STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30869 Based on interview and record review, the facility failed to ensure professional standards of practice were met, when the facility admitted a resident without physician's orders and failed to provide prescribed medications that evening. The resident was sent to a different hospital, 14 hours later, without physician's orders (Resident #1). The facility did not have a policy for obtaining physician orders at the time of admission. The sample was 3. The census was 49. Review of the resident's hospital discharge summary and discharge instructions, received via email from the facility Administrator on 9/18/24 at 5:11 P.M., with a printed time and date stamp of 8/21/24 at 2:03 P.M. central daylight time (CDT), showed: -Diagnoses of Alzheimer's dementia, high blood pressure, diabetes type 2, coronary artery disease (CAD) with left anterior descending (LAD) artery stent placement (treatment for a condition that occurs when there is a blockage in the LAD artery, which can lead to a heart attack), hypothyroidism (thyroid gland does not produce enough thyroid hormones), anxiety, depression, and seizure disorder (condition causing repeated seizures, which are abnormal electrical brain activity); -The resident had a seizure-like episode at home, on 8/12/24, with tongue biting, and was unresponsive upon arrival. The resident had another seizure in the emergency room , lasting two minutes, and characterized as a tonic-clonic (type of seizure that involves violent muscle contractions and loss of consciousness) episode with tongue biting. The resident was admitted for recurrent seizures, was stabilized eight days later and was ready for discharge but developed severe left knee pain from an acute flare of gout (a type of arthritis that causes joint pain and swelling due to a buildup of urate crystals in the joints). The resident was started on colchicine (medication used to prevent or treat gout attacks/flares) stat (immediately), followed by 0.6 mg to be continued twice daily for 5 days. -The resident's hospital discharge instructions showed the following orders: -Regular diet; -Vital signs every morning and evening; -Physical Therapy to evaluate and treat; -Occupational Therapy to evaluate and treat; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Blood sugars daily; -Weekly weights; -Colchicine 0.6 milligrams (mg) tablet, twice daily, for acute gout flare, for 4 days; -Lacosamide (anticonvulsant/seizure medication) 100 mg twice daily; -Lamotrigine (anticonvulsant/seizure medication) 25 mg once daily; -Metformin (treats type 2 diabetes) 500 mg twice daily; -Januvia (treats type 2 diabetes) 100 mg daily; -Levothyroxine (treats hypothyroidism) 75 micrograms (mcg) daily at bedtime; -Losartan (treats high blood pressure) 50 mg daily; -Atenolol (treats high blood pressure) 25 mg once daily; -Clopidogrel (prevents platelets from sticking together & forming dangerous blood clots) 75 mg daily; -Aspirin (used as blood thinner to prevent blood clots) 81 mg daily at bedtime; -Fluoxetine (antidepressant) 40 mg daily; -Omeprazole (treats gastroesophageal reflux disease) 40 mg daily before breakfast; -Timolol ophthalmic (for glaucoma) 0.5% solution, one drop into both eyes daily; -Sodium chloride hypertonic ophthalmic drops (for dry eyes), apply every evening; -Vitamin D3 (vitamin supplement) 1000 units twice daily; -Melatonin (sleep aide supplement) 10 mg daily at bedtime; -Cyanocobalamin (Vitamin B12) 500 mcg daily; -Folic acid (a B vitamin) 1 mg daily; -Glucosamine (supplement for joint health) 500 mg daily; -Omega-3 (polyunsaturated fatty acid supplement) 500 mg daily. During an interview on 9/17/24 at 11:45 A.M., the Administrator said they did not have an admissions policy which encompasses the step-by-step admission process/instructions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #1's discharge Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24, showed: -admitted [DATE]; -Moderate impairment of cognition; -Incontinent of bowel and bladder; -Functional abilities were blank/not completed. Review of the resident's medical record diagnoses, showed: -Encephalopathy (brain dysfunction with confusion, memory loss, personality changes, or coma-resulting from things such as over medicated, infection, toxins, etc.) -Conversion disorder with seizures (a mental health condition that can cause physical symptoms, including seizures, that are not caused by an underlying neurological pathology); -Type 2 diabetes; -High blood pressure; -Atherosclerotic heart disease (coronary/heart artery disease); -Open angle glaucoma (chronic eye disease of increased intraocular pressure, leading to optic nerve damage and vision loss if left untreated); -Dementia (progressive decline in cognitive abilities) with behavioral disturbances. -Alzheimer's disease (a type of dementia); -Hypothyroidism; -Major depressive disorder (persistently depressed mood, causing significant impairment in daily life); -Sleep apnea (sleep disorder-causing breathing to stop at times, during sleep); -Gastro-esophageal reflux disease (GERD-stomach contents leak into the esophagus); -Protein-calorie malnutrition (inadequate intake of protein, calories, and essential nutrients); -Unsteadiness on feet; -Vertigo (symptoms of spinning, swaying, or tilting). Review of the resident's Physician Order Sheet, dated 8/21/24, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Do not resuscitate/no cardiopulmonary resuscitation. -No special care orders, diet orders, or medication orders were listed. Review of the resident's Medication Administration Record, dated August 2024, showed No order data found. Review of the resident's electronic admission assessments list, showed: -8/21/24, Weekly skin observation; -8/21/24, Nursing admission assessment; -8/22/24, Situation-Background-Assessment-Recommendation (SBAR, a form completed by nurses, regarding important resident information/condition, to facilitate and increase the probability of effective, accurate, communication between health care professionals) communication form. Review of the resident's licensed nurse admission assessment, authored by Registered Nurse (RN) A, dated 8/21/24 at 6:29 P.M., showed: -admitted [DATE] at 1:30 P.M.; -No history of falls; -Oriented to situation and place (orientation to person & orientation to time, boxes not checked off); -Anxious mood; -Exit seeking behaviors; -Verbal communication garbled; -Understands-verbal comprehension; -Sometimes understood; -Drug regimen review was blank/not filled out. Review of the resident's progress notes, dated 8-21-24, showed: -No notes by RN A, the resident's 12-hour day shift nurse (7:00 AM to 7:00 PM), documenting the resident's arrival, admission orders verified by the physician, or medication orders sent to the pharmacy; -4:15 P.M., RN C (facility wound nurse) documented the resident's skin assessment was completed, there were skin issues present, but no open wounds; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9:01 P.M., Licensed Practical Nurse (LPN) B documented the resident was on the floor, next to the bed, lying on his/her right side. An assessment was completed and there were no injuries, skin issues, or pain. The physician was notified via a message. The resident's spouse was not reachable via the phone number provided. Review of the resident's progress notes, dated 8-22-24, showed: -3:30 A.M., LPN B documented the staff responded to a noise from the resident's room and found him/her on the floor. An assessment was completed, and the resident complained of left hip pain but refused assessment of the left hip area. The spouse's phone number did not go through. Awaited return call from the physician, Director of Nursing (DON) was notified, and ambulance service was requested; -3:50 A.M., LPN B documented the ambulance arrived and the resident was transferred to the hospital; -6:01 A.M., LPN B documented the hospital called, reported there was no fracture, and the resident was returning to the facility; -7:00 A.M., LPN D documented the resident attempted to strangle Emergency Medical Services (EMS) personnel upon return to the facility. EMS personnel did not remove the resident from the stretcher, upon return to the facility, and 911 was called to return the resident to the hospital due to the resident's harmful behavior. Review of the resident's care plan, showed: -Fall on 8/21/24 with no injury; -Fall on 8/22/24, complained of hip pain; -Interventions-Resident sent to theER on [DATE], therapy to evaluate, staff will not leave resident up in chair in room unattended, and transfer from chair to low bed in the evening; -There were no other focus items in the care plan. During an interview on 9/17/24 at 2:15 P.M., the DON said the nurse called her about both falls. The resident was in the recliner when he/she fell the first time. She told the charge nurse to put the resident to bed and for staff not to leave the resident alone when up in the chair. She added the fall care plan into the resident's electronic record later that day, on 8/22/24, after the resident was sent back to the hospital early that morning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/20/24 at 12:17 P.M., LPN B said he/she did not know the resident was a new admission and could not recall what exactly RN A said about the resident during their change of shift report. He/She was not aware the resident did not receive any medications that evening, as the Certified Medication Technician (CMT) did not report the absence of medications or orders for the resident. It was not until he/she was sending the resident to the hospital, around 3:00 A.M. on 8/22/24, that he/she became aware there were no orders for the resident. There was a manila envelope on the nursing desk, with the resident's name on it, but it was empty. There were no admission papers found at the nursing station or in the DON's mailbox. LPN B sent the resident to the hospital (not the same hospital discharged from) without physician's orders. The hospital called, requesting the resident's orders, and he/she told them there were no orders for the resident in his/her chart. During an interview on 9/20/24 at 1:55 P.M., CMT E said not every resident has medications in the evening. If a resident has medication(s) ordered to be given during his/her shift, from 6:00 P.M. to 6:00 A.M., their name will appear in the electronic record. He/She then clicks on the resident's name and the medications to give at that time, will appear. Therefore, if there are no medications ordered to be given, during that time of day, the resident's name will not appear. CMT E said he/she had no way of knowing the resident had no evening medications, because the resident's name never appeared. During an interview on 9/20/24 at 2:33 P.M., Certified Nurse Aide (CNA) F said she thought they brought the resident a dinner hall tray on 8/21/24. During an interview on 9/17/24 at 4:30 P.M., CNA G said they went to the kitchen, on 8/21/24, got the resident a dinner tray, and the tray was empty when they picked it up. During an interview on 9/13/24 at 12:15 P.M., the Administrator said the hospital, that discharged the resident to their facility, did not send any discharge papers or orders with the resident. They did not know what RN A did about it. The Administrator said it was the DON's responsibility to check all new admissions, the next day, to ensure the admission process was completed. During an interview on 9/17/24 at 12:40 P.M., the DON said she did not check the resident's chart, to ensure the admission process had been completed, because the resident discharged early that morning, on 9/22/24, before she arrived at work. The DON said she was not aware the resident was admitted without any orders, until questioned about it, by the surveyor, on 9/13/24. During an interview on 9/17/24 at 11:55 A.M., the Regional Corporate Nurse said the admission nurse's number one priority, for a new admission, is to obtain and quickly transcribe the physician's orders, so the medication orders can be sent to the outside pharmacy, and complete the whole-body skin assessment. All other assessments can be completed within the 24-hour period and the interim/initial care plan within 48 hours. The admitting nurse should have immediately called the hospital and had the resident's discharge orders faxed to the facility. MO00240959