| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265417 | A. Building<br>B. Wing | 04/10/2026 |

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| Sherbrooke Village | 4005 Ripa Avenue<br>Saint Louis, MO 63125 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident was treated in a dignified manner (Resident #98), and failed to ensure staff followed the facility's cell phone policy, which affected 4 residents (Residents #12, #3, #100 and #140). The sample size was 24. The census was 121. Review of the facility's resident rights policy, dated 1/28/26, showed:-Policy: The facility shall treat residents with kindness, respect, and dignity and ensure resident rights are being followed. The resident/resident representative will be informed of their rights upon admission. Review of the facility's employment policies and procedures, undated, showed:-Personal cell phones: Use of personal cell phones or other similar devices while on duty is prohibited. Employees must understand that our first priority is the care and welfare of the residents. Use of personal cell phones is limited to breaks and meal periods. Ringers are to be silenced while on duty, and employees may not initiate or receive calls or text messages while caring for a resident or conducting company business. If the facility determines that an employee engages in personal cell phone/texting use during work hours, he or she may be subject to disciplinary action, up to and including termination. 1.Review of Resident #98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Diagnoses included Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Observation on 4/7/26 at 745 A.M., showed the resident at the end of a hallway leading to the 300/400 dining room. The resident sat in his/her wheelchair. Certified Nursing Assistant (CNA) F walked by the resident. The resident asked CNA F to help him/her into the dining room. CNA F walked over to the resident and said he/she could not push him/her because the resident did not have his/her foot pedals. The resident looked at the aide but did not move. CNA F told the resident to use his/her feet and move towards the dining room. The resident moved a couple of feet but stopped. Unknown Aide LL walked by and asked the resident if he/she needed help. CNA F said to the aide that the resident could not find his/her foot pedals in his/her room today, and they could not push him/her without them. CNA F then turned to the resident and told the resident to move his/her feet again. The aide told the resident he/she was capable of moving his/her feet and could get him/herself to the dining room. The resident moved another couple of feet and then stopped. He/She looked at the aides with an uncomfortable look on his/her face. Unknown Aide LL then assisted the resident into the dining room. During an interview on 4/10/26 at 7:57 A.M., CNA J said if a resident asked for help, staff should have assisted the resident or found someone who could. During an interview on 4/10/26 at 8:02 A.M., Licensed Practical Nurse (LPN) K said if a resident asked for help, staff should have assisted the resident and should not have told the resident they would not help. During an interview on 4/10/26 at 1:05 P.M., the Administrator and Director of Nursing (DON) said residents should be treated and spoken to in a dignified manner. If a resident asked for help, they would have expected for staff to assist them. 2. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Diagnoses included aphasia (impaired talking and understanding language), paraplegia (impaired motor and sensory in lower extremities), hemiplegia<br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (severe or complete paralysis of one side of the body), hemiparesis (partial weakness or reduced movement on one side of the body) and dementia;-Severe cognitive impairment. Observation on 4/8/26 at 2:44 P.M., of the main dining room during lunch, showed CNA L sat next to the resident at a table in the dining room. While he/she fed the resident, he/she had ear buds in his/her ears and was looking at his/her phone. During an interview on 4/10/26 at 9:12 A.M., CNA L said cell phones were not to be used in resident care areas. He/She said on 4/8/26, he/she was on his/her phone while feeding the resident and was checking a text message. During an interview on 4/10/26 at 1:09 P.M., the Administrator and DON said staff should never be on their phones while feeding a resident or assisting residents in the dining room. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed:-Diagnoses included COPD, muscle weakness, depression, and anxiety;-Cognitively intact. During an interview on 4/06/26 at 10:40 A.M., the resident said staff were on their phones a lot. He/She said staff used their phones and headphones while providing care. 4. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Diagnoses included congestive heart failure, type two diabetes, chronic kidney disease, and major depressive disorder;-Cognitively intact. During an interview on 4/06/26 at 12:13 P.M., the resident said staff used their cell phones in the hallways. He/She said staff were on their phones a lot. 5. Review of Resident #140's quarterly MDS, dated [DATE], showed:-Diagnoses included depression, anxiety, and hypertension;-Cognitively intact. During an interview on 4/06/26 at 10:39 A.M., the resident said staff had phones out while providing care and took phone calls during care. 6. Observation on 4/08/26 at 11:00 A.M., showed CNA L sat in the 300 hallway lounge on the couch. Multiple residents were in the room. He/She was texting on his/her cell phone. Observation on 4/9/26 at 6:24 A.M., showed CNA G sat on a couch in the 300 hallway lounge. He/She sat next to a resident. He/She had headphones on and was looking at his/her phone. Observation on 4/9/26 at 6:53 A.M., showed CNA G in the hallway wearing headphones while looking at his/her phone. 7. During the resident council meeting on 4/7/26 at 2:34 P.M. five residents attended the group resident council meeting. The residents said there had been concerns noted to administration during previous resident council meetings regarding staff treating residents in a dignified manner. Residents reported care staff often come in and would turn the call light system off, telling residents I'm not your aide and then leaving without telling another staff member they required care. Staff were often heard laughing, talking loudly, or yelling at one another on the resident halls during the night shift, and have been observed on their cell phones while providing care. Resident council members noted this made them feel as if their dignity in the facility was diminished during these instances. 8. During an interview on 4/10/26 at 7:57 A.M., CNA J said staff was expected to be off of their cell phones in resident care areas. He/She said staff should only use their cellphones in the break room. 9. During an interview on 4/10/26 at 8:02 A.M., LPN K said cell phones were only to be used in the break room. He/She said staff should not be on their phones in resident care areas. 10. During an interview on 4/10/26 at 1:05 P.M., the Administrator and DON said cell phones and headphones should not be used in resident care areas. 28017622807190 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview and record review, the facility failed to ensure residents received appropriate activity of daily living (ADL, daily care) care to meet the needs of residents by leaving one incontinent resident (Resident #98) soiled and wet for an extended period. The sample was 24. The census was 121.Review of the facility's Perineal Care (cleansing of the genitals and anal area) policy, undated, showed:- Perineal care which includes care of the external genitalia and the anal area, should be offered during the daily bath and it the resident is incontinent for urine or stool; The procedure promotes cleanliness and prevents infection. It also removes irritating and odorous secretions. Review of Resident's # 98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Dependent on staff for toileting hygiene;-Required partial to moderate assist from staff for personal hygiene;-Frequently incontinent of bowel and bladder;-Diagnoses included Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Review of the residents' care plan, in use at the time of survey, showed:Focus: The resident has occasional episodes of bowel and bladder incontinence and is at risk for infection and skin breakdown;-Interventions: Assist the resident to the bathroom as desired; Offer to use the toilet before and after meals and at bedtime; Clean perineum after each incontinent episode. Observation and interview on 4/6/26 at approximately 9:00 A.M., showed the resident lay in bed and was heard from the hall yelling Nurse. The resident said he/she had been yelling for help for about 30 minutes because he/she needed to use the bathroom. At 10:01 A.M., the resident lay in bed and had a strong odor of stool present. The resident's call light was wrapped around the bed frame and out of the resident's reach. The resident said he/she could not reach his/her light and needed help going to the bathroom. At 10:32 A.M., the resident lay in bed. The resident's call light was wrapped around the resident's bed frame and out of the resident's reach. The resident said he/she was soiled and wet and no one has been in to check on him/her and he/she could not reach his/her call light. At 11:04 A.M., the resident lay in bed with a strong odor of stool and urine. Certified Nursing Assistant (CNA) DD and Licensed Practical Nurse (LPN) K entered the resident's room and had the resident turn to his/her right side. CNA DD removed the resident's brief. The resident's brief and bed pad were saturated with urine. The resident also had a large amount of diarrhea in his/her brief. The resident said he/she had not been changed all night or morning. During an interview on 4/10/26 at 7:30 A.M., Licensed Practical Nurse (LPN) W said incontinent residents were checked on every one to two hours. The CNA's and the nurses all made rounds on the incontinent residents to ensure they were clean, dry and odor free. Having the resident wait for over two hours to be cleaned was too long of a time. During an interview on 4/10/26 at 9:30 A.M., CNA X said incontinent residents were to be rounded on every two hours to ensure they were clean and dry. Resident #98 used the bathroom and should have been offered to use the restroom when the resident requested. Frequent checks were important so that the resident did not get skin breakdown. During an interview on 4/10/26 at 12:34 P.M., the Director of Nurses (DON) expected the staff to check on incontinent residents every two hours. She expected the residents to be clean, dry and odor free.<br>28068052807190280457929781 88 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #74) with an external urinary collection device (a noninvasive external tube that drains the urine from the bladder) had appropriate physician orders to include catheter care instructions and monitoring. The sample was 24. The census was 121.Review of the facility's Lippincott Nursing Procedure Book, External Urine Collection Device Use, ninth edition, page 324, published 9/2/22, showed:-External urine collection device serves as an alternative to indwelling urinary catheters (sterile tube inserted into the bladder to drain urine) in cooperative residents who don't have signs of urinary retention;-An external urine collection device designed for male residents consist of a condom catheter or other device secure to the shaft of the penis and connected to a leg bag or drainage bag;-Complications are commonly due to equipment malfunction or trauma from improper application and removal can include penile irritation, skin breakdown, swelling, ischemic (dead) tissue loss and infection;-Document the assessment finding before, during, and after device use;-Record urinary output as directed by the facility;-Document the resident's tolerance of the procedure, an intervention implemented, and the resident's response to those interventions;-If the practitioner was contacted, record the date, time and information conveyed as well as any information received;-Document teaching provided to the resident and the resident's family, and their understanding of that teaching and any need for follow up teaching. Review of Resident #74's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/26, showed:-Moderate cognitive impairment;-Dependent on staff for toileting hygiene;-External or indwelling catheter: Not checked;-Always incontinent of bowel and bladder;-Diagnoses included stroke and neurogenic bladder (a condition that makes it difficult to empty the bladder). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has episodes of bowel and bladder incontinence;-Interventions included: Assist to bathroom as desired or indicated. Cleanse peri-area (genital and rectal area) after each incontinent episode.-The resident's care plan did not address an external urinary draining device. Review of the resident's physician order sheet, dated 4/7/26, showed no orders related to the resident's external urinary drainage device. Observation on 4/7/26 at 10:15 A.M., showed a pink basin on the resident's floor containing a urinary drainage bag filled with yellow urine. The catheter tubing was laying on the floor, and a condom catheter was attached to the end of the tubing. Grey duct tape was attached to the condom catheter. During an interview, Certified Nursing Assistant (CNA) O said the resident's family member placed a condom catheter on the resident and secured it with duct tape every evening. The resident had been wearing a condom catheter at night for over a month. CNA O thought the nurses knew about it. Every morning, he/she carefully removed the condom catheter and duct tape from the resident's genitals to ensure that the resident's skin did not become damaged. CNA O did not empty the resident's drainage collection bag; he/she let the resident's family member do it. During an interview on 4/7/26 at 1:00 P.M., Licensed Practical Nurse (LPN) S said he/she was not aware the resident had been wearing a condom urinary catheter and that a family member had been securing it with duct tape. LPN S expected the staff to have notified the nurse about this so that the family could be educated and the physician could be notified. Monitoring of the condom urinary device should include skin assessments, output amounts, and the characteristics of the urine to ensure an infection was not occurring. There should be physician orders for all urinary catheters and devices, and the use of a urinary catheter should be added to the resident's care plan. During an interview on 4/10/26 at 7:30 A.M., LPN W said he/she was not aware the resident was wearing a condom urinary device at night. There should be documentation and physician orders related to the resident's condom urinary device. LPN W expected staff to inform the nurse that duct tape was being applied to the resident's condom urinary device by a family member. During an interview on 4/7/26 at 12:10 P.M., the Director of Nursing (DON) said she<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was not aware the resident's family member was applying a condom urinary drainage device and securing it with duct tape. She expected staff to let the nurse or herself know that was occurring. She expected documentation of this in the progress notes, and for staff to document skin checks, physician orders, and monitoring related to the external urinary drainage device. She expected education to be completed with the resident's family member about the use of duct tape on the urinary catheter. 2804579 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on observation, interview and record review, the facility failed to provide reasonable accommodation or intervention for pain management for two of two residents (Residents #118 and #2). One resident had uncontrolled pain for 20-hours after being discharged from a local hospital with a pelvic fracture. The facility did not administer any pharmacological or non-pharmacological approaches for pain control. The facility nurse did not try to get orders for pain medication from the on-call provider (Resident #118). Facility staff also failed to provide pain control interventions for one resident during a wound treatment (Resident #2). The sample was 24. The census was 121. Review of the facility's Pain Management policy dated 11/22, showed:-Policy: The Facility will use a systematic approach to Pain Management; Recognition, Evaluation, Treatment, & Monitoring of Pain. Individuals experiencing Pain may receive Pharmacological/Non-Pharmacological Interventions to assist in Pain Management. The Facility will provide Employees Education on Pain Management & Opioid Overdose.-Responsibility: Nursing personnel (Registered Nurse (RNs) and Licensed Practical Nurses (LPNs), Nursing Administration, Assistant Director of Nursing (ADON) and Director of Nursing (DON);-Procedure: Recognition: Evaluate/Prevent:-Recognize when Resident is experiencing Pain & Identify circumstances when Pain can be anticipated;-Evaluate Resident for Pain on admission and Routine Evaluations;-Manage/Prevent Pain, consistent with the Comprehensive Evaluation and Plan of Care;-Current Professional Standards of Practice, & Resident's Goals/Preferences;Observation for nonverbal indicators:-- Negative Vocalization (e.g., groaning, crying, whimpering, screaming);--Skin Conditions;-Verbal descriptors:--Hurting/Aching;--Burning;--Spasms;--Soreness, Tenderness, Discomfort, Pins, Needles;-Pain Evaluation: Nursing will complete a Pain Evaluation Tool, appropriate for the resident's cognitive status, to assist with evaluation of a resident's pain;-Evaluation of Pain by the Licensed Nurse or Medical Provider;--History of Pain & Treatment:---Non-Pharmacological, Pharmacological, & Alternative Medicine (CAM) Treatment;---Response/Effective to Treatment;---Ask the Resident to Rate the Intensity of his/her pain using a numerical scale, verbal or visual descriptor that is appropriate and preferred by the resident;---Reviewing the resident's current medical conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, CVA (cerebrovascular accident, stroke), venous and arterial ulcers, and multiple sclerosis chronic disease of the central nervous system));---Identifying Key Characteristics of Pain:---Duration;---Frequency;--Location;---Timing;---Pattern (e.g., constant, or intermittent);---Radiation;-Obtaining Descriptors of Pain (e.g., stabbing. aching, pressure, spasms);-Identifying activities, Resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain;-Impact of Pain on Activities of Daily Living (ADLs) (e.g., sleeping, social activities, physical activity and mobility, emotions, intimacy, appetite, and mood, etc.);--Current Prescribed Pain Medications, Dosage, Frequency, Treatments, & Modalities;-Pain Management & Treatment:--Based on the Evaluation, Nursing in collaboration with the Physician/Prescriber, other health care professionals, the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent/manage a resident's pain beginning at admission;- Factors Influencing Treatment:--Cause, location, & severity of pain;--Resident's medical condition;--Resident's current medications;-General principles for analgesics (pain medication):--Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic for pain therapy;--Consider evidence-based practice tools to assist in the evaluation of the residents pain;--Consider administering medication routinely instead of as needed (PRN) or combining longer acting medications with PRN medications for breakthrough pain;--Utilize the most effective and least invasive route for analgesic administration (e.g., oral (PO), anal, topical (on the skin), injection (below skin), infusion pump and/or transdermal);--Use lower doses of medication initially and titrate slowly upward until comfort is achieved;--Reassess and adjust the medication dose to optimize the<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | resident's pain relief while monitoring the effectiveness of the medication and work to minimize or manage side effects;--Review medical conditions which may require several analgesics and/or adjuvant medications; Documentation will clarify the rationale for a treatment regimen and acknowledge associated risks;--Opioids will be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences;--Nursing will notify practitioner if the resident's pain is not controlled by the current treatment regimen. 1.Review of Resident #118's discharge hospital paperwork dated 3/16/26 at 12:44 P.M., showed:-The resident was admitted to hospital for small facture (Fx) in the pubic symphysis (part of the pelvis);-Diagnoses: Left groin pain, chronic bilateral low back pain, obesity. diabetes, closed Fx of pelvis, and intractable (difficult to resolve) pain;-Goals: Control pain, maximize quality of life, and minimize further functional decline;-Strategies:--Activity/exercise program recommendation;--Conservative stepwise pain medicine strategy with multi-disciplinary approach;--Recommend healthy lifestyle strategies and compensatory methods as needed. Review of the hospital's After Visit Summary sheet (AVS), dated 3/16/26 at 2:33 P.M., showed:-Take these medications;- Acetaminophen 500 milligrams (mg) tablet commonly known as: Tylenol, take two tablets (1,000 mg total) by mouth every (Q) six hours as needed for pain. Last time this was given: 650 mg on 3/16/26 at 10:53 A.M.;- Cyclobenzaprine 10 mg tablet commonly known as: Flexeril take one tablet (10 mg total) by mouth three times a day (TID) as needed for muscle spasms, for muscle spasms. Last time this was given: 10 mg on 3/16/26 at 9:32 A.M.;- Hydromorphone 2 mg tablet commonly known as: Dilaudid take one tablet (2 mg total) by mouth every three hours PRN for pain. Last time this was given was 3 mg on 3/16/26 at 12:56 P.M.;- Gabapentin 600 mg tablet commonly known as: Neurontin (treats nerve pain) take two tablets (1,200 mg total) by mouth three times a day. Last time this was given 1,200 mg on 3/16/26 at 9:32 A.M. Review of the nurse progress note dated 3/16/26 at 4:38 P.M., showed a note by RN GG: Resident arrived at facility today via ambulance accompanied by two Emergency Medical Services (EMS) workers. Resident is alert & oriented (A&O) x4 (person, place, time and situation), able to make needs known and able to understand others. Admitting diagnosis is left groin pain. Residents does have a pubic, sacral (triangle bone of the spine), and lumbar (vertebra/spine) (L5) fracture. The resident is continent of bowel and bladder. The history (Hx.) of hypothyroidism (thyroid gland fails to produce sufficient hormones, slowing the body's metabolism), fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issue), chronic bilateral low back pain without sciatica (nerve), osteoporosis (weakened bones), deep vein thrombosis (DVT, red blood cells that block of the in the vein), groin pain, coronary artery disease (CAD, narrowing or blockage of the heart), stroke and diabetes. RN GG said medications were verified with in-house Nurse Practitioner (NP) T. The only new orders given was to make Protonix (treat stomach acid) twice a day (BID) instead of once a day. Another new order for albuterol sulfate HFA (prescription bronchodilator inhale) 90 micrograms (mcg) inhaler. Resident is currently in bed, no acute distress noted at this time. Review of the electronic physician's order sheet (ePOS) dated 3/2026, showed:-An order dated 3/17/26 at 2:00 P.M., Tylenol Extra Strength Oral Give 1000 mg by mouth pharmacy tablet 500 mg-An order dated 3/16/26 at 2:15 P.M., Hydromorphone HCl Oral Give one tablet by mouth pharmacy tablet 2 mg;-An order dated 3/16/26 at 2:15 P.M., Cyclobenzaprine HCl Oral tablet 10 mg;-An order dated 3/17/26 at 6:00 A.M., Gabapentin Tablet 600 mg. Review of the Medication Administration Record (MAR) dated 3/2026, showed:-Gabapentin Tablet 600 mg, Give 1200 mg by mouth three times a day for neuropathy (nerve damage), start date 3/17/26 6:00 A.M., discontinue date 3/19/26 8:34 A.M.; given one out of one time;-Cyclobenzaprine HCl Oral Tablet 10 mg, give 10 mg by mouth every eight hours as needed for muscle spasms, start date 3/16/26 at 2:15 P.M., discontinue date 3/19/26 at 8:34 A.M., not given on 3/16 or 3/17 as ordered;-Tylenol extra strength PO table 500 mg give 1,000 mg PO Q six hours as PRN for pain, start date 3/16/26 at 2:00 P.M., discontinue date 3/19/26 at 8:34 A.M.; medication not administered on 3/16 or 3/17;-Hydromorphone (continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | HCl PO tablet 2 mg, give one tablet PO Q three hours as PRN for pain, start date 3/16/26 at 1:56 P.M., discontinue date 3/19/26 at 8:34 A.M., medication not administered on 3/16 or 3/17. Review of the nurse progress note skilled evaluation on 3/16/26 at 9:20 P.M., showed: Resident's pain: pain Issue: #001: New. Location: Generalized. Pain score: 4 (on a scale of 1-10). Dull. Aching. Frequency: Intermittent. PRN medication provided. See MAR for details. Mood is pleasant, no unwanted behaviors witnessed. Resident sleeps through the night. Resident's psycho-spiritual needs are met. Review of the facility's Pain Level Summary dated 3/17/26 at 12:18 A.M., showed the resident's pain level was a 4 out of 10. Review of the facility's Pain Level Summary dated 3/17/26 at 5:33 A.M., showed the resident's pain level was a 10 out of 10, entered by RN HH. Review of RN HH's progress note on 3/17/26 at 6:45 A.M., showed the resident told staff he/she was in excruciating pain. The resident said he/she been awake crying all night, which he/she has slept a little bit but has been awake. RN HH said the resident has been on their call light to request that Certified Nurses Assistants (CNAs) re-reposition him/her frequently just to move himself/herself back to the position he/she was in before staff moved him/her to begin with. The resident told staff he/she is a CNA themselves, but we have told him/her that they are a patient now and can't think of himself/herself as a CNA now. The resident won't leave the pillows positioned in the places that the CNAs put them in to keep him/her positioned in, and as soon as resident urinates, he/she wants changed at that moment. RN HH placed a call to the exchange to notify him of the increased pain the resident had. Nurse Partitioner R is on call, awaiting return call. Review of the nurse progress notes on 3/17/26, showed:-At 7:10 A.M., spoke to NP R and his/her recommendation was to send the patient back to discharged hospital for pain management immediately; -At 8:14 A.M., EMS notified; -At 9:01 A.M., EMS arrived at facility to transport resident to local hospital. During an interview on 4/9/26 at 12:50 P.M., RN GG said his/her primary goal during an admission are vitals (blood pressure, temperature, pain and respirations), weight and skin assessment. He/she will orientate the residents to the facility and provide them with their call light. When a resident complains of pain, RN GG will let the doctor know about the pain, then the doctor would provide new orders. RN GG put the orders in the electronic medical record (EMR) and faxed other narcotic (pain meds prescribed by a doctor) prescriptions to be signed by the doctor. RN GG said he/she cannot pull medication from the eKit (emergency supply of medications), it's out of his/her control. If there was an order for Tylenol, that could be pulled from eKit. RN GG did not recall the resident, the resident did not complain of pain, nor did he/she request medication to help control his/her pain. RN GG would not know if the resident was in pain due to his/her shift ended at 7:30 P.M. RN GG did recall the next day the resident was being sent out and he/she assisted RN HH by notifying EMS a transfer was necessary. RN GG said the medical doctor will not sign scripts that authorize narcotics until the next day. Residents need to understand that the facility will not have their pain medication at the facility. During an interview on 4/10/26 at 8:03 A.M., RN HH said he/she did not remember that specific resident without the resident's records in hand. RN HH cannot be positive if the resident had an order for Tylenol, however, had the resident had an order, he/she would have administered the medication. RN HH said the resident might have informed the nurse that the medication won't work. RN HH should have documented the Tylenol administration. The pharmacy usually drops medications off at the facility around 4:00 A.M. RN HH would normally place a call to the pharmacy to see the precise drop off time. RN HH can pull from the Ekit after he/she obtains an order. RN HH was in the resident's room a lot that night. RN did not recall if the prescribed narcotic came on the morning drop. RN HH said they typically call the physician to see if there is alternative medication that staff can get out of the eKit. RN HH was unfamiliar with what was pre-stocked in the eKit; he/she guessed Dilaudid was in there. During an interview on 4/10/26 at 8:14 A.M., Vendor 2 (pharmacy) said they did not have Resident #118's name or date of birth in their records for this facility. During an interview on 4/10/26 at 8:43 A.M., CNA II said the resident did ask for pain medications that night but never said he/she was in pain. Any time a resident says they are in pain, CNA II reports it to the nurse. During an interview on 4/10/26 at 8:43 A.M., Certified Medical<br>(continued on next page) |

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| | 265417 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sherbrooke Village | 4005 Ripa Avenue<br>Saint Louis, MO 63125 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Technician (CMT) JJ said, he/she did not recall the residents, they come and go quickly over there. CMT JJ usually informs the nurse when pain medications are not delivered, however, staff can pull from the eKit. First, staff need to make sure the medical doctor (MD) signs the script, which authorizes staff to pull from the eKit. If the MD did not sign the script for the pharmacy, the pharmacy won't deliver it. During an interview on 4/10/26 at 11:53 A.M., the Administrator said the facility only uses the one pharmacy; which is vender 2, out of KC. During an interview on 4/10/26 at 12:43 P.M., the DON said she expected the staff to verify medications and fax required scripts in a timely manner. If the script is at the pharmacy and signed, then the staff can pull the medication from the eKit. The DON would expect the staff to call the physician to obtain an alternative medication that is available to aid with the resident's pain. At the time of an admission, staff need to make sure a signed script comes with the patient when they are discharged from the hospital. The DON would expect her staff to do everything possible before sending the resident out for pain to the hospital. She would expect them to call the exchange and notify the pharmacy for why medications are delayed. DON would expect a non-pharmacological approach for repositioning and for staff to add documentation. The DON would expect the staff to be proactive by requesting the hospital provide/fill the script for the resident prior to discharge. During an interview on 4/13/26 at 11:16 A.M., NP R said she received an email about a new admission who had an order for Dilaudid, but the order was not signed. The staff requested to send the resident back to the discharged hospital for pain management. NP R said that the nurses are responsible to contact the physician or exchange to obtain pain medication. The pain medication should have been addressed during regular hours when the provider was on the office, and staff are told to ask the discharged hospitalist for medications to be brought with them. NPs cannot order/prescribe opioids. Even if they could, this facility needs to have a hard copy on file, not a verbal order. NP R would have tried other topical pain medication that possibly could have helped the pain. Since the facility did not have pain medication on hand, NP R chose to send the resident back to the hospital at the resident's request. NP R said the Flexeril and Tylenol maybe could have helped. These medications are in the eKit. NP R would have provided some sort of new order if there were options. NP R said his/her exchange message was pubic fracture, no pain and crying, who request to return to the hospital. 2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/22/25, showed:-Diagnoses included: Aphasia (impaired talking and understanding language), elevated blood pressure, end stage renal disease (severe kidney failure), and dependence of dialysis;-Cognitively intact; hearing loss, other reduced mobility, muscle weakness, falls, diabetes,-Fully dependent on staff for ADLs;-Pain was present occasionally. Review of the electronic physician's order sheet dated 3/2026, showed:-An order dated 1/15/26, Hydrocodone-Acetaminophen (Vicodin) (pain medication) oral Tablet 5-325 mg Q six hours for pain as needed;-An order dated 1/15/26, Pain Scale 1-10 Q shift;-An order dated 1/15/26, Acetaminophen PO tablet 500 mg, give two tablets by mouth every six hours as needed for pain; elevated temperature. During an interview on 4/6/26 at 3:07 P.M., the resident said there had been a wound on his/her coccyx for two to three months. The wound did get better but then got worse again. Review on 4/7/26 at 9:00 A.M., of the resident's care plan, in use at the time of the survey, showed:-The care plan did not address the pain on his/her coccyx related to the pressure ulcer;- Focus: Resident is at risk for pressure ulcer that development related to reduced mobility, episodes skin, free of redness, blisters or of incontinence;-Goal: Resident will have intact skin, free of redness, blister or discoloration by/through review date;-Interventions: Educate family, care givers as to cause skin breakdown, including transfers, positioning requirements, good nutrition, and frequent repositioning, shift weight every 15 minutes, the resident needs Q two hourly turns, more often as needed or requested. Review of the MAR dated 4/2026, showed:-An order dated 1/15/26, showed: Acetaminophen PO tablet 500 mg, give two tablets by mouth every six hours as needed for pain; elevated temperature; the medication was not administered for 14 out of 14 possible opportunities;-Hydrocodone-Acetaminophen oral tablet 5-325 mg Q six hours for pain;--The resident (continued on next page) |

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| | 265417 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | received the medication eight out of 12 possible opportunities;--The resident received pain medication on 4/9/26 at 7:00 A.M. Observation on 4/9/26 at 11:27 A.M., showed the Wound Nurse asked the resident if he/she is alright? The resident said, It hurts, there are two spots on my hip bone and anus. Observation and interview on 4/9/26 at 11:40 A.M., showed CNA T and CMT V used a mechanical lift to put the resident back to bed. CNA T said the resident does have a PRN pain medication. CNA T told the resident Go ahead and scream or yell. Do what you need to. When CNA T and CMT V turned the resident, he/she hollered and moaned. CNA T said, We tried not to hurt you. During an interview on 4/9/26 at 11:40 A.M., CMT V said when he/she works, the resident complained about pain frequently. CMT V shared the resident's complaint with the nurse but was unsure if the nurse administered any pain medication. During an interview on 4/9/26 at 11:40 A.M., CNA T said when the resident had pain, they would tell the nurse, but they were unsure if the nurse administered any pain medication. Observation on 4/9/26 at 12:00 P.M., showed the resident said, Man, I have so many sore spots. CMT V asked the resident what hurt? The resident said, It's so sore, oh my god! While the Wound Nurse continued to cleanse wounds, the resident continued to yell out in pain. At 12:14 P.M., the wound cleansing process was stopped, due to pain medication needed to be administered. During an interview on 4/9/26 at 12:14 P.M., the Wound Nurse said she would contact the provider for new orders related to pain management. During an interview on 4/12/26 at 12:00 P.M., the DON said she expected the staff to address the resident's comments of pain and administer medications as ordered. 2807190 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be free from medication errors of less than 5%. The facility's medication error rate was 11.11% with three errors out of 27 opportunities observed. Staff failed to monitor one resident's blood pressure (BP) prior to administration of Midodrine (a medication to treat low BP) (Resident #86). Staff also used improper technique and failed to follow the facility's policy when they instilled eyedrops for two different types of eye medications without pausing in between types of eyedrops, for one resident (Resident #92). The sample was 24. The census was 121. Review of the facility's Physician Orders policy dated 9/22, showed:-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines.-Responsibility: Licensed Nurses, Nursing Administration, & Director of Nursing;-Physician Orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe orders.-Orders must be recorded in the Medical Record by the licensed nurse authorized to transcribe such orders;-Physician orders must be documented clearly in the medical record. The required components of a complete order;-Date and time of order;-Name of practitioner providing order;-Name and strength of medication/treatment;-Quantity/Duration;-Dosage/Frequency;-Route of administration;-Indication/Diagnosis;-Stop Date, indicated;-Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation. 1.Review of Resident #86's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/12/26, showed:-Severely impaired cognition;-Partial to moderate assistance required with activities of daily living (ADLs);-Diagnoses included: Dementia, hearing loss (HOH), and hypotension (low blood pressure). Review of the resident's care plan, in use at the time of survey, showed:-Focus: Hypotension;-Goal: Will remain free of complications related to hypotension through review date;-Interventions: Encourage adequate fluid intake and a healthy diet, give medications as ordered. Monitor for side effects and effectiveness. Review of the resident's physician orders sheet (POS) dated 4/6/26, showed;-An order date on 9/24/24, Midodrine 10 milligrams (mg) by mouth (PO) three times day (TID),-No order to check BP TID before administering Midodrine. Observation on 4/7/26 at 6:01 A.M., showed Certified Medication Technician (CMT) KK popped out a Midodrine tablet from the blister pack and into the medicine cup. CMT KK handed the resident the cup, and the resident swallowed the medication. CMT KK did not take a BP prior to the medication administration. During an interview on 4/7/26 at 6:01 A.M., CMT KK said he/she does not know what Midodrine medication is used for. The CMT said he/she really messed that up. He/She should have taken the resident's blood pressure first. CMT KK went back to take the resident's BP, and it was 130/74. Review of the medication administration record (MAR), dated 4/26, showed: During an interview on 4/10/26 at 12:34 P.M., the Director of Nursing (DON) said she expected staff to monitor residents' blood pressures prior to administration of any medications that require blood pressure checks. 2. Review of the facility's Eye Drop Administration policy dated 12/2017, showed:-Purpose: To administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner;-Procedure: For general guidelines on medication administration, refer to 7.1: Equipment and supplies for administering medications and 7.2 medications administration-general guidelines; --Tilt resident's head slightly back;--With a gloved finger, gently pull-down lower eyelid to form pouch, while instructing residents to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger and press gently to instill prescribed number of drops into pouch'' near outer corner of eye. Do NOT let tip of dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration;-While the eye is closed, use one finger to compress the tear duct in the inner [NAME] (inner canthus) of the eye for one to two minutes. This reduces systemic absorption of the medication. Alternatively, the resident may keep his/her eyes<br>(continued on next page) |

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| | 265417 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | closed for approximately three minutes.'--Wipe off tears or excess solution with clean gauze, cotton ball, or tissue;--If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, then repeat procedure above. Review of the Dorzolamide HCI- Timolol Mal manufactures dated 2024, showed:-When used with another eye drop, wait at least 5 minutes (min) before or after usage;-Step 1: Tear of safety seal;-Step 2: Unscrew the cap by lid and turn counterclockwise;-Step 3: Tilt your head back. Gently pull lower eyelid downwards to form a pocket between your eyelid and eye, while looking upward;-Step 4: Turn bottle upside down;-Step 5: Place the dropper tip of the bottle to your eye but be careful not to touch your eye with it. Gently press the bottle lightly with thumb or index finger until a single drop comes falls into your eye;- Step 5: Repeat steps 4 and 5 per physician's order. Review of Resident #92's MDS, dated [DATE], showed:-Severely impaired cognition;-Resident requires maximal assistance with ADLs from staff;-Diagnoses included: Kidney disease, hypertension (elevated blood pressure), Alzheimer's, Aphasia (language disorder-impaired words spoken, understood, and written), seizures (electrical disconnect between the neurons);-No diagnosis of glaucoma (pressure behind the eye). Review of the resident's care plan, in use at the time of survey, showed it did not address the need/reason for eye drops (gtts). Review of the resident's POS dated 4/6/26, showed;-An order dated 9/9/25, for Dorzolamide HCI- Timolol Mal (lowers ocular eye pressure related to (r/t) glaucoma) Ophthalmic (eye) Solution 2-0.5% instill both (ou) TID;-An order dated 9/9/25, for Brimonidine Tartrate ((treats glaucoma, ocular pressure) Ophthalmic Solution 0.2 %, instill 1 gtts in ou TID a day for glaucoma. Observation on 4/7/26 at 5:49 A.M., showed CMT KK pried the resident's eyelid open, while the resident resisted. CMT KK instilled one gtt of Brimonidine solution into the resident's eye and repeated the same process on the opposite eye. CMT KK held the second bottle of eye gtts, the dorzolamide timolol solution. CMT KK did not pause for any extended amount of time in between eye gtts and repeated the previous process above. During an interview on 4/7/26 at 5:49 A.M., CMT KK said the residents does not usually sleep this hard, and the resident had a hard time waking up this morning. During an interview on 4/10/26 at 12:43 P.M., the DON said she expected staff to follow policy and procedure regarding the facility's eye drop administration policy. The proper technique would be hand hygiene, gloves next and then pull the eyelid down and instill a drop into the eyelid. Then staff should wipe the extra solution off with a Kleenex and pause for 3-5 minutes between eye solutions. 28068052804579 |

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| | 265417 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was served to residents at a safe and appetizing temperature (Residents #3, # 23, #76, #100 and #140). The sample was 24. The census was 121. Review of the facility's meal service temperature log, undated, showed:-Hot food needs to maintain at 135 degrees Fahrenheit (F) or above in steamtable;-Cold food needs to maintain at 41 degrees F or below. 1. Observation on 4/8/26 at 12:56 P.M., of lunch on the memory care unit, showed:-Soup measured 126.8 degrees F;-Meatballs measured of 129.3 degrees F. Observation on 4/9/26 at 8:54 A.M., of 300 hall breakfast trays, showed:-Cream of wheat measured 80 degrees F;-Scrambled egg measured 109 degrees F;-Biscuits and gravy measured 111.1 degrees F. 2. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/26, showed:-Cognitively intact;-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), muscle weakness, depression, and anxiety. During an interview on 4/6/26 at 10:30 A.M., the resident said the food is always served cold. 3. Review of Resident #23's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included dementia, muscle weakness, and quadriplegia (paralysis of all four limbs and the torso). During an interview on 4/6/26 at 9:09 A.M., the resident said his/her food is normally served cold when he/she eats in his/her room. 4. Review of Resident #76's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included muscle weakness, seizures, chronic kidney disease, and heart failure. During an interview on 4/6/26 at 10:02 A.M., the resident said his/her food is served cold most days. 5. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included heart failure, diabetes, chronic kidney disease, and depression During an interview on 4/06/26 at 12:17 P.M., the resident said his/her room trays are normally served cold. 6. Review of Resident #140's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included depression, anxiety, and high blood pressure. During an interview on 4/06/26 at 10:29 A.M., the resident said the food is always served cold. 7. During an interview on 4/10/26 at 9:05 A.M., the Dietary Supervisor said she expected food to be served to residents at a safe and palatable temperature. 8. During an interview on 4/10/26 at 12:58 P.M., the Administrator and Director of Nursing (DON) said they expected food to be delivered to the residents at a safe and palatable temperature. 2806805 |