STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265331	A. Building B. Wing	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Rehab and Nursing	10954 Kennerly Road Saint Louis, MO 63128

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46970 Based on observation, interview and record review, the facility failed to follow its policy when an injury of unknown origin was discovered and not reported, assessed, or investigated for one resident (Resident #1). The census was 92. Review of the facility's Accident and Incident Protocol, reviewed 7/2022, included: -The facility strives to ensure that residents/patients, visitors, and/or volunteers will not experience undue discomfort and/or have their health and safety placed in jeopardy due to an unusual occurrence (accident/incident); -The facility defines an accident/incident as an event, occurrence, or happening that may produce an actual or potential undesirable outcome; -The event may be an accident or a situation that could result in an accident. Accidents/incidents may include, but are not limited to the following: 1. Unexplained bruises/skin tears; 2. Injuries of unknown origin; 3. Injury to resident/patient during handling; -Should an accident/incident occur, the facility strives to prevent such an occurrence from happening again; -A thorough investigation and follow-up will be completed. A summary of the accident/incident will be documented; -All occurrences will be reviewed by the administrator, director of nursing, and quality assurance and performance improvement (QAPI); -Accident/incident reports are initiated by a clinician as soon as the occurrences is discovered or reported; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All unusual occurrences will be reported immediately to the manager/supervisor on call and incident report completed. -Procedure: -Report the accident/incident to the physician, responsible person/family, and immediate supervisor; -Report all accidents/incidents to the administrator. Notify the administrator immediately if a medical device is suspected to have caused or contributed to an injury; -Complete an accident/incident report if the accident occurred to any of the following persons: Resident/patient -Obtain and record vital signs including neurological checks, as applicable, for minimum of 72 hours on the resident/patient. Enter the final assessment on the incident follow up and summary; -Document the occurrence in the nurse's notes of the resident/patient. Document objective facts such as: -Date; -Time; -Person involved; -Where accident/incident occurred; -Who first noticed accident/incident; -Where involved person positioned; -Assistance given; -Objective findings of the physical examination; -Names of person notified; -Document response of the family/significant other at the time of notification; Review of the accident/incident report will be completed by the director of nursing and/or nurse manager within 24 hours (72 hours on weekends and/or holidays); -Initiate an investigation of the unusual occurrence to determine cause; -Examples may include, but are not limited to: -Interview affected person, if possible; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interview all potential witnesses, to include roommate, and other residents, and visitors, and family members; -Observe the immediate surrounding environment; -Provide follow-up and resolution to the investigation; -Record the disposition on the incident report; -Review the incident report with individual responsible for retraining the staff member(s), if staff retraining is required; -Present and discuss incident report(s), investigation, action taken, and possible required actions. Review of the facility's Abuse, Neglect, Misappropriation of Resident Property, injury of unknown origin policy and procedure, revised 8/1/22, showed: -Prevention and Reporting: The Administrator has primary responsibility in the facility for implementation of the abuse/neglect program; -The facility will follow all state and federal guidelines on preventing abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include physical harm, pain, mental anguish, verbal abuse, sexual abuse, or involuntary seclusion; -The facility encourages and supports all residents, staff, and families in feeling free to report any suspected acts of abuse, neglect, misappropriation, or injury of unknown origin. The facility takes all measures possible to ensure that residents, staff, and families are free from fear of retribution if reports or incidents are filed with the facility; -The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc.; -The facility has designed and implemented processes, which strived to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property; -The facility has implemented the following processes in an effort to provide residents/patients and staff a safe and comfortable environment: -The shift supervisor (Charge Nurse, Nurse Manager, or Administrator) is identified as responsible for immediate initiation of the reporting process; -The Administrator and Director of Nursing (DON) are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect, and/or misappropriation of property standards and procedures: -Implementation: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reporting; -Investigation; -Implementation and ongoing monitoring includes of the following: -Identification; -Protection; -Investigation; -Reporting/Response; -Definitions included: Injury of unknown origin, an injury is classified as an injury of unknown origin when the following conditions are met: 1. The origin of the injury was not observed by any person, is not explained by the resident and; 2. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time; -Prevention: 1. Ensure that prevention techniques are implemented in the facility including, but not limited to, ongoing supervision of employees through visual observation of care delivery and recognition of signs of burnout, frustration, and stress. It is the responsibility of all staff to promote a safe environment for the residents. 2. Identify, correct, and intervene in situations where abuse, neglect, and/or mistreatment are more likely to occur. This includes, but is not limited to, identification/analysis of assigned staff demonstrating knowledge of individual resident's needs. Instruct staff that they are required to report concerns, incidents, and grievances. -Identification: Resident/Patient concerns report; -Incident Entry Process: -Incident Report -Follow-up/Incident report summary; -Initiate an incident entry immediately upon identification of alleged, actual or suspected abuse, neglect, mistreatment, and/or misappropriation of property; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Upon completion of an investigation the facility will determine if modifications are needed to prevent similar incidents or injuries from occurring in the future. The quality assurance investigative materials will be reviewed by the quality assurance committee at its next regularly scheduled meeting. -Investigation: 1. When an incident or suspected incident of abuse or neglect is reported, the administrator or designee investigates the incident with the assistance of appropriate personnel; 2. Initiate the investigation, the investigation should be thorough with witness statements from staff, residents, family members who may be interview able and have information regarding the allegation; 3. The investigation may consist of an interview with the person reporting the incident and witnesses, and interview with the resident and other residents, if possible, a review of the resident's medical record, an interview with staff members having contact with the resident during the period of the alleged incident, interviews with resident's roommate, family members and visitors, a review of all circumstances surrounding the incident; -Reporting/Response: -Any person witnessing or having knowledge of alleged violation involving abuse, neglect, misappropriation, or injury of unknown origin are to notify the administrator or director of nursing immediately. -Notify the appropriate State agency(s) immediately of allegations or suspicion of abuse, neglect or injury of unknown by fax or telephone after identification of alleged/suspected incident. -Person(s) initially identifying potential abuse, neglect, mistreatment, and/or misappropriation of property may, by State law, be accountable to make initial call; -Notify the legal guardian, spouse, or responsible family members/significant other of the alleged or suspected abuse, neglect, mistreatment, and/or misappropriation of property immediately (within 24 hours.); -Notify the physician immediately (within 24 hours). Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/13/23, showed: -Cognitively intact; -Chair/bed to chair transfer: partial to moderate assistance; wheelchair; -Diagnoses included: congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should), edema (swelling caused by too much fluid trapped in the body's tissues) and vitamin D deficiency. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident on 1/4/24 at 10:55 A.M., showed a white square bandage, with brownish colored stain around the top and side edges, affixed to the resident's right lower leg. The bandage was dated 1/2/24 and initialed by staff. During an interview on 1/4/24 at 10:55 A.M., the resident said he/she got the cut because an aide had hit his/her leg with the foot pedal from his/her wheelchair. He/She guessed staff were supposed to change the dressing on his/her leg one time a day but didn't know. He/She said either staff had been careless or it was an accident. Review of the resident's progress notes, showed no documentation related to an injury of unknown origin, assessment, accident/incident report initiation, or notification of the responsible party or physician. Observation on 1/4/24 at 11:30 A.M., showed the Assistant Director of Nursing (ADON) looked up the resident's physician order, nurse's note, progress notes and assessments in the resident's medical record. The ADON said there was not documentation available from any of those sources and the staff member's initials on the resident's dressing was the Director Of nursing (DON). She said there was nothing to find so she'd wrap up the search for information on the injury because the incident wasn't documented. Observation on 1/4/24 at 1:27 P.M., showed the resident's right lower leg dressing changed with staff initials, dated 1/4/24. During an interview on 1/4/24 at 11:18 A.M., Certified Nursing Assistant (CNA) B said if he/she saw a resident with an unknown injury, he/she would report it to the nurse and ask the resident what happened. During an interview on 1/4/24 at 11:30 A.M., the ADON said if a resident had an unknown injury, it would be reported to the physician, family/responsible party, DON, and the Administrator. An assessment would be completed, an incident report started and a resident interview of what happened if they were able to say. She said all actions taken should be documented in the resident's nursing and/or progress notes. During an interview on 1/4/24 at 11:49 A.M., Certified Medication Technician D said he/she would ask the resident what happened if he/she saw an injury on a resident and tell the nurse. During an interview on 1/4/24 at 11:55 A.M. Nurse E said if he/she discovered an injury of unknown origin or an injury of unknown origin was reported to him/her, he/she would assess the resident, ask the resident what happened, notify the physician, family/responsible party, and the Administrator. Nurse E said he/she would have provided whatever treatment the physician told him/her to do and document the incident in the resident's progress notes. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/4/24 at 1:45 P.M., the Administrator said she didn't know what happened to the resident's leg, but the ADON had made her aware today. She said it would need to be reviewed by the Risk Management team. She would have expected the DON to have documented what happened to the resident's leg, any interventions, skin assessment, and anyone she had notified. The Administrator expected the dressing would have been changed since 1/2/24 and staff to follow the Accident and Incident policy. She said in-service training should have been completed related to providing care and not rushing the removal of wheelchair legs. She expected to have been notified herself and would discuss with the DON what happened with the resident's leg. She said a treatment program would be implemented related to the resident's wound. MO00229621

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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 - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 46970 Based on observation, interview and record review, the facility failed to follow its policy by not obtaining a physician's order for a skin tear of unknown origin for one resident (Resident #1), thereby potentially increasing the risk of a negative outcome related to the healing process due to a diagnoses of Type 2 diabetes mellitus with diabetic chronic kidney disease. The census was 92. Review of the facility's Physician Orders policy, last revised 5/1/11, showed: -Protocol: At the time each resident/patient is admitted , the facility will have physician orders for their immediate care. Physician's orders will be verified by the attending physician at the facility. All physician orders will be dated and signed according to State and Federal regulations; -All clinicians may take verbal and/or telephone orders as permitted by their state licensure board; Procedures included: -Obtain one on the following types of physician orders: -Verbal; -Telephone order; -Transmitted by facsimile machine (fax); -Written by the physician; -Assure physician's orders include the drug or treatment and a correlating medical diagnosis or reason; -Assure medication orders include: -Route; -Dosage; -Frequency; -Strength; -Reason for administration; -Assure appropriate departments are aware of applicable orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Medication Administration General Guidelines policy, dated 11/2021, showed: -Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions; -Administration: Medications are administered in accordance with written orders of the prescriber; -Documentation (including electronic): -The individual who administers the medication dose records the administration on the resident's MAR/Electronic Medication Administration (eMAR) directly after the administration is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensue necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications; -Topical medications used in treatments are listed on the treatment administration record TAR/Electronic Treatment Administration Record (eTAR); -The resident's MAR/eMAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. If hardcopy of MAR is used, initials on each MAR are cross referenced to a full signature in the spaces provided. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/13/23, showed: -Cognitively intact; -Chair/bed to chair transfer: partial to moderate assistance; wheelchair; -Diagnoses included: congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should), edema (swelling caused by too much fluid trapped in the body's tissues), Vitamin D deficiency. Observation of the resident on 1/4/24 at 10:55 A.M., showed a white square bandage, with brownish colored stain around the top and side edges, affixed to the resident's right lower leg. The bandage was dated 1/2/24 and initialed by staff. During an interview on 1/4/24 at 10:55 A.M., the resident said he/she got the cut because an aide had hit his/her leg with the foot pedal from his/her wheelchair. He/She guessed staff were supposed to change the dressing on his/her leg one time a day but didn't know. He/She said either staff had been careless or it was an accident. Review of the resident's physician orders, showed no wound care or treatment order. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, showed no documentation related to an injury of unknown origin or otherwise, assessment, accident/incident report initiation, or notification of the responsible party or physician. Observation on 1/4/24 at 11:30 A.M., showed the Assistant Director of Nursing (ADON) looked up the resident's physician orders, nurse's note, progress notes, and assessments in the resident's medical record. The ADON said there was no documentation available from any of those sources. The staff member's initials on the resident's dressing was the Director of Nursing (DON). The ADON said there was nothing to find so she'd wrap the search up for documentation. The incident wasn't documented. The resident should have been assessed, the physician notified and an order obtained for treatment. All of this should had been documented. Observation on 1/4/24 at 1:27 P.M., showed the resident's right lower leg dressing changed with staff initials, dated 1/4/24. During an interview on 1/4/24 at 11:55 A.M. Nurse E said if he/she discovered an injury of unknown origin or an injury of unknown origin was reported, he/she would have assessed the resident, asked the resident what happened, notified the physician, family/RP, and the administrator. Nurse E said he/she would have provided whatever treatment the physician told him/her to do and document the incident in the resident's progress notes. During an interview on 1/4/24 at 1:45 P.M., the Administrator said she didn't know what happened to the resident's leg, but the ADON had made her aware today. She said she would have expected the DON to have documented what happened to the resident's leg, any interventions, skin assessment, and anyone she had notified. The Administrator expected the dressing would had been changed since 1/2/24 and for staff to follow the accident and incident policy. The incident should had been discussed with risk management and the team. She said in-service training should have been completed related to providing care and not rushing the removal of wheelchair legs. She expected to have been notified herself and would discuss with the DON what happened with the resident's leg. She said a treatment program would be implemented related to the resident's wound. MO00229621