STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265160	A. Building B. Wing	05/15/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on interview and record review, the facility failed to prevent sexual abuse between two residents (Resident #1 and Resident #2), who engaged in sexual intercourse and whose capacity to consent to sexual activity had not been determined, in a review of 13 sampled residents. Resident #1 was assessed as severely cognitively impaired and had diagnoses including Alzheimers Disease, dementia, herpes viral infection, and human immunodeficiency virus disease. Resident #2 had diagnoses including vascular dementia and depression. When Resident #2 talked to his/her responsible party after the incident, he/she told the responsible party he/she did not want the sexual activity to occur, he/she was scared, and did not want to be around Resident #1. The facility census was 85. The administrator was notified on 5/10/24 at 4:13 P.M. of an Immediate Jeopardy (IJ) which began on 5/2/24. The IJ was removed on 5/11/24 as confirmed by surveyor on-site verification. Review of the facility's abuse prohibition protocol manual, undated, showed the following: -Establish a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as, identify when, how, and whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; -The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict, such as sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing; -Examples of sexual abuse: unwanted sexual attention or touching, sexual touching of the body of a resident who cannot make decisions for themselves; -Training included teaching the staff to look for changes in residents' behavior, mood, or social interactions. Review of the facility's policy Resident and Tenant Sexual Expression, dated 10/21/22, showed the following: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Sexual expression is defined by language, gestures, conduct, or activities that indicate a desire for sexual gratification (hugging, kissing, hand holding, flirting, masturbation, touch, signs of romance or companionship, viewing of sexual-explicit materials); -Some residents who exhibit diminished decision-making capacity (example dementia, Alzheimer's disease, coma) who have a brief interview for mental status (BIMS) score of seven or below will not be allowed to consent; -The facility staff will conduct a thoughtful review of accounts of sexual expression among residents to determine a solution that best meets the needs of and protects those involved; -Outcomes of the reviews will be shared with the resident and interdisciplinary team and documented in the care or service plan. 1. Review of Resident #1's face sheet, undated, showed the following: -The resident had a power of attorney; -Diagnoses included Alzheimer's disease (type of dementia that affects memory, thinking and behavior), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizoaffective disorder (bipolar type) (episodes of mania and sometimes depression), herpes viral infection, major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and human immunodeficiency virus disease. Review of the resident's Preadmission Screening and Resident Review level II (PASARR Level II) (confirms the indicated diagnosis noted in the Level I Screen and determines whether placement or continued stay in a Nursing Facility is appropriate), dated 12/7/22, showed due to the resident's cognitive impairment, ongoing paranoid and delusional ideation, the resident required close supervision 24 hours a day to maintain safety. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 2/16/24, showed the following: -The resident had a BIMS (Brief Interview for Mental Status) score of 2, indicating severe cognitive impairment; -No behaviors documented. Review of the resident's care plan, last updated 2/28/24, showed the following: -He/She had a PASARR; -He/She had impaired cognition; -Ask open ended questions requiring only a yes/no response; -Explain all routines and procedures as they occur. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's physician orders, dated May 2024, showed the following: -Biktarvy (antiviral combination medication) 50-200-25 milligrams (mg), give one tablet orally daily for human immunodeficiency virus disease; -Valtrex (antiviral) 500 mg, give one tablet orally daily for herpes viral infection. Review of the resident's nurse's note, dated 5/2/24 at 8:10 P.M., showed the following: -Staff observed the resident lying in Resident #2's bed without clothing; -Resident #2 was not wearing bottoms/underwear; -Staff immediately separated both residents; -The nurse called the resident's power of attorney to inform him/her of the incident. Review of the resident's nurse's note, dated 5/2/24 at 11:23 P.M., showed the following: -Staff contacted the on-call nurse practitioner regarding the incident; -The nurse practitioner prescribed labs in the morning; -Staff moved the resident to another hall away from Resident #2. During an interview on 5/9/24 at 1:31 P.M., Resident #1's next of kin said the facility notified him/her that Resident #1 was found having sex with Resident #2. Review of the resident's care plan, last revised on 2/28/24, showed it did not include documentation of interventions regarding contact between Resident #1 and Resident #2, or the resident's capacity to consent to a sexual relationship. 2. Review of Resident #2's face sheet, undated, showed the following: -admitted [DATE]; -The resident had a responsible party; -Diagnoses included depression (common and serious medical illness that negatively affects how you feel, the way you think and how you act), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain) with anxiety (feeling of fear, dread, and uneasiness), and mild agitation. Review of the resident's nurse's note, dated 4/19/24 at 2:50 P.M., showed the following: -The resident was oriented to self, very confused, and needed frequent redirection and cueing; -He/She was ambulatory with steady gait; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Recent hospitalization for worsened depression, confusion, and suicidal ideation. Review of the resident's nurse's note, dated 4/19/24, showed the resident had family members that were very abusive towards him/her in the past and had not been in the resident's life for a long time. Review of the resident's care plan, last updated 4/26/24, showed the following: -The resident had the potential for drug related complications associated with the use of psychotropic medications related to cognitive impairment; -Encourage the resident to verbalize the feelings he/she had that were associated with anxiety, depression, hallucinations/delusions, or mood swings; -The resident was at risk for wandering related to cognitive impairment and took medication to suppress thought process; -Evaluate the resident's ability to understand his/her surroundings and give him/her cues and redirection as needed to promote activities of daily living participation and reduce wandering behavior; -Please provide the resident increased supervision during periods of increased wandering and exit seeking behavior; -The care plan did not include the resident's history of abuse. - It did not include documentation of interventions regarding contact between Resident #1 and Resident #2, or the resident's capacity to consent to a sexual relationship. Record review showed the resident was a new admission and the MDS, including the BIMS, had not yet been completed. Review of the resident's nurse's note, dated 5/2/24 at 8:10 P.M., showed the following: -Staff observed the resident in bed with Resident #1; -Resident #2 wore a shirt with no bottoms/underwear; -Resident #1 was nude; -The staff separated both residents; -Attempted to notify the resident's responsible party with no success; -Call made four times to contact responsible party, no answer; -Will notify oncoming shift of incident and need to inform responsible party of incident if call is returned. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's nurse's note, dated 5/2/24 at 11:20 P.M., showed the following: -The staff called the on-call nurse practitioner regarding the incident; -The nurse practitioner ordered staff to monitor the resident and assess his/her emotional state and call the primary physician in the morning; -The resident told the Director of Nursing (DON) that Resident #1 said he/she loved him/her and thought he/she loved Resident #1 as well. Review of the resident's nurse's note, dated 5/3/24 at 2:53 A.M., showed the following: -Immediately following the incident the resident had high anxiety and was combative with staff when trying to be redirected back to his/her room; -As staff members tried to get the resident dressed and back to his/her room, the resident hit staff with a cane and choked a staff member. That was not typical behavior for the resident; -The nurse called the on-call nurse practitioner and received an order for Haldol (antipsychotic) five milliliters (ml) now and repeat in eight hours as needed. Review of the resident's nurse's note, dated 5/3/24 at 10:23 A.M., showed staff contacted the primary care physician regarding the incident and received new orders for lab work and new medications. Review of the resident's nurse note, dated 5/3/24 at 4:34 P.M., showed the responsible party was informed of the incident and the primary care physician was notified due to the resident having unprotected sex. Review of the resident's nurse note, dated 5/10/24 at 1:05 P.M., showed the primary care physician ordered an antibiotic based on urine culture results. Review of the resident's physician orders, dated May 2024, showed the following: -Emtricitabine-tenofovir (antiviral) 200-300 mg, give one tablet orally daily for exposure to human immunodeficiency virus (started on 5/3/24); -Tivicay (antiviral) 50 mg, give one tablet orally daily for exposure to human immunodeficiency virus (started on 5/3/24); -Lab work included urinanalysis, hepatitis panel and HIV. During an interview on 5/9/24 at 1:09 P.M., Resident #2's responsible party said the following: -The resident was a very private person with a lifetime of physical, sexual, and verbal abuse; -The resident was upset about being placed in a nursing home, the placement made the resident feel worthless; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-After the incident, the resident said he/she and Resident #1 spoke in the hallway, touched each other's arms, but it was not okay to have sex; -After the incident, the resident told the responsible party he/she was uncomfortable with Resident #1 around, was fearful of him/her, and did not speak with him/her or make conversation. During an interview on 5/9/24 at 1:50 P.M., Resident #2 said the following: -There was sexual contact with another resident, but nothing had happened since; -He/She felt it would be easier (than living) if he/she dropped dead; -He/She did not want Resident #1 around and was scared of him/her; -He/She had nothing positive to think about. During an interview on 5/9/24 at 11:45 A.M. and 5:53 P.M., Certified Nurse Aide (CNA) C said the following: -Resident #1 hung around Resident #2 for a couple days prior to both residents being caught having sex; -He/She found Resident #1 in Resident #2's room approximately five days before the incident. They were standing in the room talking; -He/She told the night shift staff Resident #1 was in Resident #2's room and they needed to do something about it; -He/She saw a staff member enter Resident #2's room and lead Resident #1 out of the room. During an interview on 5/10/24 at 12:40 P.M., Certified Medication Technician (CMT) D said the following: -On 5/2/24, at approximately 8:00 P.M., he/she knocked on Resident #2's door with the intention of administering medication; -A wheelchair had been placed in front of the door, making it difficult to open; -He/She pushed the door open to find Resident #1 on top of Resident #2 in bed. The two residents were having sexual intercourse; -Resident #1 was upset CMT D had entered the room and yelled for him/her to get out; -It took the staff 30 minutes to get Resident #1 out of Resident #2's room; -Resident #2 was upset after the incident and continued to look for Resident #1 and hoped he/she was not in trouble. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/9/24 at 2:30 P.M., Registered Nurse (RN) E said the following: -On 5/2/24, Resident #2's door was blocked by a wheelchair. RN E was not sure where it came from because neither resident used a wheelchair and Resident #2 did not have a roommate; -A staff member reported Resident #1 and Resident #2 were having sex in Resident #2's room; -Resident #1 was naked and Resident #2 did not have bottoms on; -Both residents were separated immediately; -Resident #1 had behaviors towards staff members after the incident, which was not typical; -After the incident, Resident #2 said he/she did not want Resident #1 to get in trouble. During an interview on 5/15/24 at 2:20 P.M., the Maintenance Director said the following: -He/She witnessed Resident #1 and Resident #2 holding hands while walking down the hall prior to the incident on 5/2/24; -He/She decided to monitor what was happening and saw Resident #1 pointing to his/her room; -Both residents entered Resident #1's room still holding hands, so the Maintenance Director stopped both residents and redirected Resident #1 to come out of the room; -Resident #1 and Resident #2 left the room still holding hands; -He/She reported this issue to the charge nurse at the time, who was agency staff. During an interview on 5/10/24 at 8:25 A.M., the Assistant Director of Nursing said the following: -Resident #1 and Resident #2 sat together in the common area with Resident #2 laying his/her head on Resident #1's shoulder a day or two prior to the sexual intercourse on 5/2/24; -He/She was aware the Maintenance Director found Resident #2 in Resident #1's room previously and had redirected Resident #2 out of the room; -He/She was unaware Resident #1 was found in Resident #2's room prior to the incident on 5/2/24 but learned about it after the incident (on 5/2/24) occurred. During an interview on 5/10/24 at 10:10 A.M., the DON said the following: -Staff did not notify her the Maintenance Director found Resident #2 in Resident #1's room or Resident #1 was found in Resident #2's room prior to the incident on 5/2/24; -She expected staff would report it to her and/or the Administrator; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On the day of the incident on 5/2/24, she saw Resident #1 and Resident #2 sitting together in the common area and thought they were having a conversation; -Both residents were quiet and stayed to themselves. She was aware they were developing companionship; -The intervention prior to the incident on 5/2/24 was staff were supposed to supervise the residents while they were together to ensure their interactions were appropriate, however, this did not get passed along to the staff; -When the staff separated the residents on 5/2/24, Resident #1 had behaviors towards staff while they were trying to get him/her dressed; -After the incident, Resident #2 was upset because he/she did not want Resident #1 to get into trouble; -Resident #2 tried looking for Resident #1 after the incident; -The staff moved Resident #1 to another hall; -After Resident #1 moved to another hall, Resident #2 approached other residents of the opposite sex, who have now complained because they did not want Resident #2 bothering them. During an interview on 5/15/24 at 2:45 P.M., the Administrator said staff were to report any time they witnessed residents holding hands, going to other resident's rooms, or any other intimate contact immediately to the charge nurse and/or the Director of Nursing or Administrator. During an interview on 5/10/24 at 1:06 P.M., the primary care physician for both residents said neither resident had the cognitive ability to consent to sexual activity. The physician was unaware staff had observed the residents in each others' rooms, holding hands and showing affection to one another. Staff should monitor and report those situations as they occurred. NOTE: At the time of the complaint investigation, the violation was determined to be the immediate jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO235588

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 36185 Based on observation, interview, and record review, the facility failed to ensure facility staff provided two residents (Resident #1 and #5), of nine sampled residents who were unable to complete their own activities of daily living (ADL), the necessary care and services to maintain good personal hygiene. Staff failed to assist and provide nail care and grooming to include shaving. The facility census was 82. Review of the facility policy Bath (partial), undated showed the following: -The purpose was to maintain skin integrity, comfort, and cleanliness; -Wash face and ears, wash neck arms chest and abdomen, give special care to the folds of skin, hands, and feet. Wash thighs, legs, and feet; -Care of fingernails and toenails was part of the bath. Be certain nails are clean. Review of the facility policy Bath (shower), undated showed the following: -The purpose was to maintain skin integrity, comfort, and cleanliness; -Wash face and shampoo hair, wash upper extremities and body, wash lower extremities and feet; -The policy did not direct staff to trim nails or to shave the residents as a part of the shower routine. 1. Review of Resident #1's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) dated 3/29/24 showed the following: -Makes self understood and understands others; -Cognitively intact; -Rejection of care was not exhibited; -Functional limitation in range of motion (ROM) in upper and lower extremity with impairment on both sides; -The resident was dependent on staff for all ADLs; -Diagnoses included quadriplegia (severe or complete loss of motor function in all four limbs), traumatic subdural hemorrhage (buildup of blood on the surface of the brain that can be caused by a head injury), Review of the resident's care plan dated 4/2/24 showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had severely impaired vision; -The resident had a physical function deficit related to quadriplegia; -Assess the resident's grooming and dressing needs and provide assistance of one staff member; -Inspect skin with cares and bathing. Review of the resident's shower sheets for May 2024 showed the following: -On 5/2/24 staff documented the resident received a shower; -On 5/8/24 staff documented the resident received a shower (five days after his/her the last shower); -On 5/16/24 staff documented the resident received a shower (seven days after his/her last shower); -On 5/20/24 staff documented the resident refused a shower; -On 5/27/24 staff documented the resident received a shower, and was shaved and had a haircut (10 days after his/her last shower). Review of the resident's shower sheets for June 2024 showed the following: -On 6/4/24 staff documented the resident refused a shower; -On 6/6/24 staff documented the resident refused a shower; -On 6/8/24 staff documented the resident received a shower and was shaved. Staff documented the resident needed his/her fingernails cut, but couldn't get his/her hands to stay open (the first shower documented in eight days); On 6/13/24 staff documented the resident refused a shower; On 6/17/24 staff documented the resident received a shower (eight days after his/her last shower); On 6/20/24 staff documented the resident refused a shower. There was no documentation staff offered the resident a shower or the resident refused a shower between 6/21/24 and 6/26/24 (eight days since his/her last shower). Observation on 6/25/24 at 11:30 A.M. showed the following: -The resident was in bed. His/Her fingernails were approximately one inch in length, uneven with brown debris under many of the nails, the palms of the resident's hands had patches of dry skin and there was a foul odor to the resident's hands; -The resident was unshaven with over 1/2 inch of hair growth on his/her face, chin, and neck. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/26/24 at 12:30 P.M. showed the following: -The resident was in bed, his/her fingernails remained long, uneven with brown debris under many of the nails, the palms of the resident's hands had patches of dry skin and there was a foul odor to the resident's hands; -The resident remained unshaven and the hair growth was even more prominent than the day before. During an interview on 6/25/24 at 1:45 P.M. the resident said the following: -His/Her fingernails were extremely long, rough, and uneven, his/her nails dug into his/her palms which caused him/her pain. The staff did not wash his/her hands. He/She could smell his/her hands, it was a strong odor, it made him/her feel dirty and degraded; -He/She did not receive routine showers. He/She was always clean shaven before he/she came to the facility, it made his/her skin itch when he/she went this long without being shaved; -He/She was completely dependent on the staff for everything, and it really upset him/her that he/she didn't get the care he/she needed; -He/She always wanted a bath or cleaned up. The resident would not refuse care. During an interview on 6/26/24 at 12:40 P.M. the resident's family member said the following: -The resident's nails were always long and dirty and the resident's hands had an awful odor; -The staff never shaved the resident. The resident had always liked to be clean shaven; -It upset him/her to see the resident like this. The resident was completely dependent on the staff. 2. Review of Resident #5's quarterly MDS assessment, dated 5/2/24, showed the following -Usually understood and understands others; -Cognitively intact; -No rejection of care exhibited; -Functional impairment of range of motion (ROM) on both sides to both upper and lower body; -Dependent on staff for a shower or bath, lower body dressing and personal hygiene; -Partial to moderate assistance of a staff with dressing. Review of the resident's care plan, last reviewed on 6/10/24, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included rash or other nonspecific skin eruption (a rash that is not specific to the cause, can appear as spots blotches, bumps, red patches, welts, blisters, or dry skin, this can be itchy), tension type headache, chronic lymphocytic leukemia (a type of cancer of the blood and bone marrow), excoriation skin picking disorder (repetitive and compulsive picking as at one's skin), candidiasis (a fungal infection typically on the skin or mucous membranes) -The resident required moderate to extensive assist of one to two staff members with ADLs. The resident was able to assist with simple tasks. Assist with dressing, toileting, bathing, hygiene, and transfers; -Provide setup, oversight, encouragement, cueing, and physical assistance with assistance for ADLs; -Provide adequate rest periods between activities as needed, allow the resident to perform the task at his/her pace, allow adequate time for task completion, avoid hurrying the resident; -Shower preference, the resident had requested one shower per week. Review of resident's shower sheets dated June 2024 showed the following: -On 6/6/24 and 6/13/24 staff documented the resident refused a shower; -On 6/17/24 staff documented the resident received a shower; -On 6/20/24 staff documented the resident refused a shower; -The staff documented the resident received one shower between 6/1/24 and 6/26/24. Observation on 6/26/24 at 10:20 A.M. showed the resident lay in his/her bad. The resident had a strong body odor. The skin on the resident's arms appeared flaky and dry. During an interview on 6/26/24 at 10:22 A.M. the resident said the following: -He/She often went without a bath or shower for two weeks; -He/She would prefer a bath twice a week, but at least weekly; -He/She did the best he/she could with a washcloth, but not getting washed up with soap and water caused his/her skin to itch, and he/she felt dirty; -On the days he/she was supposed to get a bath/shower, sometimes he/she wasn't feeling well. The resident would request staff come back a little later and they would never return. Staff would just put down he/she refused, which wasn't true. 3. During an interview on 6/25/24 at 1:22 P.M. Certified Nurse Assistant (CNA) C said the following: -Resident #1's nails were long and curled in. CNA C thought the nails dug into the residents hands; (continued on next page)

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	265160	A. Building B. Wing	05/15/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was not sure who trimmed the resident's nails. During an interview on 6/25/24 at 4:00 P.M. Nurse Aide (NA) A G said Resident #1 said he/she had not received a shower for almost two weeks and needed one. During an interview on 6/26/24 at 1:30 P.M. CNA D said the following: -He/She completed a lot of the residents' showers; -Resident #1's nails were hard to trim because his/her hands were so contracted. CNA D was not sure who trimmed the resident's nails; -He/She didn't always get the residents shaved during showers, the priority was to get them clean; -He/She didn't always have time to trim nails or shave the residents; -He/She thought some showers weren't getting done because there had not been a full time shower aide on A-Hall (where Resident #1 and Resident #5 resided). During an interview on 6/26/24 at 9:15 A.M. and 1:50 P.M. the Director of Nursing (DON) said the following: -She would expect all residents to have a shower twice a week unless otherwise care planned or a special request; -She would expect staff to shave and trim residents' finger nails on shower days; -If a resident refused a shower the staff should notify the charge nurse. She would expect staff to reapproach the resident two or three times and if the resident continued to refuse his/her shower attempt again later in the week; -The A hall shower aide was moved to work weekends. Various staff were completing the A-hall showers. It was possible residents' showers were getting missed. During an interview on 6/26/24 at 12:58 P.M. the Administrator said he/she would expect the staff to shave and trim the resident's nails on shower days and as needed. Showers should be completed at least two times a week unless care planned differently. MO236489 MO237754

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 36185 Based on observation, interview, and record review, the facility failed to apply hand splints (an external device that is used to support and protect injured bones, ligaments, tendons, and other tissues and to treat contractures (a shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints) that can be caused by disease or trauma) for one resident (Resident #1) with hand contractures in a sample of nine residents. The facility also failed to apply palm protectors (used to prevent fingers from digging into the palm of your hand, to prevent skin damage and prevent further deformity) for Resident #1 as directed by Occupational Therapy. The facility census was 82. Review of the facility's Restorative Nursing Manual, dated 6/28/23, showed the following: -It is the purpose of the facility to see that each resident receives, and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care; -Objective: It is the entire staff's responsibility to prevent deterioration and further functional loss of each resident in the facility. -Range of Motion (ROM) may be defined as the extent of movement within a given joint which is normally achieved through the action of a muscle or groups of muscles; -Objectives of ROM include prevention of contractures and deformities, to stimulate circulation and to prevent contractures from becoming worse if they are already present. 1. Review of Resident #1's therapy Treatment Encounter note, dated 2/5/24, showed the following: -Orthotic management and training/initial encounter: Initial instruction provided on wearing schedule. Caregiver educated on donning (to put on)/doffing (to take off) splints and wearing schedule; -Response to session: Actively participates with skilled intervention. States his/her hands feel better with increased extension. Tolerated 7.5 hours with splints on, no redness or discomfort reported. Review of resident's therapy Treatment Encounter Note dated 2/6/24 showed the following: -Orthotic management and training/initial encounter: Initial instruction provided on donning/doffing orthosis (the correction of disorders of limbs or spine by use of braces and other devices to correct alignment or provide support). Trained Certified Nurse Aide (CNA) B on how to don/doff splints. Asked him/her to put them on the resident every morning after breakfast. Talked to the Director of Nursing (DON) regarding wearing schedule and the need for the CNAs to put on and take off the splints; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Response to session interventions: Actively participates with skilled interventions. Can wear splints for six to eight hours with no irritation or redness. Patient discharged to care of nursing staff to take over splint application. Review of the Occupational Therapy (OT) Discharge Summary dated 2/6/24 showed the following: -All goals were met; -Diagnoses included quadriplegia (severe or complete loss of motor function in all four limbs), traumatic subdural hemorrhage (buildup of blood on the surface of the brain that can be caused by a head injury), contracture of left and right hand; -The resident will achieve normal anatomical alignment of right fingers, right hand, right wrist, left fingers, left hand, and left wrist for six hours using splints to further assess and order/fabricate in order to reduce pressure and decrease risk of wounds, in order to facilitate intact skin integrity, in order to improve skin integrity and hygiene, in order to decrease pain an in order to increase tone and promote mobility. At discharge goal was met. -The resident will safely wear (splints) to further assess and order/fabricate on right hand and left hand for up to eight hours with minimal signs and symptoms of redness, swelling, discomfort or pain, at discharge goal was met; -The resident will exhibit a decrease in pain 0/10 (0 being no pain and 10 being the worse pain) to decrease pain in upper extremities to allow activities of daily living (ADL) participation; -The resident will don bilateral hand splints for eight hours every day to prevent skin breakdown, at discharge goal met; -The caregiver was trained to don/doff splints. -The resident has reached maximum potential with skilled services; -Team communication/collaboration: Collaborated with the team regarding resident's discharge/transition planning and treatment results communicated to interdisciplinary team; -Discharge recommendations splint/brace; -Restorative program not indicated at this time; -Prognosis good with consistent staff follow through. Review of the resident's Physician Order Sheets (POS) dated February 2024 showed there was no order for splints. There was no documentation in the medical record to show staff put hand splints on the resident as directed by therapy or that the resident refused to wear the splints. Review of the resident's Interdisciplinary Therapy screening dated 3/4/24 showed the following: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was dependent on staff; -CNA to put on resting hand splints, to be worn 4-6 hours every day after breakfast; -Staff fed the resident. Review of the resident's POS dated March 2024 showed there was no order for splints. There was no documentation in the medical record to show staff put hand splints on the resident as directed by therapy or that the resident refused to wear the splints. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility) staff dated 3/29/24 showed the following: -Makes self understood and understands others; -Cognitively intact; -Functional limitation in range of motion (ROM) in upper and lower extremity impairment in both sides; -The resident was dependent on staff with all activities of daily living (ADLs); -No splint or brace assistance in the last seven days. Review of the resident's care plan dated 4/2/24 showed the following: -The resident had severely impaired vision; -The resident had a physical function deficit related to quadriplegia; -Rehab screens as indicated, usually at admission, quarterly and for a change in physical function; -The care plan did not address the use of splints or palm protectors or any other devices for contractures. Review of the resident's Interdisciplinary Therapy screening, dated 6/3/24, showed the resident needed staff to put on palm protectors daily. Review of the resident's POS dated June 2024 showed there was no order for palm protectors. Observation on 6/25/24 showed the following: -At 11:30 A.M. the resident was in his/her bed. The resident did not have palm protectors or splints in place, the resident's fingernails were approximately one inch in length, very uneven with brown debris under many of the nails. The palms of the resident's hands had patches of dry skin and there was a foul odor to the resident's hands; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:30 P.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands; - At 1:45 P.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands; -At 3:30 P.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands; -At 5:00 P.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands. Observation on 6/26/24 showed the following: -At 10:00 A.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands; -At 12:30 P.M. the resident was in his/her bed. The resident did not have palm protectors or splints on his/her hands, the resident's nails remained long, very uneven with brown debris under many of the nails, the resident's hands had a foul odor. During an interview on 6/25/24 at 1:45 P.M. the resident said the following: -The staff refused to put his/her splints on because no one knew how; -He/She had splints made for his/her hands to help with contractures; -He/She also had soft hand protectors. Staff ever put them on his/her hands either. These helped with pain and kept his/her fingernails from digging into his/her palm, which was very painful; -It was getting harder for staff to open his/her hands at all, due to them being so contracted, and now when staff tried to open his/her hands, it caused increased pain. During an interview on 6/26/24 at 12:40 P.M. the resident's family member said he/she thought the resident was to have splints on his/her hands daily to prevent the resident's hands from being so contracted. The resident never had splints or hand protectors in place when he/she visited the resident. The resident always complained of pain in his/her hands. During an interview and observation on 6/26/24 at 11:25 A.M. CNA B said the following: -He/She was assigned the resident's hall; -Therapy staff educated him/her on how to put the resident's splints on. CNA B was not sure if the other CNAs were educated on this or not; -The resident usually refused the splints. CNA B got the resident to wear them a couple times; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Therapy recommended the resident use the soft palm protectors since he/she refused the hard splints; -CNA B was not sure if the resident was to use palm protectors or hand splints during the day or the frequency; -CNA B was not sure where they were kept because he/she only worked two days a week; -CNA B looked in the resident's bedside table and closet for the splints and palm protectors; -CNA B found a hard splint and palm protector in the resident's closet and put them against the resident's face (as the resident was visually impaired and unable to see them) and asked him/her which one was the one he/she was using now. The resident was not sure which one he/she was to wear; -CNA B wasn't sure so he/she did not put the splint or the palm protector on the resident; -Staff quit offering to put the splints or palm protectors on because the resident always refused. During an interview on 6/25/24 at 1:22 P.M. CNA C said the following: -The resident's hands were very contracted; -If the resident asked for his/her splints to be put on, the CNAs or the charge nurse would put them on; -The resident wore splints on his/her hand every now and then. CNA C was not sure how often the resident should wear the splints; -The resident's nails dug into his/her hands. CNA C was not sure about palm protectors being used for the resident. During an interview on 6/26/24 at 1:30 P.M., CNA D said the resident wore hand splints for a while. He/She was not sure why the resident didn't use them now. He/She was not sure if the resident had palm protectors or if he/she was to wear them. He/She thought the charge nurse would let the CNAs know if a resident had palm protectors. During an interview on 6/26/24 at 12:15 P.M. and 7/8/24 at 2:00 P.M. the Rehab Director said the following: -He/She trained CNA B on how to put on the resident's hand splints on once the resident was discharged from therapy; -Staff told the Rehab Director the resident refused to allow the staff to put his/her splints on; -He/She had no problems with putting the splints on when the resident was in therapy; -He/She thought the CNAs were too rushed and didn't take time and stretch the resident's hands as he/she had instructed them, and it had caused the resident some pain; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She recommended staff put on palm protectors because the CNAs were not getting the splints on like they were supposed to; -Eventually, if staff didn't put splints or palm protectors on the resident's hands, it would be very difficult to open the resident's hands at all because they would be so severely contracted. It would also be difficult to keep the resident's hands clean and prevent sores because the resident's nails would dig into the resident's palms. During an interview on 6/26/24 the Director of Nursing (DON) said the following: -She thought the resident refused the palm protectors and splints, but didn't remember as it had been a while; -Staff should put the splints and palm protectors on as directed by therapy or document if the resident refused them; -There was a lot of new staff so it was possible they were not getting educated on special devices (such as splints) and it was getting missed; -Since splints and palm protectors were not being put on the resident as they were supposed to, they would need to be assigned to the Restorative Aide (RA) to assure they were put on appropriately each day and documented; -Going without splints or hand protectors could affect ROM in the resident's hands, the resident may need some passive or active range of motion also to prevent decline. During an interview on 6/26/24 at 12:58 P.M. the Administrator said the following: -She would expect hand splints or palm protectors be put on the resident if it was directed by therapy; -She would expect the restorative aide to put on hand splints, palm protectors or other the devices used to assist with range of motion. MO236489