admission. If the behaviors increase or decrease, that should also be noted on the care plan. Or there just may be a note of the history if they make inappropriate comments to staff or grab at staff. 3. Review of Resident #29's progress notes, on [DATE], showed at 2:58 P.M., the resident signed up for hospice. At 4:53 P.M., hospice was present. New hospice orders received and noted. Review of the resident's physician orders, dated [DATE], showed and order on [DATE] to admit to hospice. Review of the resident's hospice care plan in use during the survey, showed: -admitted [DATE]; -Diagnosis of terminal senile degeneration of the brain (a general term for a group of neurological disorders that cause a gradual decline in cognitive function); -Related diagnoses included hypertensive heart disease with heart failure, congestive heart failure, muscle weakness, seizures, benign brain tumor, urine retention, dysphagia, falls and acid reflux; -The resident was alert and oriented to self; -Hospice visited on Mondays, Wednesdays, and Thursdays; -Services provided at each visit: Hospice staff transferred the resident with two person assist to wheelchair, provided nail care, shaved facial hair, provided peri/incontinence care, showered the resident, documented food/liquid intakes, completed skin assessment and updated the floor Nurse and Nurse Supervisor of any changes, took out trash at end of visit. Review of the resident's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -Prognosis: A chronic disease which may result in a life expectancy of less than six months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan in use during the survey, showed no documentation of hospice services and the care they provided. During an interview on [DATE] at 11:33 A.M., the DON said the resident's care plan should have been updated to include hospice and the care they provided. She is not sure why it was missed. 4. During an interview on [DATE] at 10:15 A.M. the Administrator and DON said the management or Interdisciplinary Team is responsible for updating care plans. They would have expected the residents' care plans to be updated to reflect self-harm behaviors, sexual behaviors and hospice services. 44950 46967

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992 Based on observation, interview and record review, the facility failed to ensure residents receive care consistent with professional standards. Staff failed to complete a documented assessment and documented notifications to the physician and family regarding a resident's knee wound. Staff also failed to obtain a physician's order for a dressing to the resident's right knee (Resident #110). The sample size was 26. The census was 132. Review of the facility's Prevention and Treatment of Skin Breakdown policy, dated 8/2019, showed: -Policy: It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure injuries; To implement preventative measures; and to provide appropriate treatment modalities for wounds according to the industry standards of care. -Procedure: Monitoring of skin integrity. Skin will be observed daily with care by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits on the bath or shower day will be performed by the licensed nurse. When a wound is found, notify the physician/nurse practitioner, the resident representative, and notify the supervisor. Review of the resident #110's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed: -admitted [DATE]; -Slurred speech; -Rarely or never understood; -Sometimes understands direct communication; -Diagnoses include kidney failure, aphasia (loss of speech), dementia, anxiety, and depression. Review of the resident's skin assessment, dated 12/6/24, showed: -A partial thickness wound, skin tear to the right lateral knee. Review of the resident's skin assessment, dated 12/13/24, showed: -The skin tear had healed. The nurse noted the skin tear was unremarkable and closed the report. Review of the resident's shower sheet, dated 1/21/25, showed: -A scabbed area to the right knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's shower sheet, dated 1/23/25, showed: -A scabbed over area to the right lateral knee. Review of the January 2025 progress notes showed no documentation about a wound or dressing to the resident's right knee, prior to 1/27/25. Review of the physician's orders sheet (POS) showed no treatment orders for the resident's right knee in January 2025, prior to 1/27/25. Review of the resident's treatment record, dated January 2025, showed: -No treatment order for the right knee. Observation and interview on 1/27/25 at 8:49 A.M., during the resident's care, showed a small bandage on the resident's right knee. The only viewable markings on the bandage was 1/23. Certified Nursing Assistant (CNA) B and CNA A said they were not aware of the dressing to the right knee and were not able to read the numbers on the dressing. During an interview on 1/27/25 at 9:11 A.M., Licensed Practical Nurse (LPN) I said that he/she was unaware of the resident having a wound to the right knee, that required a dressing. LPN I assessed the resident's right knee, removed the dressing, and cleaned the wound. During an interview on 1/27/25 at 10:23 A.M., LPN I said he/she left a message for the doctor regarding the wound, phoned the family about the wound, and notified the Director of Nursing (DON). During an interview on 1/28/25 at 8:19 A.M., CNA D said that he/she assists the residents with their showers and documents any sores or wounds on the shower sheet, which is turned into the charge nurse. He/she said if the sore is not treated, it could get worse or infected. During an interview on 1/28/25 at 8:24 A.M., LPN E said that the CNAs fill out the shower sheets and let him/her know if there are any skin issues with the resident. The manager or the DON performs the weekly skin assessments. Wounds have to be treated so they do not get worse or infected. During an interview on 1/27/25 at 2:39 P.M., the resident's physician said that she would expect staff to notify her as soon as possible if there is an alteration in skin integrity. During an interview on 1/28/25 at 10:12 A.M., the DON said the CNAs fill out a shower sheet on the resident's shower day and note issues with the skin. The CNAs can also fill out a Stop n Watch (a communication form) and turn the form into the nurse to notify him/her of a new skin issue. During an interview on 1/28/25 at 10:26 A.M., the Administrator said she expected the staff to follow the policies on skin and wounds.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49992 Based on interview and record review, the facility failed to ensure each nurse aide had no less than twelve hours of in-service education per year based on their individual performance review and calculated by their employment date rather than the calendar year, for eight of 10 sampled Certified Nursing Assistants (CNA) and Certified Medication Technicians (CMT). The census was 132. Review of the facility's Compliance Education and Training Policy, dated 7/1/2019, showed: -Purpose: The purpose of this policy is to standardize the requirements for initial orientation, ongoing training, focus training, and corrective training in order to educate employees and non- employees on compliance with laws regulations and facility policies and procedures, and to promote accountability; -Policy statement: The facility requires that all employees receive training on compliance with laws, regulations, facility policies and procedures, and standards of conduct. Non-employees including board members, vendor representatives, contractors, students, and volunteers who regularly work at the facility or have access to Protected Health Information are also required to receive similar training. Individuals have the responsibility and obligation to act in accordance with federal and state regulations, to know and understand the facility policies and procedures that govern their responsibilities, and to understand the consequences of failure to comply with these requirements. 1. Review of the Facility Assessment Tool, undated, completed by the facility, showed: -Effective Communication done annually in Relias (an education software); -Resident Rights and facility responsibilities done upon hire, annually in Relias, and as needed; -Abuse, Neglect, and Exploitation done upon hire, annually in Relias, and as needed; -Infection Control done upon hire, annually in Relias, and as needed; -State-approved training program for feeding assistants done in-house and led by the Infection Preventionist; -Recognizing a change in the resident's condition done upon hire, annually in Relias, and as needed; -Cultural Competency done in Relias annually; -Caring for persons with Dementia, Alzheimer's and Cognitive Impairments done upon hire, annually in Relias, and as needed. 2. Review on 1/27/24 at 11:40 A.M., of a stack of in-service trainings provided by the facility, showed documented number of hours for each in-service provided and individualized tracking records for individual staff. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CNA A's employee file, showed date of hire 8/15/19. In-service tracking provided based on hire date, showed 5.15 hours of in-service training provided during the 8/15/23-8/15/24 tracking period. Review of CNA J's employee file, showed date of hire 7/9/20. In-service tracking provided based on hire date, showed 11.35 hours of in-service training provided during the 7/9/23-7/9/24 tracking period. Review of CNA K's employee file, showed date of hire 3/25/21. In-service tracking provided based on hire date, showed 11.1 hours of in-service training provided during the 3/25/23-3/25/24 tracking period. Review of CNA L's employee file, showed date of hire 9/23/21. In-service tracking provided based on hire date, showed 10.85 hours of in-service training provided during the 9/23/23-9/23/24 tracking period. Review of CNA M's employee file, showed date of hire 7/21/22. In-service tracking provided based on hire date, showed 9.5 hours of in-service training provided during the 7/21/23-7/21/24 tracking period. Review of CNA N's employee file, showed date of hire 6/9/22. In-service tracking provided based on hire date, showed 3.35 hours of in-service training provided during the 6/9/23-6/9/24 tracking period. Review of CNA O's employee file, showed date of hire 11/30/23. In-service tracking provided based on hire date, showed 8.35 hours of in-service training provided during the 11/30/23-11/30/24 tracking period. Review of CMT P's employee file, showed date of hire 9/28/18. In-service tracking provided based on hire date, showed 10.85 hours of in-service training provided during the 9/28/23-9/28/24 tracking period. 3. During an interview on 1/28/25 at 7:10 A.M., the Administrator said she would expect staff to have the 12 hours of annual education. Staff should be trained on those items outlined in the facility assessment and those trainings required by the federal and state guidelines.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44950 Based on observation, interview and record review, the facility failed to establish a system of records for all controlled drugs with sufficient detail to enable an accurate reconciliation for ten out of ten narcotic count books reviewed. This had the potential to affect all residents with controlled substance orders. The census was 132. Review of the facility's Controlled Substances policy, original date 8/19, showed: It is the policy of Friendship Village to ensure compliance with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. -Only authorized licensed nurses that are permanent employees of Friendship Village or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. ***No agency nurse is allowed to carry narcotic keys or administer narcotics to any resident. -Controlled substances must be counted upon delivery. The nurse receiving the order must count the controlled substances together with Shift Supervisor. Both individuals must sign the designated narcotic record. -Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. -Nursing staff must count controlled drugs at the end of each shift, for each eight hour or 12-hour shift. The nurse coming on duty and the nurse going off duty must complete the count together. They must document and report any discrepancies to the Shift Supervisor and Director of Nursing (DON) immediately. -The Director of Nursing shall investigate all discrepancies in Controlled Substance reconciliation to determine the cause and identify any responsible parties and shall give the Administrator a written report of such findings. 1. Observation and review of the 1a Certified Medication Technician (CMT) cart narcotic book on 1/24/25 at 6:18 A.M., showed: -The slot for the off-going nurse for the night shift entry (1/23-1/24/25) was pre-signed prior to the count being performed; -At 6:33 A.M., the narcotics for the cart had not been counted with the on-coming nurse or CMT; -At 6:40 A.M., the on-coming CMT F pulled the narcotic cards out of the box and reviewed the narcotic sheets in the book, with no other staff member present; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 6:47 A.M., review of the 1a CMT narcotic book showed the initials of CMT F present in the nurse on-coming and nurse off-going slots for the day shift entry (1/24/25). Review of the controlled drug count sheets for the 1a CMT cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 8:49 A.M., showed: -Nurse initials documented under Off under 3:00 P.M. shift change entry for 1/24/25. -No outgoing staff signature for two of 70 opportunities; -No incoming staff signature for two of 70 opportunities; -No documentation under # of Packages, for two of 70 opportunities. 2. Review of the controlled drug count sheets for the 1a Nurse cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 8:53 A.M., showed: -No outgoing staff signature for 20 of 70 opportunities; -No incoming staff signature for 15 of 70 opportunities; -No documentation under # of Packages, for 11 of 70 opportunities. 3. Review of the controlled drug count sheets for the 1b Nurse cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:01 A.M., showed: -No outgoing staff signature for 17 of 70 opportunities; -No incoming staff signature for 14 of 70 opportunities; -No documentation under # of Packages, for nine of 70 opportunities. 4. Review of the controlled drug count sheets for the 1c CMT cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:04 A.M., showed: -Nurse Initials documented under Off at 3:00 P.M. shift change entry for 1/24/25; -No outgoing staff signature for six of 70 opportunities; -No incoming staff signature for four of 70 opportunities. 5. Review of the controlled drug count sheets for the 3c CMT cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:12 A.M., showed: -Nurse Initials documented under Off at 3:00 P.M. shift change entry for 1/24/25; -No outgoing staff signature for eight of 70 opportunities; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No incoming staff signature for nine of 70 opportunities; -No documentation under # of Packages, eight of 70 opportunities. 6. Review of the controlled drug count sheets for the 3a Nurse cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:14 A.M., showed: -Nurse Initials documented under Off at 3:00 P.M. shift change entry for 1/24/25; -No outgoing staff signature for 18 of 70 opportunities; -No incoming staff signature for 11 of 70 opportunities. 7. Review of the controlled drug count sheets for the 2c Nurse cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:22 A.M., showed: -No outgoing staff signature for 17 of 70 opportunities; -No incoming staff signature for 11 of 70 opportunities; -No documentation under # of Packages, for five of 70 opportunities. Review of the controlled drug count sheets for the 2c Nurse cart, dated 1/1/25 through 1/27/25, for 1/24/25 through 1/27/25, on 1/27/25 at 8:57 A.M., showed: -No outgoing staff signature for one of nine opportunities; -Number of packages already documented under # of Packages, for 3 PM shift count on 1/27/25. 8. Review of the controlled drug count sheets for the 2a CMT cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:25 A.M., showed: -No outgoing staff signature for 14 of 70 opportunities; -No incoming staff signature for 11 of 70 opportunities; -No documentation under # of Packages, for seven of 70 opportunities. Review of the controlled drug count sheets for the 2a CMT cart, dated 1/1/25 through 1/27/25, for 1/24/25 through 1/27/25, on 1/27/25 at 8:52 A.M., showed: -No outgoing staff signature for two of nine opportunities; -No incoming staff signature for two of nine opportunities; -No documentation under # of Packages, for one of nine opportunities. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of the controlled drug count sheets for the 2c CMT cart, dated 1/1/25 through 1/24/25, on 1/24/25 at 9:27 A.M., showed: -No outgoing staff signature for 10 of 70 opportunities; -No incoming staff signature for six of 70 opportunities; -No documentation under # of Packages, for three of 70 opportunities. Review of the controlled drug count sheets for the 2c CMT cart, dated 1/1/25 through 1/27/25, for 1/24/25 through 1/27/25, on 1/27/25 at 8:55 A.M., showed: -No outgoing staff signature for two of nine opportunities; -No documentation under, # of Packages, for one of nine opportunities. 10. Review of the controlled drug count sheets for the 2a Nurse cart, dated 1/1/25 through 1/27/25, on 1/27/25 at 8:50 A.M., showed: -No outgoing staff signature for 17 of 80 opportunities; -No incoming staff signature for 16 of 80 opportunities; -No documentation under # of Packages, for 16 of 80 opportunities. 11. During an interview on 1/28/25 at 10:15 A.M., the DON and Administrator said the narcotic count should be done at the beginning and at the end of each shift with two staff. The book should be signed at the time the count is completed, not presigned. They would not expect there to be blank spots on the narcotic sheets.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49992 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 30 opportunities observed, four errors occurred, resulting in a 13.33% error rate (Residents #60 and #98). Staff did not measure a medication in powder form on a level surface, provided a bottle of nasal spray to a resident and did not stop the resident at the ordered doses, crushed a medication that should not have been crushed and left crushed medications unattended on the medication cart. The census was 132. Review of the facility's Medication Administration, policy dated 8/19, showed: -Purpose: To clearly define Drug Administration policies in accordance with all applicable laws and standards of practice. Review of the facility's Crushing Medications policy, dated 8/19, showed: -Purpose: To enable the resident who has difficulty swallowing to take medications orally. Review of the facility's Medications Not to be Crushed list, revised 7/19, showed: -Ezetimibe (to treat high cholesterol) tablet not be crushed due to manufacturers recommendation. 1. Review of the resident #60's medical record, showed: -Diagnoses included renal disease, diabetes, congestive heart failure, atrial fibrillation (the heart beat is irregular), dementia, and depression; -An order, dated 11/14/24, Psyllium husk (to assist the bowels) 2.6 grams/4.1 gram oral powder by mouth daily for bowel health; -An order, dated 11/14/24, Flonase Allergy Relief 50 micrograms (mcg) nasal spray, two sprays into each nostril once daily for allergies. During a medication administration observation, on 1/24/25 at 7:27 A.M., Certified Medication Technician (CMT) Q held a 30 cc medication cup up over the medication cart and poured the Psyllium husk powder into the cup and shifted the contents to measure the amount. Then poured the powder into a cup and mixed with water. CMT Q gathered the remainder of medications and approached the resident and handed the resident the bottle of Flonase. The resident removed the top and sprayed each nostril a total of four times, alternating between nostrils. CMT Q intervened at that point and took the bottle from the resident. The resident consumed the contents of the cup of dissolved powder. 2. Review of the resident #98 medical record, showed: -Diagnosis of osteoporosis (softening of the bone), atherosclerotic heart disease (hardening of the blood vessels), high cholesterol, kidney failure, atrial fibrillation, and dementia; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 1/23/24, May crush medication if not contraindicated; -An order, dated 1/25/24, for Ezetimibe 10 milligrams (mg) by mouth every morning. During a medication administration observation on 1/24/25 at 7:48 A.M., CMT Q crushed the Ezetimibe tablet with the resident's other medications, mixed with pudding and approached the resident in the dining room. The resident said he/she wanted to wait until after his/her meal. CMT Q returned to the medication cart (med cart), placed the medicine cup with the crushed medications in the ice tray sitting on top of the med cart. CMT Q said, I need to keep it cold. CMT Q then left the medication cart, with the crushed medication still in the ice tray. He/She walked approximately 100 feet into the dining area where the medication cart was no longer in sight. During an interview on 1/28/25 at 8:06 A.M., CMT F said that residents should not administer their own medications without an assessment by the nurses to show the resident is able to do safely. There was list in the narcotic count book on the medication cart that contained a list of medications that could not be crushed. If staff were unable to administer medication to a resident, the medications were to be placed in a paper cup with the date, time, resident's initials, covered with another cup and secured in the medication cart. Medication should never be left unattended. When pouring a liquid or a powder medication, the medication cup should be placed on the medication cart, not up in the air. During an interview on 1/28/25 at 8:24 A.M., Licensed Practical Nurse (LPN) E said when preparing powder medication, the medication cup should be place on top of the cart, then pour the medication and measure by bending to come to eye left with the cup instead of bringing the cup to eye level. Staff should only crush medication when there was an order. During an interview on 1/28/25 at 10:12 A.M., the Director of Nursing said she expects staff to administer medication as ordered and to follow the facility's policies and procedures. Medication should never be left unattended. During an interview on 1/28/25 at 10:26 A.M., the Administrator said she would expect to staff follow the facility's policy on medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to ensure residents were free from any significant medication errors. Staff failed to administer a medication for one resident with a diagnosis of obstructive uropathy (occurs when urine flow is blocked, causing urine to build up in the kidneys) who required the medication to empty their bladder and increase urination (Resident #29). Staff failed to administer several doses of a medication used to treat anxiety for one resident (Resident #110). Staff also administered an expired medication, used to treat Parkinson's disease (an age-related degenerative brain condition) for over a week. The medication was ordered to be given twice a day. The bottle showed the medication expired October 2024 (Resident #227). These failures put residents at risk for significant medication errors that went undetected and unreported to the physician, resulting in potential for compilations related to missed doses and administering expired medications. The sample was 26. The census was 132. Review of the facility's policy Charting of Medication Administration, dated 8/2019, showed: -Purpose: To ensure proper documentation of medication administration, results, or refusal. Accurate documentation allows the nurse and other health care providers to communicate with one another and improves medication safety; -Procedure: If a prescribed drug is not given or refused by the resident, the time block is initialed by the nurse, and a circle is placed around the nurse's initials. A note of the explanation is recorded by the nurse on the back of the medication sheet or in the electronic medication administration record. If the medication is delayed, record the medication on the record that the medication was held, and the reason. Update the physician for further directions. 1. Review of Resident #29's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 11/8/24, showed: -Severe cognitive impairment; -Diagnoses included Alzheimer's disease, seizures, high blood pressure, end stage renal failure, and obstructive uropathy. Review of the resident's physician order, dated January 2025, showed: -An order on 12/8/24, for bethanechol chloride (helps to cause urination and emptying of the bladder) five milligram (mg) tablet, two tablets (10 mg) by mouth three times per day, at 7:00 A.M., 11:30 A.M., and 4:30 P.M., for urinary retention. Last dose on 1/27/25. Review of the resident's Medication Administration Record (MAR), dated January 2025, showed: -Bethanechol chloride 10 mg, start date 12/8/24. Staff to administer during breakfast, lunch, and dinner; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/5/25 at 10:21 A.M. and 12:52 P.M., staff documented medication not available. Staff initialed the medication was administered during dinner.; -On 1/6/25 at 8:56 A.M., 12:51 P.M. and 4:47 P.M., staff documented medication not available. Staff noted the medication was reordered from the pharmacy; -On 1/7/25 at 8:32 A.M., staff documented the medication was on hold. The pharmacy was notified. Staff initialed the medication was administered during lunch and dinner; -On 1/8/25-1/14/25, staff initialed the medication was administered during breakfast, lunch, and dinner; -On 1/15/25 at 11:20 A.M., staff documented medication not available. At 12:56 P.M., staff documented the medication was on hold. Staff initialed the medication was administered during dinner. During an interview on 1/27/25 at 11:33 A.M., the Director of Nursing (DON) said the resident received his/her medication from the Veteran's Administration. The medication was not available. The facility kept bethanechol in their stock medications. She would have expected staff to utilize stock medications until the medication was received. The resident's physician was not notified of the missed doses. She would have expected staff to notify the physician. During an interview on 1/27/25 at 2:39 P.M., the Medical Director said he/she would expect staff to notify him/her of multiple missed doses of medication. Multiple missed doses of the medication would worsen the symptoms controlled by the medication. 2. Review of Resident #110's Admission MDS, dated [DATE], showed: -admitted [DATE]; -Slurred speech; -Rarely or never understood; -Sometimes understand direct communication; -Diagnosis include, kidney failure, aphasia (loss of speech), dementia, anxiety, and depression. Review of resident's Physician Orders, dated 1/27/25 showed: -An order dated 11/27/24 for Clonazepam (a medication used to produce calming effect on the brain which helps reduce anxiety) 1 mg tablet by mouth three time a day for anxiety. Review of the resident's MAR, dated [DATE], showed: -Morning doses for 1/19, 1/20, 1/21, and 1/22 were not given; -Midday doses for 1/19, 1/20, 1/21, and 1/22 were not given; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evening doses for 1/21 were not given; -The notes page showed the comments for the omitted (not given) doses were on hold, none in Pyxis (automated dispensing medication machine) waiting for refill, and taken from Emergency access medication kit (EKit). Review of the resident's nurse notes showed: -No entry the medication was not given and the reason. -No entry the physician or the family were notified. During an interview on 1/24/25 at 12:03 P.M. Certified Medication Technician (CMT) F opened the medication cart and verified there was no clonazepam available for the resident. He/She reported the nurse was made aware. During an interview on 1/24/25 at 12:17 P.M., Licensed Practical Nurse (LPN) I said he/she was not aware the resident did not receive the doses of clonazepam. During an interview on 1/24/25 at 12:45 P.M., the DON said she was now aware the resident did not receive the ordered clonazepam. When the CMT identified a medication was not available they were to fill out a Stop N Watch and give the completed form to the charge nurse. The practice was when the first dose was missed, contact the pharmacy. If the resident missed three doses, then staff were to call the physician. During an interview on 1/27/25 at 2:39 P.M., the Medical Director said he/she would expect to be notified when a resident had not received their medications. The adverse reactions of the resident not receiving his/her medication was not harmful, but it could exacerbate the symptoms that were being treated. During an interview on 1/28/25 at 10:26 A.M., the Administrator said she would expect the staff to follow the facility's medication administration policy. 3. Review of Resident #227's electronic medical record (EMR) showed: -admitted [DATE] -Diagnosis: Parkinson's Disease with Axial Motor Symptoms (AMS, affects trunk and core muscles) Review of the resident's Interim Care Plan, dated 1/13/25, showed: -Problem: Resident's interim admitting diagnosis list: Parkinson's Disease with AMS; -Goal: Review diagnosis list, discuss full care planning with Interdisciplinary Team to promote highest level of function for 30 days; -Review diagnosis and treatment list, enter and review physician's orders, order medications as needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic Physician Order Sheet (ePOS) showed: -An order, dated 1/14/25, Rytary 36.25 mg-145 mg capsule, extended release. (Carbidopa-levodopa) 36. 25-145 mg by mouth twice daily for Parkinson's. Review of the resident's Treatment Administration Record (TAR), on 1/24/25, showed: -Rytary 36.25 mg-145 mg capsule, extended release. (Carbidopa-levodopa) 36.25-145 mg by mouth twice daily for Parkinson's; Diagnosis/Reason: Parkinson's. -AM dose marked as given 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, 1/20/25, 1/21/25, 1/22/25, 1/23/25, and 1/24/25; - Rytary 36.25 mg-145 mg capsule, extended release. (Carbidopa-levodopa) 36.25-145 mg by mouth twice daily for Parkinson's; Diagnosis/Reason: Parkinson's. -Late PM dose marked as given 1/14/25, 1/15/25, 1/16/25, 1/17/25, 1/19/25, 1/20/25, and 1/22/25; -Late PM dose not marked as given 1/18/25, 1/21/25, and 1/23/25. During an observation and interview on 1/24/25 at 8:50 A.M., LPN I said the resident was admitted a week and a half ago and the family brought a bottle of Rytary into the facility to administer to the resident. The 1A nurse medication cart showed the resident had a bottle of Rytary in a compartment with the resident's other medications. The expiration date on the bottle showed October 2024. LPN I verified the expiration date and said he/she was not aware the medication was expired. He/She would have the family bring in a new bottle. During an interview on 1/24/25 at 11:45 A.M., the DON said when a resident was admitted , the admission nurse took physician orders and reviewed with family or the resident. After the review was complete, the nurse called the physician to have the medications verified. The medications were then ordered from the pharmacy. If the family brought in the medication, the nurse was expected to verify the medication was the same dose ordered by the physician. She would expect staff to check the expiration date. Expired medications should not be given because they do not know the effectiveness and it may have the opposite effect if expired. The DON said the nurse gave today's morning dose of the medication after the surveyor reviewed the cart and saw the expired bottle. The nurse disposed of the bottle and then pulled the medication from the facility's stock medications. The DON said she could not remember why the family brought it in instead of getting the medication from the pharmacy. After the expired medication was found, the nurse was instructed to call the physician and complete a 72 hour medication watch to notice the expiration date. During an observation and interview on 1/27/25 at 10:26 A.M., LPN I opened the 1A nurse medication cart. The resident had a bottle of Rytary medication that was not expired. LPN I said the family brought in a new bottle and the family told the facility the family was putting samples in the bottle or something like that. LPN I said that did not matter you had to go by what was marked on the bottle. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/27/25 at 2:39 P.M., the Medical Director said he/she would expect staff not to administer expired medications. The physician said usually there were no adverse effects from receiving expired medications, but the resident may not get the effectiveness of the medication if it was expired. During an interview on 1/28/25 at 10:15 A.M., the Administrator said staff should check medication bottle expiration dates when admitting a resident or accepting medication from the resident's family. She would expect staff to check the expiration date on the medication bottle prior to administering the medication as well. 46967 49992

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to ensure residents were provided therapeutic diets as recommended by the physician and the Registered Dietician (RD), for one resident with weight loss (Resident #109). The facility failed to provide the resident's fortified chocolate milk for two observed meals. The facility also failed to provide the extra items listed on the meal ticket. The sample was 26. The census was 132. Review of Resident #109's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses wheelchair for mobility; -Weight: 163 pounds (lbs); -Supervision or touching assistance for eating (Helper provides cues or touching/steadying assistance as resident completes activity); -Diagnoses include acid reflux, diabetes, malnutrition, dementia and depression. Review of the resident's current care plan, showed: -Problem: Resident has potential for cognitive impairment; -Interventions: None listed -Goal: Resident's nutritional status will remain stable as evidenced by adequate oral intake to meet estimated nutrition and hydration needs and no significant weight change through next review. Review of the resident's electronic medical record (EMR), showed: -A progress note, dated and signed by the RD on 12/18/24 at 10:33 A.M., Resident reviewed for gradual weight loss. 163 lbs to 155.8 lbs. Cognitive impairment has affect his/her appetite and attention to stay on feeding task at meals. History of moderate protein-calorie malnutrition and diabetes. Spoke with resident today. Attempted to obtain preferences from resident. Spoke with spouse on the phone. Discussed moving resident to assist side of dining room and starting Glucerna (supplement) every day. Spouse in agreement. Will monitor supplement acceptance and weight per physician order. Refer to RD as needed; (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note, dated and signed by the RD on 1/23/25 at 1:27 P.M., Nutrition Review: Resident's weight 154 lbs remains down from usual body weight of 160-165 lbs. Last month resident started to receive more oversight, cueing, and encouragement at meals when spouse is not present. Due to resident's cognition, he/she requires reminders and directions to continue to self-feed on optimal amount. Talked to resident's spouse in dining room today. The spouse voiced concerns about resident's assistance need to prepare and complete a meal (assist putting in teeth, encourage/cue him/her through meal). Spouse requested some favorite food items be added. Spoke to Director of Nursing (DON) regarding spouse's concerns. Added items of preference (fruit, yogurt, milk) to meals. Staff have trialed resident on fortified chocolate milk. The resident has consistently drunk milk. Will add preferences to tray ticket and plan of care. Placed on weekly weights to monitor. Review of the resident's current care plan, showed it was not updated with the resident's preferences for fruit, yogurt and milk. Review of the resident's physician orders, dated 1/25, showed an order, dated 11/04/24, regular diet. Review of the resident's meal ticket, dated 1/24/25, showed: Breakfast: -Diet: Regular; -Texture: Regular; -Beverages: [NAME] (fortified chocolate milk) milk-4 full ounces (oz); -Food Adds: Fresh fruit-1 serving. Lunch: -Diet: Regular; -Texture: Regular; -Beverages: [NAME] milk-4 full oz; -Food Adds: Fresh fruit-1 serving, -Yogurt-1 each. Dinner: -Diet: Regular; -Texture: Regular; -Food Adds: Fresh fruit-1 serving. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation in the dining room on 1/22/25, showed: -At 11:33 A.M., the resident sat at a table with two other residents. The resident had a cup of water, a cup of juice, and a cup of chocolate milk in front of him/her; -At 11:52 A.M., the resident gave his/her food order; -At 12:01 P.M., dietary staff brought the resident's lunch plate and set it out of reach of the resident. The resident was not served fruit. The dietary aide cut the meatloaf on the resident's plate and walked away with the plate out of the resident's reach; -At 12:06 P.M., a staff member went to the resident and straightened out his//her chair and put the resident's food in front of him/her. The resident began to eat; -At 12:15 P.M., the resident ate approximately 25% of his/her lunch. Licensed Practical Nurse (LPN) V goes to the resident's table and instructed the resident he/she needs to eat. LPN V attempted to help the resident but the resident said he/she was done eating. Observation in the dining room on 1/23/25, showed: -At 11:28 A.M., the resident sat with his/her spouse at a table with two residents. -At 11:42 A.M., the resident was brought his/her lunch plate of the entree of the day. The resident was also brought a cup of soup and a bowl of applesauce. Yogurt was not provided. -At 12:14 P.M., the RD was at the table with the resident and his/her spouse. The RD told the spouse that she was told by staff the resident was not eating or his/her intake was decreasing when the spouse was not here. The spouse told the RD the other day, the resident sat and staff assisted other residents around him/her and not him/her. The spouse also reported that when he/she was not there, the resident only gets one plate of the entree and not the extras like he/she was supposed to get. The spouse said he/she would not be able to be at the facility tomorrow. The RD said he/she would talk to staff to ensure they assist the resident and that he/she had the extras when the spouse was not here. Observation in the dining room on 1/24/25, showed: -At 11:29 A.M., the resident sat in the dining room at a different table with different tablemates closer to the kitchenette. The resident had chocolate milk, juice, and a water cup in front of him/her; -At 11:32 A.M., the resident's food was brought to him/her. The resident was served tortellini in red sauce with Brussel sprouts. There were no extra sides or applesauce with the entree; -At 11:40 A.M., the resident ate cake. A staff member said, Look at you all doing good and you made me feed you this morning. The resident pushed his/her pasta away from him/her. The resident ate approximately 25% of his/her lunch. No further verbal cues or assistance were provided. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation in the dining room on 1/27/25 at 8:30 A.M., showed the resident sat in the dining eating breakfast. The resident had a cup of orange juice and a cup of water. The resident did not have fortified chocolate milk. The resident had two plates for breakfast. One appeared to be a type of bread dessert. The resident did not have fruit. Observation on 1/27/25 at 8:50 A.M., showed the resident had a full cup of fortified chocolate milk on his/her bedside table. The resident was not in his/her room. Observation on 1/27/25 at 9:20 A.M., showed the resident was brought back to his/her room by the Certified Nursing Assistant (CNA). The cup of chocolate milk was still on the resident's bed side table. During an interview on 1/27/25 at 9:22 A.M., CNA G said the chocolate milk in the resident's room was probably brought down from breakfast but he/she was not sure. During an interview on 1/27/25 at 10:05 A.M., LPN X said the Certified Medication Technician (CMT) hands out the special chocolate shake during medication pass. Observation on 1/27/25 at 11:50 A.M., showed the full cup of fortified chocolate milk on the resident's bed side table. Observation on 1/27/25 at 11:53 A.M., showed CNA G entered the dining room with a full cup of fortified chocolate milk and put the cup in the kitchenette. The cup of chocolate milk that was in the resident's room was no longer on the resident's bed side table. Review of the Medication Administration Record, dated 1/25, showed no order or documentation of administration of [NAME]. Observation in the dining room on 1/27/25, showed: -At 11:52 A.M., the resident sat in the dining room for lunch service. The resident sat at the table by the kitchenette. The resident had a cup of juice and a cup of water. The resident did not have a cup of the fortified chocolate milk. The resident sat with two other residents who are both eating. The resident did not have his/her food; -At 12:03 P.M., a dietary staff brought the resident's food and placed the plate in front of the resident. The resident has a cheeseburger and French fries. The resident did not have fruit or any other sides. The resident backed himself/herself up from the table in his/her wheelchair. No staff offered to assist him/her; -At 12:05 P.M., the resident started to eat. CNA G was at the resident's table. CNA G pushed in the resident's wheelchair under the table and locked his/her wheelchair. CNA G cut the resident's cheeseburger into four pieces and walked away from the table. The resident ate his/her French fries; -At 12:20 P.M., the resident ate a few French fries. The resident did not eat any of his/her cheeseburger. He/She ate all of the apple cobbler dessert. No other verbal cues were provided by staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village Sunset Hills	12651 Village Circle Drive Saint Louis, MO 63127

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at approximately 8:40 A.M., the RD said she expected staff to follow instructions and recommendations. The resident's spouse wants the resident to sit in different spots and will change what he/she wants the facility to do for the resident. The RD expected the resident to have the [NAME] milk and have different options offered that are listed on the meal ticket. She expected staff to offer an alternate if the resident did not appear to be eating. The resident did not have to eat if he/she did not want to. The resident was just on her watch list for weight loss. During an interview on 1/28/25 at 10:15 A.M., the DON and Administrator said the dietary staff should be aware of the dietician recommendations and should follow them. They expected the dietary staff to follow what is on the meal ticket. The DON said dietary should notify nursing if the resident did not have his/her fortified chocolate milk. The resident should get it as recommended by the dietician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection prevention and control when staff failed use proper hand hygiene while providing care for two of three sampled residents observed for incontinence care (Residents #110 and #44). The census was 132. Review of the facility's Hand Hygiene policy, dated 8/19, showed: -Purpose: hand hygiene is required in order to reduce the spread of potentially dangerous infectious agents and to reduce the risk of colonization or infection for health care workers that could be potentially acquired from the resident; -Policy Statement: It is the policy of this facility that hand hygiene will be provided consistent with best practices. Hand hygiene (hand washing and/or alcohol based hand rub (ABHR) includes the use of ABHR instead of soap and water in all clinical situations except when the hands are visibly soiled (blood or bodily fluids) or after caring for a resident with known or suspected Clostridium (C.) difficile or norovirus infection during an outbreak, or if infection rates of C. difficile infection are high; In these circumstances soap and water should be used. Review of the facility's Perineal Care for a Male/Female with Handwashing, effective 7/1/2023, showed: -Perform hand hygiene after removing gloves; -A. Cover all surfaces of the hands with hand sanitizer; -B. Rub together until hands are dry. 1. Review of Resident #110's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 12/4/24, showed: -Slurred speech; -Rarely or never understood; -Sometimes understand direct communication; -Always continent of bladder, frequently incontinent of bowel; -Diagnoses included kidney failure, aphasia (loss of speech), dementia, anxiety and depression. Review of the resident's care plan, dated 12/24/24, showed the resident has an alteration in elimination as related to frequently incontinent of bowel, usually continent of bladder. He/She requires dependence for all aspects of toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/27/25 at 8:49 A.M., showed Certified Nursing Assistant (CNA) B and CNA C put on gloves in the resident's room, to provide incontinence care to the resident. CNA A assisted CNA B to transfer the resident into bed with the Hoyer (a mechanical device used to assist staff with transferring residents who are totally dependent on staff) lift. After the resident was placed on the bed, CNA C asked CNA B to assist turning the resident on his/her left side, removing the Hoyer pad and lowering the resident's pants, and detaching the brief on one side. The resident was turned to the right side, the CNA lowered the resident's pants, and detached the brief. The resident was placed on his/her back. The resident was turned to his/her right, and the urine soiled brief was pushed between the resident's legs toward his/her backside. CNA C, using wipes, cleaned the front peri area, wiping from front to back. While on his/her right side, CNA B cleaned the resident's left buttock. The resident was turned to the left side, CNA C cleaned the right buttock and removed the soiled brief, and the resident was placed on his/her back. CNA B and CNA C removed their gloves. CNA B applied hand sanitizer, before putting on another pair of gloves. CNA C did not use hand sanitizer before putting on another pair of gloves. CNA C assisted CNA B with turning the resident to the right. While placing a clean brief, CNA C noted the resident may have a bowel movement. Using wipes, CNA C cleaned the stool from around the anus. CNA C removed his/her gloves and did not use hand sanitizer before putting on the new gloves. CNA C assisted CNA B to turn the resident to his/her left side. CNA B said it looked like the resident was still trying to have a bowel movement. CNA B cleaned the stool from around the anus and the resident was placed on his/her back and the brief was pulled to the front of the resident. CNA B and CNA C removed their gloves, neither using sanitizer, and each CNA put on another pair of gloves. The resident's pants were pulled back up and the resident was placed in his/her chair with the Hoyer Lift. 2. Review of Resident #44's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -Lower extremity impairment one side; -Frequently incontinent of bowel and bladder; -Diagnoses include hip fracture, benign prostatic hyperplasia (BPH, enlarged prostate) and high blood pressure. Review of the resident's care plan, dated 10/24/24, showed: -Category: Resident is on Enhanced Barrier Precautions (EBP) related to wounds; -Resident will maintain EBP without complications and will be free from new infection over the next 90 days; -Practice appropriate hand washing in between care and when visibly soiled. Ensure access to alcohol based hand sanitizer in rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/27/25 at 9:25 A.M., showed CNA G and CNA H donned gowns and gloves and entered the resident's room. CNA G assisted CNA H to transfer the resident into bed with the Hoyer lift. CNA G and CNA H removed their gloves and donned new gloves. Hand hygiene was not performed. CNA G unfastened the resident's brief and wiped the resident's inner thighs and front to back of the resident's private area. CNA G removed his/her gloves and donned new gloves. He/She did not perform hand hygiene. CNA H assisted CNA G to roll the resident to his/her right side. CNA G wiped the resident's buttock area and removed the resident's brief and a soiled dressing to the resident's buttock area. CNA G removed his/her gloves and donned new gloves. He/She did not perform hand hygiene. CNA G placed a new brief under the resident and applied barrier cream to the resident's buttock and inner thigh. CNA G did not change his/her gloves and rolled the resident to his/her back. CNA G and CNA H fastened the resident's brief and assisted the resident into his/her wheelchair with the Hoyer lift. CNA G and CNA H removed their gloves and gowns and left the resident's room. 3. During an interview on 12/27/25 at 12:51 P.M., CNA R said whenever staff change gloves, they should use hand sanitizer or if they can, wash their hands. Using hand sanitizer helps to prevent germs from spreading. 4. During an interview on 1/28/25 at 8:24 A.M., Licensed Practical Nurse (LPN) E said that staff should use hand sanitizer every time they remove gloves. Staff still need to wash their hands too. 5. During an interview on 1/28/25 at 10:15 A.M., the Director of Nurses (DON) said staff should wash their hands upon entrance to a room, gather supplies, and perform hand hygiene before care is provided. Staff should also perform hand hygiene in between glove changes because hands could be contaminated. 6. During an interview on 1/28/25 at 10:26 A.M., the Administrator said she expected staff to follow the infection control and hand hygiene policies. 49992