STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265401	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Festus Manor	627 Westwood Drive South Festus, MO 63028

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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 45872 Based on interview and record review, the facility failed to maintain the bond amount for at least one and one-half times the average monthly balance of the residents' personal funds for the last twelve consecutive months from May 2023 to April 2024. The facility census was 121. Review of the facility's policy titled, Surety Bond, revised March 2021, showed: - Our facility has a current surety bond to assure the security of all resident's funds deposited with the facility; - A surety bond is an agreement between the facility, the insurance company, and the resident or the State acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, accounts for, safeguards, and manages; - This facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of the residents; - The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring from any failure by the facility to hold, account for, safeguard and manage the residents' funds (i.e., losses occurring as a result of acts of errors or negligence, incompetence or dishonesty); - All funds (including refundable deposits) entrusted to the facility for a resident will be covered by the surety bond; - Inquiries concerning the financial security of the personal funds managed by the facility should be referred to the administrator. Review of the residents' personal funds account for the last twelve consecutive months from May 2023 to April 2024, showed: - The facility's current approved bond amount equaled $120,000.00; - The average monthly balance for the residents' personal funds equaled $91,000.00; (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An average monthly balance of $91,000.00 required a bond of at least $136,500.00. During an interview on 05/21/24 at 1:05 P.M., the Business Office Manager said he/she would expect the surety bond to be one and one-half times the average monthly balance of the residents' personal funds. During an interview on 05/21/24 at 1:05 P.M., the Regional Support Specialist said he would expect the surety bond to be one and one-half times the average monthly balance of the residents' personal funds.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 121. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible; - Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting including a clean, sanitary and orderly environment; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a depersonalized institutional setting including institutional odors. 1. Observations on 05/20/24 at 10:20 A.M., and 05/21/24 at 9:20 A.M., of the 200 Hall showed: - room [ROOM NUMBER] with several dark markings/scrapes on the wall near the bed by the door and the bed by the window; - room [ROOM NUMBER] with a large area of exposed sheetrock, peeled paint and a dark marking on the wall beside the sink; - room [ROOM NUMBER] with a large area of peeled paint with several spotted stained areas on the wall beside the bed near the window; - Two ceiling tiles with brown circle stains near a ceiling vent in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]; - Two missing ceramic tiles between the second shower and the third shower divider wall in the tub room next to the nursing office; - Two cracked ceramic tiles between the first shower and the second shower divider wall in the tub room next to room [ROOM NUMBER]. 2. Observations on 05/20/2024 at 10:22 P.M., and on 05/21/2024 at 12:45 P.M., of the 300 Hall showed: (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One ceiling tile with brown circle stains near a ceiling vent in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]; - Two ceiling tiles with brown circle stains on the ceiling in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. 3. Observations on 05/20/24 at 10:46 A.M., and on 05/21/24 at 9:22 A.M., showed 10 inch (in.) x 6 in. areas of exposed sheetrock and peeled paint on the wall by the hallway doors of Rooms 102, 103, 104, 108, 110, 114, 303, 313, 401, 405, and 412. 4. Observations on 05/20/24 at 10:51 A.M., and 12:50 P.M., on 05/22/24 at 3:51 P.M., and on 05/23/24 at 10:03 A.M., and 12:10 P.M., of the 100 Hall showed a strong urine odor. 5. Observations on 5/20/24 at 11:30 A.M., of the 400 Hall showed: - room [ROOM NUMBER] with no bathroom door; - room [ROOM NUMBER] with no bathroom door. 6. Observations on 05/22/24 at 10:27 A.M., of the 300 Hall showed: - A large brown circle stain on one ceiling tile near room [ROOM NUMBER]; - A small brown circle stain on one ceiling tile near room [ROOM NUMBER]; - A brown circle stain on one ceiling tile near room [ROOM NUMBER]. 7. Observations on 05/22/24 at 10:42 A.M., and on 05/23/24 at 12:45 P.M., of the 100 Hall showed: - room [ROOM NUMBER] with no privacy curtains for the bed by the door and the bed by the window; - room [ROOM NUMBER] with 17 broken slats on a window blind, a two foot (ft.) x 1 ft. damaged drywall above the cove base near the sink, and a brown substance around the back of the toilet seat; - Two ceiling tiles with brown circle stains near a ceiling vent and a 20 in. x 20 in. ceiling vent with a buildup of dust in the hallway by room [ROOM NUMBER]; - room [ROOM NUMBER] with a 3 in. x 4 in. hole in the bathroom door. 8. Observations on 05/22/24 at 11:30 A.M., 2:24 P.M., and 3:51 P.M., and on 05/23/24 at 10:24 P.M., showed the 300 Hall with a 10 ft. section of ceramic floor tiles with 17 one-quarter in. diameter drops of a brown substance spilled near the dining hall corridor intersection. 9. Observations on 05/22/24 at 1:45 P.M., and on 05/23/2024 at 9:05 A.M., of the laundry room showed: - A buildup of dust and debris behind the dryer; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A buildup of dust and debris behind the washer; - A 20 in. x 20 in. ceiling vent with a buildup of dust; - Two ceiling light fixtures with a buildup of dust. 10. Observation on 05/22/24 at 3:30 P.M., showed a four in. by one ft. missing tile near the bottom of the wall near the clean utility room in front of the west nurses' station. During an interview on 05/22/24 at 9:55 A.M., Housekeeper A said if he/she found anything that needed fixed, he/she wrote it down on his/her daily cleaning sheet and gave it to the supervisor to inform maintenance. He/She had not seen anything such as ceiling tiles, cracked ceramic tiles, exposed sheetrock, or peeled paint throughout the facility. During an interview on 05/22/24 at 10:09 A.M., Housekeeper B said anything that needed to be fixed was written down on a cleaning sheet and given to the maintenance department. He/She had not seen any ceiling tiles or ceramic tiles that needed replaced, but had noticed areas that needed to be painted. During an interview on 05/22/2024 at 12:05 P.M., the Maintenance Supervisor (MS) said he/she took over today in the supervisory role. He/She would prefer staff wrote down what needed to be fixed instead of verbally being told. The previous maintenance supervisor did not keep copies of what had been fixed or repaired. During an interview on 05/22/24 at 1:50 P.M., Laundry Staff S said he/she had never been told to clean any area behind the washer or dryer except for the drain behind the washer. During an interview on 05/22/24 at 1:55 P.M., the Laundry Supervisor said the area behind the appliances should be cleaned by the maintenance department. Review of the maintenance work orders showed no documentation of the areas of concern addressed. During an interview on 05/23 /24 at 9:44 A.M., the Regional Support Specialist said he/she would expect staff to inform the maintenance department of any environmental concerns to be addressed in a timely manner. He/She would expect staff to use the computer system currently in place for addressing any environmental concerns instead of verbally telling the MS. During an interview on 05/23/24 at 12:13 P.M., Housekeeper Y said the floors should be cleaned as needed if something was spilled. Nursing staff should clean body fluids, but they were always very busy. The Housekeeping Supervisor was notified when the halls or rooms had odors. The floors, beds, and furniture should be cleaned, and trash must be removed. It helps when residents moved out and the rooms were deep cleaned. During an interview on 05/23/24 at 12:17 P.M., Housekeeper W said If the hallway floors were dirty, he/she cleaned as needed. When there were odors on the hall, staff should check for the source of the odor and clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/24 at 12:31 P.M., Certified Medication Technician (CMT) X said the charge nurse should be notified when the hall had odors. Certain resident rooms often had more urine odors. During an interview on 05/23/24 at 12:35 P.M., Licensed Practical Nurse (LPN) P said urine odors were coming from certain resident rooms on the 100 Hall. Nursing staff and housekeepers were expected to clean and prevent the odors. The hallway floors should be cleaned as needed. During an interview on 05/23/24 at 12:43 P.M., the Housekeeping and Laundry Supervisor said the housekeeping staff were expected to clean the floors as needed and should look for any spot mop needs. The housekeepers were expected to report to him/her concerns with hallways that had odors. Housekeepers were told to give extra care in a specific room on the 100 Hall because the resident urinated a lot on the floor. During an Interview on 5/23/24 at 3:43 P.M., the Regional Support Specialist and Registered Nurse (RN) I/Corporate Nurse said they were not aware of resident rooms without doors and why they did not have doors. 47445 48247

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the the resident's responsible party and to the representative of the Office of Long-Term Care (LTC) Ombudsman for five residents (Resident #4, #14, #71, #84 and #110) out of six sampled residents. The facility census was 121. Review of the facility's policy titled, Transfer or Discharge Documentation, revised December 2016, showed: - When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider; - When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: the basis for the transfer or discharge and that an appropriate notice was provided to the resident and/or legal representative; - The policy did not address notifying the Office of LTC Ombudsman per the requirement. 1. Review of Resident #4's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/06/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. 2. Review of Resident #14's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/04/24, and returned to the facility on [DATE]; - The resident transferred to the hospital on 05/03/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #71's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/06/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. 4. Review of Resident #84's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 03/04/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. 5. Review of Resident #110's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 05/01/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. During an interview on 05/16/24 at 2:46 P.M., the Regional Ombudsman Coordinator said the facility did not send transfer notifications on a monthly basis. During an interview on 05/22/2024 at 1:56 P.M., Licensed Practical Nurse (LPN) C said he/she was not aware of an actual written transfer notice given to the resident and/or the responsible party at the time of transfer/discharge. During an interview on 05/22/2024 at 2:01 P.M., LPN D said he/she was not aware of a written transfer notice given to the resident and/or responsible party at the time of transfer/discharge. During an interview on 05/22/24 at 4:10 P.M., LPN P said they did not do written transfer/discharge papers other than documenting in the nurses notes. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/24 at 9:40 A.M., the Social Service Director (SSD) said the charge nurse should be filling out the notice of transfer/discharge, give it to the resident and the responsible party, and make a copy. He/She did not know where the transfer/discharge copy went after that, but it needed to be placed in a designated area. A copy should be given to the Business Office Manager (BOM) and the SSD. During an interview on 05/22/24 at 10:46 A.M., the BOM said he/she had never heard of a discharge notice or been given a copy. During an interview 05/23/24 at 11:02 A.M., Registered Nurse (RN) I/Corporate Nurse said he/she would expect the facility to provide the resident and/or the responsible party a written notice of discharge/transfer, but not necessarily for an emergency transfer. He/She would also expect the transfer notifications to be provided to the Office of the LTC Ombudsman on a monthly basis. During an interview 05/23/24 at 1:02 P.M., the Regional Support Specialist said he/she would expect the facility to provide the resident and/or the responsible party with a written notice of discharge/transfer. He/She would also expect transfer notifications be provided to the Office of the LTC Ombudsman on a monthly basis. 45872 46521 47445

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide written notification of their bed-hold policy to the resident and/or their representatives at the time of transfer for five residents (Residents #4, #14, #71, #84 and #110) out of six sampled residents. The facility census was 121. Review of the facility's policy titled, Bed Hold Policy, undated, showed: - It is the policy of the facility to notify all residents and/or resident's representative of the bed-hold policy; - If the resident or representative wants to hold the bed, a signed authorization must be obtained with each discharge; - Upon discharge, the nursing supervisor will re-inform the resident and/or responsible party of the bed-hold policy. The designee will follow up the next business day to assure the resident and/or responsible party understands the requirements of the bed-hold policy; - If the resident or representative does not choose to hold the bed, the bed will be released, and any personal belongings must be picked up within a reasonable period of time; - Bed-holds are voluntary. However, if the bed is not held, and the resident wants to be readmitted , the resident's name will be placed on a waiting list for the next available bed. 1. Review of Resident 4's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/06/24, and returned to the facility on [DATE]; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 02/04/24. 2. Review of Resident 14's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/04/24, and returned to the facility on [DATE]; - The resident transferred to the hospital on 05/03/24, and returned to the facility on [DATE]; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 02/04/24, and 05/03/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #71's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 02/06/24, and returned to the facility on [DATE]; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 02/06/24. 4. Review of Resident #84's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 03/04/24, and returned to the facility on [DATE]; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 03/04/24. 5. Review of Resident #110's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 05/01/24, and returned to the facility on [DATE]; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 05/01/24. During an interview on 05/22/24 at 1:56 P.M., Licensed Practical Nurse (LPN) C said when a resident was sent out to the hospital or emergency room , a bed hold policy should be given to the resident and/or responsible party. During an interview on 05/22/24 at 2:01 P.M., LPN D said when a resident was sent out to the hospital or emergency room , a bed hold policy should be given to the resident and/or responsible party. During an interview on 05/22/24 at 9:40 A.M., the Social Service Director (SSD) said the charge nurse should be giving the resident and/or responsible party a bed-hold policy. During an interview on 05/22/24 at 10:46 A.M., the Business Office Manager (BOM) said he/she had never heard of a bed-hold policy or been given a copy. During an interview 05/23/24 at 11:02 A.M., the Registered Nurse (RN) I/Corporate Nurse said he/she would expect the facility to provide the resident and/or responsible party a bed-hold policy upon a transfer and with written documentation of this form being provided. During an interview 05/23/24 at 1:02 P.M., the Regional Support Specialist said he/she would expect the facility to provide the resident and/or responsible party a bed-hold policy upon a transfer. 45872 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46521 47445

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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** 37575 Based on interview and record review, the facility failed to obtain a physician's order, evaluate and assess the residents' abilities, and provide education for self-care of a colostomy (a surgical procedure where the colon is diverted to an artificial opening in the abdomen) and the facility failed to implement a care plan with specific interventions tailored to meet individual needs for two residents (Resident #71 and #110) out of two sampled residents. The facility census was 121. Review of the facility's policy titled, Self-Administration of Medications, dated February 2021, showed: - Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; - If it is deemed safe and appropriate for the resident to self administer medications, it is documented in the medical record and care plan; - The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision making status. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised December 2016, showed: - The comprehensive, person-centered care plan will include measurable objectives and timeframes; describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; describe services that would otherwise be provided for the resident, but not provided due to the resident exercising his/her rights, including the right to refuse treatment; identify the professional services responsible for each element of care; and enhance the optimal functioning of the resident by focusing on a rehabilitative program; - Assessments of residents will be ongoing and care plans revised as information about the residents and the residents' conditions change. 1. Review of the Resident #71's medical record showed: - An admitted [DATE]; - Diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and colostomy; - The annual Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility staff, dated 04/17/24, showed the resident with a colostomy; - No documentation of the evaluation/assessment for the resident to self-perform colostomy care; (continued on next page)

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	265401	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Festus Manor	627 Westwood Drive South Festus, MO 63028

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of education being provided to the resident regarding colostomy care by the staff; - The resident's care plan, dated 11/21/23, did not address specific interventions tailored to meet individual needs of the resident performing self care of the colostomy. Review of the resident's Physician Order Sheet (POS), dated May 2024, showed: - An order for the colostomy, dated 02/16/24; - An order for colostomy care every shift, every day and night shift, dated 02/16/24; - No documentation of an order for the resident to self-perform colostomy care. During an interview on 05/21/24 at 10:01 A.M., Licensed Practical Nurse (LPN) F said Resident #71 did his/her own colostomy care and let staff know if help or supplies were needed. During an interview on 05/21/24 at 4:03 P.M., the resident said he/she did his/her own colostomy care. The staff gave him/her the supplies and if help was needed, he/she let the staff know. 2. Review of Resident #110's medical record showed: - An admitted [DATE]; - Diagnosis of colostomy; - The quarterly MDS, dated [DATE], the resident with a colostomy; - No documentation of the evaluation/assessment for the resident to self-perform colostomy care; - No documentation of education being provided to the resident regarding colostomy care by the staff; - The resident's care plan, dated 03/02/24, did not address specific interventions tailored to meet individual needs of the resident performing self care of the colostomy. Review of the resident's POS, dated May 2024, showed: - An order to change the ostomy bag and wafer every hour as needed, dated 05/03/24; - An order to document yes/no of the ostomy bag and wafer changes every shift, dated 05/03/24; - No documentation of an order for the resident to self-perform colostomy care. During an interview on 05/22/24 at 4:56 P.M., Resident #110 said he/she preferred to do his/her own colostomy care and could get get the supplies and assistance from staff if needed. He/She was unsure if there had ever been any education or if anyone had watched to make sure it was being done correctly. (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 05/23/24 at 9:06 A.M., LPN L said there should be an order for residents to do self-care of colostomies, documentation of the completed evaluations and assessments, and the care plan should also reflect the self-care. During an interview on 05/23/24 at 9:37 A.M., the Regional Support Specialist said the policy for self- care would be about the same as self-administering of medication. There should be an order, the resident should have had an evaluation and assessment to make sure they were capable of doing self-care, it should all be documented and care planned. During an interview on 05/23/24 10:41 P.M., LPN P said he/she would expect an order for a resident to perform colostomy self-care, an evaluation and periodic assessments of the resident's continued ability should be completed, and the care plan should also address the self-care. During an interview on 05/23/24 at 1:42 P.M., Registered Nurse (RN) I/Corporate Nurse said he/she would expect the facility to evaluate the cognition of residents that wanted to do their own colostomy care. There should be a physician order, it should be care planned and charted with on-going assessments of the situation as needed. 46521

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to ensure a urinary catheter (a tube inserted into the bladder to drain urine) drainage bag and tubing was kept off the floor and covered with a dignity bag for one resident (Resident #84) out of two sampled residents and one resident (Resident #34) outside the sample. The facility census was 121. Review of the facility policy titled, Urinary Catheter Care, dated, September 2014, showed: - Be sure the catheter bag and tubing are kept off the floor; - Did not address the use of dignity bags. 1. Review of Resident #34's medical record showed: - admitted [DATE]; - Diagnoses of neuromuscular dysfunction of the bladder (the lack of bladder control due to brain, spinal cord or nerve problems), hydronephrosis with renal and ureteral calculous obstruction (dilatation and distension of the renal collecting system of one or both kidneys due to an obstruction of urine), Lennox-Gastaut Syndrome (a severe form of different types of seizures), and cerebral palsy (a group of conditions that affect movement and posture). Review of the resident's Physician Order Sheet (POS), dated May 2024, showed an order to provide suprapubic catheter (a tube inserted into the bladder through a surgical opening in the abdominal wall to drain urine) care every shift due to hydronephrosis with renal and ureteral calculous obstruction, dated 04/26/24. Observation of the resident on 05/21/24 at 11:30 A.M., and 2:45 P.M., and on 05/22/24 at 11:30 A.M., and 1:30 P.M., showed the resident propelled the wheelchair in the hall with the catheter bag and tubing dragging the floor without a dignity bag. 2. Review of Resident #84's medical record showed: - admitted [DATE]; - Diagnoses of retention of urine, benign prostatic hyperplasia (BPH - enlargement of the prostate causing difficulty in urination), other specified disorders of the bladder, and other specified disorders of the kidney and ureter (tube that carries urine from the kidney to the bladder.). Review of the resident's POS, dated May 2024, showed: - An order for Foley (a type of catheter) catheter 16 French (Fr.) with a 30 milliliter (ml) balloon for bladder spasms/retention, dated 03/21/24; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for a 16 Fr. Foley catheter care every shift related to retention of urine, dated 3/12/24; - An order to change the 16 Fr. Foley catheter monthly and as needed (PRN) every day shift starting on the 25th and ending on the 25th of every month and PRN for leakage/blockage related to retention of urine, dated 03/12/24; - An order for Foley catheter care every shift for monitoring output, dated 3/12/24. Observation of the resident on 05/20/24 at 10:36 A.M., 12:24 P.M., and 2:13 P.M., showed the resident lay in bed with the catheter drainage bag hanging on the bed frame and the bottom of the drainage bag lay on floor with a dignity bag part way on the drainage bag and the urine visible from the hall. During an interview on 05/20/24 at 2:13 P.M., Resident #84 said he/she had a catheter due to urine retention, and was hospitalized on ce because the catheter bag wasn't emptied by staff and the urine backed up into his/her bladder. During an interview on 05/22/24 at 3:50 P.M., Registered Nurse (RN) T said a catheter drainage bag should be completely covered with a dignity bag. The drainage bag and the tubing should not touch the floor. During an interview on 05/23/24 at 2:00 P.M., Licensed Practical Nurse (LPN) G said the catheter tubing and drainage bags should never be on the floor and in a dignity bag anytime the resident was outside of the room. During an interview on 05/23/24 at 2:30 P.M., RN I/Corporate Nurse and Regional Support Specialist said the catheter drainage bag and tubing should not touch the floor and a dignity bag should be on the bag. 47445

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was dated when changed for two residents (Resident #118 and #272) and failed to ensure physician's order for oxygen was followed for one resident (Resident #272) out of four sampled residents. The facility failed to ensure a physician's order for a tracheostomy (trach - a surgical procedure to create an opening through the neck into the trachea windpipe to provide an airway) inner cannula replacement was followed for one resident (Resident #272) out of one sampled resident. The facility census was 121. The facility did not provide a policy for dating and changing oxygen tubing. 1. Review of Resident #118's medical record showed: - admitted on [DATE]; - Diagnoses of edema (swelling), chronic diastolic congestive heart failure (an inability of the heart to pump sufficient blood flow to meet the body's needs), and paroxysmal atrial fibrillation (the heart doesn't beat in a normally). Review of the resident's May 2024 Physician Order Sheet (POS) showed: - An order for oxygen at 2 liters per minute (LPM) and titrate up if needed, continuous oxygen to keep the oxygen level greater than 92 percent (%), dated 03/27/24; - An order to change the oxygen tubing and humidifier bottle weekly on Sunday, dated 03/27/24. Observation of the resident showed: - On 05/20/24 at 2:02 P.M., the resident lay in bed asleep with the oxygen at 2 LPM via nasal cannula (NC) with the tubing not dated; - On 05/20/24 at 11:30 A.M., the resident sat in a wheelchair in the dining room with 2 LPM via NC with tubing not dated; - On 05/21/24 at 11:30 A.M., the resident sat in a wheelchair the in hall with oxygen at 2 LPM via NC, tubing not dated; - On 05/21/24 at 2:10 P.M., the resident sat in a wheelchair in the room with oxygen at 2 LPM via NC, tubing not dated; - On 05/22/24 at 8:50 A.M., the resident lay in bed with oxygen at 2 LPM via NC, tubing not dated. Review of the facility's policy titled, Oxygen Administration, revised October 2010, showed to verify there is a physician's order for this, review the order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Tracheostomy Care, dated August 2013, showed: -The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas; - Tracheostomy tubes should be changed as ordered and as needed (at least monthly); - A replacement tracheostomy tube must be available at the bedside at all times; - Apply clean gloves; - Clean the stoma (an opening made surgically) with two peroxide-soaked gauze pads; - Rinse the stoma with a saline-soaked gauze pad; - Apply a fenestrated (cut) gauze pad around the insertion site; - Remove gloves and discard; - Wash hands. Review of the facility's policy titled, Suctioning the Lower Airway (Endotracheal (ET) or Tracheostomy Tube), revised October 2010, showed: - The purpose of this procedure is to remove secretions, maintain a patent (open) airway, and prevent infection of the lower respiratory tract; - Perform hand antisepsis, put on gloves, position the resident; - Connect one end of the suction tubing to the suction unit and the other end near the resident; turn on the suction unit; and remove the gloves; - Open the suction catheter kit, place the sterile drape across the resident's chest; remove the sterile cup and fill with sterile saline; - Apply sterile gloves, holding the catheter in the dominant hand and tubing in the non-dominant hand connect the catheter (plastic tube) to the tubing; - Suction a small amount of water from the cup to verify the negative pressure; - Remove the oxygen using the non-dominant hand, hyperinflate/oxygenate; - Upon inhalation, insert the catheter into the tube, advance until resistance is met or resident coughs, and pull back one to two centimeters (cm); - Apply intermittent suction and slowly withdraw the catheter rotating between the thumb and forefinger, no more than 10 seconds. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Trach Cleaning for Inner Cannula, dated 01/21/24, showed: - Facility will ensure any resident with a trach will be maintained to prevent infection and an unobstructed airway; - Supplies needed: suction machine, tubing, trach care kit, sterile saline bottles, sterile Q tips, and a small bottle of peroxide; - Wash hands and explain the procedure to the resident; - Apply clean gloves, remove the old dressing and dispose of in the removed gloves; - Open the trach kit, pour the peroxide into one side of the sterile kit and the saline in the other side, put on the sterile gloves in the kit, remove the sterile pad and place it next to the kit; - Place all gauze on the Q tips on the sterile field; - Using sterile technique, moisten one Q tip and gauze with peroxide and one with saline, place in the remaining compartment; - Once the kit is prepared, remove the inner cannula with one hand and place in the peroxide (with the clean hand); - From the sterile field, pick up the brush with the sterile hand and place it in the clean hand; - Remove the inner cannula from the peroxide with the sterile hand and use the sterile brush to cleanse the inside of the tube; - Once it is cleaned with peroxide, rinse with saline and place it back into the outer cannula of the trach; - Use a Q tip and gauze with peroxide and saline to clean the face plate of the trach; - Replace the sterile gloves with clean gloves and reapply the dressing; - Check the oxygen saturation and document the procedure. 2. Review of Resident #272's medical record showed: - admitted on [DATE] : - Diagnoses of a tracheostomy, acute and chronic respiratory failure, hypoxia (low levels of oxygen in the blood) or hypercapnia (high levels of carbon dioxide in the blood), anoxic brain damage (a complete lack of oxygen to the brain, which results in the death of brain cells), history of heart attack, and epilepsy (abnormal electrical brain activity). Review of the resident's May 2024 POS showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order to replace the inner cannula of the trach (diameter 6.4) daily and as needed (PRN) every 30 days on the night shift related to a tracheostomy, dated 05/07/24; - An order for the Shiley-DCFN trach with a trach size - 6, inner cannula diameter 6.4, outer cannula diameter 10.8, dated 05/07/24; - An order to change all trach related tubing and suction tubing weekly and PRN every night shift every Sunday related to a tracheostomy, dated 05/12/24; - An order to change the T drain trach sponge every shift and PRN when soiled for trach care related to a tracheostomy, dated 05/07/24; - An order for oxygen at 2 LPM via the trach collar continuous to keep oxygen saturations above or equal to 92%, with humidity at 28 %, dated 05/07/24; - An order for to suction the trach PRN for an increase in secretions, dated 05/07/24 Review of the May 2024 Treatment Administration Record (TAR) showed: - An order for the inner cannula to be changed daily and PRN every 30 days, dated 05/07/24; - An order for the inner cannula to be changed monthly and PRN night shift every 30 days, dated 05/07/24; - Documentation of the inner cannula changed on 05/07/24; - Documentation of the inner cannula did not need to be changed for 05/08/24 - 05/ 23/24; - The facility failed to verify the correct order on the TAR; - The facility failed to change the inner cannula daily as ordered on the May 2024 POS. During an interview on 05/22/24 at 2:45 P.M., RN I/Corporate Nurse said the inner cannula should be changed daily, not monthly. The order was documented incorrectly on the TAR. During an interview on 05/22/24 at 3:00 P.M., RN T said the night nurses were responsible for changing the inner cannula. He/She worked the day shift so never changed it. The order on the TAR to change the inner cannula monthly and PRN was incorrect and it should be changed daily. Observations on 05/21/24 at 8:42 A.M., and on 05/22/24 at 8:30 A.M., of the resident showed the resident lay in bed with oxygen at 3 LPM via the trach collar. Observation on 05/22/24 at 1:25 P.M., the resident's trach care and suctioning showed: - Registered Nurse (RN) T and Licensed Practical Nurse (LPN) G performed hand hygiene; - LPN G put on gloves and then took off the gloves to get supplies; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN T removed the water pan from the trach kit and poured water into it with his/her bare hands; - RN T removed the sterile gloves, did not perform hand hygiene, and put on gloves; - RN T cleansed the trach collar with the brush, - RN T broke sterile field, removed the sterile gloves, did not perform hand hygiene, and opened the suction package; - LPN G walked back into the room, performed hand hygiene, and put on gloves; - RN T did not perform hand hygiene and put on sterile gloves; - RN T put together the suction tubing and suctioned the resident three times with LPN moving the trach mask to oxygenate the resident in between the suctioning; - RN T failed to perform hand hygiene and to change gloves prior to cleaning the resident's mask and applying a T drain dressing to the resident's stoma. Observation on 05/22/24 at 3:20 P.M., of the resident's room trach supplies showed: - No unopened outer cannula in the resident's room; - An outer cannula in the supply closet across the facility and not near the resident. During an interview and observation on 05/22/24 at 3:20 P.M., RN T said he/she didn't think the resident had an outer cannula to the trach. RN T went to the resident's room and found an opened outer cannula in the bottom of a box. RN T wasn't aware of another outer cannula in the facility. During an interview on 05/22/24 at 3:25 P.M., RN I/Corporate Nurse said if the outer cannula came out, he/she would expect staff to put a new one in. There was another one in storage if not on the hall. Staff should have been inserviced. During an interview on 05/22/24 at 3:37 P.M., RN F said he/she was unsure if there was an outer cannula in the building. If it came out, he/she would find something to go into it and if it wasn't an outer cannula, the resident would be sent out. During an interview on 05/23/24 at 9:12 A.M., LPN Q said the night nurse changed the inner cannula. If the outer cannula came out, he/she would put one in.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47445 Based on observation, interview, and record review, the facility failed to identify, assess and provide supportive interventions for one resident (Resident #105) with a diagnosis of Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of two sampled residents. The facility's census was 121. Review of the facility's policy titled, Trauma Informed Care, revised March 2019, showed: - Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization; - The facility supports a culture of emotional well-being and physical safety for staff, residents and visitors; - Trauma-informed care is culturally sensitive and person-centered; - Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. Review of Resident #105's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, anxiety disorder (long-term loss of pleasure or interest in life), major depressive disorder (long-term loss of pleasure or interest in life), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain, depriving them of oxygen and nutrients), and Huntington's disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down and die). Review of the resident's Social Services Trauma Admission Assessment, dated 04/15/24, showed: - Diagnosis of PTSD or trauma associated event; - War veteran; - Observed combat in war; - Trouble sleeping or had flashbacks related to events experienced or saw during the war; - A war veteran and a police officer were events that occurred in life that caused significant anxiety, depression, sleeplessness, or fear; - Did not address the resident's PTSD triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician's Order Sheet (POS), dated May 2024, showed: - An order for clonazepam (an antianxiety medication) 0.5 milligram (mg) tablet by mouth two times a day for anxiety disorder, dated 05/15/24; - An order for mirtazapine (an antidepressant medication) 15 mg tablet by mouth at bedtime for depression symptoms related to major depressive disorder, dated 04/15/24; - An order for Prozac (an antidepressant medication) 10 mg by mouth in the morning for depression symptoms related to major depressive disorder, dated 04/15/24; - An order for quetiapine (an antipsychotic medication) extended release 150 mg by mouth at bedtime for mood/anxiety related to vascular dementia, dated 04/15/24. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment to be completed by staff), dated 04/22/24, showed: - Diagnosis of PTSD; - Mildly depressed; - No behaviors; - Received antipsychotic, antianxiety, and antidepressant medications daily. Review of the resident's comprehensive care plan, dated 04/15/24, showed: - Resident used antidepressant and antianxiety medications; - Resident used psychotropic (any medications that affect behavior, mood, thoughts, or perception) medications; - Resident had a mood problem and depression; - Resident had an alteration in neurological status (a change in the average mental function); - PTSD not addressed; - Goals with specific interventions to maintain the resident's psychosocial and mental health not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Festus Manor	627 Westwood Drive South Festus, MO 63028

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/20/24 at 10:51 A.M., Resident #105 said he/she was a war veteran and a police officer. No staff at the facility had talked to him/her about any triggers. Some of his/her triggers were people sitting or standing behind him/her in a room. He/She had been caught by surprise and pushed down at a store before coming to the facility. During war time, helicopters flew all the time, a lot of soldiers were lost, and the memories stuck with him/her and got worse as he/she got older. He/She had to help medics during the war and it was very hard to deal with. Observation of the resident on 05/20/24 at 10:51 A.M., showed the resident sat in a wheelchair in his/her room. The resident fidgeted more and stiffened his/her right arm next to his/her side the longer he/she talked about his/her triggers and war history. During an interview on 05/22/24 at 8:53 A.M., Registered Nurse (RN) N said a trauma assessment/PTSD screen was completed by the Social Service Director (SSD) at the beginning of the stay, usually within the first couple of days. During an interview on 05/23/24 at 12:21 P.M., Certified Nursing Assistant (CNA) M said PTSD and behaviors were located in a resident's care plan. Resident's behaviors were to be charted on. During an interview on 05/23/24 at 1:00 P.M., SSD O said he/she had not talked to Resident #105 about his/her PTSD diagnosis and triggers. SSD O was not aware of the PTSD diagnosis. If a resident had a diagnosis of PTSD, a trauma assessment should be completed. Every resident should have a trauma assessment completed. PTSD and/or trauma should be addressed on the care plan and triggers should be addressed. During an interview on 05/23/24 at 1:42 P.M., RN I/Corporate Nurse said PTSD and triggers should be addressed on the care plans.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45693 Based on observations, interview and record review, the facility failed to post the nurse staffing data with all the required components in a clear and readable format in a prominent place readily accessible to residents and visitors on a daily basis. The facility census was 121. Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised July 2016, showed: - The facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to the residents; - Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location accessible to residents and visitors and in a clear and readable format; - Inquiries concerning direct care staffing information should be referred to the Director of Nursing (DON) or to the Administrator. Observations of the facility staffing sheet located in the foyer showed: - On 05/20/24 at 11:00 A.M., a posted nurse staffing sheet, dated 03/25/24; - On 05/21/24 at 8:00 A.M., a posted nurse staffing sheet, dated 03/25/24; - On 05/23/24 at 7:50 A.M., no posted nurse staffing sheet; - On 05/23/24 at 9:45 A.M., a posted nurse staffing sheet, dated 05/22/24. During an interview on 05/23/24 at 10:00 A.M., the Regional Support Specialist said the Staffing Coordinator was responsible for posting the staffing sheet daily and it should be posted two hours prior to the start of a shift. During an interview on 05/23/24 at 11:20 A.M., the Staffing Coordinator said he/she was responsible for posting the daily nurse staffing sheets on a table by the front office. Staffing should be posted daily in the morning when he/she got to the facility shortly after 6:00 A.M. He/She had been in this position since 04/15/24, and was still getting organized and in a routine.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26904 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for one out of five medication carts. This practice had the potential to affect all residents. The facility census was 121. Review of the facility's policy titled,Controlled Substances, dated April 2019, showed: - The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications; - Personnel who are authorized to handle controlled substances are approved by the Director of Nursing (DON); - The DON maintains a list of personnel who have access to medication storage areas and controlled substance containers; - Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift; - Controlled substances are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. 1. Review of the 200/400 Hall Nurse Narcotic Count Log for Controlled Substances showed for 05/01/23 through 05/22/24, the staff missed 24 out of 132 opportunities to reconcile the narcotics. During an interview on 05/22/24 at 8:35 A.M., Certified Medication Technician (CMT) R said the narcotic sheets should be counted at each shift change by the offgoing and oncoming nurses and signed at that time. During an interview on 05/23/24 at 9:06 A.M., Licensed Practical Nurse (LPN) L said he/she would expect the oncoming and off going nurse to count and sign off on the narcotic count sheets. During an interview on 05/23/24 at 1:58 P.M., Registered Nurse (RN) I/Corporate Nurse said the narcotics should be counted at the end of each shift and signed by the oncoming and outgoing nurses. If the staff covered for anyone and the keys changed hands, then the carts also needed to be counted at that time. During an interview on 05/23/24 at 2:30 P.M., RN I/Corporate Nurse and the Regional Support Specialist said narcotics should be counted each time the keys change hands. If a narcotic was wasted, two nurses should witness it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26904 Based on observation, interview, and record review, the facility failed to label and store medications in a safe and effective manner. This had the potential to affect all residents. The facility census was 121. Review of the facility's policy titled, Insulin Administration, dated September 2014, showed: - Check the expiration date, if drawing from an opened multi-dose vial via a syringe. If opening a new vial, record the expiration date and time on the vial; - The policy did not address insulin pens. Review of Humalog (an insulin used to lower blood sugar) manufacturer's instructions, revised 08/2023, showed to throw away the Humalog Pen you are using after 28 days, even if it still has insulin left in it. Review of Novolog (type of insulin) manufacturer's instructions, revised 02/2023, showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. 1. Observation on 05/22/24 at 12:40 P.M., of the 300 Hall medication cart showed: - One Humalog pen labeled with an opened date of 04/10/24 (14 days past use date); - One Humalog pen labeled with an opened date of 03/12/24 (42 days past use date; - One Novolog pen labeled with an opened date of 04/07/24 (17 days past use date). During an interview on 05/22/24 at 12:45 P.M., Licensed Practical Nurse (LPN) C said he/she said thought it was the night shifts place to check the carts, but honestly he/she did not know. The insulin pens should be thrown away if they were out of date. During an interview on 05/23/24 at 12:30 P.M., LPN D said the insulin pens on average were good for 30 days. The nurses were responsible to check their own carts. When the insulin pens were checked and discovered out of date, then staff should throw them away and replace it with a new one at that time. Review of the facility's policy titled, Storage of Medications, dated November 2020, showed: - The facility stores all drugs and biologicals in a safe, secure, and orderly manner; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The nursing staff is responsible for maintaining medication storage; - Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurse's station or other secured location; - Schedule II-IV controlled medications are stored in separately locked, permanently affixed compartments, access to controlled medication is separate from access to non-controlled medications. Review of the facility's policy titled, Controlled Substances, dated April 2019, showed: - Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises; - Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. 2. Observation on 05/22/24 at 4:00 P.M., of the 200/400 Hall medication room refrigerator showed: - Refrigerator unlocked; - The open lock lay on top of the refrigerator; - One unopened 30 milliliter (ml) multi-dose bottle of lorazepam (an anti-anxiety medication, a controlled substance) 2 milligram (mg)/ml; - Two unopened 2 mg/1 ml vials of lorazepam. During an interview on 05/22/24 at 4:05 P.M., LPN F said the refrigerator on the 200/400 Hall should have been locked with lorazepam in it. He/she was not aware of it being unlocked. 3. Observation on 05/23/24 at 8:30 A.M., of the 500 Hall medication room refrigerator showed: - Refrigerator unlocked; - The opened lock lay on top of the refrigerator; - One opened 30 ml multi-dose bottle lorazepam 2 mg/ml bottle; - One unopened 30 ml multi-dose lorazepam 2 mg/ml bottle; - Four unopened 2 mg/1 ml vials of lorazepam. During an interview on 05/23/24 at 8:35 A.M., LPN Q said he/she forgot to put the lock back on the 500 Hall refrigerator after he/she counted the narcotic medications this morning. During an interview on 05/23/24 at 8:40 A.M., LPN G said the refrigerators and the medication room doors should be locked at all times where the refrigerators were located. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/24 at 9:00 A.M., LPN P said the refrigerators should absolutely be locked at all times due to the narcotics being stored in the refrigerator. Narcotics needed to be behind two locks, which included the refrigerator and the medication room door lock. During an interview on 05/23/24 at 1:48 P.M., Registered Nurse (RN) I/Corporate Nurse said every nurse should check their carts every shift. However it was the nurse manager's responsibility to clean and check the carts also. He/She would expect staff to remove any outdated insulin pens, dispose of them, and replace with a new one. The narcotics should be double locked at all times unless staff were actively using the medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to ensure a hospice coordinated plan of care, which addressed all aspects of the resident's medical care, was provided upon admission to hospice for one resident (Resident #16) and the facility failed to have a hospice coordinated plan of care signed by the hospice and the facility staff for two residents (Resident #16 and #61) and out of two sampled residents. The facility census was 121. Review of the facility's policy titled, Hospice Program, revised July 2017, showed: - Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being; - The coordinated care plan will reflect the resident's goals and wishes, as stated in his/her advance directives and during ongoing communication with the resident or representative, including: palliative goals and objectives; palliative interventions; and medical treatment and diagnostic tests; - The coordinated care plan shall be revised and updated as necessary to reflect the resident's current status. 1. Review of Resident 16's medical record showed: - admitted to hospice on 01/26/24; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), chronic kidney disease (a gradual loss of kidney function) type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), osteoarthritis (a type of arthritis marked by cartilage deterioration of joints and vertebrae) and pain; - No documentation of a hospice coordinated plan of care for admission to hospice on 01/26/24; - Hospice coordinated plan of care, dated 02/06/24, signed by hospice staff but not signed by facility staff. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment to be completed by facility staff), dated 05/03/24, showed the resident received hospice services. 2. Review of Resident 61's medical record showed: - admitted to hospice on 08/04/23; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hospice diagnosis of cerebral vascular disease (a term for conditions that affect blood flow to the brain) with a supporting diagnoses of Parkinson's (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) Disease, and vascular dementia (a disorder that damages brain tissue because of a lack of blood flow); - The hospice coordinated plan of care, dated 08/04/23, did not address the resident's treatments and the medical equipment required by the resident. The coordinated plan of care was signed by hospice staff, but not signed by facility staff; - The hospice coordinated plan of care, dated 04/25/24, did not address the specific days the hospice nurse was to visit the resident, the care to be provided by the facility staff, other treatments, or equipment required by the resident. The coordinated plan of care was signed by hospice staff but not signed by facility staff. Review of the resident's quarterly MDS, dated [DATE], showed the resident received hospice services. During an interview on 05/22/24 at 2:15 P.M., Licensed Practical Nurse (LPN) P said the nurses did not sign anything with hospice when a resident was admitted to hospice. Hospice came in and filled out their paperwork and facility staff would put in the orders. During an interview on 05/22/2024 at 3:42 P.M., LPN E said when a resident admitted to hospice, a coordinated plan of care should be completed on the day the resident started receiving hospice services. The coordinated plan of care should be signed and dated by the hospice staff and a facility staff. During an interview on 05/22/2024 at 3:55 P.M., Registered Nurse (RN) F said he/she would expect a coordinated plan of care to be signed and dated on the day a resident started receiving hospice services. During an interview on 05/23/24 at 1:42 P.M., RN I/Corporate Nurse said the hospice coordinated plan of care should be completed and there should be a hospice care plan. Both should specify what hospice staff were responsible for and what the facility staff were responsible for. The hospice book should be completed by hospice staff and reviewed by the unit manager to sign. 47445

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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. 37575 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent the potential spread of infectious disease. The facility failed to follow infection control practices by not performing hand hygiene or glove changes for three residents (Resident #71, #118, and #272) out of three sampled residents. This had the potential to affect all residents in the facility. Census was 121. Review of the facility's policy titled, Monitoring Compliance with Infection Control, revised August 2019, showed: - The Infection Preventionist (IP) or designee monitors the compliance and the effectiveness of our infection prevention and control policies and practices; - Monitoring includes regular surveillance of adherence to hand hygiene practices and availability of hand hygiene supplies, and the availability of personal protective equipment and its appropriate use; - The IP and/or the infection prevention control (IPC) committee provides reports to the quality assurance and performance improvement (QAPI) committee; - The QAPI committee reviews and acts upon, as necessary, surveillance and monitoring records. 1. Review of the facility's Infection Control Program, dated January 2023 through May 2024 , showed: - The infection logs not completed for July 2023 - May 2024; - The facility failed to track infections for November 2023-December 2023 and January 24-May 24. During an interview on 05/23/24 at 9:40 A.M., the IP said he/she would expect the Nursing Department to follow the facility Infection Control policy and procedure manual, Centers for Medicare and Medicaid Services and Centers for Disease Control guidelines for Infection Control program. During an interview on 05/23/24 at 1:50 P.M., the Regional Support Specialist and Registered Nurse (RN) I/Regional Nurse said the Infection Prevention/Antibiotic Stewardship had not been completed since June 2023. 2. Observation on 05/21/24 at 4:25 P.M., of Resident #71 showed: - Licensed Practical Nurse (LPN) F entered the resident's room and lay the wound care supplies on the overbed table without a barrier and did not clean/sanitize the overbed table prior to the wound care; - LPN F didn't perform hand hygiene and put on gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN F assisted the resident onto the bed and removed his/her pants and brief; - LPN F removed the dressings from the sacrum (large flat bone at the lower part of the spine) and the right and left buttocks and removed the gloves; - LPN F didn't perform hand hygiene and put on clean gloves; - LPN F cleansed and patted dry each wound and removed the gloves; - LPN F didn't perform hand hygiene and put on clean gloves; - LPN F removed scissors from his/her pocket, did not sanitize them, cut open the collagen powder (a wound treatment) packets, applied the collagen powder to the wound beds, and removed the gloves; - LPN F didn't perform hand hygiene, put on clean gloves, and placed the dressings over the wounds and secured them; - LPN failed to perform hand hygiene prior to beginning of the wound care, between each glove change, and sanitize the scissors prior to use for the resident's wound care. 3. Observation on 05/22/24 at 9:30 A.M., of Resident #118 showed: - RN T lay the resident's percutaneous endoscopic gastrostomy (PEG tube - a feeding tube surgically placed through the abdomen into the stomach) site dressing supplies to overbed table without a barrier and did not clean/sanitize the overbed table; - RN T performed hand hygiene and put on gloves; - RN T cleansed the skin around the PEG tube site and removed the brown, dried drainage from around the site; - RN T did not remove the gloves and perform hand hygiene, applied a clean dressing to the PEG tube site; - RN T failed to perform hand hygiene and change gloves when going from dirty to clean care. During an interview on 05/22/24 at 9:45 A.M., RN T said he/she should have changed gloves when going from dirty to clean care, such as after cleansing around the PEG tube site and before applying the new dressing. 4. Observation on 05/21/24 at 1:20 P.M., of Resident #272 showed: - RN T performed hand hygiene and put on gloves; - RN T removed the dressing from around the PEG tube site, and did not perform hand hygiene or remove the gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN T, with the same gloves, administered the resident's PEG tube medications and water flush, did not remove the gloves and perform hand hygiene; - RN T, with the same gloves, cleansed the PEG tube site with normal saline (a mixture of sodium chloride and water) and applied a new dressing; - RN T failed to perform hand hygiene and change gloves between dirty and clean care. Observation on 05/21/24 at 1:35 P.M., of Resident #272 showed: - RN T performed hand hygiene and put on gloves; - RN T cleansed the open areas on the resident's coccyx (small triangular bone at the base of the spinal column) and buttocks with normal saline, did not remove gloves, and did not perform hand hygiene; - RN T applied the clean dressings to the wounds; - RN T failed to perform hand hygiene and change gloves between dirty and clean care. Observation on 05/22/24 at 1:25 P.M., of the tracheostomy (trach - a surgical procedure to create an opening through the neck into the trachea windpipe to provide an airway) care and suction for Resident #272 showed: - RN T and LPN G performed hand hygiene; - LPN G put on gloves and then took off the gloves to get supplies; - RN T removed the water pan from the trach kit and poured water into it with his/her bare hands; - RN T removed the sterile gloves, did not perform hand hygiene, and put on gloves; - RN T cleansed the trach collar with the brush, - RN T broke sterile field, removed the sterile gloves, did not perform hand hygiene, and opened the suction package; - LPN G walked back into the room, performed hand hygiene, and put on gloves; - RN T did not perform hand hygiene and put on sterile gloves; - RN T put together the suction tubing and suctioned the resident three times with LPN G moving the trach mask to oxygenate the resident in between the suctioning; - RN T failed to perform hand hygiene and to change gloves prior to cleaning the resident's mask and applying a T drain dressing to the resident's stoma. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/24 at 3:40 P.M., RN T said he/she would change gloves at pretty much every step during wound care. He/She would perform hand hygiene when going in and out of resident rooms. During an interview on 05/23/24 at 2:00 P.M., LPN F said hand hygiene should be done before and after care, when entering and exiting a resident room. Hand hygiene should be done with glove changes between dirty to clean care and anytime the gloves were soiled during incontinent and wound care. Scissors should be cleaned/sanitized prior to use. During an interview on 05/22/24 at 3:20 P.M., RN T said he/she should have changed gloves and washed his/her hands when going from dirty to clean care and he/she messed up. During an interview on 05/23/24 at 2:30 P.M., RN I/Regional Nurse and Regional Support Specialist said hands should be cleansed when going from dirty to clean care and with glove changes. Also, any time entering or exiting a room hands should be cleansed. 45693 48247

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48247 Based on interview and record review, the facility failed to provide documentation of the Antibiotic Stewardship Program (a program that measures and improves how antibiotics were prescribed by clinicians and used by patients) and that its policies were reviewed annually. This had the potential to affect all residents in the facility. The census was 121. Review of the facility's policy titled, Antibiotic Stewardship-Review of Surveillance of Antibiotic of Antibiotic Use and Outcomes, showed: - Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship; - As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee. - The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics; - At the conclusion of the review, the provider will be notified of the review findings; - All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. 1. Review of the facility's Antibiotic Stewardship Program showed no documentation of completed antibiotic stewardship tracking for 11/2023 - 05/2024; Review of the facility's Antibiotic Listing Report, dated 05/23/24, showed 12 residents currently received antibiotics. During an interview on 05/23/24 at 9:40 A.M., the IP said he/she would expect the nursing department to follow the facility's policy, the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) guidelines for the Antibiotic Stewardship program. During an interview on 05/23/24 at 1:50 P.M., the Regional Support Specialist and Registered Nurse (RN) I/Corporate Nurse said the Infection Prevention/Antibiotic Stewardship had not been addressed since November 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265401	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Festus Manor	627 Westwood Drive South Festus, MO 63028

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the insect population in the facility. The facility census was 121. The facility did not provide a policy on pest control. Review of the monthly pest control invoices for January 2024 through May 2024, showed: - Service for March 2024, targeted the German roach, cockroaches, and ants; - Service for April 2024, targeted miscellaneous insects and spiders; - Service for May 2024, targeted flies, miscellaneous flies, rodents, and house mice; - Service for May 2024, recommended replacement of all insect light traps to newer ones due to not working properly. 1. Observation on 05/20/24 at 1:07 P.M., of room [ROOM NUMBER] showed two flies flew around the resident's room. During an interview on 05/20/24 at 1:07 P.M., the resident in room [ROOM NUMBER] said it was normal to see flies in the room, and they were unwanted. 2. Observation on 05/20/24 at 1:17 P.M., of room [ROOM NUMBER] showed four flies flew inside the room and landed on a restaurant carry-out bag, the resident's bedding and on the resident's face. One fly flew in the hallway outside the room. During an interview on 05/20/24 at 1:17 P.M., the resident in room [ROOM NUMBER] said the flies had been bothersome and the staff had been notified about the flies. 3. Observations on 05/22/24 of the 100 Hall showed: - At 10:09 A.M., and 11:18 A.M., one fly flew around the conference room; - At 12:58 P.M., one gnat flew around the conference room; - At 3:50 P.M., one fly flew around the 100 Hall and into room [ROOM NUMBER] and landed on a bed; - At 3:55 P.M., one fly flew around the 100 Hall and into room [ROOM NUMBER]. 4. Observation on 05/22/24 at 12:23 P.M., of the soiled laundry room area showed two flies landed on the floor. 5. Observations on 05/22/24 of the 300 Hall showed: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 10:33 A.M., one fly flew outside room [ROOM NUMBER]; - At 4:16 P.M., one fly flew outside room [ROOM NUMBER]. 6. Observation on 05/23/24 at 11:14 P.M., of the dining room area showed three gnats flew around and two flies landed on the ice machine drain. 7. Observations on 05/23/24 of the 100 Hall showed: - At 10:23 A.M., three flies flew outside room [ROOM NUMBER]; - At 11:11 A.M., two flies and two gnats flew outside room [ROOM NUMBER]; - At 11:27 A.M., three flies flew toward the smoking area; - At 12:12 P.M., one fly flew outside room [ROOM NUMBER]. During an interview on 05/23/24 at 12:13 P.M., Housekeeper Y said it was normal to see flies in the hallway and some residents had issues that created more flies. Floors were mopped daily and rooms were cleaned to try and control the flies. The flies had gotten worse since he/she had been here, and the warmer rooms were the worst. During an interview on 05/23/24 at 12:17 P.M., Housekeeper W said flies were common and one specific room on the 300 Hall was bad with flies. The resident had urinals that might attract the bugs. He/she had not been told to do anything other than to speak with the supervisor and make reports of the flies. During an interview on 05/23/24 at 12:35 P.M., LPN P said the flies were an issue, but they came and went. They probably came indoors from the smoking area or other exits. During an interview on 05/23/24 at 12:38 P.M., the Maintenance Supervisor (MS) said the flies were common and there was spray used for the rooms as needed. Fly strips were used in some of the residents' rooms. Pest control was contacted if there were concerns with insects that had been documented. During an interview on 05/23/24 at 12:43 P.M., the Housekeeping and Laundry Supervisor said the housekeepers come to him/her if there were concerns with flies or pests. Most of them did well with reporting that concern. Maintenance was contacted if fly traps were needed. Maintenance slips were used if there were any concerns. The flies hadn't been as bad on the 400 Hall lately but probably were bad on the 100 Hall due to concerns with some residents. During an interview on 05/23/24 at 3:43 P.M., the Regional Support Specialist and Registered Nurse (RN) I/Corporate Nurse said they expect the halls and rooms to be free of pests. Flies should be reported to the supervisor or put in a pest control book. A pest control log was kept that should be updated when a pest was observed. Pest control was supposed to be provided monthly or as needed.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45693 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year. This affected two out of two sampled Certified Nurse Assistants (CNA) M and V. The facility's census was 121. The facility did not provide an in-service training policy. Review of the facility's policy titled, Staffing, revised October 2017, showed: - The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment; - Licensed nurses and CNAs are available 24 hours a day to provide direct resident care services; - Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 1. Review of CNA M's employee record showed: - Hire date of 11/21/22; - A total of 10 topics covered for annual inservice training for November 2022 through November 2023; - No documentation of the length of time for each in-service provided; - No documentation of Abuse and Neglect training provided; - No documentation of at least twelve hours of in-service education for November 2022 through November 2023 provided. 2. Review of CNA V's employee record showed: - Hire date of 12/26/22; - A total of eight topics covered for annual inservice training for December 2022 through December 2023; - No documentation of the length of time for each in-service provided; - No documentation of at least twelve hours of in-service education for November 2022 through November 2023 provided. (continued on next page)

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 05/22/24 at 2:30 P.M., Registered Nurse (RN) I/Regional Nurse and Regional Support Specialist said that CNAs should receive 12 hours of in-service training. That training would include abuse and neglect.