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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265338	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester House, The	550 White Road Chesterfield, MO 63017

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 37681 Based on interview and record review, the facility failed to ensure residents or the resident's responsible party (RP) were invited to participate in all aspects of person-centered care planning for six of 18 sampled residents (Residents #66, #80, #292, #50, #62 and #54). The census was 78. Review of the facility's Comprehensive Care Plans and Revisions policy, reviewed 8/22/23, showed: -Policy: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care; -Procedure; -The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care; -When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery; -Definition: Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident; -Procedure; -Facility staff develops the comprehensive care plan within seven days of the completion of the comprehensive assessment and review and revise the care plan after each assessment; -The facility should provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation. 1. Review of Resident #66's medical record, showed: (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -RP was a family member; -Diagnoses included muscle weakness, need for assistance with personal care, chronic kidney disease, chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and high blood pressure. During an interview on 8/22/24 at 4:28 P.M., the resident's RP said the resident was admitted to the facility back in January 2024. He/she was never contacted or invited to participate in a care plan meeting. He/she would like to attend care plan meetings. During an interview on 8/28/24 at 1:01 P.M., the Social Services Director (SSD) said she had not contacted the resident's RP for a care plan meeting. Review of the resident's medical record, showed no documentation indicating the RP was invited, or participated in the care plan meetings. 2. Review of Resident #80's re-admission Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/5/24, showed: -Moderate cognitive impairment; -No behaviors; -Partial/moderate assistance in eating; -Diagnoses included heart failure, high blood pressure, thyroid disease, arthritis, malnutrition. Review of the resident's medical record, showed he/she was his/her own responsible party. There were no care plan meeting documentation notes. During an interview on 8/22/24 at 11:25 A.M., the resident said he/she had not participated in a care plan meeting. He/She had no family and was able to make decisions for him/herself. The resident did not know the facility's plan for him/her and he/she had requested to be transferred to another facility. 3. Review of Resident #292's admission MDS, dated [DATE], showed: -Moderate cognitive impairment; -No behaviors; -Independent on functional abilities; -Diagnoses included stroke, anemia, high cholesterol, seizure, malnutrition and Schizophrenia (a serious mental health condition that affects how people think, feel and behave). (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed he/she was his/her own responsible party. There were no care plan meeting documentation notes. During an interview on 8/22/24 at 2:40 P.M., the resident said he/she had not been to a care plan meeting nor had any staff asked to the resident to attend a care plan meeting. 4. Review of Resident #50's annual MDS, dated [DATE] showed; -Cognitively moderately impaired; -Diagnoses included kidney failure, dementia, arthritis, malnutrition and depression. Review of the resident's social services notes, showed no documentation regarding care plan meetings. During an interview on 8/28/24 at 10:00 A.M., the resident said he/she could not recall his/her last care plan meeting. 5. Review of Resident #62's quarterly MDS, dated [DATE], showed; -Cognitively intact; -Diagnoses included heart disease, kidney failure, anxiety and depression. Review of the resident's social services notes, showed no documentation regarding care plan meetings and/or notification of family, and/or POA, regarding care plan meetings. During an interview on 8/26/24 at 8:43 A.M., the resident said he/she said he/she had not had a care plan meeting in a while. 6. Review of Resident #54's quarterly MDS, dated [DATE], showed; -Cognitively intact; -Diagnoses included heart failure, kidney failure, diabetes and high blood pressure. Review of the resident's social services notes, showed no documentation regarding care plan meetings and/or notification of family, and/or POA, regarding care plan meetings. 7. During an interview on 8/28/24 at 1:01 P.M., the SSD said she was responsible for scheduling and documenting care plan meetings. She held care plan meetings for short term and skilled residents upon admission and discharge. She had not held care plan meetings for long-term residents. Residents #66, #80, #292, #50, #62 and #54 were long-term residents and she had not had care plan meetings with the resident or RP. During an interview on 8/28/24 at 1:25 P.M., the MDS coordinator said the SSD was responsible for updating care plan meetings and sending out notices to residents and RPs. Care plan meetings had not been consistent. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 4:36 A.M., the Administrator and Director of Nursing (DON) said they would expect care plan meetings to be held quarterly and as needed. Residents and RPs were expected to receive notification of care plan meetings. 45083

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 42247 Based on interview and record review, facility staff failed to notify, in a timely manner, the family/resident representative of three residents' change of room assignment after they tested positive of COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) (Residents #62, #31, and #14). The facility census was 78. Review of the facility's COVID-19 Policy, reviewed on 7/12/24, showed: -Place a resident with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The resident should have a dedicated bathroom; -The facility could consider designating entire units within the facility, with dedicated healthcare provided, to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high; -Limit transport and movement of the resident outside of the room to medically essential purposes; -Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other healthcare facilities; -Residents should only be placed in a COVID-19 care unit if they have confirmed SARSCoV-2 infection; -The facility's policy failed to mention that the residents' representative must be promptly notified if there were changes in room assignments. 1. Review of Resident #62's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/10/24, showed; -Cognitively intact; -Diagnoses included heart disease, kidney failure, anxiety and depression. Review of the resident's nurse's progress notes, showed: -On 8/12/24 at 3:56 P.M., called and spoke with family, and physician aware of resident COVID 19 diagnoses. Family expressed thankfulness for the call. Resident will be moving to Hall 500; -On 8/16/24 at 3:55 A.M., resident remains on isolation due to COVID positive. No cough, fever, shortness of breath or distress noted. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/22/24 at 5:23 P.M., showed the resident in his/her room on the 500 Hall, laying in bed. Observation on 8/26/24 at 8:40 A.M., showed the resident in his/her room on 400 Hall, laying on his/her bed. Review of the resident's census showed the resident was moved off the isolation unit on 8/23/24. Review of the resident's medical record, showed no documentation the family was made aware the resident was moved. 2. Review of Resident #31's medical record, showed: -Cognitively intact; -Diagnoses included: COVID-19. Review of the progress notes, dated 8/15/24, showed at 3:45 P.M., the resident was tested for COVID-19, per facility policy-results were positive for COVID-19. Doctor and family made aware. Resident was transferred to another unit private room for isolation and respiratory precautions and observations. Observation on 8/22/24 at 2:47 P.M., showed the resident lay in bed in a private room on the isolation unit. Observation on 8/28/24 at 8:43 A.M., showed the resident was in his/her old room and lay in bed, with his/her oxygen on. The resident said he/she was glad to be back in his/her room. Review of the progress notes dated, 8/16/24 through 8/27/24, showed no documentation the family was made aware of the room change. 3. Review of Resident #14's medical record, showed: -Moderately impaired cognition; -Diagnoses included: Covid-19. Review of the progress notes, dated 8/16/24, showed at 9:19 A.M., resident was tested on [DATE] for COVID-19, per facility policy-results were positive for COVID-19. Doctor and family made aware. Resident was transferred to another unit-private room for isolation and respiratory precautions and observations. Observation on 8/22/24 at 2:16 P.M., showed the resident sat in a wheelchair next to the bed in his/her room on the isolation unit. Observation on 8/27/24 at 9:00 A.M., showed the resident sat in his/her wheelchair in a new room, on another unit. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's census showed the resident was moved off the isolation unit on 8/26/24. Review of the progress notes dated 8/26/24 through 8/27/24 showed no documentation the family was made aware the resident was moved. 4. During an interview on 8/27/24 at 12:53 P.M., Licensed Practical Nurse (LPN) D said if a resident tested positive for Covid, they would be moved to isolation. The nurse who transferred the resident to the isolation unit was responsible for notifying the doctor and the family. When a resident was transferred off the isolation unit the nurse who received the resident was responsible for notifying the doctor and the family. 5. During an interview on 8/27/24 at 1:33 P.M. LPN A said if a resident tested positive for Covid, the resident would be moved to the isolation unit. He/She would notify the Director of Nursing, Administrator, Medical Records, the doctor, and the family. The process would be same when the resident moved off the isolation unit. 6. During an interview on 8/27/24 at 3:40 P.M., the Administrator said she would expect the family to be notified when a resident was moved. 45083

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans to address the specific needs of three of 18 sampled residents. (Residents #36, #79, and #292) . The census was 78. Review of the facility's Comprehensive Care Plans and Revisions policy, reviewed 8/22/23, showed: -Policy: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care; -Procedure; -The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care; -When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery; -Definition: Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident; -Procedure; -Facility staff develops the comprehensive care plan within seven days of the completion of the comprehensive assessment and review and revise the care plan after each assessment; -The facility should provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation. 1. Review of Resident #36's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/18/24, showed: -admitted [DATE]; -Cognitively intact; -No rejection of care; -Required substantial/maximal assistance for mobility; -Indwelling catheter (a medical device that drains urine from the bladder); (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included urinary tract infection (UTI) and diabetes; -Bed rail not used. Review of the resident's physician orders, reviewed 8/5/24, showed: -Order dated 5/2/24. May insert midline catheter for five day IV (intravenous line, a flexible plastic tube that's inserted into a vein to deliver fluids, medicine, or blood products into the bloodstream) treatment; -Order dated 7/27/24. May use bedrails for assist with bed mobility Review of the resident's Evaluation for Use of Bed Rails, dated 8/6/24, showed: -Is resident being considered for bed rail or assistive device for the bed? Yes; -Recommended type: 1/4 partial rails. Review of the resident's care plan, revised 8/22/24, in use during the time of the investigation, showed no information regarding the use of an indwelling catheter or bed rails. Observations on 8/22/24 at approximately 2:44 P.M., 8/23/24 at 8:16 A.M. and 8/26/24 at 4:53 A.M., showed the resident lay in bed on his/her back. Quarter length side rails were raised on both sides. The resident's catheter bag hung on the right side of the bed, in a privacy bag. 2. Review of Resident #79's Evaluation for Use of Bed Rails, dated 6/7/24, showed: -Is the resident being considered for Bed Rail or assistive device for the bed? Yes; -Recommended type: 1/2 partial rails. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Required supervision or touching assistance with transfers; -Diagnoses included anemia, kidney disease, seizures and depression. Review of the resident's care plan, revised 8/6/24, in use during the time of the investigation, showed no information regarding the use of bed rails. Review of the resident's physician orders, last reviewed on 8/21/24, showed no order for the use of bed rails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/22/24 at approximately 11:30 A.M., 8/23/24 at 8:10 A.M. and 8/26/24 at 4:58 A.M., showed the resident lay in bed on his/her back. Half length bed rails were raised on both sides of the bed. 3. Review of Resident #292's admission MDS, dated [DATE], showed: -Moderate cognitive impairment; -No behaviors; -Independent on functional abilities; -Diagnoses included stroke, anemia, high cholesterol, seizure, malnutrition, Schizophrenia (a serious mental health condition that affects how people think, feel and behave). Review of the resident's medical record showed the resident received a Level II Pre-Admission Screening Resident Review evaluation, (PASRR, this evaluation is required for all individuals suspected of mental illness ad/or intellectual disability or related condition seeking nursing home facility admission or wish to continue residing in a nursing facility). Review of the resident's care plan, in use at the time of the survey, showed it did not include the resident's PASRR II evaluation and the resident's mental health condition. During an interview on 8/22/24 at 2:40 P.M., the resident said he/she had not been to a care plan meeting nor had any staff invited him/her to attend a care plan meeting. 4. During an interview on 8/28/24 at 1:01 P.M., the Social Services Director said care plans were updated by the MDS Coordinator and herself. She was not sure how often they were supposed to be updated but thought they should be updated annually or quarterly. Care plans should be specific to each resident and should include information regarding catheters and bed rails. Level two screenings should also be included on the care plan. During an interview on 8/28/24 at 1:25 P.M., the MDS coordinator said everyone was responsible for updating care plans. Care plans should be resident specific and include care needs such as side rails, nutrition status, activities of daily living and catheters. Care plans were updated quarterly, annually and as needed. The Social Services Director was responsible for care plan meetings and sending out notices to residents and resident representatives. The care plan updates had not been consistent. During an interview on 8/28/24 at 4:36 P.M., the Administrator and Director of Nursing (DON) said care plans should be resident specific and include information regarding bed rails, catheters, weights, activities, activities of daily living and level two information. 45083

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on interview and record review, the facility failed to ensure a discharge summary was completed, including a recapitulation of the resident's stay and final summary of the resident's status at the time of discharge, for two of three residents investigated for discharge (Residents #54 and #89). The census was 78. 1. Review of Resident #54's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/24/24 showed; -Cognitively intact; -Diagnoses included heart failure, kidney failure, diabetes and high blood pressure. Review of the resident's progress notes, showed; -On 3/17/2024 at 9:29 A.M., Note Text: Resident requested that Social Services send referral for possible transfer, will follow up on referral; -On 3/29/2024 at 4:16 P.M., Note Text: Resident does not want to transfer to another facility anymore. Attempted to contact resident's family regarding Medicaid benefits. No answer, left a voicemail; waiting on a call back; -On 4/12/2024 at 5:21 P.M., Note Text: Per resident's family request, Social Services will send referral to another facility for possible transfer closer to family. Will follow up; -On 8/21/24 at 8:45 A.M., Note Text: Assessment complete. Resident ambulates in wheelchair. Resident is compliant with medication. Resident is compliant with Activities of Daily Living (ADLs). Resident prefers in room activities. Resident does have active discharge plans to transfer to a different facility; -On 8/28/2024 at 12:46 P.M., Note Text: Resident discharged from facility to new facility. Resident states he/she wants to be closer to his/her family. Resident vitals complete, complete assessment done before resident left, has all belongings. Review of the resident's medical record, showed no discharge summary, including a recapitulation of the resident's stay, was completed. 2. Review of Resident #89's medical record, showed: -admitted [DATE]; -Diagnoses included kidney failure, quadriplegia, muscle weakness, need for assistance with personal care and cognitive communication deficit; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-discharged [DATE]. Review of the resident's progress notes, showed: -5/28/24 at 8:49 A.M., a Social Services note said home care did not accept referral due to capacity. Social Services Director (SSD) sent referral to another home health. Resident states plans to cancel discharge plans and medical transportation. Resident made aware of insurance noncoverage but refuses to fulfill financial obligations. Resident is aware of long-term option. Resident refuses to disclose personal banking information for Medicaid coverage at this time. SSD will follow up on future discharge plans; -5/28/24 at 9:59 A.M., SSD wrote medical transportation is still scheduled to pick resident up on 5/28/24 at 2:00 P.M Resident decided to keep discharge plans but still refuses to fulfill financial obligations post skilled services; -5/28/24 at 11:45 A.M., a nursing note. Patient given discharge paperwork. All questions answered. All medication given. Left at approximately 2:10 P.M. with medical transportation; -5/28/24 at 8:59 P.M., a nursing note. Resident has been discharged . Review of the resident's medical record, showed no discharge summary, including a recapitulation of the resident's stay, was completed. During an interview on 8/28/24 at 1:45 P.M., the Clinical Quality Coordinator provided the resident's progress notes and said nursing may have provided the resident with the discharge summary and they did not keep a copy of it. 3. During an interview on 8/28/24 at 1:01 P.M., the SSD said she did not recall completing a discharge summary, including the recapitulation of the residents' stay or when the residents discharged from the facility. During an interview on 8/28/24 at 4:36 P.M., the Administrator and Director of Nursing (DON) said they would have expected a discharge summary, including the recapitulation of the resident's stay, was completed when a resident discharged from the facility. 37681

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 37681 Based on observation, interview and record review, the facility failed to ensure residents who received activities of daily living (ADL) received personal care in accordance with their personal needs for three of 18 sampled residents (Residents #36, #79 and #50). The census was 78. Review of the facility's Activities of Daily Living (ADLs), revised 2/12/24, showed: -Policy: The resident will receive assistance as needed to complete ADLs. Any change in the ability to perform ADLs will be reported to the nurse; -Federal Regulations: F677 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Review of Resident #36's medical record, showed diagnoses included Parkinsonism (a clinical syndrome characterized by tremor, rigidity and postural instability) unspecified tremors and high blood pressure. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/25/24, showed: -Cognitively intact; -No rejection of care; -Required partial/moderate assistance with eating; -Dependent on staff for all personal hygiene; -Diagnoses included urinary tract infection (UTI), and diabetes; -Height: 74 inches -Weight: 176 pounds. Review of the resident's care plan, in use during the time of the investigation, last revised on 8/22/24, showed: -Diagnoses included Parkinson's disease, unspecified tremors and diabetes; -No information regarding the resident's ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/22/24 at approximately 2:44 P.M., showed the resident lay in bed on his/her back with a hospital gown on. The resident's hospital gown, arms, hands and bed sheets had several red and pink spots. The resident said he/she had cake earlier that day and no one assisted him/her with eating or cleaning up afterwards. Staff never assisted the resident. The only time the resident received assistance with food or cleaning, his/her spouse and adult child would have to assist. Observation on 8/23/24 at 8:16 A.M., showed the resident lay in bed on his/her back. The resident had on the same hospital gown covered in what the resident described as cake. Red splotches remained on the bed sheets and the resident's arms. The resident's call light was on the floor next to the bed. Observation and interview on 8/23/24 at 9:02 A.M., showed the resident sat up in bed assisted and was assisted by his/her spouse who fed the resident. The resident had on the same hospital gown with the red and pink splotches. The resident's arm and bed sheets also showed pink and red splotches. The resident's spouse said he/she arrived and the resident was thirsty and hungry. His/Her bedding, gown and clothing was dirty and covered with red and pink splotches. The resident said his/her call light was out of reach and he/she kept yelling out for someone to change him/her during the late night and early morning. He/She yelled for an hour straight and no one came to check on him/her. The resident's spouse said he/she would feed the resident and clean him/her up. Observation on 8/26/24 at 4:53 A.M., showed the resident lay in bed on his/her back with his/her eyes closed. A handwritten sign said please assist me with meals hung at the door and on the wall of the resident's room. Observation on 8/26/24 at 8:47 A.M., showed the resident lay in bed on his/her back. The resident's covered breakfast tray was on the night stand. The resident opened his/her eyes and said he/she was hungry. The resident's breakfast meal consisted of biscuits and gravy, oatmeal, juice and water. He/She said he/she was hoping someone would feed him/her. The resident's hands were shaking. Observation on 8/26/24 at 9:01 P.M., showed the resident's tray of food was removed. He/she said staff came and took the tray and did not offer to feed him/her. He/She did not receive any assistance with breakfast and was still hungry. Observation and interview on 8/26/24 at 2:01 P.M., showed Certified Nursing Assistant (CNA) L stood over the resident and fed him/her lunch. When asked about the resident's breakfast tray, CNA L at first said he/she thought he/she fed the resident. The resident said, No, you came and took my food away. CNA L then said, Didn't your son/daughter feed you? The resident said No and they did not visit with him/her today. CNA L then said the resident had not had any breakfast. Observation and interview on 8/27/24 at 10:13 A.M., showed the resident lay in bed and smelled of feces. His/Her spouse was present and said they pushed the call light about 10 minutes ago and was waiting for someone to change the resident. When the spouse arrived that morning, the resident's breakfast tray was untouched. The spouse placed signs throughout the resident's room to remind staff to feed the resident. CNA B and CNA K, who were not assigned to the resident, said they would change the resident. (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 8/27/24 at 10:34 A.M., CNA B said he/she was familiar with the resident and he/she needed total assistance with meals. The resident's hands shook and he/she would not be able to feed him/herself.

During an interview on 8/28/24 at 9:08 A.M., CNA N said he/she was familiar with the resident and he/she definitely needed total assistance with meals due to his/her hand shaking.

During an interview on 8/28/24 at 2:46 P.M., Licensed Practical Nurse (LPN) A said if residents needed assistance with ADLs, including meal assistance, staff was required to assist with meals. CNAs should feed the residents. If a resident was dirty and the bedding was dirty, staff were to ensure the resident was clean and had clean bedding.

During an interview on 8/28/24 at 4:36 P.M., the Administrator and Director of Nursing (DON) said residents should be assisted with grooming and meals. It was unacceptable to leave the resident laying with cake on his/her hospital gown and bedding. The resident should have been assisted with his/her meal.

2. Review of Resident #79's care plan, in use during the time of the survey, revised 4/26/24, showed:

-Focus: Activity's of daily living assistance needed to maintain or attain highest level of functioning;

-Goal: Resident wishes to attain prior level of functioning;

-Interventions: Assist with mobility and activity's of daily living as needed;

-Focus: The resident is at risk for break in skin integrity related to ulcers and immobility;

-Goal: Maintain intact skin with no skin breaks through the next review;

-Interventions: Clean and dry skin after each incontinent episode.

Review of the resident's quarterly MDS, dated [DATE], showed:

-Cognitively intact;

-No behaviors;

-Required supervision and/or touching assistance with toileting hygiene;

-Diagnoses included anemia, neurogenic bladder, UTI, seizures and depression.

During an interview on 8/26/24 at approximately 5:20 A.M., CNA I was not aware the resident was assigned to him/her. The resident was not checked during the night shift until after this interview.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/24 at 5:24 A.M., CNAs F and I entered the resident's room to provide personal care. CNA I said they were going to do a complete bed-change because the resident was soaked. He/She said the resident usually used a urinal during the night but last night he/she did not. The pad under the resident was saturated with urine and the sheet under the pad had a ring on it and was wet down to the resident's knees. During an interview on 8/28/24 at 4:36 P.M., the Administrator and DON said residents were to be checked regularly and would expect ADLs to be carried out. 3. Review of Resident #50's annual MDS, dated [DATE] showed; -Cognitively moderately impaired; -Upper/lower extremities: No impairment; -Eating: Dependant-staff does all of the effort. Resident does none of the effort to complete the activity; -Diagnoses included kidney failure, dementia, arthritis, malnutrition and depression. Review of the resident's physician's orders, showed: -An order dated 7/31/24, for a 2 Calorie Med Pass Supplement (a fortified nutritional shake, adding calories and protein to the diet); -An order dated 7/13/24 for a Regular diet, Regular texture, Thin consistency. Review of the Registered Dietician's (RD) progress note, date 8/1/2024 at 1:21 P.M., showed RD was stopped by resident's roommate. Roommate let RD know the resident may need some assistance during meal times. RD spoke with resident who confirmed he/she needs help. Resident's hands are contracted and this makes it difficult for the resident to feed himself/herself. Resident hesitant on wanting help, but admits he/she needs it. RD empathized with resident and provided support. Also encouraged resident to eat in the dining room more often as well. Spoke with interim DON about issue. Recommend having staff assist resident during meal times to ensure he/she is able to eat and receive adequate nutrition. Resident has gained weight recently but body mass index (BMI, is a calculation that estimates body fat percentage, by comparing a person's weight to their height. A BMI under 18.5 is described as underweight. Between 18.5 and 24.9 defined as a healthy range. Between 25 and 29.9, is considered overweight, and between 30 and 39.9 , described as obesity), still only 20.1, Med pass, twice a day was ordered on 7/31/24. Observation on 8/27/24 at 9:15 A.M., and at 1:30 P.M., showed the resident in his/her room, seated on his/her bed with a meal tray on his/her bedside table. He/She slowly moved his/her utensil to his/her food, then to his/her mouth. The resident ate his/her meal without assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/28/24 at 1:18 P.M., showed the resident in his/her room, seated on his/her bed. CNA P entered the resident's room with the resident's meal tray and placed the tray on the resident's bedside table. CNA P exited the room. The resident began attempting to eat his/her lunch. CNA P entered the room again, removed the tray from the resident's bedside table, and sat the tray on a chair at the foot of his/her bed. CNA P said he/she removed the tray because the resident ate slowly and he/she wanted to be able to help him/her eat, then exited the room. The resident's roommate walked over to the resident's tray, removed the pudding, and sat the pudding on the resident's bedside table. The resident said he/she was hungry and started eating his/her pudding, slowly moving the spoon to the pudding and then to his/her mouth, without assistance. Observation on 8/28/24 at 1:30 P.M., showed the resident in his/her room, seated on his/her bed. A meal tray was placed on his/her bedside table. The resident ate his/her meal without assistance. During an interview on 8/28/24 at 12:16 P.M., the RD said she expected staff to provide meal assistance when needed. A CNA should be assisting the resident with his/her meals. During an interview on 8/28/24 at 4:37 P.M., the Administrator said she expected staff to provide ADL care, including feeding assistance when needed. MO00240295

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 37681 42247 Based on observation, interview and record review, the facility failed to provide an on-going activity program based on resident preferences to support residents in their choice of activities and meet the needs of residents. The resident council meeting participants reported activities to be insufficient. In addition, residents observed and interviewed reported concerns with the activity program for eight of 18 sampled residents (Residents #54, #26, #50, #62, #44, #55, #22 and #36). The census was 78. Review of the facility's Therapeutic Activities Program, dated reviewed 9/21/23, showed: -Activities -refers to any endeavor, other than routine activities of daily living (ADLs), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence; -Program scheduling: -It is important for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed. Additionally, a resident's needs and choices for how he or she spends time, both inside and outside the facility, should also be supported and accommodated, to the extent possible, including making transportation arrangements; -Individual or independent programming ensures that all residents who are unable or unwilling to participate in group programs have consistent, goal-oriented, and individualized recreation opportunities. All residents have a need for engagement in meaningful activities; -Residents who prefer not to participate in group programs and/or are independently involved in recreation pursuits will be identified through the assessment process: -Individual interventions will be developed based on each resident's assessed needs and the family will be notified for any special requests; -Each resident's individual program will include interventions that meet the resident's assessed social, emotional, physical, spiritual, and cognitive functioning needs. These approaches will reflect the resident's lifestyle and interests and will be incorporated into the interdisciplinary care plan; -Group programming ensures each resident the opportunity for active participation in group programming designed to accommodate his or her social and/or cognitive abilities and to promote quality of life. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's August 2024 Activity's calendar, showed: -8/1/24 Coffee and Chat at 9:00 A.M. in the activity room, Price is Right in activity room at 10:00 A.M. and Pretty Nails in the activity room at 2:00 P.M. -8/2/24 Coffee and Chat at 9:00 A.M. in the activity room, Price is Right in activity room and movies in the activity room; -8/3/24 Coffee and Chat at 9:00 A.M. in the activity room, Price is Right in activity room at 10:00 A.M. and Pretty Nails in the activity room at 2:00 P.M.; -8/4/24, 8/11/24, 8/18/24 and 8/25/24 Jazz with breakfast at 7:30 A.M., Worship Services at 10:30 A.M. and puzzles and games all day; -8/5/24, 8/12/24, 8/19/24 and 8/26/24,Coffee and chat at 9:00 A.M., Price is Right at 10:00 P.M., Social hour from 2:00 P.M. to 5:00 P.M.; -8/6/24, 8/13/24, 8/20/24, and 8/27/24 Jazz with breakfast at 7:30 A.M., Catholic Services at 10:30 A.M. and social hour at 2:00 P.M.; -8/7/24, 8/14/24 and 8/21/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M. on 8/7 and 8/21, Movie at 2:00 P.M.; -8/8/24, 8/15/24 and 8/22/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M. and social hour at 2:00 P.M.; -8/9/24 and 8/24/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M. and Pretty nails on 2:00 P.M.; -8/10/24, 8/16/24, 8/30/24 and 8/31/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M., and Craft with [NAME] at 2:00 P.M.; -8/23/24, coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M. and Social hour at 2:00 P.M.; -8/28/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M., and Craft with [NAME] at 2:00 P.M.; -8/29/24 Coffee and chat at 9:00 A.M., Price is Right at 10:00 A.M. and Pretty nails on 2:00 P.M. Review of the facility's resident council minutes, dated 8/8/24, showed eight residents attended the Resident Council meeting. The residents requested more outings and entertainment. Residents would like to have activities outside of the facility. 1. Observations on all days of the survey on 8/22 and 8/23/24 and 8/26 through 8/28/24, showed no activities taking place. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a group interview on 8/23/24 at 9:33 A.M., five residents, who the facility identified as alert and oriented, attended the group meeting. All five residents said no activities had taken place in about three weeks. They were also to stay in their rooms because of a COVID outbreak. Prior to the COVID outbreak, they were still limited in the activities and expressed this to facility staff. 3. Review of Resident #54's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/24/24 showed; -Cognitively intact; -Diagnoses included heart failure, kidney failure, diabetes and high blood pressure. Review of the resident's Activities Assessment, dated 11/7/23, showed: -Interest in life/activities: Very interested; -Type: Large group, small group, one on one: Very important. Review of the resident's care plan, in use during the survey, showed: -Focus: Participates in activities of choice through computer, word searches, reading and his/her favorite television programs; -Goals: Staff will assist with activities of choice through next review; -Interventions: Staff will assist with resident's preferred activities which include computer, watching television, word searches and favorite television programs. Observation and interview on 8/22/24 at 5:11 P.M., showed the resident sat on his/her bed in his/her room. The resident said there had not been any activities in a while. The only activities the resident did was watch television. 4. Review of Resident #26's quarterly MDS, dated [DATE], showed; -Cognitively intact; -Diagnoses included heart failure, high blood pressure, respiratory failure and diabetes. Review of the resident's care plan, in use during the survey, showed: -Focus: At risk for alteration in psychosocial well-being due to isolation/quarantine related to COVID-19; -Goal: The resident will have no indications of psychosocial well-being problem while in quarantine/isolation; -Interventions: Provide resident with in room activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/22/24 at 5:15 P.M., showed the resident sat on his/her bed in his/her room. The resident said there had not been any activities in a while. The only things the resident and his/her roommate had been doing was watching television and reading. 5. Review of Resident #50's MDS, dated [DATE], showed; -Cognitively moderately impaired; -Diagnoses included kidney failure, dementia, arthritis, malnutrition and depression. Review of the resident's Activities Evaluation, dated 7/25/24, showed: -Activities preferences: Bingo and Cards; -Type: One on one, small group: Somewhat important. Review of the resident's care plan, in use during the survey, showed: -Focus: Resident participates in activities of choice through watching favorite television programs, religious services, current event programs, news programs, music, movies and friends and family visits; -Goal: Staff will assist resident with activities of choice through next review; -Interventions: Staff will assist with getting resident to preferred activities, including favorite television programs, religious services, current event programs, news programs, music, movies and friends and family visits; -Focus: The resident is dependent on staff for meeting physical and social needs due to cognitive deficits; -Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date; -Interventions: Invite the resident to scheduled activities, thank resident for attendance at activity function. The resident needs assistance/escort with all activity functions; -Focus: Resident has COVID + alteration in psychosocial well-being due to isolation/quarantine related to COVID-19 visitation/restrictions; -Goal: The resident will have no indications of psychosocial well-being problems while in quarantine/isolation; -Interventions: Provide resident with in room activities. During an interview on 8/28/24 at 10:00 A.M., the resident said he/she could not remember when the last activities were provided by staff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #62's quarterly MDS, dated [DATE] showed; -Cognitively intact; -Diagnoses included heart disease, kidney failure, anxiety and depression. Review of the resident's care plan, in use during the survey, showed: -Focus: At risk for alteration in psychosocial well-being due to isolation/quarantine related to COVID-19; -Goal: The resident will have no indications of psychosocial well-being problems while in quarantine/isolation; -Interventions: Provide resident with in room activities. Observation and interview on 8/26/24 8:43 A.M., showed the resident in his/her room, seated on his/her bed. He/she said he/she was unaware of any activities going on this month. 7. Review of Resident #44's admission MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included: heart failure, high blood pressure, diabetes, and thyroid disorder; -How important is it to you: -If you have books, newspapers, and magazines to read? Somewhat; -Listen to music you like? Somewhat; -Be around animals such as pets? Somewhat; -Keep up with the news? Somewhat; -To do things with group of people you like? Somewhat; -To do your favorite activities? Somewhat; -Go outside to get fresh air when the weather is good? Somewhat; -To participate in religious services or practices? Somewhat. Review of the Activity Evaluation dated 7/24/24, showed: Activity pursuit patterns and preferences: reading. Review of the care plan in use at the time of survey, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: resident was at risk for alteration in psychosocial well-being due to isolation/quarantine related to: COVID-19 restrictions or other reason for isolation/quarantine; -Goal: The resident will have no indications of psychosocial well-being problem while in quarantine/isolation; -Intervention included: provide resident within room activities. Observation and interview on 8/26/24 at 8:50 A.M., showed the resident lay in bed watching TV and said the facility had not had activities since Covid. No one had offered in room activities. He/She would like to do crossword puzzles or word search. Observation on 8/27/24 at 8:21 A.M., showed the resident lay in bed watching TV. During an interview on 8/28/24 at 12:53 A.M., Licensed Practical Nurse (LPN) D said the resident participated in activities. He/She participated in Resident Council and lots of stuff. During an interview on 8/28/24 at 2:00 P.M., Certified Nurse Aide (CNA) B said the resident did not participate in activities. The resident did what he/she wanted to do and he/she participated in activities. 8. Review of Resident #55's annual MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included: high blood pressure, arthritis, depression, and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves); -How important is it to you: -If you have books, newspapers, and magazines to read? Very important; -Listen to music you like? Very important; -Be around animals such as pets? Very important; -Keep up with the news? Very important; -To do things with group of people you like. Very important; -To do your favorite activities? Very important; -Go outside to get fresh air when the weather is good? Very important; -To participate in religious services or practices? Very important. Review of the resident's care plan in use at the time of survey, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: resident participates in activities of choice through religious services/studies Resident Council music, TV programs, bingo, family, and friends visit, dominoes, cards, and board games; -Goal: Staff will assist resident with his/her activities of choice through next review; -Interventions: Staff will assist resident with activities of choice which include religious services/studies Resident Council, music, TV programs, bingo, family and friends visit, dominoes, cards, and board games. Review of the resident's Activity Evaluation, dated 5/30/24, showed; -Activity pursuit patterns and preferences: bingo, board games, cards, music, television; -Other preferences: frequency of activities, daily. Observation and interview on 8/22/24 at 1:34 P.M., showed the resident sat in his/her room watching TV. He/She said there were no activities because the residents on one unit had Covid. Observation on 8/23/24 at 7:44 A.M., showed the resident watched TV in his/her room. During an interview on 8/27/24 at 8:48 A.M., the resident said the staff told him/her to stay in his/her room because the facility had COVID on another unit. The facility did not offer in room activities. He/She would like a puzzle or to play cards. 9. Review of Resident #22's Activities Evaluation, dated 5/20/22, showed: Finds strength in faith, family/friend visits, music and religious services. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitive impairment; -No behaviors; -Diagnoses included diabetes, stroke, hemiplegic, dementia and malnutrition. Review of the resident's care plan, revised 5/10/24, in use during the time of the investigation, showed: -Focus: Resident will participate in activities of choice through family and friend visits, music, religious services and favorite television programs; -Goal: Staff will assist resident with activities of choice; -Interventions: Staff will assist resident with getting to his preferred activities such as family visits, music and religious services. During an interview on 8/22/24 at approximately 3:00 P.M., the resident said things were going okay at the facility. They didn't provide activities, but if they did, he/she would participate. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of Resident #36's admission MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Diagnoses included Urinary Tract Infection (UTI) and diabetes. Review of the resident's Activities Evaluation, dated 7/18/24, showed: -Likes activities. Pets, movies important; -One to one activities preferred. Review of the resident's care plan, last revised 8/22/24, in use during the time of the investigation, showed no information regarding the resident's activities of choice. During an interview on 8/22/24 at approximately 2:45 P.M., the resident said he/she had not participated in activities and staff had not offered activities or one on one visits. He/She would like to participate in activities if it was offered. 11. During an interview on 8/28/24 at 1:38 P.M., CNA B said the residents were not receiving activities. He/She was unsure why. The residents had complained because of a lack of activities. He/She had not seen any activities take place for at least a month. During an interview on 8/28/24 at 2:04 P.M., CNA S said residents were not receiving activities and had complained about it. 12. During an interview on 8/28/24 at 10:10 A.M., the Activity's Director (AD) said all activities were suspended after the COVID outbreak. She said it had been about three weeks. Prior to the outbreak, residents came to the activity room and watched Price is Right and drank coffee. She had an assistant who was supposed to conduct room visits and one on one activities, but the assistant was out with COVID. The AD said she completed some activities recently, but had no documentation. 13. During an interview on 8/28/24 at 4:36 P.M., the Administrator and Director of Nurses (DON) said they would expect residents to receive activities, even during a COVID outbreak. The activities should have been documented. The facility had a full-time AD and an assistant. The Administrator would expect the facility to provide activities and provide in room activities.

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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. 45083 Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice by failing to follow the wound treatment order, resulting in an untreated non-pressure wound, for one sampled resident (Resident #292). The sample was 18. The census was 78. Review of the facility's Wound Care Policy, revised on 7/12/24, showed: -Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standard of practice, the comprehensive person-centered care plan, and the residents' choices; -The skin care program developed by the facility is interdisciplinary and implemented using a team approach; -The skin care program's interdisciplinary team functions as an action team; -Each discipline has a vital role in wound care. All disciplines focus on assessment, planning. implementing, and documenting care; -Communication is vital and should occur daily at the stand-up meeting, and in Grand Rounds, then weekly at the Resident at Risk (RAR) meeting, and monthly at the Quality Assurance and Performance Improvement (QAPI) Committee meeting. Review of Resident #292's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 8/2/24, showed: -Moderate cognitive impairment; -No behaviors; -Independent on functional abilities; -Diagnoses included stroke, anemia, high cholesterol, seizure, malnutrition and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Review of the resident's care plan in use at the time of survey, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: The resident has an arterial ischemic ulcer (wounds that occur when there is poor blood flow to the legs, causing tissue death and open wounds) of the left heel and ankle related to vascular insufficiency; -Goals: The resident will be free from infection or complications related to arterial ulcer through the review date; -Interventions: Assess wound: size, depth, margins, peri wound skin, sinuses (wounds that extend from the skin surface to various underlying tissues), undermining (wounds that appear small on the outside but grows larger underneath the skin). Exudates (fluid that leaks out of blood vessels into nearby tissues), edema, granulation (type of tissue formed on the surfaces of a wound during the healing process), infection, necrosis (death of body tissue, usually caused by a lack of blood flow to the tissue), eschar (dead tissue that forms over healthy skin), gangrene. Inspect feet daily, especially between the toes. Keep the feet clean and dry. Review of the resident's electronic medical record, showed: -A diagnosis of acquired absence of other left toes; -On 7/30/24, an order of Betadine External Solution (Povidone-Iodine, used to treat and prevent skin infections in minor burns, lacerations, cuts, and abrasions). Apply to left heel topically every day shift for wound. Paint heel with betadine, cover with gauze and Kerlix (bandage rolls and dressings used for wound care). During an interview and observation on 8/22/24 at 2:40 P.M., the resident's left foot dressing was coming loose and dirty. The dressing was not dated and initialed. The resident said sometimes, he/she had to ask the nurse to have the wounds cleaned and dressing changed. He/She did not remember the last time the dressing was changed. Observation on 8/26/24 at 5:00 A.M., showed the resident asleep in bed, facing the window with his/her feet uncovered. The left foot dressing was dirty, the bottom had black dirt and stained with wound drainage on the top part. The dressing was dated 8/24. During an interview on 8/26/24 at 1:14 P.M., the resident said the wound dressing was not changed for a couple of days. He/She was aware the wound dressing was stained and dirty, but no one would change the dressing over the weekend. During an interview on 8/26/24 at approximately 1:20 P.M., the Licensed Practical Nurse (LPN) C said the assigned nurse was responsible for providing wound care when the wound nurse was not available or not on the schedule. During an interview on 8/28/24 at 4:40 P.M., the Administrator said she would expect staff to follow the wound treatment as ordered. She would expect staff to follow their wound/skin care policy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37681 42247 Based on observation, interview and record review, the facility failed to ensure one resident with wounds received necessary treatments. and services to promote healing (Resident #31). The sample size was 18. The census was 78. Review of the facility's Skin Integrity & Pressure Ulcer/Injury Prevention and Management Policy, dated revised: 7/9/2024, showed: -Skin observations also occur throughout points of care provided by Certified Nurse Aide's (CNA) during Activities of Daily Living (ADL) care (bathing, dressing, incontinent care, etc.). Any changes or open areas are reported to the Nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed; -When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. Review of Resident #31's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 6/11/24, showed: -Cognitively intact; -Diagnoses included: heart failure, stoke, calciphylaxis (a rare, serious disease that involves a buildup of calcium in small blood vessels of fat tissues and skin), end stage renal disease (ESRD, chronic irreversible kidney failure) and colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon); -Number of unhealed pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction), Stage three (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling): one; -Open lesion other than ulcers, rashes, cuts (e.g. cancer lesion) was checked. Review of the care plan, in use at the time of survey, showed: -Focus: resident has a break in skin integrity to right lower extremity (RLE, leg) related to calciphylaxis wound, ESRD, date initiated 7/5/24; -Goal: Minimize risk for symptoms of infection through next review; -Interventions included: Observe dressing (every shift). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: has breaks in skin integrity to RLE related to calciphylaxis. refer to wound observation tool; -Goal: Maintain intact skin with no skin breaks through next review; -Interventions: treatment as ordered; -Focus: has pressure ulcer noted refer to wound observation tool; -Goal: the resident's pressure ulcer will show signs of healing and remain free from infection by/through review date; -Interventions: administer treatments as ordered. During an interview on 8/22/24 at 4:55 P.M., the resident said he/she had wounds on his/her bottom and on the right leg and heel, staff are not changing the dressings like they should be. The wound nurse ordered the dressing to be changed twice day, but the staff were not doing that, so the treatment got changed to daily. The wound on the right heel has increased in size. It will heal and they will stop the dressing but when they do that, the wound comes back. Review of the Treatment Administration Record (TAR), dated 8/1/24 through 8/23/24, showed: -An order for: Cleanse sacral wound with Vashe (used for cleansing, irrigating, moistening, debridement, and removal of foreign material including microorganisms and debris from exudating and/or dirty wounds) solution, apply fibercol (a soft, absorbent dressing) to wound bed, cover with border gauze dressing every evening shift, every Tuesday, Thursday, Saturday for wound, start date 7/1/24. Discontinue date 8/23/24; -Documentation showed three out of 10 opportunities were blank; -An order for: Mupirocin ointment 2% (Bactroban, antibiotic) apply to right lower leg topical every shift for wound infection for seven days, cleanse right lower leg with Vashe wound cleanser, allow to soak for 15 minutes, apply Santyl (sterile enzymatic debriding ointment) with Bactroban to wound bed, cover with calcium alginate (highly absorbent dressing that promotes healing) cut to fit inside wound edges. cover with boarded gauze; change dressing three times a day (TID), start date was 8/2/24 and stop date was 8/9/24; -Documentation showed two out of 21 opportunities were blank; -An order for: Santyl ointment 250 unit/gm apply to right lower leg topically every shift for wound care, cleanse right lower leg with Vashe wound cleanser, allow to soak for 15 minutes, apply Santyl with Bactroban to wound bed, cover with calcium alginate cut to fit inside wound edges. cover with boarded gauze; change dressing TID, start date: 8/2/24. Discontinue date 8/17/24; -Documentation showed: two out of 44 opportunities were blank; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order for: Santyl ointment 250 unit/gm, apply to right lower leg every shift for wound care. Cleanse right lower leg with Vashe wound cleanser, allow to soak for 15 minutes, apply Santyl cover with calcium alginate cut to fit inside the wound edges. Wrap with kerlix (gauze) daily, order date 8/17/24. Discontinue date 8/21/24; -Documentation showed: four out of 12 opportunities were blank; -An order for: skin prep (quick drying skin protectant) apply to right heel topically every shift, order date 7/23/24; -Documentation showed: six out of 59 opportunities were blank. Review of the progress notes, dated 8/1/23 through 8/23/24, showed: -On 8/7/24 at 2:00 P.M., resident leave of absence (LOA) this shift, treatment not completed; -On 8/11/24 at 11:08 P.M., Gentamicin Sulfate Cream 0.1%, apply to right lower leg rear topically every day and evening shift for wound care, UTC was documented; -On 8/11/24 at 11:09 P.M., Santyl ointment 250 unit/gm, apply to right lower leg every shift for wound care; unable to complete treatment ordered supplies are unavailable at this time; -On 8/17/24 at 6;48 A.M., Santyl, apply to right lower leg topically every shift for wound; resident did not want it changed now, relates should only be changed once per day; -On 8/19/24 at 6:27 A.M., Santyl, apply to right lower leg topically every shift for wound care; not available; -On 8/19/24 at 6:28 A.M., skin prep spray, apply to right heel topically every shift; not available. Review of the TAR, dated 8/1/24 through 8/23/24, showed: -On 8/7/24 the treatments were documented as a 10 (see progress notes); -On 8/11/24, the gentamicin and Santyl were documented as a 10; -On 8/17/24, the Santyl for evening shift was blank and night shift was documented as administered; -On 8/19/24, Santyl and skin prep were documented with a 10. Review of the TAR, dated 8/24/24 through 8/25/24, showed: -An order for: cleanse sacral wound with Vashe solution, apply collagen sheet with alginate to upper part of wound bed, cover with border gauze dressing every day shift every Monday, Wednesday, Friday, Sunday for wound. Resident had two medications for wound order, may place one dressing over entire wound area. Order Date was 8/23/2024; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation showed: one out of one opportunity was blank; -An order for: Cleanse sacral wound with Vashe, apply Xeroform (a sterile non adherent dressing) to lower section of wound bed, cover with border gauze dressing every day shift every Monday, Wednesday, Friday, Sunday for wound Resident has two medications for wound order, may place one dressing over entire wound area. Order date was 8/23/2024; -Documentation showed: one out of one opportunity was blank; -An order for: Santyl ointment 250 unit/gm, apply to right lower leg every day shift every Monday, Wednesday, Friday, Sunday for wound care. Cleanse right lower leg with Vashe wound cleanser, allow to soak for 15 minutes, apply santyl cover with calcium alginate cut to fit inside wound edges, wrap with kerlix, order date was 8/22/24; -Documentation showed one out of two opportunities was blank. Review of the progress notes dated 8/24/24 through 8/26/24, showed: -On 8/26/24 at 4:10 P.M., soft area noted to right heel, with 2 open areas (o/a) noted, 1.75 centimeters (cm) x 1.5 cm o/a to the top, with a 2 cm x 1.5 cm o/a noted at the base of heel, doctor made aware. New order (n/o) given cleanse with Vashe, cover with foam dressing every day and as needed; -On 8/26/24 at 5:03 P.M., skin prep not applied. Cleaned and measured, notable o/a to center-to update doctor; -There was no documentation showing if the treatment was or was not completed on 8/25/24. Observation and interview on 8/26/24 at 11:16 A.M., showed the resident lay in bed. Licensed Practical Nurse (LPN) E entered the resident's room and removed the resident's blanket. The resident had a dressing on his/her right mid-calf area. The dressing had old drainage on it. The pillow under the resident's leg had a large amount of yellowish colored drainage on it. The nurse removed the dressing and soaked the wound with Vashe wound cleanser for 15 minutes, then cleaned the wound and applied a new dressing. The nurse positioned the resident on his/her side and removed the dressing form the sacrum (triangular bone located above the coccyx). The dressing was dated 8/24/24. There was large yellowish ring on the pad and sheet under the resident. The nurse said this was unacceptable. The nurse provided wound care and applied a new dressing. Then, the nurse went to get the Director of Nursing (DON). A few minutes later, the nurse and the DON entered the resident's room. The nurse showed the DON the discoloration on the bed and told the DON the resident did not urinate and he/she had a colostomy. The DON said the discoloration was 100% drainage. Observation of the right heel showed the skin was peeling off the heel and there were two open areas. The nurse described the open areas as a Stage two (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister) and said the wounds were past skin prep. The DON asked the nurse if the resident was seen by the wound care team on Friday and the nurse said yes. The DON said the heel did not get that way in two days and skin prep was no longer an acceptable treatment. The DON said all the managers worked over the weekend and no one reported to her that the resident's treatments were not done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 12:53 P.M., LPN D said usually the wound nurse did the treatments. If the wound nurse did not provide the wound care, the floor nurse would do it. A blank on the TAR meant someone forgot to chart or it was not done. If he/she saw a blank on the TAR, he/she would assess the resident to see if the bandage was changed or not. If the bandage had a wrong date on it, he/she would ask the resident because the nurses might have written the wrong date on it. If a resident's wound was draining, he/she expected staff to change the resident's sheets and clean the dressing. If a resident's sheets were soiled, he/she expected staff to change them. Resident #31's wound weeps a lot. He/She was seen by the wound team and they are aware of the drainage. All staff can do is follow the orders and change the dressing and sheets. During an interview on 8/28/24 at 1:33 P.M., LPN A said many times the nurse on the floor did the treatments. A blank on the MAR/TAR meant it was not done but he/she cannot be sure of it. If he/she saw a blank, he/she would tell the DON and check the progress of the bandage. During an interview on 8/26/24 at 11:16 A.M., the DON said if a staff member saw a wound, she expected them to clean the wound and report it to the doctor and the DON. Staff should measure wounds and document what they see. She expected staff to change soiled linens and turn and reposition the resident every couple of hours. The DON expected staff to follow physician orders. During an interview on 8/28/24 at 4:36 P.M., the Administrator said she expected wound care to be completed per physician orders. MO00240295 MO00226243 45083

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to ensure a resident with a significant weight loss was provided appropriate mealtime assistance resulting in a 9.43% weight loss within a 30 day time frame (Resident #36). In addition, the facility failed to notify the physician and Registered Dietician (RD) when a resident experienced a weight loss for one resident (Resident #31) and failed to ensure nutritional supplements and double portions were provided for one resident at risk for weight loss (Residents #22). The sample size was 18. The census was 78. Review of the facility's Hydration and Nutrition policy, revised 8/24/23, showed: -Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status; -Federal Regulations; -Based on a resident's comprehensive assessment, the facility must ensure that a resident; -Maintains acceptable parameters of nutritional status; -Is offered sufficient fluid intake to maintain proper hygiene and health; -Is offered a therapeutic diet when there is nutritional problem and the health care provider orders a therapeutic diet; -Procedure; -A physician's order is obtained for all regular and therapeutic diets, including those with modified textures; -A minimum of three meals are provided each day. If a meal or particular food is refused, the resident is offered a substitute of a similar nutritive value; -The resident is positioned properly to consume meals and snacks. Assistance is provided as needed; -An ongoing assessment of the ability to consume and assimilate food and fluid is conducted by nursing personnel and all concerns are reported to the nurse; -Consultation with dietary and therapy personnel, is performed on admission and as needed; -The physician is notified of any concerns 1. Review of Resident #36's weight, dated 7/17/24 at 8:33 A.M., showed an admission weight of 176.0 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/25/24, showed: -Cognitively intact; -No rejection of care; -Required partial/moderate assistance with eating; -Dependent on staff for all personal hygiene; -Diagnoses included urinary tract infection (UTI), and diabetes; -Height: 74 inches; -Weight: 176 pounds. Review of the resident's Assessment/Nutritional Data Collection, dated 8/1/24, showed: -Regular diet with house supplements; -Height of 74.0 inches; -Weight: Body Mass Index (BMI) based on weight from hospital documents where resident was documented to weigh 180 pounds; -Meal intake: 0-50%; -Confused; -Feeding/Dining ability: Limited Assist; -Pressure Injury (injury to the skin and underlying tissue resulting from prolonged pressure on the skin); -At risk for malnutrition; -Monitoring/Evaluation of weight, intakes, chewing/swallowing, independence level and skin; -Resident admitted on [DATE]. Noted to be on hospice but is a full code. Resident is alert and oriented to person and place and not eating well on regular diet with regular texture. Has an order for house shakes (nutritional supplements) twice a day. Unsure of recent weight loss. No weight taken since admitted to facility. Has wounds and at risk for malnutrition due to inadequate by mouth intake and increased needs for wound healing. Please obtain weight. Review of the resident's weight, dated 8/2/24 at 3:25 P.M., showed the resident weighed 176.0 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's current care plan, revised on 8/22/24, showed: -Diagnoses included Parkinson's disease, unspecified tremors and diabetes; -No information documented regarding the resident's nutritional status or activities of daily living. Review of the resident's Nutrition Assessment/Nutritional Data, dated 8/22/24, showed: -Regular diet; -Weight of 176 pounds on 8/2/24; -Comment related to meal intake: varied, mostly 26-75%; -Feeding/Dining ability: Limited assist; -No behaviors that would affect nutritional status; -At risk for malnutrition; -Resident readmitted on ,d+[DATE]. Noted to be on hospice but is a full code. Not eating very well on regular diet with regular texture. Intakes have been mostly 26-75%. Resident has wounds and at risk for malnutrition due to inadequate by mouth intakes and increased needs for wound healing. Recommend ordering weekly weights. During an observation and interview on 8/22/24 at approximately 2:44 P.M., the resident lay in bed on his/her back. The resident said he/she had cake earlier and was not cleaned up. He/She needed help with meals and staff never fed him/her. The only time he/she ate was when his/her spouse and adult child visited. Observation on 8/23/24 at 8:44 A.M., showed the resident lay in bed on his/her back. His/Her breakfast tray was on the bedside table, covered. No staff member assisted the resident. Observation on 8/23/24 at 9:02 A.M., showed the resident's spouse in the resident's room, feeding the resident. The spouse said when he/she arrived, the plate of food was covered and no one had set up the resident's tray. If he/she had not been there, the resident would not have received anything to eat. Staff never fed the resident. He/She had spoken to staff and asked them to feed the resident as he/she was unable to feed him/herself. The resident ate 100% of his/her meal with his/her spouse's assistance. Observation on 8/26/24 at 4:53 A.M., showed a handwritten sign saying please assist me with meals hung at the door and on the wall of the resident's room. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Observation on 8/26/24 at 8:47 A.M., showed the resident lay in bed on his/her back. The resident's covered breakfast tray sat on the night stand. The resident opened his/her eyes and said he/she was hungry. The resident's breakfast meal consisted of biscuits and gravy, oatmeal, juice and water. He/She said he/she was hoping someone would feed him/her. The resident's hands shook as he/she tried to open the covered tray. He/she dropped the tray and was unable to feed him/herself. No staff assisted the resident. Observation on 8/26/24 at 9:01 A.M., showed the resident's tray of food was removed. He/She said staff came and took the tray and did not offer to feed him/her. He/She never received any assistance with breakfast and was still hungry. The resident said he/she did not eat and was still hungry. Observation and interview on 8/26/24 at 2:01 P.M., showed Certified Nursing Assistant (CNA) L stood over the resident and fed him/her lunch. When asked about the resident's breakfast tray, CNA L at first said he/she thought he/she fed the resident. The resident said, no, you came and took my food away. CNA L then said, Didn't your (son/daughter) feed you? The resident said no and they did not visit with him/her today. CNA L then said the resident had not had any breakfast. Observation and interview on 8/27/24 at 10:13 A.M., showed the resident lay in bed. His/Her spouse said when he/she arrived this morning, the resident's breakfast tray was untouched. The spouse placed signs throughout the resident's room to remind staff to feed the resident. Observation and interview on 8/27/24 at 10:34 A.M., showed CNA B and CNA K weighed the resident using a mechanical lift. The resident weighed 159.4 pounds, indicating a 9.43% weight loss since 8/2/24. CNA B said he/she was familiar with the resident and he/she needed total assistance with meals. The resident's hands shook and he/she would not be able to feed him/herself. During an interview on 8/28/24 at 9:08 A.M., CNA N said he/she was familiar with the resident and he/she definitely needed total assistance with meals due to his/her hand shaking. During an interview on 8/28/24 at 2:46 P.M., Licensed Practical Nurse (LPN) A said if residents were at risk for weight loss and required staff to assist with meals, the CNAs should feed the residents. During an interview on 8/27/24 at 12:16 P.M., the Registered Dietician (RD) said 9.43% within less than 30 days was considered a significant weight loss. The resident required assistance with meals and she expected staff to feed the resident as he/she was at risk for malnutrition. During an interview on 8/28/24 at 4:36 P.M., the Administrator and Director of Nursing (DON) said the resident was at risk for malnutrition and could not feed him/herself. The resident experienced a significant weight loss and staff should have fed the resident. 2. Review of Resident #31's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included heart failure and diabetes. Review of the weight tab, showed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Weight on 5/7/24 was 168.7 pounds; -Weight on 8/2/24 was 158 pounds, which showed a 6.34% weight loss for three months. Review of the progress notes, dated 8/8/24 through 8/27/24, showed: -On 8/8/24 at 12:34 P.M., the resident was discussed in a meeting on 8/7, monthly note for wounds and hemodialysis (HD, process for removal of waste and excess water from the blood due to kidney failure) has 30 mL of Prosource twice daily ordered, recommended to increase Prosource to three times daily to aid in wound healing and for increased needs for HD; -There was no documentation showing the physician was notified of the RD recommendations. Review of the physician summary sheet, dated 8/26/24, showed: -An order for Prosource (nutritional supplement) Give 30 milliliters (mL) by mouth two times a day for protein supplement for wound healing; -There was no physician order for Prosource three times a day. Review of the Medication Administration Record (MAR), dated August 1, 2024, through August 27, 2024, showed Prosource 30 mL was administered twice daily. During an interview on 8/28/24 at 12:53 P.M., Licensed Practical Nurse (LPN) D said if the dietician made a recommendation, the MDS nurse or the DON would enter the recommendation into the medical record. If LPN D saw a recommendation in the medical record, he/she would call the doctor and get an order, then enter it into the medical record. During an interview on 8/28/24 at 1:33 P.M., LPN A said if he/she received a dietary recommendation, he/she would call the doctor and verify the recommendation and if the order was okayed, it would be entered into the computer. During an interview on 8/24/24 at 4:36 P.M., the DON said she expected staff to notify the physician of weight loss and she expected dietary recommendations to be addressed within 48 hours. 3. Review of Resident #22's quarterly Nutrition Data Collection, dated 6/3/24, showed: -Double portions for all meals; -Fortified foods; -Height: 72 inches; -Weight on 5/6/24 of 137.2; -Resident eating fairly well on regular diet with regular texture and thin liquid, receiving double portions of food. Encourage intakes. Recommend ordering house shakes twice a day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Weight Summary, showed: -6/10/24, a weight of 137.2 pounds. Review of the resident's care plan, revised 6/15/24, showed: -Focus: The resident has an activity of daily living self-care performance deficit related to weakness, impaired mobility and cognitive impairment; -Goal: The resident's activity of daily living will be met through the review date; -Interventions: The resident requires assistance by staff times one to eat; -Focus: The resident is at risk for weight fluctuation related to current health status and bilateral above the knee amputation, dysphagia and diabetes; -Goal: Resident wishes to maintain current weight through next review; -Intervention: Assist with meals as needed. Diet order as ordered. Supplements as ordered and does not like milk. Weekly weights, fortified foods, nutritional juice and double portions. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitive impairment; -No behaviors; -Required set up and clean up for meals; -Diagnoses included high blood pressure, diabetes, stroke and malnutrition. Review of the resident's undated POS, in use during the time of the investigation, showed no orders for health shakes or double portions. Review of the resident's Weight Summary, showed: -7/2/24, a weight of 136.8 pounds; -8/2/24, a weight of 134.1; -8/22/24, a weight of 132.3 pound, indicating 3.29% weight loss since 7/2/24. Review of the resident's breakfast meal ticket, dated 8/23/24, showed: -Allergies/dislikes: Dairy; -Regular texture/Double portions; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Fortified shakes. Observation and interview on 8/23/24 at 8:21 A.M., showed the resident received his/her plate of food. The meal consisted of one bagel, approximately two tablespoons of mixed fruit cocktail and approximately two tablespoons of cottage cheese. Milk and juice were on the tray. The resident said the food was disgusting and he/she would not eat it. No fortified shake was on the resident's tray. The resident said he/she did not recall ever receiving a fortified shake. The resident said he/she wanted oatmeal, but did not receive it. Observation on 8/23/24 at 8:25 A.M., showed the resident staring at his/her meal. The DON and another staff member walked in the resident's room and took the milk from his/her tray. Review of the resident's lunch meal ticket, dated 8/23/24, showed: -Regular texture/double portions; -Beef tip, butter pasta, sauerkraut, desert, dinner roll and juice. Observation on 8/23/24 at 12:47 P.M. , showed the resident received his/her lunch tray. The meal consisted of one roll, one serving of beef and noodles, one serving of vegetables, a cup of banana pudding, water and juice. The resident did not receive double portions. During an interview on 8/23/24 at 12:49 P.M., the resident said he/she did not receive sauerkraut. He/She did not like the beef pasta and would not eat it. He/She also did not receive a health shake today. Review of the resident's breakfast meal ticket, dated 8/26/24, showed regular texture/double portions. Observation on 8/26/24 at approximately 8:30 A.M., showed the resident in bed with his/her breakfast on the night stand. The breakfast consisted of one biscuit covered in gravy, one serving of scrambled eggs, a cup of oatmeal, water and juice. The resident said he/she planned to eat everything on the plate. Observation on 8/27/24 at 9:17 A.M., showed CNAs B and K weighed the resident using a mechanical lift. The resident weighed 132.6 pounds. Observation and interview on 8/27/24 at 12:00 P.M., showed frozen health shakes in the facility's main kitchen. The Dietary Manager (DM) said the health shakes were kept in the refrigerator and freezer, but they had not passed them out with meals. She was not sure when the shakes were last passed out with meals. During an interview on 8/27/24 at 12:16 P.M., the RD said the resident was recommended for house shakes and she expected staff to ensure it was on the physician's order and the resident was to receive it. The CNAs would place beverages, including milk, and shakes, on the carts to pass in between meals instead of with meals to ensure residents received health shakes. The resident should have received shakes if there was an order or recommendation. The resident was also supposed to receive double portions with each meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/28/24 at 4:36 P.M., the Administrator and DON said the resident had a diagnosis of malnutrition. The resident experienced a weight loss in the past and should have received fortified shakes and double portions. MO00240295 42247 45083

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on observation, interview and record review, the facility failed to ensure physicians' orders for respiratory evaluation and treatments were followed for five residents out of 18 sampled residents (Residents #50, #62, #31, #14, and #44). The facility census was 78. Review of the facility policy binder, showed no policies regarding respiratory illness/infections. 1. Review of Resident #50's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/26/24 showed; -Cognitively moderately impaired; -Diagnoses included kidney failure, dementia, arthritis, malnutrition and depression. Review of the resident's nurse's progress notes, showed on 8/12/24 at 3:55 P.M., the resident was diagnosed positive for COVID-19, respiratory precautions in place. Review of the resident's physician's orders, showed: An order, dated 8/15/24, for Respiratory Evaluation and Treatment as indicated. Complete Respiratory assessment under assessment Tab. Contact Family, Primary Care Physician (PCP), Director of Nursing (DON), and document abnormal finding every shift for COVID, may discontinue (d/c) when facility is out of outbreak. Review of the resident's care plan, in use during the survey, showed: -Focus: At risk for respiratory illness due to exposure to COVID-19; -Goal: The resident will not experience complications requiring hospitalization while in quarantine; -Interventions: Educate the resident on the need and purpose of the quarantine period. Monitor for change in condition and notify practitioner of findings. Perform respiratory assessment on an ongoing basis while in quarantine. Place resident in an appropriate room to reduce exposure risk to self or others. Review of the resident's respiratory evaluations, dated 8/15/24 through 8/26/24, showed 15 out of 30 evaluation opportunities were not completed. 2. Review of Resident #62's quarterly MDS, dated [DATE] showed; -Cognitively intact; -Diagnoses included heart disease, kidney failure, anxiety and depression. Review of the resident's nurse's progress notes, showed on 8/12/24 at 3:56 P.M., the resident was diagnosed positive for COVID-19, respiratory precautions in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician's orders, showed: An order, dated 8/15/24, for Respiratory Evaluation and Treatment as indicated. Respiratory Evaluation, and Treatment as indicated. Complete Respiratory assessment under assessment Tab. Contact Family, PCP, DON, and document abnormal finding every shift for COVID, may discontinue (d/c) when facility is out of outbreak. Review of the resident's care plan, in use during the survey, showed: -Focus: At risk for respiratory illness due to exposure to COVID-19; -Goal: The resident will not experience complications requiring hospitalization while in quarantine; -Interventions: Educate the resident on the need and purpose of the quarantine period. Monitor for change in condition and notify practitioner of findings. Perform respiratory assessment on an ongoing basis while in quarantine. Place resident in an appropriate room to reduce exposure risk to self or others. Review of the resident's respiratory evaluations, dated 8/15/24 through 8/26/24, showed 21 out of 30 evaluation opportunities were not completed. 3. Review of Resident #31's medical record, showed: -Cognitively intact; -Diagnoses included: COVID-19. Review of the care plan, in use at the time of survey, showed: -Focus: resident has a respiratory infection related to COVID positive; -Goal: the resident's symptoms will resolve without hospitalization ; -Interventions included: observe and notify the physician if the resident experiences increased respiratory distress such as shortness of breath or low oxygen saturation. Review of the physician order report, dated 8/27/24, showed: An order for: respiratory evaluation and treatment as indicated. Complete respiratory assessment under assessment Tab. Contact Family, PCP, DON, and document abnormal finding every shift for COVID, may discontinue (d/c) when facility is out of outbreak. The start date was 8/15/24. Review of the resident's respiratory evaluations, dated 8/15/24 through 8/26/24, showed 19 out of 30 evaluation opportunities were not completed. 4. Review of Resident #14's medical record, showed: -Moderately impaired cognition; -Diagnoses included: COVID-19. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan, in use at the time of survey, showed: -Focus: resident is at risk for respiratory infection related to positive COVID test; -Goal: resident will experience no complications requiring hospitalization s; -Interventions: observe and notify physician if the resident experiences fever, cough, low oxygen saturation and shortness of breath. Review of the order summary sheet, dated 8/23/24, showed: An order for Respiratory Evaluation and Treatment as indicated. Complete respiratory assessment under assessment tab. Contact family, PCP, DON, and document abnormal finding, every shift for COVID, may discontinue when facility is out of outbreak. The start date was 8/15/24. Review of the resident's respiratory evaluations dated 8/15/24 through 8/26/24, showed 19 out of 30 evaluation opportunities were not completed. 5. Review of Resident #44's medical record, showed: -Moderately impaired cognition; -Diagnoses included: COVID-19. Review of the care plan, in use at the time of survey, showed: -Focus: At risk for respiratory exacerbation related to COVID 19. Symptoms sneezing, runny nose, watery eyes; -Goal: the resident will not experience complications requiring hospitalization s while in quarantine; -Interventions: monitor for change in condition and notify practitioner of finding. Review of the physician's order sheet, dated 8/26/24, showed: An order for Respiratory Evaluation, and Treatment as indicated. Complete respiratory assessment under assessment tab. Contact family, PCP, DON, and document abnormal finding, every shift for COVID, may discontinue when facility is out of outbreak. The start date was 8/15/24. Review of the resident's respiratory evaluations dated 8/15/24 through 8/24/24 showed 13 out of 27 evaluation opportunities were not completed. 6. During an interview on 8/28/24 at 12:53 P.M., Licensed Practical Nurse (LPN) D said all residents in the facility were currently getting a respiratory assessment completed every shift and documented under the respiratory assessments tab. The assessments consisted of assessing the residents for signs and symptoms of COVID, such as headaches, body aches and cold symptoms, and checking vital signs and oxygen saturation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 8/28/24 at 1:33 P.M. LPN A said the nurses were responsible for completing the respiratory assessments. The assessments were completed daily until the order ends and are documented on the Medication Administration Record. 8. During an interview on 8/28/24 at 4:36 P.M., the Administrator said she expected staff to follow the physician's orders and she would expect the respiratory assessments to be completed. 42247

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 33 opportunities, for errors, four errors occurred, resulting in a 12.12% medication error rate (Residents #242, #30, #23 and #29). The census was 78. Review of the facility's Administration of Medication Policy, dated 8/24/23, showed: -Policy: The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms; -Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medications in a skilled nursing facility; -Staff who are responsible for medication administration will adhere to the 10 rights of medication administration: -Right Drug: every drug administered must have an order from the provider. Compare the order with the Medication Administration Record (MAR) for accuracy. Compare the label on the drug to the information on the MAR three times: -Before removing the container from the drawer; -As the drug is removed from the container, and; -At the bedside before administering it to the resident; -Right Dose: check the MAR and the doctor's order before medicating. Use standard measuring devices such as syringes, graduated cups, or scaled droppers. If there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering; -A physician order that includes dosage, route, frequency, duration, and other required considerations including the purpose, diagnosis or indication for use is required for administration of medication. Review of the information provided by the facility, titled Insulin Pen Use, undated, showed: -An insulin pen looks like a writing pen, contains an insulin reservoir, and has a dial or knob for setting the dose and a button at the back for injecting the dose. A disposable needle must be attached to the pen for each use; -Insulin preparation: -Remove the pen cap and attach the needle to the pen according to the manufacturer's instructions; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Prime the pen: hold the pen vertically with the needle pointing up, dial one or two units on the dosage knob, and presses the injection button several times until a drop of insulin appears at the tip of the needle. Unless otherwise directed by the manufacturer; -Dial the dosage knob to the correct dose. Review of the facility's Infusion Therapy-Intravenous (IV Fluids) Policy, dated revised 8/8/2023, showed: -Policy: The facility assures that each resident receives care and services for the provision of parenteral fluids consistent with professional standards of practice in order to provide safe administration of parenteral fluids by qualified, competent, and trained staff in accordance with state laws/practice acts; -The policy did not show how to or when to flush the line. 1. Review of Resident #242's medical record, showed: -Alert and able to make needs known; -Diagnosis of endocarditis (a life-threatening inflammation of the inner lining of the hearts chambers and valves). Review of the care plan, in use at the time of survey, showed: -Focus: Infection endocarditis; -Goal: Infection will resolve by review date; -Interventions included medications as ordered. Review of the physician's order summary, dated 8/23/24, showed: -An order for: IV: blood draw, flush with 10 milliliters (ml) normal saline (NS) before blood draw. Discard 5 ml blood, then draw for labs. Flush with 20 ml NS after blood draw *If non-valved catheter follow with Heparin (blood thinner) 10 units/ml as needed for blood draws; -There were no other orders to flush the peripherally inserted central catheter (PICC, a thin flexible tube inserted into a vein in the upper arm and threaded into a large vein in the upper chest) line. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/23/24 at 8:18 A.M., showed a staff member told Licensed Practical Nurse (LPN) J a resident needed to be stopped. LPN J said he/she needed to stop the residents IV, the night nurse hung it and he/she needed to disconnect it. LPN J entered the resident's room, the resident was resting on top of the bed, there was no IV infusing. LPN J asked the resident who stopped his/her IV. The resident said the other nurse stopped; the night nurse stopped it. LPN J flushed the PICC line with 10 ml of NS and 5 ml of heparin. LPN J said he/she would not know if the night nurse flushed the PICC line or not. LPN J went back to the staff member to verify which resident needed to be stopped. The staff member said it was another resident's feeding tube that needed to be stopped. During an interview on 8/23/24 at 8:46 A.M., the resident said the night nurse flushed his/her PICC line when they stopped the IV pump. 2. Review of Resident #30's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 8/2/24, showed: -Cognitively intact; -Diagnosis of diabetes. Review of the physician order summary, dated 8/23/24, showed: -An order for: Lantus (long-acting insulin) 100 unit/mL, inject 30 unit subcutaneously (under the skin) in the morning for diabetic. Observation on 8/23/24 at 7:20 A.M., showed Licensed Practical Nurse (LPN) E removed the Lantus insulin pen from the top drawer of the cart, put a needle on the end of the insulin pen, turned the dial to 30 and administered the insulin; -The LPN did not prime the insulin pen. 3. Review of Resident #23's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included diabetes. Review of the physician order summary, dated 8/23/24, showed: -An order for: Basaglar Kwik pen (long-acting insulin) 100 unit/mL, inject 30 unit subcutaneously in the morning related to diabetes; Observation on 8/23/24 at 7:35 A.M., showed LPN E removed the Basaglar insulin pen from the top drawer of the cart, put a needle on the end of the insulin pen, turned the dial to 30 and administered the insulin; -The LPN did not prime the insulin pen. 4. Review of Resident #29's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnoses included: chronic obstructive pulmonary disease (COPD, lung disease), high blood pressure and coronary artery disease (CAD, plaque buildup in the wall of the arteries that supply blood to the heart). Review of the physician order summary, dated 8/23/24, showed: -An order for bumex (water pill) 2 milligrams (mg), give 2 mg one time a day related to COPD. Observation on 8/23/24 at 7:46 A.M., showed LPN J pulled the card of bumex 2 mg out of the drawer and punched two tablets of 2 mg (total of four mg) and administered to the resident. 5. During an interview on 8/23/24 at 1:54 P.M., LPN J said when he/she administered insulin he/she would put the needle on the insulin pen and turn the dial to the dose of insulin and administer it. IV lines are flushed before and after the antibiotic. He/She would flush with whatever was ordered. There should be a physician order to flush the IV. 6. During an interview on 8/23/24 at 2:05 P.M., LPN D said if the medication was 2 mg and the order said to administer 2 mg, he/she would give one tablet. Insulin should be primed with two units before turning the dial to the dose order. IV lines should have a physician order to flush them. The order will include how often to flush and what to flush with. 7. During an interview on 8/23/24 at 2:15 P.M., the Director of Nursing (DON) said she expected staff to follow the five rights when administering medications (right patient, right drug, right time, right dose, and right route) and she expected staff to follow the physician's orders. If a medication was 2 mg and the order said to administer 2 mg, staff should administer one pill. Insulin pens only need to be primed when they are first started. IV lines should have a physician's order for when to flush them. Heparin should never be given without a physician order. 8. During an interview on 8/28/24 at 4:36 P.M., the Administrator said she expected medications to be administered per physician orders and she expected staff to follow the facility's policy and procedures. MO00240295 MO00236848 MO00232662

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on observation, interview and record review, the facility failed to provide residents with food that was palatable and at a safe and appetizing temperature for 7 of 18 sampled residents (Residents #80, #38, #292, #81, #54, #36 and #79). The census was 87. Review of the facility Safe Food Handling Policy, dated 10/7/19, and revised on 4/16/23 and reviewed on 5/1/2024, showed: -All food purchased, stored and distributed is handled with accepted food-handling practices, and per federal, state and local requirements; -Danger Zone-means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause food borne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS). Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a food borne illness outbreak if consumed; -Food Distribution-means the processes involved in getting food to the resident. This may include holding foods hot on the steam table or under refrigeration for cold temperature control, dispensing food portions for individual residents, family style and dining room service, or delivering meals to residents' rooms or dining areas, etc. When meals are assembled in the kitchen and then delivered to residents' rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart. 1. Review of Resident #80's re-admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 8/5/24, showed: -Moderate cognitive impairment; -No behaviors; -Partial/moderate assistance in eating; -Diagnoses included heart failure, high blood pressure, thyroid disease, arthritis, malnutrition. During an interview on 8/26/24 at 1:43 P.M., the resident said lunch was terrible and tasted horrible. The resident only ate a few bites of mashed potato and chocolate pudding. He/She said foods were always served cold. 2. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No impairment of both upper and lower extremities; -Diagnoses included anemia (not having enough healthy red blood cells), high blood pressure, diabetes, high cholesterol, anxiety and depression. During an interview on 8/22/24 at 2:23 P.M., the resident said the food was not good and was always served cold, especially meals served in resident rooms. He/She said his/her family brings food when they visit. 3. Review of Resident #292's admission MDS, dated [DATE], showed: -Moderate cognitive impairment; -No behaviors; -Independent on functional abilities; -Diagnoses included stroke, anemia, high cholesterol, seizure, malnutrition Schizophrenia (a serious mental health condition that affects how people think, feel and behave). During an interview 8/22/24 at 2:40 P.M., the resident said the facility's food was not good and cold when received. 4. Review of Resident #81's admission MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included: high blood pressure, end stage renal disease (ESRD, chronic irreversible kidney failure), dementia and Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors). During an interview on 8/22/24 at 1:51 P.M. and on 8/26/24 at 1:17 P.M., the resident said the food was not too good and sometimes the food was cold. 5. Review of Resident #54's quarterly MDS, dated [DATE] showed: -Cognitively intact; -No swallowing disorders; -Diagnoses included heart failure, kidney failure, diabetes and high blood pressure. During an interview on 8/22/24 at 5:11 P.M., the resident said the food is always cold. 6. Review of Resident #36's admission MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

-No rejection of care;

-Diagnoses included urinary tract infection (UTI) and diabetes.

During an interview on 8/22/24 at approximately 2:44 P.M., the resident said the food was not good. When it arrived to his/her room, it was always cold. The facility offered choices, but the choices were not good. He/She ate the food because that was all that was offered.

7. Review of Resident #79's quarterly MDS, dated [DATE], showed:

-Cognitively intact;

-No behaviors;

-Diagnoses included anemia, UTI and malnutrition.

During an interview on 8/22/24 at 11:30 A.M., the resident said the food sucks, and You get what you get. Staff would come around with a menu but it was not honored. The food was often delivered cold and staff were not able to warm it up.

8. During an observation on 8/28/24 at 8:50 A.M., during meal service, a sample tray was removed from the meal service cart on the 200 Hall. The food temperatures showed:

-Sliced ham, 87 F;

-Scrambled eggs, 88.7 F;

-Hashbrown, 89 F;

-Buttered bread, hard to the touch.

9. During an observation on 8/28/24 at 9:28 A.M., a test tray was removed from the hall cart on the 500 unit at 9:28 A.M. The food temperatures showed:

-Scrambled eggs, 108.5 F;

-Sliced ham, 93.0 F;

-Oatmeal, 92.1 F;

-Hashbrown, 101.1 F.

10. During an interview on 8/28/24 at 3:02 P.M., the Dietary Manager said staff should ensure food was served on time and not served cold.

11. During an interview on 8/28/24 at 4:37 p.m., the Administrator said hot foods were to be served hot and cold food should be cold. The food should be palatable and served in a timely manner.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MO00232662 MO00226243 MO00225362 37681 42247 45083

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when staff failed to wear appropriate personal protective equipment (PPE), in accordance with the facility's policy, during high-contact activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, medical device care or use, and wound care) with residents on enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (an umbrella term for bacteria and other microorganisms that are resistant to antibiotics and other drugs designed to kill them) that employs targeted gown and glove use during high contact resident care activities) for five residents (Residents #79, #74, #19, #242 and #36). Furthermore, the facility failed to follow their incontinent care policy when staff provided perineal area care (cleansing between the legs and buttocks area) for three residents (Resident #79, 74, and #19). In addition, the facility failed to follow their Tuberculosis (TB, serious illness that mainly affects the lungs) policy for employees for six out of ten employees sampled. These failures had the potential to affect all residents in the facility. The sample was 18. The census was 78. Review of the facility's Enhanced Barrier Precautions Policy, reviewed on 6/3/24, showed: -EBP are indicated for residents with any of the following: -Wounds and/or indwelling (left inside the body) medical devices even if the resident is not known to be infected or colonized (germs on the body but do not make you sick) with a multidrug-resistant organism (MDRO, a bacterial infection that is resistant to multiple antibiotics, making it difficult to treat); -Wounds generally include chronic wounds; Examples of chronic wounds include, but are not limited to, pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction), diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers (ulcers caused by decrease in blood circulation); -Indwelling medical device examples include central lines (a long, flexible tube that's inserted into a vein near the heart); -Procedure: -The facility should develop a process to communicate which residents require the use of EBP for all high-contact resident care activities. The facility may choose to post signage on the door or wall outside of the resident room indicating the resident is on EBP; -Examples of high-contact resident care activities requiring gown and glove use include: -Bathing/showering; -Transferring; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter (drains urine from the bladder into a bag outside the body) and feeding tube (surgically inserted through the stomach wall and into the stomach to provide nutritional support); -Wound care: any skin opening requiring a dressing. Review of the EBP sign, undated, showed: -Everyone must clean their hands before entering and before leaving the room; -Providers and staff must also: wear gown and gloves for the following high contact resident care activities: -Bathing/showering; -Transfers; -Changing linens; -Providing hygiene; -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter and feeding tube. Review of the facility's Hand Hygiene Policy, revised 6/30/24, showed: Associates perform hand hygiene (hand washing, antiseptic hand wash and alcohol-based rub) (even if gloves are used) in the following situations: -Before and after contact with the resident; -After contact with body fluids; -After removing PPE (e.g., gloves, gown, eye protection, facemask). Review of the facility's Perineal Care of the Female Patient Policy, undated, showed: -Introduction: Perineal care, which includes care of the external genitalia and the anal area, should occur during the daily bath and if the patient is incontinent of urine or stool. The procedure promotes cleanliness and prevents infection; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Implementation: perform hand hygiene; put on gloves and as needed, other personal protective equipment to comply with standard precautions. -Using a washcloth: -Wet a washcloth with warm water from a running spigot (or from a clean and disinfected bath basin) and apply mild soap; -Separate the patient's labia with one hand; -Using gentle downward strokes, clean the perineal area from the front to the back; -Wet a clean washcloth and rinse thoroughly from front to back; -Pat the area dry with a bath towel; -Turn the patient onto the side, to expose the anal area; -Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back; -Using disposable cloth: -Open the package and remove a wet cloth; -Separate the patient's labia with one hand; -Using gentle downward strokes, clean from the front to the back of the perineum; -Turn the patient onto the side, to expose the anal area; -Using a new cloth, clean the anal area, starting at the posterior vaginal opening and wiping from front to back; -Completing the procedure; -After cleaning the perineum, perform hand hygiene, apply new gloves, apply a moisture-barrier skin protectant as needed; -Discard soiled articles in the appropriate receptacle; -Remove and discard your gloves and, if worn, other personal protective equipment; -Perform hand hygiene. Review of the Perineal Care of the Male Patient Policy, undated, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Introduction: Perineal care, which includes care of the external genitalia and the anal area, should occur during the daily bath and after urination and bowel movements in cases of incontinence. The procedure promotes cleanliness and prevents infection; -Implementation: perform hand hygiene; put on gloves and as necessary, other personal protective equipment to comply with standard precautions; -Wet the washcloth with warm water from a running spigot (or from a clean, disinfected bath basin) and apply mild soap; -Hold the shaft of the penis with one hand; -Wash the penis with the washcloth, beginning at the tip and working in a circular motion from the center to the periphery (outer edge); -Wet a clean washcloth and rinse the area thoroughly, using the same circular motion; -Wash the rest of the penis, using downward strokes toward the scrotum. If appropriate, rinse well and pat dry with a towel; -Clean the top and sides of the scrotum; if appropriate, rinse thoroughly and pat dry; -Turn the patient onto the side, if possible, to expose the anal area; -Clean the bottom of the scrotum and the anal area. If appropriate, rinse well and pat dry; -Using disposable cleaning cloths: -Open the package and remove a wet cloth; -Hold the shaft of the penis with one hand, use the other hand to clean the urethral meatus with the cloth; -clean the penis with the cloth, beginning at the tip and working in a circular motion from the center to the periphery; -Using downward strokes toward the scrotum, clean the rest of the penis; -Clean the top and sides of the scrotum; -Turn the patient onto the side, if possible, to expose the anal area; -Clean the bottom of the scrotum and the anal area; -After cleaning the perineum, perform hand hygiene, apply new gloves, apply a moisture-barrier skin protectant, as necessary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Tuberculosis- Testing and Screening (Associates, and Volunteers) Policy, dated revised: 6/28/2024, showed: -Missouri facilities should follow state regulation l9 CSR 20-20.100 that indicates that screening of residents on admission, and pre-employment and annual testing of associates and volunteers who work 10 hours or more per week; - All associates (and volunteers) are screened and tested for tuberculosis at the time of hire (baseline testing); - New associates or volunteers who have been made a conditional offer shall be screened for presence of infection through the following measures: pre-placement risk assessment and symptom evaluation. The facility should use the Individual TB risk assessment and symptom screening tool for non-residents unless a state tool is mandated; -The facility should also perform skin test for Mycobacterium (M, causative agent of TB). Tuberculosis using the Mantoux skin test (TST, a skin test to determine if someone has latent TB). Skin testing will employ the two-step procedure. (If the reaction to the first test is less than 10 millimeters (mm) induration (bump), a second test will be given 1-3 weeks later); -Individuals with a documented history of a positive TST will not undergo skin testing. They will, however, be required to bring documentation from their private physician or the local health department of their work-up following conversion (i.e., chest x-ray report). Employment may begin only after documentation attesting to the non-infectious nature of the associate has been received; -Individuals with documented history of a negative TST performed within the last 12 months need to receive only 1 intradermal injection (between the layers of skin) of Purified Protein Derivative (PPD). (NOTE: In this instance, the prior skin test serves as the first step of a two-step procedure); -Individuals with no documented history of a TST skin test within the last 12 months will undergo the two-step procedure. 1. Review of Resident #79's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 4/30/24, showed: -Cognitively intact; -Occasionally incontinent of urine. Review of the care plan in use at the time of survey, showed: -Focus: The resident has indwelling catheter related to diagnosis of neuropathic bladder (lacks bladder control due to brain, spinal cord, or nerve problem); -Goal: Will have no complications related to indwelling catheter use; -Interventions: EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's order summary, dated 8/28/24, showed, an order for EBP, diagnosis: Indwelling catheter, start date was 6/15/24. Observation on 8/26/24 at 5:24 A.M., showed a sign on the door for EBP. Certified Nurse aide (CNA) F and CNA I entered the resident's room wearing a face mask, performed hand hygiene and put gloves on. CNA I said the resident usually used a urinal during the night but last night he/she did not. The resident would need a complete bed change. CNA F used a washcloth and cleaned the resident's front peri area in a circular motion, then CNA F wrung the washcloth out over the resident's front perineal area. He/She then used disposable wet wipes to finish cleaning the area. CNA F used the same gloves and one washcloth to wash the resident's upper body and face. Neither CNA wore a gown while providing care to the resident and did not change gloves between dirty and clean. 2. Review of Resident #74's admission MDS, dated [DATE], showed: -Should brief interview for mental status be conducted? No; -Had short- and long-term memory problem; -Diagnoses included: gastrostomy tube (g-tube, feeding tube). Review of the care plan in use at the time of survey, showed: -Focus: The resident required tube feeding related to dysphagia (difficulty swallowing); -Goal: The resident will remain free of side effects or complications related to tube feeding through review date; -Interventions: EBP. Review of the physician order summary, dated 8/28/24, showed an order for EBP, diagnosis: G-tube. Observation on 8/26/24 at approximately 5:15 A.M., showed a sign on the door for EBP. CNA I and CNA F entered the resident's room, performed hand hygiene, and put gloves on. The resident was lying in bed with an abdominal binder (used to secure a G-tube, and provide support and stability during physical activity) on above the G-tube. Staff cleaned the front part of the perineal area, rolled the resident towards the window, then removed the brief and cleaned the back side. Staff put a clean sheet and pad on half the bed and tucked a clean brief under the resident, then rolled the resident towards the door and removed the soiled linens from the bed and placed in a bag. Staff then straightened out the linens and brief, rolled the resident onto his/her back and fastened the brief. With the same gloves on, staff reached inside the resident's drawers, then took a towel and wiped the resident's mouth; -Staff did not wear a gown while proving care and did not change their gloves when going from dirty to clean. 3. Review of Resident #19's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Current number of unhealed pressure ulcers; unstageable (unable to visualize wound bed): one. Review of the physician's order summary, dated 8/28/24, showed an order for EBP, diagnosis: wound. Observation on 8/26/24 at approximately 5:02 A.M. showed CNA I and CNA F entered the resident's room. There was a sign on the door for EBP. Both CNAs had a face mask on, performed hand hygiene and put gloves on. CNA F put peri-wash on a washcloth and started to wash the resident's suprapubic area (region of abdomen located below the umbilical region) in a circular motion. CNA I instructed CNA F to hand him/her a washcloth with peri-wash on it and CNA I provided instructions on how to provide perineal care as he/she provided the care to the resident. Neither CNA wore a gown while providing care to the resident. 4. Review of Resident #242's medical record, showed: -Alert and able to make needs known; -Diagnoses included: endocarditis (a life-threatening inflammation of the inner lining of the heart's chambers and valves). Review of the physician's order summary, dated 8/23/24, showed: -An order for: Observe peripherally inserted central catheter (PICC, a thin flexible tube inserted into a vein in the upper arm and threaded into a large vein in the upper chest) line insertion site every shift for signs and symptoms of infection, notify Medical Doctor (MD) accordingly; -An order for: PICC gauge: 22; total length: 40; number of lumens (outside the body the PICC line splits into 1, 2 or 3 tubes): 3; type of infusion: continuous, intermittent, total parenteral nutrition (TPN, a special formula given through a vein provides most of the nutrients the body needs), Peripheral parenteral nutrition (PPN, a medical abbreviation for supplemental nutrition administered intravenously to patients who are unable to get enough nutrients from food), maintenance. Observation on 8/23/24 at 8:18 A.M., showed: -Licensed Practical Nurse (LPN) J entered the resident's room, wearing a face mask and flushed the PICC line; -There was no sign on the door indicating the resident was on EBP and staff did not wear a gown when he/she flushed the PICC line. 5. Review of Resident #36's admission MDS, dated [DATE], showed: -Cognitively intact; -Dependent with toileting and personal hygiene; -Indwelling catheter; -Has pressure ulcers ; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Westchester House, The		STREET ADDRESS, CITY, STATE, ZIP CODE 550 White Road Chesterfield, MO 63017	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included: Progressive neurological disorder (conditions where there is a progressive deterioration in functioning), urinary tract infection, diabetes, high blood pressure. Review of the physician's order summary, dated 7/18/24, showed orders for EBP, diagnoses: Catheter, and wounds. Observation on 8/27/24 at 10:16 A.M., showed CNAs B and K entered the resident's room to weigh the resident using mechanical lift with scale. The resident had bowel incontinence and both CNAs provided perineal care. Neither CNA wore gowns while providing the care. 6. During an interview on 8/28/24 at 8:45 A.M., Certified Medication Technician (CMT) N said residents with wounds were on EBP. He/She would know which residents were on EBP because there would be a sign on the door. Staff were to wear face masks, gowns and gloves while providing direct care. 7. During an interview on 8/28/24 at 8:59 A.M., CMT O said he/she would know which residents were on EBP because there would be a sign on the door and a cart outside the door. Residents are on EBP because they have a catheter, wound or they are on antibiotics. PPE should be worn every time staff enter the resident's room. 8. During an interview on 8/28/24 at 12:53 P.M., LPN D said staff know if a resident was on isolation because there would be a sign on their door. Staff should wear a face mask, gown, and gloves while providing direct care to the residents who were on EBP. 9. During an interview on 8/28/24 LPN A said EBP was used for residents with feeding tubes, catheters, and wounds. Staff should wear face mask, gown and gloves while providing peri care, wound care, and g-tube feedings. He/She was not sure if staff needed to wear PPE while assisting residents with transfers. 10. Review of Employee AA's employee file, showed: -Date of hire: 8/7/24 -There was no documentation showing the employee received a 2 step TST. Review of Employee BB's employee file, showed: -Date of hire: 7/25/24; -There was no documentation showing the employee received a 2 step TST. Review of Employee CC's employee file, showed: -Date of hire: 7/10/24; -There was no documentation showing the employee received a 2 step TST. Review of Employee DD's employee file, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester House, The	550 White Road Chesterfield, MO 63017

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Date of hire: 3/6/24; -There was no documentation showing the employee received a 2 step TST. Review of Employee EE's employee file, showed: -Date of hire: 1/17/24; -There was no documentation showing the employee received a 2 step TST. Review of resident FF's employee file, showed: -Date of hire: 1/10/24; -1st TST was documented as given on 1/10/24; -There was no documentation showing the results of the 1st TST and there was no documentation showing a second TST was completed. 11. During an interview on 8/28/24 at 4:36 P.M., the Administrator said she would expect for staff to change their gloves and perform hand hygiene when going from dirty to clean and follow the facility's policies and procedures on proper perineal care. She would expect for staff to wear PPE per the facility's policy. She would expect for staff to have their TB testing completed according to the policy. 45083