STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265324	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing Center	100 Woodland Court Arnold, MO 63010

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47678 Based on interview and record review, the facility failed to ensure a code status was consistently documented throughout the medical record for two residents (Residents #17 and #92) out of 21 sampled residents and for two residents (Residents #33 and #53) outside the sample. The facility census was 127. Review of the facility's policy titled, Advance Directives, not dated, showed: - Upon admission, every resident or resident representative is asked to determine code status; - Full Code - cardiopulmonary resuscitation (CPR - an emergency procedure consisting of chest compressions if the heart stops beating or the person stops breathing) performed when the resident experiences a catastrophic event such as cardiac/respiratory arrest or Do Not Resuscitate (DNR - does not want CPR); - The resident's code status will be reviewed with the resident and/or the resident representative annually; - The resident has the right to change their code status at any time. Review of facility's Code Status book (a book that gives each resident's code status) showed: - For Resident #17, a DNR code status; - For Resident #33, a DNR code status; - For Resident #53, a DNR code status; - For Resident #92, a Full Code status. 1. Review of Resident #17's medical record showed: - An admitted [DATE]; - A DNR code status on the facesheet; (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: 265324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for a DNR code status, dated [DATE]; - A Full Code status signed by the resident, facility representative, and the physician on [DATE]. Review of the resident's care plan, last revised [DATE], showed: - A DNR code status on [DATE]; - Social Services Designee (SSD) discussed advanced directives and code status with the resident and/or the resident representative on [DATE]; - Assure advanced directives were discussed and appropriate paperwork was obtained on [DATE]; - Advanced directives, when available, will be used according to policy for Full Code status on [DATE]. During an interview on [DATE] at 9:10 A.M., Resident #17 said staff went over the code status a couple months ago and he/she signed something. The resident said he/she wanted to be a Full Code. 2. Review of Resident #33's medical record showed: - An admitted [DATE]; - A DNR code status on the facesheet; - A DNR code status signed by the resident's representative, facility representative, and the physician on [DATE]; - A Full Code status signed by the resident's representative, facility representative, and the physician on [DATE]; - An order for DNR code status, dated [DATE]. Review of the resident's care plan, reviewed [DATE], showed: - A Full Code status, dated [DATE]; - Staff will follow the advance directive as written, dated [DATE]. 3. Review of Resident #53's medical record showed: - An admitted [DATE]; - A Full Code status on the facesheet; - A DNR code status signed by the resident, facility representative, and the physician on [DATE]; - An order for Full Code status, dated [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Woodland Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Woodland Court Arnold, MO 63010	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, reviewed [DATE], showed: - A Full Code status, dated [DATE]; - My advanced directive order for Full Code status will be honored, dated [DATE]; - Staff to initiate CPR and call 911, dated [DATE]. 4. Review of Resident #92's medical record showed: - An admitted [DATE]; - A DNR code status on the facesheet; - A Full Code status signed by the resident, facility representative, and the physician on [DATE]; - An order for DNR code status, dated [DATE]. Review of the resident's care plan, reviewed [DATE], showed: - My advance directive decision for Full Code status will be honored, dated [DATE]; - I have a copy of my advanced directives scanned into my electronic medical record or placed in a code status binder located at the nurses station, dated [DATE]. During an interview on [DATE] at 9:18 A.M., the Administrator said staff were instructed to open the scanned signed advance directive in the resident's electronic chart to confirm the code status. There was a book with copies of the advanced directives kept in the SSD's office. During an interview on [DATE] at 2:00 P.M., the SSD said he/she was in charge of the residents' code status but another staff member had taken over the task. The SSD had a binder in his/her office with the residents' code status. 49152 49999

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NAME OF PROVIDER OR SUPPLIER: Woodland Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Woodland Court Arnold, MO 63010	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a facility-initiated transfer when 13 residents (Residents #7, #17, #30, #34, #37, #39, #48, #50, #92, #101, #105, #121, and #126) out of 13 sampled residents transferred to the hospital. The facility's census was 127. Review of the facility policy titled, Hospital Transfer and Bed Hold Policy, undated, showed: - If the attending physician orders his/her patient to be transferred to the hospital, the family or responsible party will be notified and arrangements will be made; - Before there is a transfer of a resident to a hospital or a resident goes on a therapeutic leave, the resident and family or Durable Power of Attorney (DPOA) will be notified twice. The first will be during the admission process by the reading of the Bed Hold Policy. The second notice will be provided to the resident and family or DPOA at the time of the transfer to the hospital. A copy of this policy will be sent with other papers accompanying the resident to the hospital. 1. Review of Resident #7's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 10/05/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 2. Review of Resident #17's medical record showed: - The resident transferred to the hospital for medical evaluation on 07/31/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 3. Review of Resident #30's medical record showed: - The resident transferred to the hospital for medical evaluation on 08/08/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #34's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/06/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 5. Review of Resident #37's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 07/10/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 10/06/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 6. Review of Resident #39's medical record showed: - The resident transferred to the hospital for medical evaluation on 11/24/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 7. Review of Resident #48's medical record showed: - The resident transferred to the hospital for medical evaluation on 02/18/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/05/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 08/16/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 8. Review of Resident #50's medical record showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 02/20/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/08/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/25/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 9. Review of Resident #92's medical record showed: - The resident transferred to the hospital for medical evaluation on 11/25/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 10. Review of Resident #101's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/02/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/10/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/30/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 06/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 06/27/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 11. Review of Resident #105's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 08/16/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 09/11/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 12. Review of Resident #121's medical record showed: - The resident transferred to the hospital for medical evaluation on 12/05/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. 13. Review of Resident #126's medical record showed: - The resident transferred to the hospital for medical evaluation on 06/04/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative of the resident's transfers to the hospital. During an interview on 12/06/24 at 1:30 P.M., the Social Services Designee (SSD) said the nurses were responsible for notifying the resident's representative of the resident's transfer to the hospital. During an interview on 12/06/24 at 2:30 P.M., the Administrator said the resident's representative should be notified by phone of the resident's transfer to the hospital but the facility did not notify them in writing. The Resident Transfer form was filled out by the nurse transferring the resident to the hospital and that form was given to emergency medical services to pass along to the hospital staff. The hospital staff should give it to the resident's representative. The notification was not mailed to the resident representatives because they would not receive it until after the resident had returned to the facility in most cases. 49150 49152 49999

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to inform the resident and/or legal representative in writing of their bed hold policy at the time of transfer to the hospital for 12 residents (Resident #7, #17, #30, #34, #37, #48, #50, #92, #101, #105, #121, and #126) out of 13 sampled residents. The facility's census was 127. Review of the facility policy titled, Hospital Transfer and Bed Hold Policy, undated, showed: - In the event that you are transferred to a hospital, a copy of the bed hold policy will be sent with you. If you are a Medicaid recipient, you have access to Therapeutic Leave. You have 12 days leave between January and June and 12 days between July and December of each year; - Before there is a transfer of a resident to a hospital or a resident goes on a therapeutic leave, the resident and family or Durable Power of Attorney (DPOA) will be notified twice. The first will be during the admission process by the reading of the Bed Hold Policy. The second notice will be provided to the resident and family or DPOA at the time of the transfer to the hospital. A copy of this policy will be sent with other papers accompanying the resident to the hospital. 1. Review of Resident #7's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 10/05/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 2. Review of Resident #17's medical record showed: - The resident transferred to the hospital for medical evaluation on 07/31/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 3. Review of Resident #30's medical record showed: - The resident transferred to the hospital for medical evaluation on 08/08/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #34's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/06/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 5. Review of Resident #37's medical record showed: - The resident transferred to the hospital for medical evaluation on 05/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 07/10/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 10/06/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 6. Review of Resident #48's medical record showed: - The resident transferred to the hospital for medical evaluation on 02/18/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/05/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/13/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 08/16/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 7. Review of Resident #50's medical record showed: - The resident transferred to the hospital for medical evaluation on 02/20/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/08/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 04/25/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 8. Review of Resident #92's medical record showed: - The resident transferred to the hospital for medical evaluation on 11/25/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 9. Review of Resident #101's medical record showed: - The resident transferred to the hospital for medical evaluation on 04/02/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/10/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/30/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 06/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 06/27/24, and readmitted to the facility on [DATE]; - No documentation the resident or the resident representative was informed in writing of the facility bed hold policy at the time of the transfers. 10. Review of Resident #105's medical record showed: -The resident transferred to the hospital for medical evaluation on 08/16/24, and readmitted to the facility on [DATE]; -The resident transferred to the hospital for medical evaluation on 09/11/24, and readmitted to the facility on [DATE]; - No documentation the resident or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 11. Review of Resident #121's medical record showed: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital for medical evaluation on 12/05/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. 12. Review of Resident #126's medical record showed: - The resident transferred to the hospital for medical evaluation on 06/04/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer. During an interview on 12/06/24 at 2:35 P.M., the Administrator said that the bed hold policy was sent with the resident to the hospital at the time of transfer and that the hospital staff were responsible for giving it to the resident's representative. 49150 49152 49999

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on interview and record review, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for two residents (Residents #3 and #17) out of 21 sampled residents. The facility census was 127. Review of the facility's policy titled, Care Plan Section Responsibility, March 2024, showed: - A care plan will be developed upon admission per Centers for Medicare and Medicaid Services (CMS) guidelines. It will be updated quarterly, and annually per CMS guidelines to ensure that there is a continuity of care, and is in accordance with the individual's needs. Care plan will also be updated with a significant change of condition; - The care plan must be based upon the resident assessment, choices and advance directives, if any. As the resident's status changes, the facility, attending practitioner, and the resident representative, to the extent possible, must review and/or revise care plan goals and treatment choices. 1. Review of Resident #3's medical record showed: - An admitted [DATE]; - Diagnoses of urinary tract infections, falls, polyneuropathy (sensation issues involving peripheral nerves), long term use of antibiotics, hypothyroidism, major depressive disorder (MDD - long-term loss of pleasure or interest in life), anxiety disorder (persistent worry and fear about every day situations), hypertension (high blood pressure), atrial fibrillation (abnormal heart rate and rhythm), heart failure (inability for heart to pump blood as it should), and pain. Review of the resident's Physician Order Sheet (POS), dated December 2024, showed: - An order for apixaban (anticoagulant) 5 milligrams (mg) oral every 12 hours, dated 09/27/24; - An order for famciclovir (antiviral medication) 250 mg oral once a day in morning, dated 09/27/24; - An order for gabapentin (nerve pain medication) 300 mg oral every 12 hours, dated 09/27/24; - An order for duloxetine (depression medication) 60 mg oral once a day in morning, dated 10/03/24; - An order for alprazolam (anxiety medication) 0.5 mg oral once a day at bedtime, dated 11/17/24. Review of the resident's care plan, last reviewed on 10/04/24, showed: - The anticoagulant not addressed; (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The antiviral medication not addressed; - The nerve pain medication not addressed; - Depression and anxiety medications, depression, and anxiety not addressed; - Heart failure not addressed. 2. Review of Resident #17's medical record showed: - An admitted [DATE]; - Diagnoses of chronic kidney disease, cerebrovascular disease (damage to the brain from interrupted blood supply), asthma (lung condition making breathing difficult), blindness in one eye, diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), hypertension, atrial fibrillation, and unspecified psychosis (a mental disorder with a severe loss of contact with reality). Review of the resident's POS, dated December 2024, showed: - No order for Xanax (anxiety medication); - No order for Remeron (depression medication); - An order for quetiapine (antipsychotic medication) 100 mg oral once a day at bedtime, dated 08/07/24. Review of the resident's care plan, last reviewed on 10/20/24, showed: - Received Xanax for anxiety, initiated 03/23/22; - Received quetiapine 75 mg at bedtime, updated 10/27/22; - Vision impairment with intervention to provide large print reading material, initiated 01/10/22; - Weight loss related to significant weight loss evidenced by Remeron 7.5 mg for seven days then increase to 15 mg, initiated 09/14/22. During an interview on 12/03/24 at 2:43 P.M., Resident #17 said he/she was completely blind and could only see light differences and shadows. He/She couldn't read at all because of being blind. Resident #17 said he/she can tell if someone was around him/her by the shadow but could not tell who was there and relied on his/her other senses like hearing to distinguish the people he/she interacted with. During an interview on 12/06/24 at 12:25 P.M., Licensed Practical Nurse (LPN) Q said Resident #17 was completely blind and could only see light differences and shadows. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing Center	100 Woodland Court Arnold, MO 63010

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 10:38 A.M., the Minimum Data Set (MDS - a mandatory assessment completed by the facility staff) Coordinator would expect the care plan to accurately reflect the resident's current condition. During an interview on 12/06/24 at 5:45 P.M., the Director of Nursing (DON) and Administrator said they would expect the care plan to accurately reflect the resident's current condition.

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NAME OF PROVIDER OR SUPPLIER: Woodland Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Woodland Court Arnold, MO 63010	

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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 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** 47447 Based on observation, interview, and record review, the facility failed to monitor and consistently implement interventions, including adequate supervision consistent with resident needs, goals and current professional standards of practice, in order to eliminate or reduce the risk of falls and accidents and failed to update the care plan with new interventions to prevent additional falls for two residents (Residents #3 and #39) out of two sampled residents. The facility also failed to prevent resident access to liquor in an unlocked office. This had the potential to affect all residents who were able to move freely around the facility. The facility census was 127. Review of the facility policy titled, Falls, dated 09/22/21, showed: - The Minimum Data Set (MDS - a federally mandatory assessment completed by facility staff) defines a fall as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force; - Procedure following a fall includes ascertaining if there were injuries, providing treatment if necessary, fill out a fall event report for any falls sustained by a resident, determine possible cause of fall, neuro checks will be initiated with unwitnessed falls or if a head injury is apparent at time of fall, notify physician, family, and supervisor. - Review with physician if there is a necessity for physical or occupational evaluation and complete documentation in resident's chart; - The nursing office will follow up with the review and assessment and the care plan office will follow up with the interventions; - The care plan team will address the risk factors for the fall and revise the resident's care plan and/or facility practices, as needed, to reduce the likelihood of another fall; - All staff in-serviced on falls yearly and as needed and is part of the New Hire Orientation Program; - All residents are to be assessed by licensed nurses for falls on admission and the care plan team will be reviewed quarterly. 1. Review of Resident #3's admission MDS, dated [DATE], showed: - Cognition intact; - Dependent on staff for toileting and to go from lying to sitting positions; - Dependent on staff for lying to sitting and sitting to lying positions; - Sit to stand and toilet transfer not attempted due to medical condition or safety concerns; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident used a wheelchair and/or walker. Review of the resident's medical record showed: - No documentation of a fall on 12/03/24; - No documentation of an assessment of the fall on 12/03/24; - No documentation of notification to appropriate persons per the facility policy for the fall on 12/03/24. Review of the resident's care plan, last revised 10/04/24, showed: - At risk for falls evidenced by total dependence with transfers and fall within last month, dated 09/27/24; - Impaired physical mobility evidenced by total dependence to transfer and ambulate, dated 09/27/24; - Provide appropriate level of assistance to promote safety of the resident, dated 09/27/24; - Interventions included assist resident with activities of daily living (ADLs) and keep call light and most frequently used personal items within reach, dated 09/27/24; - The fall with interventions on 12/03/24, was not addressed. During an interview on 12/04/24 at 12:32 P.M., Resident #3 said he/she fell on [DATE] at 7:30 P.M. After waiting for someone to the answer the call light he/she pressed a little after 4 P.M., the resident had soiled him/herself from not being able to wait any longer to go to the bathroom. CNA N and an unknown nurse assistant (NA) came in the room to assist the resident from the wheelchair back to the bed. CNA N and the unknown NA lifted the resident up with the gait belt and on the way to the bed, one of the resident's legs buckled and the resident fell on his/her knees to the ground. CNA N and the unknown NA got another staff member to help put a Hoyer lift (a mechanical lift) sling pad under the resident and was transferred by the Hoyer lift to the bed. He/She usually could get to the bed from the wheelchair with assist of one to two staff members but was weak from waiting so long in the wheelchair. He/She did not have enough strength to help as much with transferring to the bed. During an interview on 12/04/24 at 5:30 P.M., CNA N said on 12/03/24 at around 9:30 P.M., the resident transferred to the bed with his/her help and another staff with a gait belt. The resident's leg buckled before making it to the bed and he/she and the other staff member lowered the resident to the ground. He/She put a Hoyer lift sling pad under the resident and transferred the resident back to the bed with the Hoyer lift. It was not reported to any other staff since he/she helped lower the resident to the ground and the resident did not fall. During an interview on 12/06/24 at 4:40 P.M., CNA P said if someone was lowered to the ground during a transfer, then it was not considered a fall and he/she would not alert the nurse. If someone did fall, then he/she would get the nurse. The nurse was in charge of charting everything in the computer and notifying everyone who needed to be notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 39's Admission MDS, dated [DATE], showed: - Cognition intact; - Partial/moderate assistance with mobility and ambulation; - Wheelchair or walker for assistive devices. Review of the resident's medical record showed: - Resident fell on [DATE], at the nurses station and hit the back of his/her head resulting in bleeding from a head wound and sent to the hospital for evaluation; - No documentation of a fall or an assessment for 12/05/24. Review of the resident's care plan, last revised 10/17/24, showed: - At risk for falls as evidenced by problem with balance and fall within last two to six months, dated 10/10/24; - Interventions included to maintain record of falls and evaluate for patterns, assist with ADL's as needed, and assess contributing factors related to fall history, dated 10/10/24; - The falls with interventions on 11/24/24, and 12/05/24, were not addressed. Observation on 12/05/24 at 9:27 A.M., showed Resident #39 in his/her room standing up and supporting him/herself on the roommate's bed with both hands. The resident lost his/her balance and fell on his/her buttocks landing on the floor on right side of the bed. Staff saw the resident on the floor and told Licensed Practical Nurse (LPN) O. LPN O said the resident was care planned for falls and liked to be on the floor to scoot around. LPN O asked a another staff to get the resident from his/her room and bring them to the nurse's station for one-on-one closer observation. During an interview on 12/03/24 at 11:29 A.M., CNA L said Resident #39 liked to be on the ground and scoot around. He/She usually did not fall, but lay himself/herself on the ground. The resident should be care planned for it. During an interview on 12/06/24 at 5:45 P.M., the Director of Nursing (DON) said if a fall was witnessed and hit his/her head, or unwitnessed and couldn't verify if the resident hit his/her head, then the Medical Director wanted all residents sent to the emergency room . If a fall was witnessed and hit his/her head, she would expect the licensed nurse to do an incident report. If a resident did not hit his/her head, then do an incident report, follow for 72 hours with neuro checks. It was considered a fall if a resident was assisted to the floor, but if a resident placed themselves on the floor, it would not be considered a fall. She did not know about Resident #3's or Resident #39's falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Observations of the unlocked Activity Director's office on 12/04/24 at 7:54 A.M., and 4:31 P.M., and 12/05/24 at 7:54 A.M., and 11:36 A.M., showed a 12 pack of alcoholic beer, an unopened bottle of rum, two 1/2 bottles of tequila, a bottle of coffee liqueur, an opened 1/4 bottle of blue agave tequila, an opened bottle of white rum, an unopened bottle of white rum, a 1/2 bottle of peach schnapps, a 1/2 bottle of brandy, and a 1/2 bottle of amaretto on a shelf visible from the hallway through the opened door. No staff were present. Two residents walked in the hallway outside of the Activities Director's office. During an interview on 12/05/24 at 11:45 A.M., the Activity Director said residents didn't usually enter his/her office if no one was in it, but there had been confused residents enter the office and use the trash can as a bathroom. The door was closed and locked when he/she left for lunch and for the day. The door was not closed when he/she stepped out of the office for a short period. During an interview on 12/06/24 at 6:00 P.M., the Administrator said he expected liquor to be stored in a location that was not accessible to the residents. 49152

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility failed to assess residents for the use of side rails prior to installation or use, the facility failed to obtain informed consent from the resident or if applicable, the resident representative, and the facility also failed to provide on-going monitoring, supervision, and routine maintenance of the beds with side rails in use for eight residents (Residents #3, #7, #48, #50, #105, #111, #127, and #389) out of eight sampled residents. The facility's census was 127. The facility did not provide a policy for side rails. 1. Review of Resident #3's admission Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 10/04/24, showed: - Intact cognition; - Dependent with bed mobility; - Diagnoses of falls, difficulty walking, morbid obesity (overweight), pain, heart failure (the heart does not pump blood as well as it should), and atrial fibrillation (abnormal heart beat). Review of the resident's care plan, revised 10/04/24, showed: - Risk of falls related to history of falls; - Bed mobility with supervision and transfers with total assist. Review of the resident's medical record showed: - Side rail evaluation completed on 09/27/24; - No documentation of informed consent for the use of the side rails. - On 12/03/24 at 11:10 A.M., the resident rolled side to side holding on to the bilateral quarter side rails in the upright position while staff performed incontinence care; - On 12/06/24 at 10:30 A.M., the resident lay in bed with the bilateral quarter side rails in the upright position. During an interview on 12/03/24 at 11:00 A.M., Resident #3 said he/she used the side rails to turn and reposition himself/herself in bed and did it independently. 2. Review of Resident #7's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Intact cognition; - Dependent with bed mobility; - Diagnoses of anemia (low blood levels of iron), heart failure, hypertension (high blood pressure), neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems), wound infection, diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), hyperlipidemia (high blood level of cholesterol), seizure disorder (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), anxiety disorder(persistent worry and fear about everyday situations), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of the resident's care plan, revised 11/05/24, showed: - Risk for falls; - Impaired physical mobility. Review of the residents' medical record showed: - Side rail evaluation completed on 10/06/23; - No documentation of quarterly side rail assessments; - No documentation of informed consent for the use of the side rails. Observations of the resident showed: - On 12/03/24 at 11:30 A.M., and 12/05/24 at 9:30 A.M., the resident lay in bed with the bilateral quarter side rails in the upright position. During an interview on 12/04/24 at 9:00 A.M., Resident #7 said he/she used the side rails to turn himself/herself in bed. 3. Review of Resident #48's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Moderate assistance with bed mobility; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of coronary artery disease (a condition that occurs when the arteries in the heart narrow or become blocked restricting blood flow to the heart), heart failure, hypertension, peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), DM, hyperlipidemia, fracture, stroke, dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), and psychotic disorder (a severe mental illness that causes a person to lose touch with reality and have abnormal perceptions and thoughts). Review of the resident's care plan, revised 08/21/24, showed: - Risk of falls related to a fall; - Resident will assist with turning and repositioning in bed and transfers. Review of the resident's medical record showed: - Side rail evaluation completed on 02/13/24; - No documentation of quarterly side rail assessments; - No documentation of informed consent for the use of the side rails. Observations of the resident showed: - On 12/03/24 at 11:12 A.M., the resident lay on the right side while holding onto the U-shaped side rail in the upright position on the right side of the bed; - On 12/06/24 at 11:50 A.M., the resident rolled side to side holding onto the U-shaped side rail in the upright position on the right side of bed while staff performed wound care and incontinence care. 4. Review of Resident #50's quarterly MDS, dated [DATE], showed: - Moderately impaired cognition; - Moderate assistance with bed mobility; - Diagnoses of cancer, anemia, coronary artery disease, hypertension, renal failure, DM, hyperlipidemia, anxiety disorder, and depression. Review of the resident's care plan, revised 09/16/24, showed: - Risk for falls; - Impaired physical mobility; - Requires extensive assistance with bed mobility and transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed: - Side rail evaluation completed on 04/11/24; - No documentation of quarterly side rail assessments; - No documentation of informed consent for the use of the side rails. Observations of the resident showed: - On 12/03/24 at 11:24 A.M., and 12/04/24 at 1:00 P.M., the resident lay in bed with the bilateral quarter side rails in the upright position. During an interview on 12/03/24 at 11:20 A.M., Resident #50 said he/she used the side rails to turn himself/herself in the bed. 5. Review of Resident #105's quarterly MDS, dated [DATE], showed: - Cognition mildly impaired; - Partial to moderate assistance for bed mobility; - Diagnoses of anxiety, major depressive disorder, stroke, DM, and osteoarthritis. Review of the resident's care plan, revised 11/04/24, showed: - Risk for falls; - Limited bed mobility; - Impaired physical mobility and range of motion due to contracture of the left hand and cognitive status mildly impaired. Review of the resident's medical record showed: - No documentation of side rail assessments; - No documentation of informed consent for the use of the side rails. Observation on 12/05/24 at 8:15 A.M., showed the resident lay in bed with the bilateral one-quarter, inverted U-shaped side rails in the upright position. 6. Review of Resident 111's admission MDS, dated [DATE], showed: - Cognition intact; - Bed mobility rolling, sit to lying, and lying to sitting in bed require supervision or touching assistance; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Sit to stand or bed to chair transfer require partial to moderate assistance; - Diagnoses of cancer, DM, right humerus (upper arm bone) fracture, stroke, dementia, and traumatic brain injury (TBI), COPD, and falls. Review of the resident's care plan, revised 10/19/24 showed: - Impaired physical mobility; - A recent fracture related to a fall; - Vertigo (dizzy feeling) and syncope (sudden temporary loss of consciousness); - Elopement attempts. Review of the resident's medical record showed: - No documentation of side rail assessments; - No documentation of informed consent for the use of the side rails. Observation on 12/06/24 at 8:20 A.M., showed: - The resident lay sideways in bed with the bilateral U-shaped quarter side rails in the upright position. 7. Review of Resident #127's admission MDS, dated [DATE], showed: - Moderate cognitive impairment; - Moderate assistance with bed mobility; - Diagnoses of atrial fibrillation (a heart condition that causes an irregular heartbeat, often resulting in a faster than normal rate), hypertension, urinary tract infection (a bacterial infection that occurs in the urinary tract), dementia, malnutrition (lack of sufficient nutrients in the body), anxiety disorder, depression, and COPD. Review of the resident's care plan, revised 10/09/24, showed: - Risk of falls related to a fall; - The resident will assist with turning and repositioning in bed and transfers. Review of the resident's medical record showed: - Side rail evaluation completed on 02/13/24; - No documentation of quarterly side rail assessments; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of informed consent for the use of the side rails. Observation of the resident showed: - On 12/05/24 at 9:42 A.M., the resident lay in bed with the bilateral U-shaped side rails in the upright position. During an interview on 12/06/24 at 3:19 P.M., Resident #127's family member said the resident used the side rails to turn side to side and get out of bed. 8. Review of Resident #389's admission MDS, dated [DATE], showed: - Cognition intact; - Standby assistance with bed mobility; - Diagnoses of anemia, atrial fibrillation, heart failure, hypertension, renal failure, wound infection, hyperlipidemia, thyroid disorder (a condition that occurs when the thyroid gland doesn't produce the right amount of hormones), arthritis, and depression. Review of the resident's care plan, revised 11/23/24, showed: - High risk of falls. Review of the resident's medical record showed: -Side rail evaluation completed on 11/17/24; - No documentation of informed consent for the use of the side rails. Observations of the resident showed: - On 12/06/24 at 8:00 A.M., the resident lay in bed with the bilateral U-shaped side rails in the upright position; - On 12/06/24 at 8:22 A.M., the resident sat on the left edge of the bed with the bilateral U-shaped side rails in the upright position. During an interview on 12/06/24 at 3:15 P.M., Resident #389 said he/she used the side rails to reposition in bed. During an interview on 12/06/24 at 2:45 P.M., the Director of Nursing (DON) said she would expect side rail assessments to be done quarterly and with changes. During an interview on 12/19/24 at 8:50 A.M., the DON said the nurse managers on the hall were responsible for the completion of the informed consent of the side rails and the MDS Coordinator was responsible for the quarterly assessments of the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49152 49999

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility failed to ensure residents diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure appropriate services to promote the resident's highest level of functioning and psychosocial needs were provided for two residents (Residents #108 and #115) out of three sampled residents. The facility census was 127. The facility did not provide a policy regarding dementia care. 1. Review of Resident #108's medical record showed: - An admitted [DATE]; - Diagnosis of unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking). Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 09/16/24, showed: - Diagnosis of dementia; - Able to understand others and to be understood. Review of the resident's care plan, last reviewed 09/16/24, showed: - Did not address dementia; - Did not address specific problems, interventions, or goals for dementia care; - Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. Observations of the resident showed: - On 12/03/24 at 12:05 P.M., the resident lay in bed with the head of the bed raised; - On 12/04/24 at 8:35 A.M., and 12/05/24 at 9:05 A.M., the resident lay in the bed with his/her eyes closed; - On 12/04/24 at 12:35 P.M., the resident lay in bed with the head of the bed raised and ate lunch. 2. Review of Resident #115's medical record showed: - An admitted [DATE]; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing Center	100 Woodland Court Arnold, MO 63010

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnosis of dementia. Review of the resident's care plan, dated 11/08/24, showed: - Did not address dementia; - Did not address specific problems, interventions, or goals for dementia care; - Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. During an interview on 12/06/24 at 5:50 P.M., the Director of Nursing (DON) said dementia should be addressed on the care plan. During an interview on 12/10/24 at 10:38 A.M., the MDS Coordinator said he/she would expect individualized dementia care to be addressed on the care plan. 47678

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NAME OF PROVIDER OR SUPPLIER Woodland Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Woodland Court Arnold, MO 63010	

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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. 47678 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 31 opportunities with two errors made, for an error rate of 6.45%, which affected two residents (Residents #48 and #71) out of two sampled residents. The facility census was 127. Review of the facility's policy titled, Medication Administration General Guidelines, revised May 2021, showed: - Medications are administered as prescribed in accordance with manufacturers' specifications; - Personnel authorized to administer medications do so only after having familiarized themselves with the medication. Review of the insulin lispro (a rapid acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) KwikPen (insulin in a pen-type device) Manufacturer Instructions for use, revised July 2023, showed: - Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; - Not priming before each injection may result in too much or too little insulin; - Turn the dose knob to select two units; - Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top; - With the needle pointing up, push the dose knob until it stops and zero is seen in the dose window, hold and count to five slowly; - There should be insulin at the tip of the needle, if not, repeat no more than four times. Review of the Fiasp (a rapid acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Touch Pen instructions, revised July 2023, showed: - To prime the pen, turn the dose selector to select 2 units; - Hold the pen with the needle pointing up; - Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; - Keep the needle pointing upwards, press the push-button all the way in; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The dose selector returns to zero; - A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times; - Select your dose; - Give injection. 1. Review of Resident #48's Physician's Order Sheet (POS), dated December 2024, showed: - An order for insulin lispro per sliding scale (progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges) for a blood sugar of 201-250, give four units, dated 08/23/24. Observation of the resident medication administration on 12/06/24 at 11:50 A.M., showed: - Registered Nurse (RN) A administered insulin lispro four units subcutaneously (an injection just beneath the skin) to the resident per sliding scale for a blood sugar of 244; - RN A failed to prime the insulin pen prior to the administration of the insulin. 2. Review of Resident #71's POS, dated December 2024, showed: - An order for Fiasp inject per sliding scale for a blood sugar of 251-300, give eight units, dated 11/16/2024. Observation of the resident's medication administration on 12/06/24 at 11:45 A.M., showed: - RN B administered Fiasp eight units subcutaneously to the resident per sliding scale for a blood sugar of 260; - RN B failed to prime the Fiasp pen prior to the administration of the insulin. During an interview on 12/06/24 at 11:55 A.M., RN B said he/she was unaware insulin pens needed to be primed. During an interview on 12/06/24 at 3:29 P.M., RN A said he/she primed insulin pens prior to the first use, not with each administration. During an interview on 12/06/24 at 5:55 P.M., the Director of Nursing (DON) said insulin pens should be primed with each use. During an interview on 12/06/24 5:59 P.M., the DON and the Administrator said they expect the facility medication error rate to be less than five percent.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47678 Based on observation, interview, and record review, the facility failed to ensure four vials of Tubersol (a solution used during a tuberculosis (a serious bacterial infection that mainly affects the lungs) test were dated when opened. This had the potential to affect all residents. The facility's census was 127. Review of the facility's policy titled, Storage of Medications, revised 07/22/24, showed: - The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, all such drugs should be returned to the dispensing pharmacy or destroyed; - Did not address dating vials when opened. Review of the manufacturer's recommendations for Tubersol, revised 03/18/24, showed the solution should discarded 30 days after date opened. Observation on 12/06/24 at 8:51 A.M., of the medication refrigerator in the Terrace medication room showed: - Two opened vials of Tubersol solution not dated. Observation on 12/06/24 at 9:15 A.M., of the medication refrigerator in the Pavilion medication room showed: - Two opened vials of Tubersol solution not dated. During an interview on 12/06/24 at 8:53 A.M., Registered Nurse (RN) B said multi-dose vials should be dated when opened and discarded if not used in one month. During an interview on 12/06/24 at 9:17 A.M., Registered Nurse (RN) A said Tubersol vials should be dated when opened and be discarded after 30 days of opening. During an interview on 12/06/24 at 5:55 P.M., the Director of Nursing (DON) said tuberculin solution vials should be dated when opened and discarded after 30 days of opening.

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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** 47447 Based on observation, interview, and record review, the facility failed to follow infection prevention precautions for one resident (Resident #48) out of six sampled residents by not performing proper hand hygiene and glove changing techniques during care and failed to provide infection prevention precautions by not following enhanced barrier precautions (EBP) for two residents (Residents #71 and #389) out of two sampled residents. The facility census was 127. Review of the facility policy titled, Personal Protective Equipment (PPE) Usage (Glove Policy), undated, showed: - Wash hands in between glove changes. Review of the facility policy titled, EBP, dated 04/01/24, showed: - EBP will be utilized by the staff for any residents with chronic wounds or indwelling medical devices during any high-contact with that resident. 1. Review of Resident #48's medical record showed: - Resident on contact precautions (wear a gown and gloves to prevent the spread of a bacteria or virus when entering the resident's room) for Clostridium difficile infection (a highly contagious bacteria that causes inflammation of the colon and diarrhea), diagnosed on [DATE]; - An order for a wound vac (a technique using a suction pump, tubing, and a dressing to remove excess drainage and promote healing in wounds) to be changed two times a week, dated 09/06/24. Observation of the resident's wound vac dressing change on 12/06/24 at 11:50 A.M., showed: - Registered Nurse (RN) A performed hand hygiene, put on a gown, gloves, and entered the resident's room; - RN A removed the resident's items from the bedside table and cleaned the bedside table with a disinfectant wipe; - RN A raised the resident's bed; - RN A changed gloves and did not perform hand hygiene; - RN A removed the dressing from the wound; - RN A changed gloves and did not perform hand hygiene; - RN A removed the gown, gloves, and performed hand hygiene; - RN A left the room to get additional supplies; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN A performed hand hygiene, put on a gown, gloves, and entered the resident's room; - RN A cleaned the wound, did not change gloves, did not perform hand hygiene, and wiped the skin around the wound with skin prep (a protective barrier applied to the skin before procedures or treatments that may involve adhesives, tapes, or friction); - RN A did not change gloves, did not perform hand hygiene, and changed the resident's wound vac dressing and connected the tubing to the wound vac pump; - RN A did not change gloves, did not perform hand hygiene, and cleaned the resident's peri area; - RN A did not change gloves, did not perform hand hygiene, and applied barrier cream to the peri area; - RN A did not change gloves, did not perform hand hygiene, and placed a clean brief on the resident; - RN A changed gloves and did not perform hand hygiene; - RN A lowered the resident's bed to the lowest position; - RN A removed gloves, gown, performed hand hygiene, and left the resident's room. During an interview on 12/06/24 at 4:30 P.M., RN A said gloves should be changed when going from dirty to clean procedures on the same resident and hands should be sanitized when gloves were changed and before entering and leaving residents' rooms. 2. Review of Resident #71's medical record showed: - An order for a Foley catheter (a tube inserted into the bladder to drain urine), dated 10/02/24. Observation on 12/06/24 at 11:45 A.M., of the resident's blood glucose monitoring showed: - No signage for EBP; - RN B entered the room, performed hand hygiene, put on gloves, and did not put on a gown; - RN B performed the blood glucose monitoring for the resident. 3. Review of Resident #389's medical record showed: - An order for daptomycin (an antibiotic that treats bacterial infections) and ertapenem (an antibiotic that is used to treat severe infections) to be administered through peripherally inserted central catheter (PICC - a long, thin, flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart), dated 11/18/24; - An order for dressing change to the left knee every day, dated 11/18/24; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for the PICC line dressing change every 7 days, dated 11/18/24. Observations of the resident's care showed: - No signage for EBP; - On 12/06/24 at 8:00 A.M., RN A entered the room, performed hand hygiene, put on gloves, did not put on a gown, and performed the PICC line care; - On 12/06/24 at 8:22 A.M., RN A entered the room, performed hand hygiene, put on gloves, did not put on a gown, and performed glucose monitoring; - On 12/06/24 at 11:30 A.M., RN A entered the room, performed hand hygiene, put on gloves, did not put on a gown, removed the antibiotic from the PICC line, flushed the PICC line with saline, and capped the PICC line. During an interview on 12/06/24 at 8:25 A.M., RN A said he/she did not wear a gown for the PICC line care. During an interview on 12/06/24 at 5:45 P.M., the Director of Nursing (DON) said hand hygiene should be performed before applying gloves, when changing gloves, and after care was completed. Gloves should be worn during resident care and should be changed when going from a dirty procedure to a clean procedure. She would expect staff to use EBP for residents with indwelling tubes and wounds. 47678 49999

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 47447 Based on observation, interview, and record review, facility staff failed to conduct regular inspections of all bed frames, mattresses, side rails, and enabler bars as part of a regular maintenance program for eight residents (Residents #3, #7, #48, #50, #105, #111, #127, and #389) out of eight sampled residents. The facility's census was 127. The facility did not provide a policy on inspections of side rails. 1. Review of Resident #3's medical record showed no maintenance inspection for the side rails. Observations of the resident showed: - On 12/03/24 at 11:10 A.M., the resident rolled side to side holding on to the bilateral quarter side rails in the upright position while staff performed incontinence care; - On 12/06/24 at 10:30 A.M., the resident lay in bed with the bilateral quarter side rails in the upright position. 2. Review of Resident #7's medical record showed no maintenance inspection for the side rails. Observations of the resident showed: - On 12/03/24 at 11:30 A.M., and 12/05/24 at 9:30 A.M., the resident lay in bed with the bilateral quarter side rails in the upright position. 3. Review of Resident #48's medical record showed no maintenance inspection for the side rails. Observations of the resident showed: - On 12/03/24 at 11:12 A.M., the resident lay on the right side while holding onto the U-shaped side rail in the upright position on the right side of the bed; - On 12/06/24 at 11:50 A.M., the resident rolled side to side holding onto the U-shaped side rail in the upright position on the right side of bed while staff performed wound care and incontinence care. 4. Review of Resident #50's medical record showed no maintenance inspection for the side rails. Observations of the resident showed: - On 12/03/24 at 11:24 A.M., and 12/04/24 at 1:00 P.M., the resident lay in bed with the bilateral quarter side rails in the upright position. 5. Review of Resident #105's medical record showed no maintenance inspection for the side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/05/24 at 8:15 A.M., showed the resident lay in bed with the bilateral one-quarter, inverted U-shaped side rails in the upright position. 6. Review of Resident #111's medical record showed no maintenance inspection for the side rails. Observation on 12/06/24 at 8:20 A.M., showed: - The resident lay sideways in bed with the bilateral U-shaped side rails in the upright position. 7. Review of Resident #127's medical record showed no maintenance inspection for the side rails. Observation of the resident showed: - On 12/05/24 at 9:42 A.M., the resident lay in bed with the bilateral U-shaped side rails in the upright position. 8. Review of Resident #389's medical record showed no maintenance inspection for the side rails. Observations of the resident showed: - On 12/06/24 at 8:00 A.M., the resident lay in bed with the bilateral U-shaped side rails in the upright position; - On 12/06/24 at 8:22 A.M., the resident sat on the left edge of the bed with the bilateral U-shaped side rails in the upright position. During an interview on 12/06/24 at 4:30 P.M., the Administrator said entrapment assessments were not done and he had never heard of an entrapment assessment. During an interview on 12/19/24 at 8:50 A.M., the Director of Nursing (DON) said maintenance did inspect the bed rails as needed. During an interview on 12/19/24 at 9:47 A.M., the Maintenance Director said the bed rails were checked monthly through work orders sent by nursing. The work order states whether the rails need put on or taken off. Maintenance did not measure or assess the rails for entrapment. 49152 49999

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49999 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year for two certified nurse aides (CNA R and CNA S) and failed to provide the required annual competencies of Dementia Care (care of a resident with an impaired ability to remember, think, or make decisions) for one CNA S out of two CNA's sampled. The facility census was 127. The facility did not provide a CNA in-service training policy. Review of the facility assessment, dated October 31, 2017, showed: - Required in-service training for nurse's aides must: 1. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; 2. Include dementia management training and resident abuse prevention training; 3. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents to as determined by the facility staff; 4. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. 1. Review of the facility's April 2023 through April 2024 in-service records showed: - Certified Nurse Aide (CNA) R's hire date of 04/11/22; - CNA R attended ten hours of in-services. 2. Review of the facility's October 2023 through October 2024 in-service records showed: - CNA S's hire date of 10/28/22; - CNA S attended eight hours of in-services; - CNA S did not attend an annual competency in-service on Dementia Care. During an interview on 12/06/24 at 12:10 P.M., the Administrator said the in-services provided the required subjects, but the facility did not track the amount of hours completed for each CNA. During an interview on 12/06/24 at 12:10 P.M., the Director of Nursing (DON) said the in-services last about 30 minutes long. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 5:45 P.M., the DON said she would expect CNA's to have 12 hours of in-service training annually to include Abuse/Neglect and Dementia care