STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30687 Based on interview and record review, the facility failed to follow their abuse policy by thoroughly investigating in a timely manner allegations of resident to resident altercations (Residents #15 and Resident #16, and Residents #10 and Resident #11). The sample was 10. The census was 98. Review of the facility Abuse, Neglect, Exploitation or Mistreatment Policy, dated 5/1/2018, showed the following: -Policy: -The facility's leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately; -The facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment and will implement immediate action to safeguard resident; -The facility's leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law. -Component: Identification: -Staff members will identify and assess suspected or alleged reports of abuse or neglect, focusing on objective and observable evidence, such as suspicious bruising, witness reports regarding unusual occurrences or patterns or trends of potential abuse or neglect; -Physical assault/abuse: 1. Hitting; 2. Slapping; 3. Pinching; (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: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Chestnut Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 10954 Kennerly Road Saint Louis, MO 63128	

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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	4. Kicking; 5. Controlling behavior through corporal punishment. -Investigation: -The facility maintains that all allegations of abuse, neglect, misappropriation of property, etc. are thoroughly investigated and appropriate actions are taken. If the alleged abuse or neglect involves serious physical harm to the resident, please contact the Regional [NAME] President of Operations. You may be directed to contact the Legal Department. The Legal Department will determine whether to direct an investigation so as to protect the results of such investigation from third-party discovery. In the event another resident, a family member or visitor is accused of abuse against a resident, the facility will intervene and take appropriate steps to safeguard the patient/resident during and after the investigation; -The facility conducts an internal investigation through the Legal Department, if applicable, and reports the results to enforcement agencies within five working days or as prescribed by state law. Enforcement agencies include but are not limited to the state's survey and certification agency; -Investigations are prompt, comprehensive and responsive to the situation and contain founded conclusions; -The investigation may include but is not limited to the following: -Identification and removal of the alleged perpetrator; -Identification of the alleged victim; -Type of alleged abuse; -Where and when the incident occurred; -Written summaries of interviews with individuals having first-hand knowledge of the incident. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated facility staff and the interviewer will record all witness accounts in a document, written, dated and signed by the interviewer. -Resolution/outcome; -Measures taken to prevent future incidents; -All documents pertaining to the investigation must be complied and stored in the administrator's office; -Notify and release the results of the investigation as prescribed by law. Contact the Legal Department with any questions regarding what can and cannot by produced (If the investigation was privileged by an attorney in the Legal Department, consult with the attorney before any investigation documents are provided to the authorities); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Refer patients/residents to private or public community agencies/hospitals/medical centers that provide or arrange for the evaluation/examination of abuse victims as prescribed by law; such examinations should be conducted for any allegation of rape, sexual assault/molestation or coercion. Take measures to protect materials, items that may be needed for investigation, such as clothing sheets; -Take measures to ensure confidentiality to the extent practicable. 1. Review of Resident #15's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/24, showed the following: -No cognitive impairment; -Other symptoms of behaviors not directed towards others: one to three days; -Supervision to moderate assistance with activities of daily living (ADLs); -Congestive heart failure, high blood pressure and dementia. Review of the resident nurse's note, dated 11/30/24 at 2:18 P.M., showed this nurse was at desk and heard yelling. The nurse stood up and seen this resident hit another resident with an open hand. The resident was up ambulating in hallway. This resident stopped in middle of hall and stated I will break your neck to another resident. At this time other resident pushed this resident back and this resident hit the other resident with an open hand. There was no injury noted. A call was placed to the resident's family. The resident's physician was notified with report of resident to resident altercation. A new order was received to send the resident to the hospital for evaluation. During an interview on 12/3/24 at 10:05 A.M., the resident said he/she was fine and did not remember the altercation. Review of Resident #16's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Delusions; -Supervision with ADLs; -Diagnoses of high blood pressure, end stage renal disease and hip fracture. Review of the resident's nurse's notes, date 11/30/24 at 2:24 P.M., showed the nurse was at nurse's station and heard two residents yelling. The nurse stood up and seen this resident being hit with an open handed on chin. There were no injury noted. The resident refused to go to hospital. The resident's physician was notified of the altercation. During an interview on 12/3/24 at 9:59 A.M., the resident said he/she was fine and had no concerns. The resident said he/she did not remember the altercation. (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	During an interview on 12/4/24 at 12:06 P.M., Licensed Practical Nurse (LPN) A said Resident #15 was walking down the hall and Resident #16 said something like, I will break your neck. Resident #15 hit Resident #16 with an open hand across the face. The residents were separated. LPN A said he/she contacted Director of Nursing (DON), and both residents' physicians. LPN A said he/she did not know if an investigation was started or if the state agency was contacted. Review of the residents' medical records, showed no documentation of the Administrator, DON, or ADON being notified regarding the altercation. 2. Review of Resident #10's admission MDS, dated [DATE], showed the following: -No cognitive impairment; -No moods or behaviors; -Dependent with ADLs; -Diagnosis of stroke. Review of the resident's nurse's notes, dated 12/1/24 at 11:17 A.M., showed this nurse heard screaming coming from resident's room. Upon entering the room, the resident's roommate (Resident #11) was assaulting him/her by hitting him/her in the face several times causing his/her glasses to break. After separating the residents, this resident was visibly upset but otherwise no apparent injuries. The resident's family was notified and wanted him/her evaluated in the emergency room . The resident's physician was notified and the ambulance was notified of need for transport to the hospital. During an interview on 12/2/24 at 8:41 A.M., the resident said yesterday, 12/1/24, he/she was laying in his/her bed and his/her roommate (Resident #11) came over and asked did he/she want to fight. The resident said he/she said no. Resident #11 came over and started hitting him/her in his/her upper left arm and in his/her face with a fist. The resident said the staff came in to stop him/her. Review of Resident #11's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No moods or behaviors; -Partial to moderate assistance with ADLs; -Diagnoses of high blood pressure and dementia. Review of the resident's nurse's notes, date 12/1/24 at 3:29 P.M., showed the nurse was called to resident's room due to screams for help. Upon entering room, the nurse found this resident hitting his/her roommate (Resident #10) in the face and trying to pull him/her out of the bed. This resident was brought out of the room to nurses station and the resident's physician was called. An order was received to transfer to the resident to the hospital for evaluation. The ambulance was notified of need for transport. The resident's representative was notified and messages were left for a return call. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/2/24 at 11:19 A.M. Certified Medication Technician (CMT) B said he/she just left the resident's room and he/she was fine. CMT B said about five minutes later, he/she heard Resident #10 screaming and went into the room. Resident #10 was half off the bed and his/her roommate (Resident #11) was in his/her wheelchair hitting Resident #10 with his/her fist. The charge nurse came to assist with separating the residents. Resident #11 was taken to the nurse's station and Resident #10 was assessed by the charge nurse. CMT B said he/she was not asked to write a statement until today. CMT B said she just wrote the statement. CMT B said the charge nurse notified the receptionist and he/she sent a group chat to management. CMT B said in his/her experience, an investigation should have been started immediately. During an interview on 12/3/24 at 12:05 P.M., Licensed Practical Nurse (LPN) C said he/she went to the residents' room after hearing screaming. LPN C said he/she found the two residents doing a tug of war with a cane. LPN C asked what happened and Resident #10 said Resident #11 asked him/her if he/she wanted to fight. Resident #10 said Resident #11 starting hitting him/her in the face with his/her fist and broke his/her glasses. LPN C said the broken glasses were found in the bed. LPN C said he/she did not have the phone numbers of the Administrator, DON, or ADON. LPN C told the receptionist and the receptionist sent a group chat to them. LPN B did not write a statement or start an investigation. He/She was told management does the investigations. During an interview on 12/3/24 at 12:24 P.M., Receptionist D said LPN C called him/her and said the residents were being sent out to the hospital. Receptionist D said he/she sent a group text message at 10:46 A.M. on 12/1/24. The text went to the Administrator, DON, ADON and other management. The ADON responded back at 11:16 A.M. and said it needed to be reported to the state agency. Receptionist D said he/she told LPN C. LPN C said he/she does not report incidents. During an interview on 12/3/24 at 12:38 P.M., the ADON said on 12/1/24 at 11:15 A.M., he/she got a text message regarding the incident. The ADON said he/she responded the incident needed to be reported to the state agency. The ADON said the Administrator or the Social Service Director (SSD) would start the investigation and report to the state agency. The ADON said an investigation and a report to the state agency was not started until 12/2/24 when the surveyor entered the building and asked about the altercation. During an interview on 12/3/24 at 12:51 P.M., the SSD said he/she received a text message from Receptionist D saying there was a resident to resident altercation. SSD said he/she suggested Resident #11 be brought up to the second floor to keep the residents separated. Both of the residents were sent to the hospital. The SSD said at 11:16 A.M., the ADON sent a text message saying the Administrator or the SSD would start the investigation and report the altercation to the state agency. SSD said he/she did not start an investigation and did not know how to report it to the state agency. Review of the residents' medical records, showed no documentation of the Administrator, DON, or ADON being notified regarding the altercation. 3. During an interview on 12/3/24 at 1:27 P.M., the DON said she did not start the investigations of the resident to resident altercations until 12/2/24. The DON said she did not remember getting a call regarding the altercations. At that time, the new Administrator said she has only been with the facility less that 24 hours, however she expected the facility's policy to be followed as written. MO00245921 (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	MO00245984 MO00245986

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30687

Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the Department of Health and Senior Services (DHSS) within the required time after residents were involved in resident to resident altercations (Residents #15 and Resident #16, and Residents #10 and Resident #11) The sample size was 10. The census was 98.

Review of the facility Abuse, Neglect, Exploitation or Mistreatment Policy, dated 5/1/2018, showed the following:

-Policy:

-The facility's leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately;

-The facility shall report immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures.

-The facility's leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law.

-Component: Reporting/Response:

-All alleged violations concerning abuse, neglect, or misappropriation of property are reported verbally immediately to the Facility Abuse Coordinator, the Administrator and to other officials in accordance with state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities);

-An analysis is completed to determine what changes are needed, if appropriate, to prevent further occurrences;

-Complete the Investigation Summary Log, maintained by the Administrator or his/her designee;

-Employees always have the right to report allegations directly to the state agency for elder abuse prevention.

1. Review of Resident #15's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/24, showed the following:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No cognitive impairment; -Other symptoms of behaviors not directed towards others: one to three days; -Supervision to Moderate assistance with activities of daily living (ADLs); -Diagnoses of congestive heart failure, high blood pressure and dementia. Review of the resident nurse's note, dated 11/30/24 at 2:18 P.M., showed this nurse was at desk and heard yelling. The nurse stood up and seen this resident hit another resident with an open hand. The resident was up ambulating in hallway. This resident stopped in middle of hall and stated I will break your neck to another resident. At this time other resident pushed this resident back and this resident hit the other resident with an open hand. There was no injury noted. A call was placed to the resident's family. The resident's physician was notified with report of resident to resident altercation. A new order was received to send the resident to the hospital for evaluation. During an interview on 12/3/24 at 10:05 A.M., the resident said he/she was fine and did not remember the altercation. Review of Resident #16's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Delusions; -Supervision with ADLs; -Diagnoses of high blood pressure, end stage renal disease and hip fracture. Review of the resident's nurse's notes, date 11/30/24 at 2:24 P.M., showed the nurse was at nurse's station and heard two residents yelling. The nurse stood up and seen this resident being hit with an open handed on chin. There were no injury noted. The resident refused to go to hospital. The resident's physician was notified of the altercation. During an interview on 12/3/24 at 9:59 A.M., the resident said he/she was fine and had no concerns. The resident said he/she did not remember the altercation. During an interview on 12/4/24 at 12:06 P.M., Licensed Practical Nurse (LPN) A said Resident #15 was walking down the hall and Resident #16 said something like, I will break your neck. Resident #15 hit Resident #16 with an open hand across the face. The residents were separated. LPN A said he/she contacted the Director of Nursing (DON), and both residents' physicians. LPN A did not know if an investigation was started or if the state agency was contacted. 2. Review of Resident #10's admission MDS, dated [DATE], showed the following: -No cognitive impairment; -No moods or behaviors; (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent with ADLs; -Diagnosis of stroke. Review of the resident's nurse's notes, dated 12/1/24 at 11:17 A.M., showed this nurse heard screaming coming from resident's room. Upon entering the room, the resident's roommate (Resident #11) was assaulting him/her by hitting him/her in the face several times causing his/her glasses to break. After separating the residents, this resident was visibly upset but otherwise no apparent injuries. The resident's family was notified and wanted him/her evaluated in the emergency room . The resident's physician was notified and the ambulance was notified of need for transport to the hospital. During an interview on 12/2/24 at 8:41 A.M., the resident said yesterday, 12/1/24, he/she was laying in his/her bed and his/her roommate (Resident #11) came over and asked did he/she want to fight. The resident said he/she said no. Resident #11 came over and started hitting him/her in his/her upper left arm and in his/her face with a fist. The resident said the staff came in to stop him/her. Review of Resident #11's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No moods or behaviors; -Partial to moderate assistance with ADLs; -Diagnoses of high blood pressure and dementia. Review of the resident's nurse's notes, date 12/1/24 at 3:29 P.M., showed the nurse was called to residents' room due to screams for help. Upon entering room, the nurse found this resident hitting his/her roommate (Resident #10) in the face and trying to pull him/her out of the bed. This resident was brought out of the room to nurses station and the resident's physician was called. An order was received to transfer to the resident to the hospital for evaluation. The ambulance was notified of need for transport. The resident's representative was notified and messages were left for a return call. Resident is currently in the hospital for evaluation. During an interview on 12/2/24 at 11:19 A.M. Certified Medication Technician (CMT) B said he/she just left the resident's room and he/she was fine. CMT B said about five minutes later, he/she heard Resident #10 screaming and went into the room. Resident #10 was half off the bed and his/her roommate (Resident #11) was in his/her wheelchair hitting Resident #10 with his/her fist. The charge nurse came to assist with separating the residents. Resident #11 was taken to the nurse's station and Resident #10 was assessed by the charge nurse. CMT B said he/she was not asked to write a statement until today. CMT B just wrote the statement. CMT B said the charge nurse notified the receptionist and he/she sent a group chat to management. CMT B said in his/her experience, an investigation should have been started immediately. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 12:05 P.M., Licensed Practical Nurse (LPN) C said he/she went to the resident's room after hearing screaming. LPN C said he/she found the two residents doing a tug of war with a cane. LPN C asked what happened and Resident #10 said Resident #11 asked him/her if he/she wanted to fight. Resident #10 said Resident #11 starting hitting him/her in the face with his/her fist and broke his/her glasses. LPN C said the broken glasses were found in the bed. LPN C said he/she did not have the phone numbers of the Administrator, DON, or ADON. LPN C said he/she told the receptionist and the receptionist sent a group chat to them. LPN B said he/she did not write a statement or start an investigation. He/She was told management does the investigations. During an interview on 12/3/24 at 12:24 P.M., Receptionist D said LPN C called him/her and said the residents were being sent out to the hospital. Receptionist D said he/she sent a group text message at 10:46 A.M. on 12/1/24. The text went to the Administrator, DON, ADON and other management. The ADON responded back at 11:16 A.M. and said it needed to be reported to the state agency. Receptionist D said he/she told LPN C. LPN C said he/she does not report incidents. During an interview on 12/3/24 at 12:38 P.M., the ADON said on 12/1/24 at 11:15 A.M., he/she got a text message regarding the incident. The ADON said he/she responded the incident needed to be reported to the state agency. The ADON said the Administrator or the Social Service Director (SSD) would start the investigation and report to the state agency. The ADON said an investigation and a report to the state agency was not started until 12/2/24 when the surveyor entered the building and asked about the altercation. During an interview on 12/3/24 at 12:51 P.M., the SSD said he/she received a text message from Receptionist D saying there was a resident to resident altercation. SSD said he/she suggested Resident #11 be brought up to the second floor to keep the resident separated. Both of the residents were sent to the hospital. The SSD said at 11:16 A.M., the ADON sent a text message saying the Administrator or the SSD would start the investigation and report the altercation to the state agency. SSD said he/she did not start an investigation and did not know how to report it to the state agency. 3. During an interview on 12/3/24 at 1:27 P.M., the DON said she was told only the Administrator will report to the state agency. At that time, the new Administrator said she has only been with the facility less that 24 hours, however she expected the facility's policy to be followed as written which includes reporting to the state agency in a timely manner. MO00245921 MO00245984 MO00245986

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	265331	A. Building B. Wing	10/21/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46967 Based on interview and record review, staff failed to implement a system to ensure facility staff communicated a report on residents' conditions to agency staff prior to their shifts and failed to direct agency staff where to find the binder containing instructions on residents' care needs. The facility failed to ensure one resident's (Resident #18) care plan instructions for staff reflected the resident's assessed needs, including use of mechanical lift for transfers. On 12/17/24 around 12:00 P.M., an unknown nurse directed Certified Nurse Aide (CNA) C to transfer the resident from his/her bed without communication of the resident's need for mechanical lift transfer. CNA C utilized a gait belt, instead of using a Hoyer lift (mechanical lift). The resident fell during the transfer and sustained fractures to his/her ribs, legs, and left ankle. The resident's physician said staff failed to notify him/her of the incident until later in the evening. EMS did not transfer the resident to the hospital until 10:08 P.M. and reported the resident was hard to arouse. Additionally, the facility failed to appropriately respond to a resident's (Resident #17) change of condition and failed to contact the resident's physician. The resident had multiple falls between 12/6/24 and 12/10/24. The sample was 2. The census was 96. The Administrator was notified on 1/14/25 at 5:32 P.M., of an immediate jeopardy (IJ) which began on 12/17/24. The IJ was removed on 1/16/25 as confirmed by surveyor on-site verification. Review of the facility's Change in Condition and When to Notify the Physician policy (undated), showed: -Purpose: To provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a resident's condition; -When there is a change in condition, the physician must be notified. Below are examples of what is considered a change in condition: -Altered mental status: Includes sudden change in mental status or loss of consciousness; -Edema: Abrupt onset or increased amount; -Falls: All falls; -Nurses must assess residents frequently for change in condition. If a change is observed, check vital signs and note anything different with the resident. Relay the information to the physician.; -Make sure to document physician called, signs and symptoms observed, family notification and all interventions taken. Review of the facility's Fall programs policy and procedure, reviewed 1/2023, showed: -Purpose: To identify all resident who have a high risk for falls and to ensure adequate interventions are in place to prevent major injury; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Policy: An investigation of all falls will be completed by the Director of Nursing (DON)/designee and submitted to the interdisciplinary team (IDT) committee for review; -Fall risk evaluation (UDA) will be completed on every resident upon admission/re-admission by the nurse on shift the resident is admitted on ; -When a resident is identified as being at a high risk for falls, this will be identified on the baseline care plan upon admission and the fall intervention notes on the Kardex (gives a brief overview of each resident); -When a resident within the facility falls, the nurse will assess/evaluate the resident and document in the electronic medical record. Neuro checks will be initiated for all un-witnessed falls, residents who hit their head. 1. Review of Resident #18's PT discharge summary, dated 6/29/23, showed: -Total assistance/Hoyer (mechanical transfer) on 6/6/23, resident refused on 6/19/23, and unable to complete on 6/29/23; -Instructed nursing caregivers in positioning maneuvers and safety precautions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/17/24, showed: -admitted [DATE]; -Moderate cognitive impairment; -Diagnoses included stroke, major depressive disorder and repeated falls; -Upper and lower extremity impairment on one side; -Substantial to maximum assistance with mobility; -Transfers: Dependent on staff for lying to sitting on the side of the bed. Sit to stand not attempted due to medical condition or safety concerns; -No falls since admission. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident had an activities of daily living (ADL) self-care performance deficit due to activity intolerance; -Interventions: The resident required extensive assistance by one staff to turn and reposition in bed and move between surfaces; -Focus: The resident was at risk for falls due to deconditioning, stroke, and right-side weakness; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Interventions: Anticipate and meet the resident's needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; -The care plan did not instruct staff to utilize the Hoyer lift for transfers. Review of the resident's progress notes, showed: -On 12/9/24 at 7:12 P.M., resident seen by physician for chronic pain. New order for tramadol (used for short term relief of chronic pain) 50 milligram (mg), twice daily (BID) given; -On 12/17/24 at 5:30 P.M., staff monitored the resident for pain to ankle. He/She complained of pain to ankle this morning. At 8:40 P.M., the resident said his/her ankle was hurting. He/She was being assisted from bed and heard a pop. Oncoming nurse notified. At 8:56 P.M., the nurse received report the CNA on day shift attempted to transfer the resident and heard a pop. The resident had been in severe pain in bilateral lower extremities. The areas were painful to touch, and right leg appeared swollen. He/She complained of pain to left leg, but no bruising present in either extremities. The resident rated pain ten out of ten. Resident's physician notified of events. He/She gave orders to increase tramadol 50 mg BID to 100 mg BID and obtain three view x-ray of right ankle to rule out fracture/dislocation. X-ray technician said he/she would come out on 12/18/24. The resident remained in bed. His/Her vitals were stable with no acute distress noted. At 9:40 P. M., order received from physician to send resident to hospital. The resident responded to painful stimuli but did not answer questions. Resident transported to hospital by Emergency Medical Services (EMS). Review of the resident's EMS report, dated 12/17/24, showed: -At 10:08 P.M., EMS responded to the facility for a resident with an altered mental status. The resident was laying in his/her bed. Staff said the resident heard a loud pop during a transfer earlier in the day. He/She had been lethargic since. The resident was lethargic and hard to arouse. The resident was very large and an additional EMS personnel were called to transfer resident from bed. The resident was given oxygen. He/She became hypotensive (having low blood pressure) during transport to hospital. At 10:43 P.M., the resident's blood pressure was 58/33. Review of the resident's hospital records, showed -admitted on [DATE] at 10:46 P.M.; -According to EMS, the resident had a history of stroke, alert and oriented times three and almost completely bedbound; -The resident was given vasopressor (used to treat low blood pressure shock); -The resident said he/she fell . He/She could not remember what happened before or after the fall; -Right and left lower extremity range of motion decreased due to pain; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-X-rays revealed both femurs (thigh bones) were fractured in the wider part, near the middle of the bone. The bone was broken in multiple pieces due to significant trauma. Fractures of the distal left tibia and fibula (break in the lower leg bone which requires immediate medical attention. Usually caused by a fall or hard blow to the leg, or sudden twist of the leg). Fracture of left calcaneal (heel bone), bruise on right thigh and rib fractures of the left first rib, right third, fifth and sixth ribs; -The resident had brittle bones; -The resident was admitted to the intensive care unit until blood pressure stabilized. Review of the facility's investigation dated 12/20/24, showed: -On 12/17/24 at approximately 12:00 P.M., agency CNA C reported he/she went into the resident's room to provide incontinence care. He/She changed the resident and cleaned him/her up. CNA C put the gait belt on the resident and sat him/her up on the side of the bed. The wheelchair was adjacent to the bed. CNA C told the resident he/she was going to stand him/her up. The resident said okay. They stood for a split second and CNA C heard a pop from down below. He/She thought it was the resident's knee or ankle. CNA C helped the resident back into bed with the gait belt; -The resident was transferred to the hospital later in the evening; -The resident was diagnosed with multiple bone fractures; -Nursing staff was in-serviced on safe transfers; -No documented conclusion to the investigation. During an interview on 1/10/25 at 12:00 P.M., CNA C said the nurse (he/she didn't know the nurse's name) told him/her to get the resident out of bed on 12/17/24. The nurse said the resident was going to say he/she could not walk or stand, but get him/her up anyway. The nurse did not provide the agency CNA with instruction on the appropriate method to transfer the resident. CNA C entered the resident's room around 12:00 P.M. The resident said he/she did not get out of bed. He/She did not want to get up. CNA C told the resident the nurse said he/she had to get up. CNA C lowered the resident's bed then put the wheelchair next to it. He/She used the gait belt to sit the resident up on the side of the bed. The resident stood up and said Oh. CNA C heard a pop and used the gait belt to sling the resident back on the bed. CNA C retrieved a Hoyer pad and was going to get help to transfer the resident. The resident did not want to be transferred. He/She was complaining of pain in his/her legs. CNA C went to get the nurse. The Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) F assessed the resident's legs. They said they would wait and see how it looked later. CNA C was transferred to another hall. The nurse did not tell CNA C if the resident was a one or two person assist. CNA C did not ask anyone how the resident should be transferred. Agency staff are supposed to get report from the Charge Nurse at the start of their shift. Sometimes the facility is short staffed, and they do not give report. He/She did not get report on the day of the incident. LPN F asked the resident why he/she did not tell CNA C he/she was a Hoyer lift transfer. The resident's legs buckled when he/she stood up. CNA C grabbed the resident with the gait belt, quickly. The resident's legs did not look out of place. CNA C did not know about the binder at the nurse's station. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/25 at 2:27 P.M., LPN A said he/she was assisting another resident when CNA C told him/her he/she was transferring the resident and heard a pop. The resident was complaining of pain. He/She told CNA C to ask the ADON to assist him/her. The ADON and LPN F said the resident did not need x-rays. They instructed the Certified Medication Technician (CMT) to give the resident pain medication. The ADON and LPN F said they notified the physician. LPN A assessed the resident. He/She is not sure what time he/she assessed the resident. During shift change, the evening nurse and LPN A assessed the resident for pain. He/She complained of pain in his/her left and right ankle. His/Her pain was a ten. The oncoming nurse contacted the physician. The physician increased the resident's tramadol to 100 mg and ordered an x-ray. The x-ray technician could not come out until the following day. The physician gave an order to send the resident to the hospital. He/She was bedbound. The resident was a two person assist with a Hoyer lift. During an interview on 1/10/25 at 11:11 P.M., the ADON said CNA C said he/she sat the resident up on the side of the bed. When the resident stood up, CNA C heard a pop. The resident complained of pain in his/her right ankle. When the ADON entered the resident's room, the resident was laying in bed and LPN F was assessing his/her right ankle. He/She had range of motion (ROM) in his/her right ankle. The ADON left the room to get the charge nurse. She is not sure if the physician was notified immediately after the incident. She is certain he was contacted later in the evening. The physician ordered an x-ray. She thinks the resident was a two person assist with a Hoyer lift. She did not see a Hoyer lift in the resident's room when she entered. She remembered seeing a gait belt on the bed or in CNA C's hand. She is not sure if the resident could bear weight prior to this incident. Agency staff are supposed to get report prior to shift change. Review of the binder containing care instructions for residents, dated 1/14/25, showed for Resident #18: -Transfer: The resident required extensive assist by 1 staff to move between surfaces. Upon return from hospital, use mechanical lift and two staff assist (updated 12/19/24). During an interview on 1/10/25 at 12:55 P.M., LPN F said he/she was stopped in the hall by CNA C. He/She entered the resident's room and the resident was laying in the bed. The resident complained of pain in his/her right ankle. He/She had ROM in his/her right ankle. The CNA attempted to transfer the resident by him/herself. LPN F did not ask the resident if he/she fell . He/She cannot remember if the resident was a one or two person assist. He/She did not remember seeing a gait belt or Hoyer lift in the resident's room. He/She does not remember if the resident's physician was notified. The nurse assigned to the resident would have been responsible for notifying the physician. The facility used agency staff often. Agency staff were supposed to view the binder at the nurse's station. The binder contained information about the residents. There was not a system in place to verify if they reviewed the binder. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/10/25 at 1:33 P.M., the resident's physician said staff notified him of the incident later in the evening. He/She gave an order to increase pain medication to 100 mg and obtain an x-ray. Staff said the resident was still complaining of pain and he/she told them to send the resident to the hospital. He/She is not sure what time staff contacted him/her. He/She tried to figure out severity based on the report from the staff. Staff said the resident was in pain. He/She was not aware of the severity of the injuries. He/She did not think a simple fall would cause the resident's injuries. The gait belt could have caused the rib fractures. Maybe he/she fell , twisted his/her legs, causing the femur fractures. The resident's injuries are not consistent with the CNA's story. He/She expected staff to give him a thorough report. The resident was bedbound and he/she did not know why they got him/her up. During an interview on 1/13/25 at 9:51 A.M., the Staffing Coordinator said CNA C was sent to another hall, because someone was sick and had to leave. Agency staff are supposed to get report from the Charge Nurse at the start of their shift. She does not know if they receive any training. During an interview on 1/13/25 at 10:23 A.M., the DON said agency staff are supposed to get a verbal report from the Charge Nurse about their assignments. There is a binder at each nurse's station with the residents' Kardex, which includes the residents' ADL needs. It is updated as needed or with a change of condition. There is not a system in place to ensure agency staff are getting report and reviewing the binder. During an interview on 1/13/25 at 1:04 P.M., the Administrator and ADON said the fractures occurred when CNA C attempted to transfer the resident. The resident stayed in bed most of the time. Agency staff should get report prior to their shift. 2. Review of Resident #17's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included rectal cancer, cirrhosis of the liver, depression and muscle weakness; -History of falls; -No falls in two-six months prior to admission; -Independent with transfers; -Supervision with personal hygiene and toileting; -Partial to moderate assistance with showers; -He/She used a walker. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: The resident had an ADL self-care performance deficit due to impaired mobility, weakness, chronic health conditions. He/She was often non-compliant with asking for assistance prior to moving about; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Interventions: Staff discussed with resident/family/power of attorney any concerns related to loss of independence, decline in function. Encouraged the resident to discuss feelings about self-care deficit. Encouraged the resident to participate to with each interaction. Encouraged the resident to use call light for assistance. Monitored/documented/reported as needed (PRN) any changes, potential for improvement, reasons for self-care deficit, expected course, and declines in function; -Focus: The resident is at risk for falls due to cirrhosis, cancer, non-compliance, incontinence with generalized weakness, impulsivity, and impaired safety awareness; -Interventions: Resident educated on proper use of call light for assistance. Resident educated on rising slowly and using grab bars when transitioning from sitting to standing. Educated the resident/family/caregivers about safety reminders and what to do if fall occurred. Reviewed information on past falls and attempted to determine cause of falls. Recorded possible root causes. Altered/removed any potential causes if possible. Review of the resident's post fall evaluation, dated 12/6/24, showed: -Fall details: The fall occurred on 12/06/2024 at 5:30 A.M. in the resident's bathroom. The fall was unwitnessed. The resident was in a hurry to grab something to get back on the toilet. The resident had a skin tear and said his/her head hurt. The resident's physician notified on 12/6/24; -Contributing Factors: The lighting was poor and there was fluid spilled on floor. He/She was not using cane/walker as instructed; -Vitals: Temperature 97.9, blood pressure 118/71, pulse 80, respirations 18; -Pain: The resident complained of head pain. Pain indicated via facial expressions and non-verbal sounds. Pain level was an eight out of ten. Review of the resident's progress notes, showed: -On 12/6/24 at 8:38 A.M., the resident fell in his/her bathroom. He/She had a skin tear to left front knee with head injury and pain to left side of head. Family notified. At 9:43 A.M., the resident refused vital signs. He/She said he/she was fine. He/She denied pain to head and/or knee. Skin tear cleansed and dressing applied. His/Her knee was slightly swollen. No shortening noted. He/She was able to move his/her knee without discomfort; -On 12/7/24 at 6:00 A.M., the resident was continued on incident follow up (IFU). His/Her vital signs were stable and strong at baseline. He/She was neurologically alert and oriented. He/She was educated to ask for help when moving around; -On 12/8/24 at 6:08 P.M., the resident was on IFU following a fall. He/She fell to left side had a skin tear to his/her left knee. He/She denied pain. Discoloration noted to area near left eye. He/She said it happened a while ago; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA H's written statement: On 12/6/24 he/she was assigned to the resident. He/She checked on the resident several times during his/her shift. The resident sat on the toilet the entire shift. He did not eat his meals. He declined assistance. He/She checked on the resident prior to end of shift at 6:30 P.M. and he was still on the toilet. On 12/8/24, when CNA H entered the resident's room, he was sitting on the toilet. The resident was very confused. He thought he was at the hospital; -No documented conclusion. During an interview on 1/9/25 at 2:28 P.M., LPN B said he/she worked with the resident on 12/9/24 and 12/10/24. The resident fell often. He had a fall the weekend before 12/10/24 and sustained two black eyes. He/She did not know if the fall was witnessed. On 12/9/24, the resident had a fall around 9:00 A.M. He/She entered the resident's room to obtain vitals. The resident's eyes were black and blue. He was on the toilet. He refused to let LPN B change his clothes. LPN B and two other staff assisted the resident from the toilet to bed. The resident stayed in bed for 45 minutes, then sat back on the toilet. He was on the toilet the entire shift. On 12/10/24 at approximately 9:00 A.M., he/she entered the resident's room to obtain vitals. He was weak, and his eyes were swollen shut. LPN B notified the DON. When LPN B returned to the resident's room, he was on the floor, by the recliner. The resident said the cats and dogs made him fall. He could not stand up without assistance. Two CNAs assisted him off the floor. The resident requested to use the bathroom. The CNAs cleaned the resident up and he/she was sent to the hospital. The resident had rectal cancer and would sit on the toilet with his head between his legs. Sometimes, the resident sat on the toilet for an entire 12-hour shift. Prior to 12/10/24, the resident was mobile and walked around the facility. The resident often refused care and medication. The physician was aware the resident refused care, had falls and was sitting on the toilet for hours every day. During an interview on 1/13/25 at 11:21 A.M., CNA E said the resident was very weak and confused on 12/9/24. His eyes were black and swollen. He could not see. CNA E told him, he/she had to assist him because he could not see. The resident kept getting up and trying to go to the bathroom. He would not let staff help him. The resident was not combative. He was delusional. The resident would not let staff clean him up. CNA E removed the resident's dirty clothes and he put them back on. The resident has cancer and is embarrassed about it. Staff tried to get the resident to use briefs and he refused. He is not sure if the resident's doctor was notified of his change in condition. During an interview on 1/14/25 at 11:20 A.M., CMT D said he/she usually passed meds and provided care sometimes. The resident received his/her stool medication at 12:00 P.M. On 12/7/24, CMT D noticed the resident's face was red. On 12/8/24, the resident was confused and did not want to lay down. His eyes were black and blue. CMT D told LPN G the resident's face was getting worse. LPN G said the resident fell earlier in the morning. LPN G did not assess the resident or notify the physician. On 12/9/24, the resident's eyes were swollen shut. CMT D notified LPN B. LPN B assessed the resident. The resident was sitting on the toilet with his head between his legs. The resident was weak and could not open his eyes. CMT D, LPN B and a CNA helped the resident from the toilet to the bed. The resident stayed in bed for 45 minutes then returned to the toilet. The resident was alert and oriented times three (to person, place and time) at baseline. He could ambulate and transfer without assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

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.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/13/25 at 9:23 A.M., the physician's social worker said according to the physician's notes, he/she saw the resident on 11/12/24. The physician went to see the resident on 12/11/24 and he was not at the facility. The physician received a voicemail on 12/6/24 at 7:46 A.M., from LPN A. LPN A said the resident fell , hit his head, and had a skin tear on his knee. On 12/10/24 at 12:05 P.M., LPN B informed the physician the resident was being sent out to the hospital. The physician was not notified of falls on 12/8/24 and 12/9/24. The physician was not aware the resident refused care and sat on the toilet for hours. During an interview on 1/13/25 at 1:10 P.M., the Administrator and ADON said when a resident falls and hits their head, the physician is notified, and neuro checks are completed for 72 hours. The nurses complete the neuro checks. She does not know when Resident #17's swelling started. They were aware of the falls on 12/10/24 but were not informed of the other falls. 3. During an interview on 1/13/25 at 1:10 P.M. and 1/14/25 at 7:00 P.M., the Administrator said nursing staff are responsible for updating the care plans. Resident #18's care plan should have been updated. If Resident #17's eyes were swollen, the physician should have been notified and he/she should have been sent out. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the G level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s). MO00246395 MO00246450 MO00246460 MO00246790 MO00246791 MO00246793 MO00246843

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 30687 Based on interview and record review, the facility failed to address a recommendation from the Registered Dietitian (RD) for a resident with a significant weight loss, to prevent further weight loss (Resident #2). The sample was six. The census was 101. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed the following: -Severe cognitive impairment; -Dependent with activities of daily living (ADLs); -Diagnoses of a stroke; -Weight 157 pounds (lbs); -Gastronomy tube (g-tube, flexible, hollow tube that is inserted through the stomach wall and skin to deliver food and medicine directly to the stomach); -Risk for pressure ulcers(a localized area of damaged skin or tissue that occurs when pressure is applied to the skin for a prolonged period of time). Review of the resident's care plan, dated 7/5/24, showed the following: -Focus: G-tube: Alteration in nutritional status related to g-tube placement; -Intervention: Check g-tube for placement prior to administering medication or anything via g-tube per house policy; -Focus: Potential for impaired nutritional status regards to use of enteral feeding, weight loss variable intake and diagnosis of dysphasia (a communication disorder that affects a person's ability to understand and produce language) and depression; -Goal: Maintain healthy body weight plus or minus 10 lbs; -Interventions: Monitor changes in weight. Assess nutrition status quarterly and with significant changes in weight. Review of the resident's weight summary, showed the following: -07/09/2024, 151.7 lbs; -08/09/2024, 139.6 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nutrition/Dietary Note, dated 8/29/24, showed the resident is at 139.6 lbs with significant weight loss. The resident receives med pass supplement (supplement for calories and protein) twice a day, g-tube feeding: Jevity (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) 1.5 240 ml bolus if he/she does not eat 50% of his/her meal and at bed time. The resident is on a regular diet. The resident by mouth intake appears poor. Would discontinue the med pass supplement and recommend to change g-tube feeding to 240 ml scheduled bolus three times a day between meals and at night with 250 ml of water flushed every four hours. Review of the resident's medical record, showed no documentation of notification to the resident's physician, hospice nurse or the resident's family regarding this recommendation. Review of the resident's medical record, showed documentation of an order for this recommendation. Review of the resident's weight summary, showed the following: -9/30/2024, 132.1 lbs; -10/01/2024, 132.1 lbs. -12.2% weight loss in three months. During an interview on 10/11/24 at 2:20 P.M., the RD said the recommendation was based on the resident's significant weight loss. The additional protein would assist with weight gain and wound healing. This is a typical recommendation for significant weight loss. The RD said he/she expected the facility to recommend the change to the resident's physician for consideration. During an interview on 10/9/24 at 1:04 P.M., the Hospice Nurse said he/she was not aware of the RD's recommendation. The Hospice Nurse said if he/she would have known about the recommendation, he/she would have contacted the family and if they would agree, he/she would have approved the recommendation. The Hospice Nurse said he/she should have been notified about the recommendation. During an interview on 10/15/24 at 9:50 A.M., the Wound Nurse Practitioner (WNP) said he/she was not aware of the RD's recommendation. The WNP said he/she would have approved the recommendation to assist with the resident's wound healing. During an interview on 10/9/24 at 12:29 P.M., the Director of Nursing (DON) said she started with the facility on 8/12/24. She was not made aware of the recommendation. The DON said the previous Assistant Director of Nursing (ADON) was responsible to follow of the recommendations. The DON said once the recommendation is received, it should go to the Charge Nurse. The Charge Nurse should contact the resident's physician and if necessary, the hospice nurse for approval. The DON and Administrator did not know why the recommendation was not followed. During an interview on 10/16/24 at 8:11 A.M., Physician A said the facility did not make him/her aware of the recommendation. Physician A said the purpose of the recommendation would assist in healing the resident's wounds. Physician A said he/she should have been made aware of the significant weight loss and the recommendation. Had he/she known about the recommendation, he/she would have approved it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 8:48 A.M., the Administrator said the facility did not have a nutritional policy. MO00243244 MO00243545