STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265195	A. Building B. Wing	09/19/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to treat each resident with respect and dignity, when they failed to ensure one resident was assisted by female staff after he/she expressed his/her preference (Resident #7). The sample size was seven. The census was 90. The administrator was notified on 10/30/24, of the past non-compliance. The facility updated the resident's care plan regarding caregiver preferences and the resident was assigned female staff for direct care. Staff are knowledgeable of the resident's wishes and follow the staffing assignments. The deficiency was corrected on 9/27/24. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/18/24, showed: -Cognitively intact; -Diagnoses included heart failure, high blood pressure, renal failure, malnutrition, asthma, and respiratory failure; -Partial/moderate assistance with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear. Review of the resident's medical record, showed: -admitted [DATE]; -A progress note, dated 10/26/21, showed care plan meeting today with resident. Resident wants to keep his/her shower days Wednesday and Saturdays and he/she wants a female shower aide. Review of the facility's investigation, showed: -Date of incident: 9/27/24; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident is alert and oriented x 4 and is a reliable historian. Resident stated that he/she wanted to go to bed and needed to use the restroom beforehand. Male staff was there assisting him/her. He/She explained to the CNA how he/she needed help being placed onto the toilet. CNA A tried telling him/her how he/she needed to do it himself/herself and explained how to do it. The resident stated the CNA became frustrated with him/her, but finally helped him/her. The resident always likes to leave his/her panties on for bed. CNA A kept telling him/her no. He/She demanded that he/she be allowed to wear his/her panties to bed. The resident stated that staff grabbed him/her under his/her arms while in the wheelchair and tossed him/her into bed roughly. The resident then said that CNA A moved his/her wheelchair to the wall and refused to leave it by his/her bed where he/she always likes to keep it. When CNA A was leaving the room, he/she moved his/her bedside table away from the bed, out of reach; -The resident said for now on, he/she would only like to have women caregivers other than CNA B, who is male; -He/She also gave a list of people that he/she is okay with providing him/her care to the staffing coordinator. It consists of men and women. Review of the resident's care plan, updated 9/27/24, showed: -Focus: The resident has an Activity of Daily Living (ADL) self-care performance deficit; -Interventions: No Male Certified Nurse Aide (CNA) except CNA B per his/her request. Only female CNAs otherwise. During an interview on 10/30/24 at 1:30 P.M., the resident said he/she remembered the incident. A male, agency CNA came into his/her room. CNA A started to put the resident's pants on and the resident said, no. The resident assumed CNA A was assisting him/her to the bathroom. The resident started kicking CNA A with his/her feet. CNA A tossed the resident's shoes on the floor, and said, I cannot do this and left the room. CNA A returned a few minutes after the resident turned on the call light. The resident said he/she always preferred female staff. He/She will ask who his/her shower aide is and if it is not female, he/she will refuse. Staffing had been a problem and he/she had to swallow his/her pride and allow male staff to assist him/her. During an interview on 10/30/24 at 2:23 P.M., Certified Medication Technician (CMT) E said the resident prefers only female staff. It has always been that way. During an interview on 10/30/24 at 2:28 P.M., CNA B said the resident preferred female aides only for his/her showers. At first, it was always bathing. Now the resident's preference for the past three months has been female staff. During an interview on 10/30/24 at 3:42 P.M., the Administrator and Director of Nursing (DON) said they were not sure when the resident's medical record was updated and female staff only was documented, but it sounds like it was right after the most recent incident. They would have expect the resident's preferences to be care planned. If a resident preferred female only staff, they pass that information during report. They would expect staff to treat residents with dignity and respect. If a resident is uncomfortable with staff, they would expect it to be reported to nursing so they can make arrangements for another staff to assist. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00242863 44950

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for one resident with a gastronomy tube (g-tube, a tube placed through the abdomen into the stomach to provide nutrition, hydration and medication) (Resident #3) and one resident with a Suprapubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) (Resident #1). The facility also failed to ensure additional ordered skin treatments were completed for these two residents and four other residents sampled (Residents #2, #4, #5 and #6). The sample size was 6. The census was 88. 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Moderate cognitive impairment; -Always incontinent of bowel and bladder; -Skin Assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? Yes; -Does resident have pressure ulcer at Stage 2: Yes-1; -Skin and ulcer treatments: pressure reducing device for chair and bed, pressure ulcer care, application of nonsurgical dressings (with or without topical medications) other than to feet, application of ointments/medications -other than to feet; -Diagnoses included neurogenic bladder (bladder does not empty properly due to neurologic condition), seizures, malnutrition, anxiety and depression. Review of the resident's [DATE] Treatment Administration Record (TAR), showed: -An order, dated [DATE], Skin Observation every evening shift every Sunday; -No documentation of treatment completed [DATE], [DATE] and [DATE]; -An order, dated [DATE], Calmoseptine (moisture barrier cream) to buttocks every shift and as needed (PRN); -No documentation of treatment completed: -Day shift- [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -Evening shift- [DATE], [DATE] and [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated [DATE], g-tube site care: Remove old dressing, clean with soap and water, allow to dry, place split gauze over and secure with tape daily in the evening; -No documentation of treatment completed on [DATE], [DATE] and [DATE]; -An order, dated [DATE], cleanse open area to coccyx with normal saline (NS), apply calcium alginate (highly absorbent wound dressing), cover with silicone border dressing daily and PRN every day shift for wound care; -No documentation of treatment completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of the resident's [DATE] TAR, showed: -An order, dated [DATE], Calmoseptine to buttocks every shift and as needed (PRN); -No documentation of treatment completed: -Evening shift-[DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], g-tube site care: Remove old dressing, clean with soap and water, allow to dry, place split gauze over and secure with tape daily in the evening; -No documentation of treatment completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], cleanse open area to coccyx with NS, apply calcium alginate, cover with silicone border dressing daily and PRN every day shift for wound care; -No documentation of treatment completed on [DATE] and [DATE]. Observation and interview on [DATE] at 1:05 P.M., showed the resident lay in bed. Hospice Certified Nursing Assistant (CNA) D entered the room to provide the resident's bed bath. Licensed Practical Nurse (LPN) A rolled up the resident's gown to show the resident's g-tube site. The site was bright red with dried reddish material around the site. LPN A said the area should be covered with a dressing. LPN A left the room to get supplies. CNA D said he/she does not work at the facility but assists with bathing the residents on hospice. He/She said most of the time when he/she goes to provide the bed bath there is not a dressing on the resident's g-tube site. CNA D said the day shift nurses try really hard though especially LPN A. The CNA does not think it is possible for the resident to be able to reach and remove the dressing himself/herself. 2. Review of Resident #1's admission MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Urinary catheter and incontinent of bowel; -Skin assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? No; -Skin and ulcer treatments: pressure reducing device for chair; -Diagnoses included neurogenic bladder, enlarged prostate, multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), depression and bipolar disorder. Review of the resident's, [DATE]-[DATE] (Resident was sent to the hospital on [DATE] and returned on [DATE]. Resident expired on [DATE]), TAR showed: -An order, dated [DATE] to [DATE], Zinc Oxide External Ointment 20% Zinc Oxide (Topical) Apply to buttocks excoriation topically two times a day for excoriation; -No documentation of treatment completed: -A.M. Shift: [DATE], [DATE], [DATE], and [DATE] and [DATE]; -HS (bedtime) Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], Flush suprapubic catheter with 30 milliliters (ml) NS every shift at bedtime for catheter care; -No documentation of treatment completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE] to [DATE], Triad Hydrophilic Wound Dress External Paste (Wound Dressings). Apply to buttock topically every shift for prevention; -No documentation of treatment completed: -A.M. Shift: [DATE], [DATE] and [DATE]; -Evening Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE] to [DATE], cleanse open areas to back of left leg with NS. Apply Dakin's (an antiseptic solution used to clean infected topical wounds) wet to dry dressing daily and PRN every day shift for wound care; -No documentation of treatment completed on [DATE], [DATE] and [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated [DATE] to [DATE], Dakin's (,d+[DATE] strength) External Solution 0.25 % (Sodium Hypochlorite). Apply to left leg wound topically one time a day for left leg wound wet to dry dressing; -No documentation of treatment completed on [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], Triad Hydrophilic Wound Dress External Paste (Wound Dressing). Apply to buttock topically every shift for prevention. Cleanse buttock, pat dry, apply after each bowel movement (BM); -No documentation of treatment completed: -A.M. Shift: [DATE] and [DATE]; -Evening Shift: [DATE], [DATE] and [DATE]; -An order, dated [DATE], Cleans area to bilateral lower extremities with Dakin's Wound Cleanser (DWC), pack with iodoform packing strips, cover with abdominal gauze pad (ABD), wrap with kerlix. One time a day every 3 days for open area; -No documentation of treatment completed on [DATE] and [DATE]. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -Always incontinent of bowel and bladder; -Skin assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? No; -Skin and ulcer treatments: pressure reducing device for chair and bed, application of nonsurgical dressings (with or without topical medications) other than to feet, application of ointments/medications other than to feet; -Diagnoses included diabetes, Alzheimer's, and dementia. Review of the resident's [DATE], TAR showed: -An order, dated [DATE], Miconazole Powder. Apply to affected areas topically every shift for preventative; -No documentation of treatment completed: -A.M. Shift-[DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evening Shift-[DATE], [DATE] and [DATE];. -An order, dated [DATE], Skin Observation every evening shift every Saturday; -No documentation of treatment completed [DATE], [DATE], and [DATE]; -An order, dated [DATE], Eucerin External Lotion. Apply to bilateral lower extremities topically two times a day for dry and scaly skin; -No documentation of treatment completed: -A.M. Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]; -Evening Shift: [DATE], [DATE] and [DATE]; -An order, dated [DATE], Santyl (an enzyme used to help the healing of burns, skin wounds, and skin ulcers) External Ointment. Apply to right anterior thigh topically every day shift for wound; -No documentation of treatment completed [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of the resident's [DATE], TAR showed: -An order, dated [DATE], Miconazole Powder. Apply to affected areas topically every shift for preventative; -No documentation of treatment completed: -A.M. Shift-[DATE] and [DATE]; -Evening Shift-[DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], Skin Observation every evening shift every Saturday; -No documentation of treatment completed [DATE]; -An order, dated [DATE], Eucerin External Lotion. Apply to bilateral lower extremities topically two times a day for dry and scaly skin; -No documentation of treatment completed: -A.M. Shift: [DATE] and [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evening Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], Santyl External Ointment. Apply to right anterior thigh topically every day shift for wound; -No documentation of treatment completed [DATE], [DATE], and [DATE]; -TAR marked with 9 (Other-See progress notes) [DATE], [DATE], and [DATE]. Review of the resident's progress notes, did not show documentation related to Santyl treatment not given. Observation on [DATE] at 1:20 P.M., showed the resident in his/her room, in a chair. The resident gave CNA F permission to remove his/her socks and shoes. The resident's lower legs appeared dry and scaly. CNA F said the resident's legs appear fine except for some dry skin. 4. Review of Resident #4's significant change MDS, dated [DATE], showed: -Cognitively impaired; -Always incontinent of bowel and bladder; -Skin assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? No; -Skin and ulcer treatments: pressure reducing device for chair, application of ointments/medications other than to feet; -Diagnoses included end stage renal disease (ESRD), arthritis, Alzheimer's, anxiety, and depression. Review of the resident's [DATE], TAR showed: -An order, dated [DATE], Eucerin Lotion. Apply to body topically one time a day for dry skin; -No documentation of treatment completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; -An order, dated [DATE], Apply calmoseptine to bilateral buttocks for moisture-associated skin damage (MASD) preventative every shift; -No documentation of treatment completed: -A.M. Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evening Shift: [DATE], [DATE] and [DATE]. Review of the resident's [DATE] TAR showed: -An order, dated [DATE], Eucerin Lotion. Apply to body topically one time a day for dry skin; -No documentation of treatment completed on [DATE]; -An order, dated [DATE], Apply calmoseptine to bilateral buttocks for MASD preventative every shift; -No documentation of treatment completed: -A.M. Shift: [DATE]; -Evening Shift: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. 5. Review of Resident #5's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Always incontinent bowel and bladder; -Skin assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? No; -Skin and ulcer treatments: pressure reducing device for chair and bed, application of ointments/medications other than to feet; -Diagnoses included dementia, high blood pressure, and heart failure. Review of the resident's [DATE] (Resident hospitalized [DATE]-[DATE]), the TAR showed: -An order, dated [DATE], Calmoseptine ointment. Apply to buttocks topically every shift for wound prevention; -No documentation of treatment completed: -A.M. Shift- [DATE]; -Evening Shift-[DATE] and [DATE]; -Night Shift-[DATE], [DATE] and [DATE];. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated [DATE], Triad Hydrophilic Wound Dress External Paste. Apply to buttocks topically every shift for skin care; -No documentation of treatment completed: -A.M. Shift- [DATE]; -Evening Shift-[DATE] and [DATE]; -Night Shift-[DATE], [DATE] and [DATE]. Review of the resident's [DATE], TAR showed: -An order, dated [DATE], Calmoseptine ointment. Apply to buttocks topically every shift for wound prevention. -No documentation of treatment completed: -Evening Shift-[DATE], [DATE] and [DATE]; -Night Shift-[DATE]; -An order, dated [DATE], Triad Hydrophilic Wound Dress External Paste. Apply to buttocks topically every shift for skin care; -No documentation of treatment completed: -Evening Shift-[DATE], [DATE] and [DATE]; -Night Shift-[DATE]. 6. Review of Resident #6's significant change MDS, dated [DATE], showed: -Cognitively intact; -Always incontinent of bowel and bladder; -Skin assessment: Resident at risk of developing pressure ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher? No; -Skin and ulcer treatments: pressure reducing device for chair; -Diagnoses included heart failure, acid reflux, ESRD, anxiety, and depression. Review of the resident's [DATE] TAR, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated [DATE], Nystatin powder. Apply to breasts/abdomen folds topically in the evening for redness and excoriation. Apply to both breasts and to abdominal folds; -No documentation of treatment provided on [DATE], [DATE] and [DATE]. Review of the resident's [DATE] TAR, showed: -An order, dated [DATE], Nystatin powder. Apply to breasts/abdomen folds topically in the evening for redness and excoriation. Apply to both breasts and to abdominal folds; -No documentation of treatment given on [DATE] and [DATE]; -An order, dated [DATE], Triad Hydrophilic Wound Dress External Paste. Apply to buttocks topically every shift for skin breakdown; -No documentation of treatment given: -Evening Shift: [DATE] and [DATE]; -Night Shift: [DATE]. 7. During an interview on [DATE] at 1140 A.M., the Director of Nursing (DON) said she rarely has issues with day shift not being able to get assigned tasks done. She rarely works evenings. The DON has heard of issues with evening staff and agency staff. 8. During an interview on [DATE] at 2:00 P.M., the DON and Administrator said they would absolutely expect staff to follow orders for all shifts. When there is a blank spot on the Medication Administration Record (MAR) or TAR, it means that the medication is not given and/or the treatment is not done. If it is not documented, it is not done. They expected staff to sign the MAR/TAR, document, and notify the physician. Skin assessments and treatments should be completed as ordered. If they are unable to complete them, then they should notify DON. If something is documented with a 9, it means it wasn't done and the reason should be documented. 9. On [DATE] at 10:18 A.M., the physician order policy was requested from the Administrator at the facility. During an interview on [DATE] at 10:50 A.M., the Administrator said the facility follows the state and federal guidelines for physician orders. MO00241601

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview and record review, the facility failed to follow their fall policy when the facility failed to assess and complete neurological checks as indicated per facility policy and implement fall interventions as indicated on the plan of care, for three residents (Residents #2, #9, and #8). The sample size was 7. The census was 90. Review of the facility's Fall Risk Reduction policy, revised 2/2019, showed: -Purpose: -To identify residents at risk for falls and implement the interventions to reduce risks; -To ensure appropriate and prompt follow up of resident falls to reduce risk of further falls; -To measure effectiveness of fall reduction interventions; -Procedure: -Residents will be assessed for fall risk at the time of admission/re-admission; and weekly for 3 weeks in conjunction with each quarterly and significant change Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) and after each fall; -Action Steps Following a Fall: -First be sure that the resident is safe; -Do not move the resident until the resident has been assessed by a licensed nurse; -Do not move the resident if you suspect possible fracture; -Provide basic first aid if indicated; -Make sure the resident is comfortable; -Ask the resident what were you doing just prior to the fall, what was different this time (even residents' with dementia may be able to tell you); -Observe and preserve the fall scene. Preserve any faulty equipment involved; -Call 911, as indicated by severity of injury; -Take vital signs; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the fall was un-witnessed and if the resident is not able to definitively validate that he/she did not strike his/her head, implement neurological checks (neuro-checks, assessment to determine the presence of head injury) and continue for 72 hours; -Schedule for Neurological Assessment Following Potential Head Injury: Every 15 minutes time four, every 60 minutes times four, every 4 hours times four, every shift for 72 hours; -Review the resident's physician's orders for any recent medication additions or changes; -Contact the resident's physician (or physician on-call); -Contact the resident's representative; -Complete a fall scene investigation and begin root cause analysis; -Huddle with staff concerning the fall and gather data; -Update a new fall risk assessment, immediately update the care plan, and implement interventions to further reduce the risk of recurrence; -Investigate the fall and review in Resident At Risk Meeting; -Documentation in the Medical Record: -Time of fall; -What happened-the facts; -Findings of resident physical evaluation/assessment; -Conduct an updated fall risk assessment; -Time physician notified; -Time resident representative notified; -Follow-up care and residents' response; -Review and revise care plan. Review of the facility's Condition Change (Observing, Recording, and Reporting) Policy, revised 2/2019, included: -Policy: To observe, record, and report any condition change to the attending physician so proper treatment will be implemented. -Procedure: After resident falls, injuries, or changes in physical or mental condition, monitor the following which include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe and inquire if resident has headache or pain; -Observe for personality changes; -Observe for alternations in consciousness; -Observe for incontinence; -Observe for sensory weakness; -Observe for generalized weakness; -Observe for speech disorder; -Observe for gait, posture, or balance disorder; -Observe for change in ambulation status; -Observe for changes in ability to eat or drink; -Monitor vital signs: -Post fall or injury: every shift for 72 hours; -Change in condition: every shift until stable; -If resident has sustained trauma to the head or uncertain related to possible head injury, neuro-checks are to be done: -Every 15 minutes x 4 (1st hour post injury); -Every 30 minutes x 4; -Every 4 hours x 4; -Every shift x 72 hours, or until stable; -Neuro-checks to include at minimum assessment of pupil response, motor response (checking hand grasps) and level of consciousness; -Notify physician of change of condition and up-date as needed based on continued observation; -If change of condition is acute, have someone stay with the resident while the nurse is calling the attending physician, if necessary. If you are unable to reach the attending physician or the physician on call, call the facility medical director; -Document observations, assessments and communication related to resident change in condition in the medical record providing objective data; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Complete an incident, accident, or task management report per facility policy; -Notify resident's responsible party; -Monitor resident's condition frequently until stable. Review of a sample Neurological Assessment Flow Sheet, showed: -A column for date, time, level of contentiousness, right pupil response, left pupil response, hand grips motor function, extremities motor function, blood pressure, pulse, respirations, comments/nurse signature; -Key: -Level of consciousness: Narrative description of behavior and response to stimuli; -Pupil response: Pupils equal and reactive to light (PERLA), brisk (B), sluggish (S), nonreactive (NR), pinpoint (PP), dilatated (DIL), fixed (FIX); -Motor function hand grasps: Hands grasps equal (=), right hand grasp greater than left (R>L), left hand grasp greater than right (L>R), unable to follow commands (U), absent due to medical condition (AB); -Motor function extremities: Moves all extremities ([NAME]), moves right arm (RUE), Moves left arm (LUE), moves right leg (RLE), moves left leg (LLE), unable to follow commands (U), past medical conation prevents voluntary movements (AB), appropriate pain response (APP). 1. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -Functional limitation in range of motion: No impairment to the upper or lower extremities; -Mobility: -Substantial/maximal assistance required to: Roll left and right; sit to lying; lying to sitting on side of bed; -Dependent for: Chair/bed-to-chair transfer; tub/shower transfer; -Sit to stand and toilet transfer not applicable; -Walking 10 feet not attempted due to medical condition or safety concerns; -Always incontinent of bowel and bladder; -Any falls since admission or prior assessment, whichever is more recent: Yes, one with injury (except major); (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included diabetes, Alzheimer's disease, and dementia. Review of the facility's incident and accident report, provided on 10/30/24, showed the following for the resident: -The resident had an unwitnessed fall on 9/12/24 and 9/19/24; -The report did not show a fall on 9/30/24. Review of the resident's assessments, for September and October 2024, showed the most recent fall assessment evaluation completed on 9/13/24 with a score of 9. A score of 10 or higher indicates high fall risk. Review of the resident's care plan, updated on 9/25/24, showed: -Need: The resident is at risk for falls related to confusion. Unaware of safety needs/has had actual fall; -Goal: The resident will not sustain serious injury through the review date; -Interventions/Tasks: Anticipate and meet the resident's needs, check and change every 2-3 hours for incontinence, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Review of the resident's electronic medical record (EMR), showed: -A progress note, dated 9/30/24 at 11:50 P.M., resident fell out of bed face down at approximately 10:10 P. M. Resident had laceration to head with blood on floor. Resident refused to allow assist to turn. Yelling to leave him/her alone. Vitals taken: Temperature: 97.2 (normal 97.8 through 99.1), blood pressure (BP): 112/87 (normal 90/60 through 120/80), pulse: 53 (normal 60 through 100), and respirations 20 (normal 12 through 22). Nurse had certified nursing assistant (CNA) call 911. Resident was transported to the hospital for evaluation. Hospice was called and informed. The resident's family member was called and informed nurse practitioner (NP); -A progress note, dated 10/1/24 at 2:10 A.M., resident returned from hospital with two emergency medical technician's (EMT) and son. Resident transferred into bed, bed in low position. Hematoma (a collection of blood that pools outside of a blood vessel, usually caused by an injury or trauma) noted to top of head and some scrapes, bruising noted to left side of face. Resident has bruise to right wrist with pressure bandage. Pressure bandage also noted to left wrist; -No documentation of neuro-checks every 4 hours times four started or completed after the resident returned from the hospital; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note, dated 10/1/24 at 12: 29 P.M., resident continues on follow-up for fall. Resident has no complaints of pain or discomfort related to fall. Resident up in dining room for all meals today. Resident noted to have bruising on top of head from fall as well. Neuro-checks and range of motion within normal limits for this resident. Will continue to monitor. Vital signs: BP: 131/66, temperature: 98.0, pulse: 80, respirations: 20, SPO2 (percentage of oxygen in the blood) 95% (normal 95% through 100%) room air; -A progress note, dated 10/2/24 at 4:53 A.M., showed resident alert in bed talking. Neuro-check within normal limits. No complaints voiced. Vital signs: BP: 120/68, pulse: 79, respirations: 18, temperature: 98.3; -A progress note, dated 10/3/24 at 5:13 A.M., neuro-check within normal limits for the resident. In low bed with mat at bedside for safety. No complaints voiced. Hematoma still noted to top of scalp. Vital signs: BP: 130/60, pulse: 62, respirations: 18, temperature: 97.6; -No further neuro-checks documented as completed in the progress notes for the 9/30/24 fall; -No neuro-check form completed to show the results of assessment, to include motor function and pupil response of any of the neuro-check documented as completed in the progress notes. During an interview on 10/30/24 at 12:10 P.M., Licensed Practical Nurse (LPN) C said unwitnessed falls have neuro-checks completed. If they are sent to hospital and come back within 24 hours, then staff are to restart the neuro-checks. A fall assessment should be completed even if the resident is sent out. Every fall needs a fall assessment even if they have multiple falls in one day. 2. Review of Resident #9's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -Functional limitation in range of motion: No impairment to the upper or lower extremities; -Used a wheelchair; -Mobility: -Independent to: Roll left and right; sit to lying; lying to sitting on side of bed; sit to stand; chair/bed-to-chair transfer; and toilet transfer; -Walk 10 feet: Independent; -Walk 50 feet: Not attempted due to medical condition or safety concerns; -No falls since admission or prior to assessment, whichever is more recent; -Occasionally incontinent of bladder, always continent of bowel; -Diagnoses include end stage renal disease (ESRD), diabetes, heart failure, and high blood pressure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised on 7/2/24, showed: -Need: Resident at risk for falls/actual fall due to neuropathy (weakness, numbness, and pain from nerve damage); -Goal: Resident will be free of falls through the next review; -Interventions/Tasks: Encourage resident to call staff for assistance to transfer, evaluate fall risk on admission and as needed, if fall occurs initiate frequent neuro and bleeding evaluation per facility protocol. Review of the facility's incident and accident report, showed the resident had an un-witnessed fall on 10/21/24 at 2:08 P.M. Review of the resident's EMR, showed: -The most recent fall assessment completed, dated 7/15/24, score of 8. A score of 10 or higher indicate high fall risk; -No fall assessments completed on or after 10/21/24. Review of the resident's progress notes, reviewed 10/30/24 at 11:04 A.M., showed: -A progress note, dated 10/21/24 at 12:19 P.M., resident was found in the bathroom by the dining room, on his/her knees and hands. Resident has a bump on the right side of forehead and left side of face. Resident also has skin tears to left elbow. Steri-strips (thin adhesive strips which can be used to close small wounds) were used to patch the skin tear. Resident also has an abrasion on each knee. These were cleaned and cover with Band-Aids. NP was made aware. Neuro-checks were started, vital signs are within normal limits and resident can move all extremities and stand up and walk as he/she does usually (baseline). POA called and made aware; -A progress note, dated 10/22/24 at 5:30 A.M., this nurse found dried blood on left side of resident's face and on his/her sheets. This nurse gently cleansed his/her face with soap and water. CNA helped resident get dressed and assisted the resident to his/her wheelchair. Vital signs: BP: 158/68, pulse: 100, temperature 97.7; -A progress note, dated 10/23/24 at 4:31 A.M., resident in low bed resting. Neuro-check within normal limit. Dressing and Band-Aids intact. No complaints voiced. Vital signs: BP: 124/69, pulse: 78, respirations: 18, temperature 97.7; -A progress note, dated 10/24/24 at 3:57 A.M., resident in low bed. Alert. Neuro-check within normal limit. No complaints voiced. Vital signs: BP: 114/72, pulse: 90, respirations: 18, temperature 97.8; -No other neuro-checks completed for the 10/21/24 fall with head injury found in the resident's EMR; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No neuro-check form completed to show the results of assessment, to include motor function and pupil response of any of the neuro-check documented as completed in the progress notes. Observation on 10/30/24 at 11:35 A.M., showed the resident lay in bed on his/her right side. The resident's eyes closed. A greenish/yellow bruise (indicated and older healing bruise) noted to his/her left cheek. 3. Review of Resident #8's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Always incontinent of bowel and bladder; -Functional limitation in range of motion: No impairment to the upper or lower extremities; -Mobility: -Substantial/maximal assistance required to: Roll left and right; sit to lying; lying to sitting on side of bed; sit to stand; chair/bed-to-chair transfer; toilet transfer; tub/shower transfer; -Walk 10 feet: Not attempted due to medical condition or safety concerns; -Did the resident have a fall any time in the last month prior to admission: Yes; -No falls since admission or prior assessment, whichever is more recent; -Diagnoses include Alzheimer's disease, arthritis, and high blood pressure. Review of the resident's care plan, revised 8/20/24, showed: -Need: Resident is at risk for falls related to confusion, cognitive deficits, weakness, need for maximum/total assistance with activities of daily living, incontinence, history of falls, tries to get up without assistance. Has had an actual fall trying to get out of bed; -Goal: The resident will not sustain serious injury through the review date; -Interventions/Tasks: Follow facility fall protocol, low bed and fall mats on each side of the bed, take to bathroom after meals (initiated 10/9/24). Review of the facility's incident and accident report showed the resident had unwitnessed falls on 9/19/24, 9/21/24, 9/22/24, and 10/6/24. Review of the resident's assessments, for September and October 2024, showed: -One fall assessment evaluation completed on 9/22/24. Score of 17 indicated the resident at high risk or falls; -No fall assessment evaluations completed for the 9/19/24, 9/21/24, and 10/6/24 falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's EMR showed: -A progress note, dated 10/6/24 at 3:17 P.M., resident found on floor in room lying on right side with head near wall. Denies hitting head alert and oriented times one. Assisted to bed from floor with staff assist of three. Yells out when picked up from floor. No shortening of any limb noted. Vital Signs: BP 141/78, pulse: 76, respirations: 20, oxygen: 96% room air. Physician called to report fall, no answer. Family member called. Resident remains in room now in chair. Bed in lowest position with mat on floor. No redness or swelling noted. Unable to tell what happened. Staff aware of fall, aware of previous fall interventions, aware to monitor resident; -No neuro-checks documented as completed in the progress notes for the 10/6/24 fall; -No neuro-check form completed to show the results of assessment, to include motor function and pupil response of any of the neuro-check documented as completed in the progress notes. During an interview on 10/30/24 at 11:55 A.M., LPN D said if a resident falls then the nurse does an assessment. During the assessment, staff check if the residents are coherent, chart, and fill out a neuro-check sheet. Nurses should always do neuro-checks if the resident is not alert and oriented at baseline. The family and physician should be notified as well. 4. During an interview on 10/30/24 at 3:45 P.M., the Director of Nursing (DON) and Administrator said they would expect the fall policy to be followed when a resident has a fall. Staff should obtain vitals, notify the provider, POA, and DON. A fall risk assessment should be completed for every fall. Neurochecks should be initiated for an unwitnessed fall or when a resident hits their head. If a resident is sent out, the neuro-checks should be restarted. A skin assessment should also be completed and there should be a note charted in the resident's progress notes. MO00243113