STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265341	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillars of North County Health & Rehab Center, The	13700 Old Halls Ferry Road Florissant, MO 63033

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39857 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure the call light was within reach for two of 22 sample residents (Resident (R) 163 and R34) reviewed for accommodation of needs and preferences. This failure had the potential to cause R163 and R34 to have unmet care needs. Findings include: 1. Review of R163's Face Sheet located under the Profile tab of the electronic medical record (EMR), revealed R163 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease and chronic obstructive pulmonary disease. Review of R163's entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/25 and located under the RAI (Resident Assessment Instrument) tab, showed there had been no assessment of R163's cognition prior to her passing on 03/18/25. Review of R163's Progress notes, dated 03/07/25 through 03/18/25 and located under the Assessments tab of the EMR, revealed documentation the resident had multiple falls during her stay. Review of R163's Care Plan located in the EMR under the Care Plan tab and last revised 03/14/25, revealed R163 was at risk for falling, due to history of falls, cognitive impairments, decreased safety awareness, required assistance of daily living (ADL) assistance with transfers and mobility, incontinence. - 03/11-Had an unwitnessed fall, found by staff, no injuries. 03/12- Had an unwitnessed fall, bruise to face. During an observation and interview on 03/18/25 at 10:10 AM, R163 was observed lying in her bed. Her call light was clipped to the privacy curtain approximately three feet out of reach. R163 did not know where her call light was. Her daughter was present and retrieved the call light, her daughter revealed the call light was usually clipped to the curtain when she came in each morning. During an observation on 03/18/25 at 2:30 PM, the call light was observed clipped to the privacy curtain, out of sight, and out of reach of the resident. 2. Review of R34's Face Sheet located under the Profile tab of the EMR, revealed R34 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, and epilepsy. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Pillars of North County Health & Rehab Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 13700 Old Halls Ferry Road Florissant, MO 63033	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R34's significant change MDS with an ARD of 01/29/25 and located under the RAI (Resident Assessment Instrument) tab, revealed R34 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R34 was moderately cognitively impaired. Review of R34's Progress notes, dated 03/07/25 through 03/18/25 and located under the Assessments tab of the EMR, revealed documentation the resident had several recent falls. Review of R34's Care Plan located in the EMR under the Care Plan tab and last revised 02/18/25, revealed R34 was at risk for injuries due to history of falls with injuries, had a displaced intertrochanteric fracture of right femur, and subsequent encounter for closed fracture with routine healing. During an observation on 03/18/25 at 10:35 AM, R34 was observed lying in his bed watching television. His call light was draped over the light affixed to the wall over the bed, out of reach of R34. During an observation on 03/18/25 at 2:45 PM, the call light remained draped over the light affixed to the wall, over R34's bed out of sight, and out of reach of the resident. During an observation on 03/19/25 at 9:30 AM, the call light remained draped over the light affixed to the wall, over R34's bed out of sight, and out of reach of the resident. During an observation and interview on 03/19/25 at 10:10 AM, Licensed Practical Nurse (LPN) 1 stated that residents' call lights should be within reach. Upon observation of R34's call light hanging over the light fixture, she confirmed that it was improperly placed and out of reach of the resident. LPN1 said she would place it back within reach of R34. LPN1 stated that all staff were responsible for ensuring call lights were accessible. During an interview on 03/19/25 at 11:00 AM, Registered Nurse (RN) 1 confirmed that all staff were responsible for ensuring call lights were in reach of the residents.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40415 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure one of ten residents (Resident (R) 55) reviewed for bathing had his preference of bathing type of 22 sample residents. The failure affected R55's right to make choices and honor preferences. Findings include: Review of facility policy titled, Resident Rights, dated 08/31/23, indicated The resident has the right to accommodations of residents need and preferences . The resident has the right to make choices that are significant to the resident . Review of R55's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he admitted on [DATE] with diagnoses including, quadriplegia, C5-C7 incomplete, depression, and hypertension. Review of R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, located under the MDS 3.0 Resident Assessments tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated he was cognitively intact. The importance of bath choice was marked, indicating the bath of his choice was very important to R55. Review of R55's care plan, dated 10/22/24 and located under the Care Plan tab of the EMR did not address R55's bath type or shower preferences. Review of daily shower sheets for January 2025, February 2025, and March 2025, provided by the facility, revealed R55 had received a bed bath on regular scheduled days. During an observation and interview on 03/20/25 at 4:20 PM R55 was sitting up in wheelchair at bedside with bed prepared with pads and towels for a bed bath. R55 stated he told his Certified Nurse Assistant (CNA) he wanted a shower, and she replied, the shower bed was broken. During an interview 03/20/25 at 4:25 PM, CNA9 revealed she was going to give R55 a bed bath. When asked if she knew he preferred a shower she stated she did, but the shower bed was broken, and he would not use the shower chair. During an interview on 03/21/25 at 4:41 PM CNA8 revealed she was told by R55 that he had gotten a bed bath when he wanted a shower. She stated she knew R55 preferred a shower and not a bed bath, but the shower bed was broken. She stated R55 did not feel comfortable using the shower chair because it did not have any leg rests, and his legs drag because he did not have any control of them. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 3:54 PM, the Maintenance Director (MD) stated he did not know of any concerns with the shower bed until the evening of 03/09/25 when he was notified by a staff member by phone that all four of the wheels on the shower bed were missing. He stated he notified the Administrator on the morning of 03/10/25 and she ordered the wheels the same morning. He stated the wheels came in on 03/11/25 and he put them on the shower bed. The Administrator provided the invoice, and the MD provided the facilities maintenance logs with weekly checks of the Hoyer lifts and shower chair and bed, and no concerns were noted. MO00250981

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on interviews, record review, and policy review, the facility failed to implement policies and procedures for ensuring the reporting of an allegation of abuse to the Administrator and to the State Survey Agency (SSA) for one of three residents (Resident (R) 24) reviewed for abuse of 22 sample residents. These failures placed residents at risk of continued verbal abuse, which could cause depression, fear, or mental anguish. Findings include: Review of the facility's undated policy titled, Staff Obligations to Prevent & Report Abuse, Neglect, and Theft, dated 12/26/16, revealed The facility will report to the State agency .any incident of alleged abused [sic], neglect, exploitation, or mistreatment .The alleged violations are to be reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Staff are obligated to report to the administrator of the facility and to other officials . Review of R24's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed she admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, vascular dementia, fibromyalgia, depression, and anxiety. Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/16/25, located under the MDS 3.0 Resident Assessments tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she was cognitively intact. The assessment revealed R24 did not exhibit mood symptoms but exhibited verbal behavioral symptoms directed toward others several times a week but less than daily. Review of R24's Care Plan, dated 06/01/24 and located under the Care Plan tab of the EMR, revealed [R24] exhibiting problems as seen by: Verbally Abusive, Socially Inappropriate and Disruptive. The approaches included: Provide meds [medications] as ordered and monitor effectiveness .Encourage family support and/or involvement .[and] Psychiatric consult as needed .Encourage [R24] to keep involvement in activities of choice .[and] Encourage [resident] to vent feelings, fears, frustrations PRN [as needed]. During an interview on 03/18/25 at 3:24 PM, R24 stated a female Certified Nurse Aide (CNA) on the night shift cussed me out. She stated the CNA cursed at her and was mean and nasty. R24 stated this happened about two or three weeks ago and she had reported the situation to the Activity Director (AD). The resident added she did not recall the CNA's name, but stated the CNA still worked with her most nights and she would know the CNA when she saw her. R24 stated this situation made her angry. During an interview on 03/18/25 at 3:42 PM, the Administrator stated no incidents of abuse had been reported to the SSA in 2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/18/25 at 3:49 PM, the AD stated R24 had mentioned to her on 03/13/25, during the Resident Council meeting that she and a night shift CNA had words and the CNA was cussing. The AD added R24 could not tell her when the incident occurred or the name of the CNA. The AD stated she had not done anything further to investigate the allegation and she shared this allegation with the Social Services Director (SSD) for follow-up. During an interview on 03/18/25 at 4:24 PM, the SSD stated the AD mentioned to me this morning that R24 made an allegation of being cussed out by a CNA. The SSD stated she did not hear of the allegation until 03/18/25 and she passed the information on to the Administrator to begin the reporting and investigation process. The SSD added that R24 had a history of making false accusations and was unable to recall any details, dates, or names associated with the allegation. The SSD stated this allegation should have been reported to the Administrator immediately for follow-up when it was made on 03/13/25. During an interview on 03/18/25 at 4:33 PM, the Administrator stated she did not know the allegation was made on 03/13/25 and stated her expectation was that the allegation be reported to her immediately when it was made for appropriate follow-up, including notification to the SSA. The Administrator stated she had interviewed R24, and the resident was able to identify the alleged CNA by description, and CNA6 was suspended pending investigation. MO00251300

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52322 Based on record review and interviews, the facility failed to obtain a level two pre-admission screening and resident review (PASARR) assessment for one of one residents (Resident (R) 19) reviewed for PASARR of 22 sample residents. This failure could affect R19 from receiving services to assist in the treatment of psychiatric diagnoses. Findings include: Review of the Admission Referral Paperwork located in the Document tab of the EMR, dated 03/18/24, revealed R19 had diagnosis which included anxiety disorder 02/03/17, schizoaffective disorder 11/24/23, and major depressive disorder 03/29/22. Review of the Face Sheet located in the Profile tab of the EMR revealed R19 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder, anxiety disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/24, revealed R19 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R19 was moderately cognitively impaired. Review of the PASARR Level One located in the Document tab of the electronic medical record EMR, dated 02/10/17, revealed R19 had a level one PASARR which did not reflect new psychiatric diagnoses of schizoaffective disorder, major depressive disorder, and anxiety disorder. Review of the Progress Note, dated 05/19/24 and located in the Progress Note tab of the EMR, revealed R19 was transferred to the psychiatric hospital for evaluation due to combativeness with staff and exit seeking in the facility. Review of the Care Plan problem located in the Care Plan tab, dated 01/22/25, revealed . [named R19] experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). [named R19] has episodes of paranoia r/t [related to] past life events. [named R19] thinks that someone is coming in the facility to cause him harm and he periodically attempts to exit seek. [named R19] uses inappropriate language and threatens staff at times. [named R19] pulls his clothing off the hangers and out of the closets and puts them on the floor . During an interview on 03/19/25 at 2:24 PM, the Social Service Director (SSD) confirmed R19 did not have a level two PASARR assessment. The SSD expected to be notified to redo a PASARR for R19. Further interview revealed the SSD suspected the psychiatric diagnoses were present before admittance to the facility. During an interview on 03/21/25 at 4:28 PM, the Administrator stated she did not know R19 had admitted with the diagnoses which would qualify the resident to be reevaluated for level two PASARR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 26006 Based on interview, record review, and policy review, the facility failed to ensure a comprehensive Care Plan was developed for two of 25 sampled residents (Resident (R) 111 and R27) to address R111's pain and R27's dependence on staff for activities of daily living (ADLs). These failures had the potential to contribute to inadequate or inappropriate pain intervention for R111 and lack of provision of ADL care for R27. Findings include: Review of the facility policy titled, Resident Assessment Instrument, dated November 2017, revealed, Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning .Within seven (7) days of the completion of the resident assessment, a comprehensive care plan will be developed. 1. Review of R111's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he admitted to the facility on [DATE] with diagnoses including arthritis, pain in the left hip and right hand, muscle weakness, and general pain. Review of R111's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/25 and located under the MDS 3.0 tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. He received pain medication and non-pharmacological pain approaches and did not have pain upon assessment. During an interview on 03/18/25 at 3:07 PM, R111 stated his pain had increased over the last few days in his hip, and he was receiving morphine and Tylenol to control the pain. Review of R111's Orders tab of the EMR revealed a physician's order, dated 02/19/25, for acetaminophen, 1, 000 milligrams (mg) three times a day as needed for pain and a physician's order, dated 02/20/25, for morphine, 15mg twice a day for pain. Review of the Care Plan tab of R111's EMR revealed there was no Care Plan addressing pain, non-pharmacological pain interventions, and pain medication use. During an interview on 03/21/25 at 2:25 PM, the MDS Coordinator (MDSC) stated the resident had diagnosis of pain, used scheduled morphine, and should have had a pain Care Plan in place to ensure individualized and appropriate pain intervention. The MDSC stated the pain Care Plan should have been there but was forgotten. 2. Review of R27's Face Sheet located under the Face Sheet tab of the EMR, revealed she admitted on [DATE] with diagnoses including congestive heart failure, anxiety, glaucoma, and adult failure to thrive. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R27's admission MDS with an ARD of 01/09/25 and located under the MDS 3.0 tab of the EMR, revealed a BIMS score of seven out of 15 indicating severely impaired cognition. R27 was dependent on staff for oral hygiene, toileting hygiene, showering, dressing, and personal hygiene. She required substantial/maximal assistance with eating. R27 required substantial/maximal assistance with bed mobility and was dependent on staff for transfers and mobility. Review of the Care Plan tab of R27's EMR revealed there was no Care Plan addressing her need for assistance with ADLs. During an interview on 03/21/25 at 2:31 PM, the MDSC stated R27 was totally dependent on staff for ADLs, and this should have been included in the Care Plan. She stated an ADL Care Plan would be added.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39857 Based on observations and interviews, the facility failed to ensure nail care was provided for one of 22 sample residents (Resident (R) 34) reviewed for activities of daily living (ADL). This failure had the potential to cause R34 to have unmet care needs. Findings include: Review of R34's Face Sheet located under the Profile tab of the electronic medical record (EMR), revealed R34 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, chronic obstructive pulmonary disease, and epilepsy. Review of R34's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/25 and located under the RAI (Resident Assessment Instrument) tab, reveal R34 has a Brief Interview for Mental Status (BIMS) of 12 out of 15 which indicated R34 was moderately cognitively impaired. Review of R34's Care Plan located in the EMR under the Care Plan tab and last revised 02/27/25, revealed Resident is totally dependent on nursing for all aspects of care .Resident will be kept well groomed, free of odors and clean and dry through to next care plan review. During an observation and interview on 03/18/25 at 10:35 AM, R34 was observed lying in his bed watching television. R34's fingernails were noted to be greater than half an inch over his fingertips. When asked if he preferred long nails, R34 stated no I want them trimmed. During an observation on 03/19/25 at 9:30 AM, R34's nails remained greater than half an inch over his fingertips. During an observation and interview on 03/19/25 at 10:10 AM, Licensed Practical Nurse (LPN) 1 was asked to enter R34's room and look at R34's fingernails. LPN1 stated that R34 was on hospice so the hospice aide should have trimmed R34's nails. LPN1 was asked who was responsible for trimming a resident's nails if the hospice didn't, LPN1 stated they were, and stated she would get R34's nails trimmed. During an interview on 03/20/25 at 2:00 PM, Certified Nurse's Assistant (CNA) 4, was asked who was responsible for trimming a resident's nails if hospice didn't, CNA4 stated we are, unless the resident is diabetic then the nurse will trim the resident's nails. During an interview on 03/20/25 at 2:15 PM, CNA3 was asked who was responsible for trimming a resident's nails if hospice didn't, CNA3 stated we are, unless the resident is diabetic then the nurse will trim the resident's nails. During an interview on 03/20/25 at 2:30 PM, LPN3 was asked who was responsible for trimming a resident's nails if hospice didn't, LPN3 stated we are, unless the resident is diabetic then the nurse will trim the resident's nails.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40415 Based on observations, interviews, and record review, the facility failed to ensure one of 22 sample residents (Resident (R) 55) reviewed for appointments had scheduled physician's appointments. The failure increased R55's risk of delayed medical care. Findings include: Review of R55's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he admitted on [DATE] with diagnoses including, quadriplegia, C5-C7 incomplete, depression, and hypertension. Review of R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, located under the MDS 3.0 Resident Assessments tab of the EMR, revealed a Brief Interview for Mental Status (BIMS)' score of 14 out of 15 which indicated he was cognitively intact. During an observation and interview on 03/20/25 at 4:00 PM, R55 stated he had an appointment that he was unaware he had and at the last minute he was notified so needed to get ready. R55 pointed to white board on wall that had his appointments written on it and his phone that he verbally commanded appointment reminder. R55 indicated he told Registered Nurse (RN) 1 he did not have time to get ready and was not prepared. During a phone interview on 03/20/25 at 4:15 PM, Spinal Orthopedic Scheduler (SOS) indicated that the appointment was originally scheduled as a follow up appointment for 03/18/25 and on 02/27/25 the appointment was rescheduled for 03/20/25 at 2:00 PM due to a scheduling conflict with the Spinal Orthopedic office. During an interview on 03/20/25 at 4:30 PM, RN1 indicated she was assigned to R55 and stated she was aware of R55 having an appointment on 03/20/25 at 2:00 PM and had forgotten about the appointment. RN1 indicated the night nurse routinely pulled the appointment sheets from the appointment binder located on the Nurses Station desk and gave it to the oncoming nurse in report and due to having a contract nurse the night of 03/19/25 she was unaware of the process for appointments. I attempted to reach contract nurse but was not successful. RN1 indicated she was reminded of R55 appointment at 1:30 PM and went to R55 room to inform him of the appointment and due to R55 being total care and not knowing previously of the appointment R55 refused as he did not have time to get ready and was not prepared. The appointment sheet was verified as in the appointment binder. During an interview on 03/21/25 at 10:00 AM Reception (REC) indicated she took the call on 02/27/25 to reschedule appointment for R55, wrote it on the appointment sheet and placed a copy in the master notebook she kept at her desk and put a copy in the appointment book at the Nurses Station for the 300-hall. When asked who notified R55 of his appointments she replied, no specific person. MO251413

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NAME OF PROVIDER OR SUPPLIER: Pillars of North County Health & Rehab Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 13700 Old Halls Ferry Road Florissant, MO 63033	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on interview, record review, and policy review, the facility failed to ensure one of three residents (Resident (R) 32) reviewed for dialysis received as-needed medication as ordered and her physician was notified when a dialysis appointment was missed of 22 sample residents. These failures had the potential to cause significant risks, including increased mortality, hospitalization , and cardiovascular complications, due to the buildup of toxins and fluids in the body. Findings include: Review of the facility policy titled, Care of a Resident with End-Stage Renal Disease, dated November 2017, revealed Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care .Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. The policy did not address procedures for missed dialysis appointments. Review of R32's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed she admitted to the facility on [DATE] with diagnoses including end-stage renal disease, anemia, and malnutrition. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/25 and located under the MDS 3.0 tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognition. R32 received dialysis. During an interview on 03/19/25 at 4:24 PM, R32 could not recall if she missed any dialysis appointments. Review of R32's Care Plan, dated 04/18/22 and located under the Care Plan tab of the EMR, revealed, [R32] is at risk for complications due to End Stage Renal Disease & Hemodialysis therapy. [R32] attends .on Tuesdays, Thursdays, and Saturdays for dialysis. Transportation arrives at 0930. The approaches included providing a therapeutic diet, monitoring labs, observing for infections or complications, and If transportation has not arrived by scheduled time; (not after dialysis appointment) Please inform sister. Review of the Orders tab of R32's EMR revealed a physician's order, which originated on 12/24/22, for one packet of Lokelma (for treatment for high levels of potassium in the blood) powder as needed for missed dialysis days. Review of R32's Progress Notes tab of the EMR revealed there was no documentation on 03/01/25 to indicate a missed dialysis appointment. During an interview on 03/18/25 at 2:29 PM, the Administrator stated the facility van was broken and R32 had to rely on Medicaid transportation to dialysis appointments. The Administrator stated on 03/01/25, R32 missed a dialysis appointment because transportation did not show up. She added R32 did not have any health concerns related to the missed dialysis appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R32's March 2025 Medication Administration Record (MAR), located under the Reports tab of the EMR, revealed the Lokelma was not administered on 03/01/25. During a telephone interview on 03/21/25 at 1:20 PM, the Dialysis Center Social Worker (DSW) stated R32 missed her dialysis appointment on 03/01/25. She stated the corresponding note was Cancelled - patient related. During an interview on 03/21/25 at 4:04 PM, the Director of Nursing (DON) stated if a resident missed a dialysis appointment, she would expect a note to be documented in the EMR, the physician to be notified, and for R32, Lokelma to be administered as ordered. The DON stated she was not aware of R32's missed appointment on 03/01/25. During an interview on 03/21/25 at 4:30 PM, Licensed Practical Nurse (LPN) 3, who worked with R32 on 03/01/25, stated R32 missed dialysis on 03/01/25 because her transportation did not show up. LPN3 stated she did not document the missed appointment and did not notify the physician of the missed appointment. LPN3 stated she did not administer Lokelma to R32 on 03/01/25 because she did not know about the order. LPN3 stated since the order was not scheduled, and she typically did not look at all the as-needed medications for each resident, she did not know it needed to be administered. LPN3 stated the Lokelma should have been given on 03/01/25.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observation, interview, record review, and policy review, the facility failed to ensure one of one resident (Resident (R) 14) reviewed for dental was provided with a visit to the dentist as ordered by the physician to address a mouth infection of 22 sample residents. This failure had the potential to lead to spread of infection, increased pain, and difficulty eating for R14. Findings include: Review of the facility's policy titled, Dental Examination/Assessment, dated July 2014, revealed 1. Prior to, or within ninety (90) days after admission, the resident shall undergo a dental examination. 2. Dental examinations will be made by the resident's personal dentist or by the facility's Consultant Dentist. 3. Records of dental care provided shall be made a part of the resident's medical record. 4. Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist. Review of R14's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he admitted on [DATE] with diagnoses including ulcerative oral mucositis and cirrhosis. Review of R14's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/06/25 and located under the MDS 3.0 tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. He did not have any oral problems. During an interview on 03/18/25 at 10:45 AM, R14 stated he needed to see a dentist because he had rotten teeth, missing teeth, and a broken tooth in front. R14 stated he had an oral abscess which was painful. He stated the physician prescribed antibiotics and said he should see a dentist, but he had not heard anything further about seeing the dentist. R14 added he was chewing his food on one side of his mouth and really needed to get his teeth taken care of. R14's mouth was observed with several missing teeth on one side and a broken tooth on the top front. Review of R14's Nurse's Note, dated 01/23/25 and located under the Progress Notes tab, revealed, [Physician] visited today, new orders received for Dentist appointment ASAP [as soon as possible] r/t [related to] tooth/gum infection, Orajel [pain ointment] to gums QID [four times a day] prn [as needed] for soreness et [and] Augmentin [antibiotic] 500 mg PO [orally] BID [twice daily] x 7 days. Review of a Physician's Orders sheet in R14's hard chart at the nurses' station revealed a handwritten physician's order, dated 01/23/25, for dentist appointment ASAP. Review of R14's hard chart at the nurses' station and Resident Documents tab of the EMR revealed there was no record of a dental visit. During an interview on 03/21/25 at 2:11 PM, the Social Services Director (SSD) stated she was not aware of the physician's order to see a dentist on 01/23/25. The SSD stated the nursing staff typically communicated a need to see a dentist either to her for in-house services or to the receptionist if an outside appointment needed to be made. The SSD stated R14 had not seen a dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 3:20 PM, the receptionist stated she never received information requesting a dental appointment for R14. During an interview on 03/21/25 at 4:05 PM, the Director of Nursing (DON) stated the nurse who reviewed and signed off on the physician's order for a dental appointment should have communicated the information to the SSD or receptionist for follow up. She stated R14 had not seen the dentist.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52322 Based on observation, record review, interviews, and facility recipe review, the facility Dietary [NAME] (DC) failed to ensure the puree chicken lunch entree was proper texture for four of four residents (Resident (R) 6, R13, R39, and R262) reviewed for pureed diet of 22 sample residents. This failure had the potential to make the entree unpalatable and difficult to swallow for the residents who required a puree meal. Findings include: Review of the Chicken Maple Glazed Puree Thick recipe found in the dietary department recipe folder for week five lunch, dated 10/15/24, revealed .Maple Glazed Chicken 10 serving 1 breast. Chicken Base 1 1/8 teaspoon. Water 1 cup 2 tablespoons. Food Thickener 2 2/3 cup. WASH HANDS. 1. Place prepared Maple Glazed Chicken into food processor. 2. Add broth and process until smooth in texture. 3. Add food thickener and process 4. briefly until mixed. scrape down sides with spatula and reprocess. Pour into the steam table pan coated with cooking spray. Cover tightly and heat in conventional oven at 350 Fahrenheit until temperature reaches .145 Fahrenheit: Final Internal cooking F. Temperature Must Reach a minimum of 145 degrees F, Held for minimum of 15 seconds. Let set 5-10 minutes before serving .Portion one #8 scoop of pureed Maple Glazed Chicken per serving . 1. Review of R6's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, revealed R6 was admitted to the facility on [DATE] with diagnoses which included quadriplegia and traumatic brain injury. R6 required a mechanically altered diet. Review of the Order Report located in the electronic medical record (EMR) under Orders tab, dated 12/27/23, revealed R6 was ordered a .thin/puree (Reg) regular as tolerated . 2. Review of R13's annual MDS with an ARD of 01/03/25, revealed R13 was admitted to the facility on [DATE] with a diagnosis which included cerebral palsy. R13 required a mechanical altered diet. Review of the Order Report located in the EMR under Orders tab, dated 12/13/24, revealed R13 required a . thin/Puree (reg) as tolerated . 3. Review of R39's quarterly MDS with an ARD of 01/25/24, revealed R39 was admitted to the facility on [DATE] with a diagnosis of Malnutrition. R39 required a mechanical altered diet. Review of the Order Report located under the Orders tab of the EMR under Orders tab, dated 03/20/25, revealed R39 required a regular puree diet with thin liquids. 4. Review of R262's Face sheet located under the Face Sheet tab of the EMR revealed R262 was admitted to the facility on [DATE] with a diagnosis of dysphagia. Review of the Order Report dated 03/01/25 and located under the Orders tab of the EMR, revealed R262 required a regular, puree, diet with nectar thick liquids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation in the kitchen at the steam table on 03/20/24 at 12:39 PM, revealed a tray of puree chicken that contained water surrounding the chicken. During an interview on 03/20/25 at 1:46 PM, the DC confirmed she did not use thickener for the puree chicken. The Dietary Aide (DA) stated honestly I forgot. There was a lot going on just I forgot. During an interview on 03/20/25 at 1:50 PM, the Dietary Manager (DM) stated I noticed it (puree chicken). We have the thickener gel we could have just mixed it up. It should have been made right. During an interview on 03/21/25 at 4:10 PM, the Administrator stated she expected the DC to follow the recipe to make puree chicken.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40415 52322 Based on observations, interviews, and facility policy review, the facility failed to maintain the walk-in refrigerator at 41 degrees Fahrenheit (F) or below during two of two observations in one of one kitchen of 55 of 71 census residents which could have caused food spoilage and failed to distribute and maintain clean water pitchers for three of three residents (Resident (R) 47, R61, and R38) observed for cleanliness. This failure had the potential to affect resident safety. Findings include: Review of the facility's policy titled, Safe Food Preparation and Safe Handling, dated January 2012, revealed . Food will be prepared to conserve maximum nutritive value in a safe and sanitary environment . Review of the 2022 Food and Drug Administration Food Code, dated 01/18/23, and located at https://www.fda.gov/media/164194/download?attachment, page 3-28, revealed Time/ temperature control for safety food shall be maintained .at 41 degrees F or less. Review of the facility's policy titled, Bedside Water Containers, dated February 2012, revealed Bedside water containers will be cleaned and sanitized daily. 1. The food service department will maintain a minimum supply of two (2) complete water container sets for each resident. 2. The nursing staff is responsible for replacing the dirty complete water container set with a clean set and placing the set outside the kitchen door. 3. Food service will collect the dirty sets . wash, rinse and sanitize them. Food service will also return a complete sanitized water container set .outside the kitchen on a covered rack for access by nursing staff. 1. Observation in the kitchen on 03/18/25 at 9:34 AM, revealed no walk-in refrigerator temperatures were recorded on temp log since 03/16/25. During an interview, the Dietary Manager (DM) stated the Dietary [NAME] (DC) would put in the temperatures each shift. I normally come and check it. We have to catch up two days. Observation in the kitchen on 03/18/25 at 9:42 AM, revealed the walk-in refrigerator thermometer read 46 degrees F. Observation and interview in the kitchen with the DM on 03/18/25 at 5:09 PM revealed the walk-in refrigerator thermometer read 42 degrees F. The DM stated the walk-in refrigerator temperatures were supposed to be checked and recorded during the weekend. If the thermometer was not up to temperature, they should have called me to call someone to check and service the refrigerator. During an interview on 03/21/25 at 4:02 PM, the Administrator stated she expected the refrigerator to be at the desired temp and the staff monitor the temps daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 03/18/25 at 11:24 AM revealed R47's water container was on his bedside table with unknown brown substance on the side of the container. Observation on 03/18/25 at 12:28 PM revealed R61 drinking out of his water container with unknown brown substance on the handle. Observation on 03/18/25 at 11:17 AM revealed R38's water container was in the bathroom on the back of the toilet tank noted with brown unknown substance on handle and side of container. During an interview on 03/21/25 at 3:58 PM, the Dietary Manager (DM) stated the water pitchers are to be cleaned every morning and to my knowledge the pitchers are washed every day. I am not always in the kitchen as I have a lot of responsibilities, and I am not completely up to date with all the policies. DM also stated, We do not have two complete water container sets for each resident and do not have space for them. During an interview on 03/21/25 at 3:57 PM, the Activities Director (AD) stated it was the responsibility of the nursing and dietary staff to make sure the water containers were cleaned.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on interview, record review, and policy review, the facility failed to ensure three of 22 sample residents (Resident (R) 2, R32, and R7) had accurate physician's orders. These failures had the potential to affect provision of hospice services for R2, provision of dialysis and communication with the dialysis center for R32, and provision of restorative services for R7. Findings include: Review of the facility's policy titled, Obtaining and Following Physician Orders, dated July 2014, revealed Physician orders will be obtained by licensed personnel and followed. If the licensed professional does not in his/her best judgment think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order. If those orders are not followed for any reason, the Physician and Director of Nursing will be promptly notified. Procedure: 1. Physician orders may be obtained by: a. The physician visiting and writing the order. b. The physician visiting and giving a verbal order. c. The facility contacting the physician via phone. d. The facility contacting the physician via fax. 2. Obtain the order. 3. Completed a telephone order slip for verbal or telephone orders. Follow the Telephone Order. 1. Review of R2's Face Sheet located under the Face Sheet tab of the EMR revealed R2 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease. Review of the significant change MDS with an ARD of dated 12/18/24, revealed R2 had a BIMS score 11 out of 15 which indicated R2 was moderately cognitively impaired. Review of the physician orders, dated 06/07/23 and located in the Order tab of the EMR, revealed .Hospice Evaluation and Treat . During an interview on 03/21/25 at 6:36 PM, the Administrator confirmed R2 continued to have hospice orders and were just discontinued yesterday. I expect the nursing staff to go through and discontinue the order so the medical record could be accurate. 2. Review of R32's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR), revealed she admitted to the facility on [DATE] with diagnoses including end-stage renal disease, anemia, and malnutrition. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/25 and located under the MDS 3.0 tab of the EMR, revealed R32 received dialysis. Review of R32's Orders tab of the EMR revealed an active physician's order, dated 04/26/22, for Dialysis T-Th-Sat [Tuesday, Thursday, and Saturday] at Chromally American Kidney Center . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 10:19 AM, the Administrator stated the Chromally dialysis clinic closed down, and R32 was now receiving dialysis at the Forest Park dialysis center. The Administrator stated the physician's order in the EMR was incorrect and needed to be fixed. The administrator stated she was aware of a problem with inaccuracy of physician's orders in the EMR and they need to get cleaned up. The Administrator stated she expected orders to be accurate and up to date. During a telephone interview on 03/21/25 at 1:20 PM, the Forest Park Dialysis Center Social Worker (DSW) stated the Chromally dialysis center had closed and R32 was receiving dialysis at Forest Park since November 2024. 3. Review of R7's Face Sheet located under the Face Sheet tab of the EMR revealed she admitted to the facility on [DATE] with diagnoses including cerebral infarction, hemiplegia, unspecified affecting left nondominant side, and chronic kidney disease. Review of R7's quarterly MDS with an ARD of 01/07/25 and located under the MDS 3.0 tab of the EMR, revealed that R7 required substantial to max assistance for self-care with a BIMS score of 11 out of 15 which indicated R7 was moderately cognitively impaired. Review of orders, dated 11/10/23 with no end date (open ended) and located under the Orders tab of the EMR, indicated R7 was to receive Restorative Dining x2 meals/day x5 days/ week to provide support as needed due to low vision. Once A Day, Restorative Program x3 days/ week for Right hand splint up to 4 hours for contracture management. Once A Day Restorative Program x3 days/ week for Right UE [upper extremity] PROM [Passive Range OF Motion] x10 all joints, all directions. During an interview on 03/19/25 at 1:59 PM, the Administrator stated the physician's order in the EMR was incorrect and needed to be fixed, R7 did not have splints any longer and they did not have a Restorative therapy program, but the Certified Nurse Assistant (CNAs) were trained to do the range of motion (ROM). When asked if the ROM was done as ordered the Administrator stated No, that is an old order and should not still be there. The Administrator stated she was aware of a problem with inaccuracy of physician's orders in the EMR and they need to get cleaned up. The Administrator stated she expected orders to be accurate and up to date. 40415 52322

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, interviews, record review, and policy review, the facility failed to ensure staff donned (put on) appropriate personal protective equipment (PPE) for three of five residents (Resident (R) 43, R61, and R262) reviewed for use of Enhanced Barrier Precautions of 22 sample residents. These failures had the potential to cause the spread of infection from staff to other residents. Findings include: Review of the facility's policy titled, Isolation Precautions/Enhanced Barrier Precaution (EBP), dated 04/01/24, revealed Enhanced Barrier Precautions is [sic] used in combination with Standard Precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing .EBP will be used for any resident who meets the following criteria: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; Chronic wounds, such as, pressure ulcer, venous stasis ulcers, diabetic ulcers, unhealed surgical wounds; Indwelling medical devices, such as, central lines, urinary catheters, feeding tubes, and tracheostomies 2. Residents who meet the above criteria, EBP are recommended when performing the following high-contact resident care activities: Dressing, Providing hygiene, Bathing/showering, Transferring, Changing linens, Changing briefs or assisting with toileting, Indwelling medical devices care, Chronic wound care. 3. Place EBP sign at entrance to the room for the resident [sic] who meet the criteria. Staff will clean their hands before entering and when leaving the room. Staff will wear gloves and a gown for High-Contact Resident Care Activities. 1. Review of R43's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he admitted to the facility on [DATE] with diagnoses including stage three pressure ulcers of the sacrum and right buttock and stage two pressure ulcer of the left buttock. Review of R43's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/25 and located under the MDS 3.0 tab of the EMR, revealed he had a current stage three pressure ulcer. Review of the Wound Observation History tab of the EMR revealed on 03/13/25, a wound to R43's coccyx was present and measured six centimeters (cm) long, 6cm wide, and 0.3cm deep. Review of R43's Orders tab of the EMR revealed an active order, dated 02/21/25, to Cleanse coccyx with wound cleanser/NS [normal saline], apply Medihoney [Wound & Burn Dressings, containing Active Leptospermum (Manuka) Honey (ALH)] with dry dressing daily. During an observation on 03/20/25 beginning at 10:39 AM, a sign was posted outside R32's room indicating EBP was required. The Wound Physician (WP) and his accompanying Wound Licensed Practical Nurse (WLPN) both entered the room and donned gloves but did not wear a gown. They cleaned R32's bottom, cleaned the pressure ulcer with normal saline, assessed the wound, and applied the dressings, all while not wearing gowns. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillars of North County Health & Rehab Center, The	13700 Old Halls Ferry Road Florissant, MO 63033

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the WP and WLPN on 03/20/25 at 10:50 AM, the WP stated he did not wear a gown during the wound treatment for R43. The WLPN confirmed she did not wear a gown during the wound treatment. The WP stated regulation called for gowns to be worn while providing care for residents with wounds; however, he did not have any gowns available at the moment and was taking care of the wound real quick. During an interview on 03/21/25 at 3:57 PM, the Infection Preventionist (IP) stated she had done training with all the staff on using EBP but had not conducted training with the WP or WLPN. The IP stated she expected any staff member providing direct care to a resident on EBP to wear a gown as well as gloves. The IP stated residents requiring EBP included those with open wounds, catheters, feeding tubes, or other indwelling devices. 2. Review of R61's Face Sheet located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including a left heel pressure ulcer. Review of R61's EMR under the Wound Observation History tab revealed on 03/13/25, he had a pressure ulcer to the sacrum measuring 1cm long, 0.3cm wide, and 0.1cm deep. Review of R61's Orders tab of the EMR revealed an active physician's order to, apply barrier cream to coccyx q [every] shift et prn [and as needed]. During an observation in R61's room on 03/20/25 at 12:28 PM, Certified Nurse Assistant (CNA) 7 was in the room assisting R61 with incontinence care and changing his bed linens while he was in bed. CNA7 was wearing gloves but no gown. CNA7 exited the room at 12:34 PM. During an interview on 03/20/25 at 12:41 PM, CNA7 stated she was from a staffing agency, and this was her first day at the facility. CNA7 stated she had assisted R61 with incontinence care and a total bed linen change. She confirmed she did not wear a gown while providing care and stated she did not have any available in R61's room. CNA7 stated R61 was on EBP, and gowns and gloves should be worn while providing care. During an interview on 03/21/25 at 4:02 PM, the IP stated R61 had a current open pressure ulcer and required EBP. The IP stated the CNA should have worn a gown while providing care to R61. The IP stated she had provided education to facility staff on EBP but had not provided education to agency staff. 3. Review of R262's Face Sheet located under the Face Sheet tab of the EMR revealed R262 was admitted to the facility on [DATE] with a diagnosis of nontraumatic intracerebral hemorrhage intraventricular. Observation on 03/20/25 at 10:56 AM revealed R262 door had EBP signage on the door and on top of the PPE supplies in the room. Observation and interview on 03/20/25 at 10:59 AM revealed CNA2 entered the room and observed R262 was exposed from the top of her upper body. CNA2 confirmed she did not put on PPE before attempting to dress R262. 52322

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on record review, interview, and policy review, the facility failed to ensure two of five residents (Resident (R) 164 and R61) reviewed for vaccinations, who consented to receive vaccinations, were administered the vaccines of 22 sample residents. These failures had the potential to cause avoidable spread of pneumonia or influenza. Findings include: Review of the facility's policy titled, Infection Control, dated July 2017, revealed Residents and employees are offered the influenza vaccine annually between October and March. The pneumococcal vaccine is offered to all residents at the time of admission and throughout their stay as per current standards of practice. 1. Review of R164's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed she admitted to the facility on [DATE] with diagnoses including dementia and right lower leg fracture. Review of R164's Pneumococcal Vaccine Consent and Release, dated 02/03/25 and provided by the facility, revealed she consented to receive the pneumococcal vaccine. Review of R164's EMR under the Preventative Healthcare and Resident Documents tabs revealed no record the pneumococcal vaccine was administered. During an interview on 03/21/25 at 6:28 PM, the Infection Preventionist (IP) stated R164 had consented to receive the pneumococcal vaccine, and it should have been administered. The IP stated it should not take this long to administer the vaccination and stated it had been missed. 2. Review of R61's Face Sheet located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including a left heel pressure ulcer. Review of R61's Influenza Vaccine Consent and Release, dated 02/27/25 and provided by the facility, revealed R61 consented to receive the influenza vaccination. Review of R61's EMR under the Preventative Healthcare and Resident Documents tabs revealed no record the influenza vaccine was administered. During an interview on 03/21/25 at 6:28 PM, the IP stated R61 consented to receive the influenza vaccination but had not yet received it. The IP stated it should not have taken so long after consent was obtained and the vaccine should have been administered; however, R61 was missed.

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	265341	A. Building B. Wing	03/21/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, record review, interviews, and policy review, the facility failed to maintain clean and bug-free bathroom vents, store urinals and plungers in a sanitary manner, and maintain fixtures/equipment in a safe and functional manner for 11 of 26 residents (Resident (R) 27, R24, R43, R111, R14, R9, R112, R56, R11, R26, and R30) observed for the environment. These failures had the potential cause avoidable allergies or spread of infection and injury from broken fixtures/ equipment. Findings include: Review of the facility's policy titled, Routine Maintenance, dated 08/06/22, revealed Maintenance staff is responsible to ensure that preventative, routine maintenance is completed in compliance with applicable life safety standards and needs of the facility. A housekeeping policy was requested but was not received prior to the survey exit. 1. Review of R56's entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/26/25 and located in the MDS 3.0 tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE]. Review of R11's quarterly MDS with an ARD of 11/15/24 and located in the MDS 3.0 tab of the EMR, revealed she was admitted to the facility on [DATE]. During an observation on 03/18/25 at 10:09 AM in the shared bathroom of R56 and R11, the vent had a thick coating of grey dust and white stringy matter that appeared like cobwebs all across the openings. A spider was hanging from a cobweb approximately two feet below the vent near the toilet. During an observation along with the Maintenance Director (MD) on 03/21/25 at 3:32 PM in the shared bathroom of R56 and R11, the dusty, stringy vent and spider hanging down were again observed. The MD confirmed the vent needed to be cleaned and the cobwebs dusted. The MD stated the housekeeping staff was expected to dust the bathroom vents during regular cleaning. 2. Review of R26's entry MDS with an ARD of 02/10/25 and located in the MDS 3.0 tab of the EMR, revealed he was admitted to the facility on [DATE]. Review of R30's annual MDS with an ARD of 12/19/24 and located in the MDS 3.0 tab of the EMR, revealed he was admitted to the facility on [DATE]. During an observation on 03/18/25 at 10:42 AM in the shared bathroom of R26 and R30, a plunger was in direct contact with the floor and numerous dead bugs were in the light fixture cover. During an observation along with the MD on 03/21/25 at 3:36 PM, the plunger was again in direct contact with the floor and the bugs were still in the light fixture. The MD stated the plunger should have been kept in a plastic tub to keep it from contact with the floor or other surfaces and the bugs in the light needed to be cleaned. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pillars of North County Health & Rehab Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 13700 Old Halls Ferry Road Florissant, MO 63033	

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R14's entry MDS with an ARD of 01/04/25 and located under the MDS 3.0 tab of the EMR, revealed he was admitted to the facility on [DATE]. Review of R9's quarterly MDS with an ARD of 02/07/25 and located under the MDS 3.0 tab of the EMR, revealed he was admitted to the facility on [DATE]. During an observation in the shared bathroom of R14 and R9 on 03/18/25 at 10:45 AM, a plunger was observed directly in contact with the bathroom floor and the bathroom vent fan had a coating of grey dust and white stringy matter that appeared like cobwebs across the openings. During an observation along with the MD on 03/21/25 at 3:38 PM in the shared bathroom of R14 and R9, the plunger was in contact with the floor and the dusty, stringy bathroom vent were confirmed by the MD. He stated the plunger should not be directly on the floor and the vent needed to be cleaned. 4. Review of R24's quarterly MDS with an ARD of 01/16/25 and located in the MDS 3.0 tab of the EMR, revealed she was admitted to the facility on [DATE]. During an observation in R24's room on 03/18/25 at 11:56 AM, the bathroom vent fan had a thick coating of grey dust and white stringy matter that appeared like cobwebs across the openings. During an observation along with the MD on 03/21/25 at 3:41 PM in R24's room, the bathroom vent was again observed coated in dust and stringy white matter. The MD stated this needed to be cleaned and it looked like it was covered in cobwebs. 5. Review of R112's admission MDS with an ARD of 03/03/25 and located in the MDS 3.0 tab of the EMR, revealed she was admitted to the facility on [DATE]. During an observation on 03/18/25 at 11:59 AM in R112's room, the top piece of her bed's footboard, with four sharp nails and screws sticking out of it, was on top of the resident's dresser. There were sharp, broken edges of wood on the footboard around where the nails and screws had been torn out. During an observation along with the MD on 03/21/25 at 3:38 PM, the broken piece of the footboard with the sharp nails and screws was again on top of the dresser and the footboard had jagged edges of wood around the holes. The MD stated this could cause an accident because it was sharp and needed to be fixed immediately. 6. Review of R27's admission MDS with an ARD of 01/09/25 and located in the MDS 3.0 tab of the EMR, revealed she was admitted to the facility on [DATE]. During an observation in R27's room on 03/18/25 at 2:58 PM, a plunger was observed directly in contact with the bathroom floor and the bathroom ceiling light was missing its cover, exposing the bulbs and mechanism. During an observation along with the MD in R27's room on 03/21/25 at 3:31 PM, the plunger was again observed in contact with the bathroom floor and the light without a cover. The MD stated the plunger should be stored in a plastic tub to keep it from coming in contact with the floor and he was unaware the light was missing its cover. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of R43's admission MDS with an ARD of 02/03/25 and located in the MDS 3.0 tab of the EMR, revealed he was admitted to the facility on [DATE]. Review of R111's entry MDS with an ARD of 02/19/25, revealed he was admitted to the facility on [DATE]. During observations in the shared bathroom of R43 and R111 on 03/18/25 at 3:07 PM and 03/21/25 at 2:58 PM, two dirty urinals, without labels, were hanging on the handrail and were in direct contact with the rail. During an observation along with the MD on 03/21/25 at 3:35 PM in the shared bathroom for R43 and R111, a staff member was in the bathroom placing the urinals in plastic bags. The MD stated urinals should be stored in bags for sanitation purposes. During an interview on 03/21/25 at 3:30 PM, the MD stated the facility had a process to receive work requests from staff via a mailbox and paperwork request slips. He stated he received requests infrequently and had not received work requests for any of the above issues. The Director of Housekeeping was not available for interview.