STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265500	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bernard Care Center	4335 West Pine Blvd Saint Louis, MO 63108

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure personal funds withdrawn from the resident trust account were appropriately accounted for and used exclusively for three residents (Residents #36, #48 and #26). The facility failed to ensure withdrawals for personal spending were authorized by the resident and/or the resident's legal guardian, and signed off and approved by the appropriate facility staff, in accordance with the facility's policy. The facility identified 105 residents with funds handled by the facility. The census was 133. Review of the facility's Resident Trust policy, revised 11/8/23, showed: -Purpose: Complete procedures on resident trust responsibilities; -General Information Regarding Responsibilities of Holding Resident Funds: --The facility shall keep an accurate and maintained accounting system for the residents that choose to have their personal funds managed. These funds shall be safeguarded by the facility, using complete and separate accounting principles; --Personal funds of the resident shall be exclusively for the resident, which must be authorized in writing. The individuals who can authorize such transactions may be the resident, his/her legal guardian, or legal representative (who may not be an employee at the facility); --The resident trust bank account should have at least two (2) facility personnel as check signers. One such person is the Administrator and the other(s) should be chosen at the discretion of the Administrator. However, no one who handles the petty cash box, the checkbook, the posting of transactions, or assists residents in shopping for personal items should be a signer on the account; --All receipts and records shall be retained for at least seven (7) years from the end of the fiscal year during which the receipts and records were originally made; -Making Withdrawals from the Resident Trust Account: -All checks written out of the trust account should be prepared by the Resident Trust Clerk and signed by the Administrator or other designated signer and should always be accompanied by a check request or other supporting documentation. All checks written out of the resident trust account should be copied prior to deposit or disbursement and attached to the appropriate documentation; (continued on next page)

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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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Family members or friends who do not have legal access to a resident's account but wish to purchase clothing or personal items for a resident can do one of the following: --1. Purchase the items needed and bring in the receipts to the Resident Trust Clerk. The clerk will then verify that a) the resident requested the items by signing the check request form and b) the resident has sufficient funds to reimburse the purchases; --2. Have the resident sign a check request form to make the check payable to the individual wanting to purchase the items. The Resident Trust Clerk must verify the funds are available before writing the check. 1. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/1/24, showed: -Severe cognitive impairment; -Diagnoses included unspecified intellectual disabilities (limits to a person's ability to learn at an expected level and function in daily life), mild mental retardation and schizophrenia (serious mental illness that affects how a person things, feels, and behaves). Review of the resident's medical record, showed the resident listed as his/her own financial responsible party. The resident has a legal guardian. Review of the resident's trust account records, showed: -On 3/7/24, a withdrawal for personal spending, in the amount of $2,000.00; -Check request, dated 3/7/24; -Make payable to: Life Enrichment Director; -Request/comment: $2000.00; -Signed by Financial Coordinator, Social Services (SS) or designee, and Life Enrichment Director; -*Note all receipts must be submitted with request. All receipts must include the resident's name, signature (if applicable), amount, and description; -On 3/7/24, a withdrawal for personal spending, $52.16; -Check request, dated 3/13/24: -Make payable to: Life Enrichment Director; -Request/comment: $52.16; -Signed by Financial Coordinator, Social Services (SS) or designee, and Life Enrichment Director; (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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-*Note all receipts must be submitted with request. All receipts must include the resident's name, signature (if applicable), amount, and description; -Receipt from Sam's Club, dated 3/9/24: -Gift card, ending 9256, $206.48; -Gift card, ending 1891, $206.48; -Gift card, ending 3094, $206.48; -Gift card, ending 7750, $206.48; -Gift card, ending 6440, $206.48; -Total or receipt: $1032.40; -Receipt not signed by resident; -Receipt from Sam's Club, dated 3/10/24: -Gift card, ending 1142, $500.00; -Gift card, ending 7237, $500.00; -Two gift card fees, totaling $9.76; -Total on receipt: $1009.76; -Receipt not signed by resident. Review of the withdrawals made on 3/7/24, showed a total of $2,052.16. Review of the receipts dated 3/9/24 and 3/10/24, showed a total of $2,042.16. A difference of $10.00 between withdrawals and receipt totals. During an attempted interview on 4/18/24 at 10:24 A.M., the resident was unable to answer questions regarding his/her funds. During an interview on 4/17/24 at 11:17 A.M., the Financial Coordinator said the resident had limited cognition. He/She was nearing his/her spenddown limit of around $5,500.00, so the Life Enrichment Director withdrew $2,000.00 from his/her account to get the money off the books. The money was used to purchase gift cards to be used at a later time. After the Life Enrichment Director purchased the gift cards, he gave them to the Financial Coordinator in a sealed envelope, along with the receipts of purchase. 2. Review of Resident #48's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included Alzheimer's disease, dementia, schizophrenia and depression. Review of the resident's medical record, showed the resident listed as his/her own financial responsible party. Review of the resident's trust account records, showed: -On 3/7/24, a withdrawal for personal spending, in the amount of $2,000.00; -Receipt from Sam's Club, dated 3/21/24: -Gift card ending 9417, $500.00; -Receipt not signed by resident; -Receipt from Schnucks, dated 3/25/24: -Gift card, ending 7068, $500.00; -Receipt not signed by resident; -Receipt from Sam's Club, dated 3/26/24: -Gift card, ending 5565, $500.00; -Gift card, ending 7998, $500.00; -Receipt not signed by resident. During an attempted interview on 4/18/24 at 10:24 A.M., the resident unable to answer questions regarding his/her funds. 3. Observation on 4/18/24 at 7:33 A.M., showed the Financial Coordinator opened a safe in her office and withdrew two sealed envelopes. During an interview, the Financial Coordinator said the two envelopes contained gift cards purchased for Residents #36 and #48. There are no other gift cards or envelopes of money in the safe belonging to other residents in the facility. Review of the sealed envelope for Resident #36 and his/her receipts of purchase, showed: -Gift card ending 7237, on the resident's receipt from 3/10/24; -Gift card ending 1142, on the resident's receipt from 3/10/24; -Gift card ending 8717, not on the resident's receipts; -Gift card ending 7998, not on the resident's receipts; -The gift card is on a receipt of purchase for Resident #48, dated 3/26/24. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the sealed envelope for Resident #48 and his/her receipts of purchase, showed: -Gift card ending 9417, on the resident's receipt from 3/21/24; -Gift card ending 5565, on the resident's receipt from 3/26/24; -Gift card ending 9256, not on the resident's receipts; -The gift card is on a receipt of purchase for Resident #36, dated 3/9/24; -Gift card ending 3094, not on the resident's receipts; -The gift card is on a receipt of purchase for Resident #36, dated 3/9/24; -Gift card ending 1891, not on the resident's receipts; -The gift card is on a receipt of purchase for Resident #36, dated 3/9/24. Review of gift cards and receipts for Residents #36 and #48, showed; -Resident #48 missing gift card ending 7068 for $500.00; -Resident #36 missing gift cards ending 7750 and 6440, totaling $412.96. During an interview on 4/18/24 at 7:33 A.M., the Financial Coordinator said gift cards were purchased for Residents #36 and #48 to spend down their accounts. The gift cards for the residents must have gotten mixed up. She is not sure to whom the gift card ending 8717 belongs. She is not sure where the missing gift cards are. Neither Resident #48 nor Resident #36 have made purchases, or have had purchases made for them, using their gift cards. Gift cards were purchased for the residents to spend down their accounts. When money is withdrawn for spenddown and cannot be signed off by the resident, it should be signed off by her, Social Services, and the shopper. After all three parties sign, a check is issued for the shopper, which is the Life Enrichment Director. After the Life Enrichment Director purchased the gift cards, he brought them back to the facility with the receipts and gave them to the Financial Coordinator in sealed envelopes, which she put in the safe. She made sure the receipts matched the withdrawal amounts authorized for both residents, but did not count the gift cards or check them against the receipts. 4. Review of Resident #36's trust account records, showed: -On 2/20/24, a withdrawal for personal spending, in the amount of $1,000.00; -Check request, dated 2/20/24: -Make payable to: Life Enrichment Director; -Request/comment: $1,000.00; -Signed by Financial Coordinator on 2/20/24; (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No signature from Social Services or designee; -No signature from shopper; -*Note all receipts must be submitted with request. All receipts must include the resident's name, signature (if applicable), amount, and description; -For accounting use section with party authorizing approval: blank; -Receipt from WalMart, dated 3/28/24, total $879.72, included; -32 ONN television; -Six Dove beauty products; -Approximately eight toiletries from Head and Shoulders, Crest and Suave; -Receipt not signed by resident; -Receipt from Marshalls, dated 3/28/24, total $167.10, included: -Two items coded as beauty accessories; -One item coded as jewelry/watches; -Three items coded as accessories/luggage; -Receipt not signed by resident. Review of the resident's inventory sheets, showed the last personal inventory sheet updated on 12/14/22. No documentation on the resident's inventory sheets of items purchased using the money withdrawn from the resident's account on 2/20/24. During an interview on 4/18/24 at 7:33 A.M., the resident shook his/her head no when asked if he/she recently received a new television, accessories, or toiletries. The resident was unable to respond regarding specific questions pertaining to funds. Observation on 4/18/24 at 7:50 A.M., showed the resident's room did not have a television, jewelry, accessories, luggage, bags or Dove beauty products. 5. Review of Resident #48's trust account records, showed: -On 2/20/24, a withdrawal for personal spending, in the amount of $1,000.00; -Check request, dated 2/20/24: -Make payable to: Life Enrichment Director; (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Receipt not signed by resident. Review of the resident's inventory sheets, showed the last personal inventory sheet updated on 10/25/22. No documentation on the resident's inventory sheets of items purchased using the money withdrawn from the resident's account on 2/20/24. Observation on 4/18/24 at 10:24 A.M., showed no totes, watches, paper, baskets, iron, hair beauty supplies, antenna, or clock radio. During an interview, the resident was unable to answer questions regarding the items. 6. Review of Resident #26's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included blindness to right eye and low vision to left eye, schizophrenia, and bipolar disorder (mood disorder). Review of the resident's medical record, showed the resident listed as his/her own financial responsible party. The resident has a legal guardian. Review of the resident's trust account records, showed: -On 2/20/24, a withdrawal for personal spending, in the amount of $2,000.00; -Check request, dated 2/20/24: -Make payable to: Life Enrichment Director; -Request/comment: $1,000.00; -Signed by Financial Coordinator on 2/20/24; -No signature from Social Services or designee; -No signature from shopper; -*Note all receipts must be submitted with request. All receipts must include the resident's name, signature (if applicable), amount, and description; -For accounting use section with party authorizing approval: blank; -Receipt from Bath and Body Works, undated, total $169.99, included: -18 body care items purchased; -Receipt not signed by resident; -Receipt from WalMart, dated 2/25/24, total $44.00, included: (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two watches; -Receipt not signed by resident; -Receipt from WalMart, dated 2/25/24, total $247.19, included: -Two watches; -Two units of ladies socks; -Four smock dresses; -Receipt not signed by resident; -Receipt from Sam's Club, dated 2/25/24, total $488.87, included: -Three 2-packs of bras; -One package of feminine hygiene pads; -Two bottles of Dove body wash; -Five units of Fructis, [NAME], and Dove toiletries; -Receipt not signed by resident. Review of the resident's inventory sheets, showed the last personal inventory sheet updated on 8/10/23. No documentation on the resident's inventory sheets of items purchased using the money withdrawn from the resident's account on 2/20/24. Observation on 4/18/24 at 10:28 A.M., showed the resident seated in a wheelchair in his/her room, not wearing a watch. No watches, ladies socks, feminine hygiene products, smock dresses, Bath and Body Works products, or toiletries from Dove, Fructis, or [NAME] observed. During an interview, the resident exhibited confusion. During an interview on 4/18/24 at 10:29 A.M., Certified Nurse Aide (CNA) B said the resident is blind. He/She did not wear smock dresses and did not use Bath and Body Works products, unless the products were provided by staff. 7. During an interview on 4/18/24 at 11:18 A.M., the Financial Coordinator said the facility's management company notifies Social Services when a resident is near their spenddown limit. Social Services notifies the Financial Coordinator and she notifies the Life Enrichment Director. The Life Enrichment Director makes the purchases and gives her the receipts. She checks the purchase amount against the check, and then files the documents. She does not review the items purchased on the receipts. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 11:18 A.M., the Life Enrichment Director said when he is notified that a resident is near their spenddown limit, he goes and talks to the resident about what they need. He obtains a check from the Financial Coordinator and goes shopping for the resident. He is the only facility employee to go shopping for residents. He goes shopping for multiple residents at the same time. When he is finished shopping, he gives the Financial Coordinator the receipts of purchase and then he inventories all of the resident's purchased items by labeling the items with the resident's name and adding the item to the resident's personal inventory sheet. He maintains the inventory sheets for all residents and keeps them in a binder in his office. Once the items are inventoried, he gives the resident their items. The resident does not sign off on having received the items. He purchased gift cards for Residents #36 and #48, but must have gotten them mixed up with each other and other residents. He purchased multiple gift cards for multiple people on those days. He does not recall the names of the other residents he purchased gift cards for on the same day. He gave the gift cards and receipts to the Financial Coordinator and when the residents are ready to use them, he will get the gift cards from the Financial Coordinator, make the purchases, and provide the Financial Coordinator with the receipts. He understands that by mixing up the gift cards, it means resident money is not properly accounted for. Resident #26 is legally blind. He/She asked for a watch, so the Financial Coordinator purchased this for him/her. The resident does not use feminine hygiene pads and does not wear dresses or use Bath and Body Works products. The receipts for these items do not belong to Resident #26 and have been mixed up with another resident. The Financial Coordinator understands that by mixing up receipts, there is no way to properly account for items purchased with the resident's money. The clock radio and antenna purchased for Resident #48 should be in the resident's room. The totes purchased for Resident #48 are in the basement. The receipt showing a purchase of [NAME] Crocker items does not belong to Resident #48 and was mixed up with someone else's. The television purchased for Resident #36 is in the basement. Observation on 4/18/24 at 11:59 A.M., showed the basement's beauty shop with a cart of items, including a 32 TCL television. The box was not labeled with a resident's name. During an interview, the Life Enrichment Director said the TCL television is the television purchased for Resident #36. When asked about the television brand name as TCL, but the receipt of purchase showing a brand name of ONN, the Life Enrichment Director said he did not know why the brand names were listed differently. He knows the TCL television belongs to Resident #36 and he will write the resident's name on the television when it is removed from the box. The Life Enrichment Director opened a door to a storage room in the basement containing stacks of tubs and miscellaneous personal effects throughout the room, from floor to ceiling, along each wall. When asked about the location of the 18 gallon tubs purchased for Resident #48, the Life Enrichment Director pointed to two red tubs with no labels or resident names indicated, one of which had a layer of dust along the rim. He could not provide a location of the other tubs on the purchase receipts. He knows which personal effects in storage belong to each resident in the facility. He understands the personal effects should be labeled with a resident's name. Activities staff is responsible for updating inventory sheets. The employee primarily responsible for this left in January 2024, and the inventory sheets have not been updated since then. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview on 4/18/24 at 12:21 P.M., the Administrator said sometimes money is withdrawn for personal spending and used to purchase gift cards for residents who want to use their gift cards on purchases for things like Door Dash or other food deliveries. She was not aware money was being withdrawn from resident accounts and used to purchase gift cards that remained in the safe in order to get money out of the resident's account when close to their spenddown limits. She expects money withdrawn from a resident's account to be used for the resident. She expects more than one person to sign off on the money being withdrawn and for receipts to be maintained accurately to reflect purchases made with resident money. She expects purchased items to be inventoried as soon as possible. During an interview on 4/19/24 at 10:26 A.M., the Administrator said when resident's spenddown money is going to be used, she expects the resident representative and/or guardian to be consulted. The 18 gallon totes on a receipt for Resident #48 were purchased for the facility's use, and should not have been purchased using the resident's funds. Resident #26 can see a little, but would not be able to read a watch. He/She can express his/her wants and needs, but cannot make his/her own decisions regarding his/her finances. It is possible that when the Financial Coordinator received receipts from the Life Enrichment Director, she checked the dollar amount, and not what specific items were purchased. Now knowing there are discrepancies with the purchase receipts, the facility will have to investigate.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 40290 Based on interview and record review, the facility failed to ensure general accounting principles were followed by failing to follow up on outstanding checks during monthly resident trust fund reconciliations. This facility identified 105 residents with funds handled by the facility. The census was 133. Review of the facility's Resident Trust policy, revised 11/8/23, showed: -Purpose: Complete procedures on resident trust responsibilities; -Resident trust bank reconciliation: --A reconciliation of the bank statement, checkbook, and resident trust funds module must be completed monthly. This will be completed by the facility's management company staff accountant responsible for the facility's financials; -The Resident Trust Clerk will review the monthly bank reconciliation for any outstanding checks listed that are over two months. If this is found, the Resident Trust Clerk will void the check listed and reissue a new check to reflect current date to be in accordance with state regulation. Review of the facility's monthly resident trust reconciliation, from April 2023 through March 2024, showed outstanding checks as follows: -Check #1394, October 2015, $30.00; -Check #2644, July 2019, $573.06; -Check #2880, March 2020, $72.89; -Check #2915, March 2020, $41.71; -Check #2953, May 2020, $10.00; -Check #3073, July 2020, $102.00; -Check #3103, August 2020, $1,238.00; -Check #3104, August 2020, $158.17; -Check #3436, April 2021, $134.00; -Check #3437, April 2021, $134.00; -Check #3438, April 2021, $134.00; (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Check #3519, June 2021, $1,857.99; -Check #3726, November 2021, $149.96; -Check #4060, February 2023, $115.00; -Check #4154, March 2023, $1,121.00; -Check #4428, December 2023, $2,740.00; -Check #4434, December 2023, $224.46. During an interview on 4/17/24 at 8:37 A.M., the Financial Coordinator said the resident trust account is reconciled each month by an accountant with the facility's management company. The Financial Coordinator factors outstanding checks into the monthly reconciliation, which are carried over to the following month if they are not cashed. When trained for this position, she was never instructed to investigate outstanding checks. She does not have the authority to cancel or void checks. During an interview on 4/18/24 at 12:21 P.M., the Administrator said the resident trust account is reconciled monthly by the accountant with the facility's management company. The accountant notifies the Financial Coordinator when there are any issues that need to be addressed. The Administrator expected outstanding checks to be investigated during the resident trust reconciliation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40290 42795 Based on observation, interview and record review, the facility failed to provide a homelike environment when staff served meals on Styrofoam and used plastic utensils, provided a dirty wheelchair to one resident (Resident #102), and did not clean three resident rooms (Resident #130, room [ROOM NUMBER], and room [ROOM NUMBER]). The sample was 26. The census was 133. Review of the facility's housekeeping deep cleaning policy, dated 6/29/23, showed: -Purpose: to ensure all rooms are clean; -Policy: Deep cleaning is to be completed as scheduled. This includes complete pull-outs of furniture in rooms, wall cleaning, floor cleaning (scrubbing and waxing included), restrooms to be cleaned and disinfected, cobwebs removed, beds and rails to be cleaned, sprinkler heads to be cleaned, light covers to be clean and free of bugs, over-bed light covers to be cleaned and free of bugs, sinks cleaned, windows to be cleaned and ensure no spider webs, drapes and curtains to be cleaned (including privacy curtains), call lights to be clean and free from dust/dirt build-up, floors, closets and doorways are to be free from wax/dirt build up, etc. All areas should be monitored on a daily basis and all resident living areas and non-living areas should be clean and odor free; -Daily Cleaning: pick up all trash and put into trash can and empty. Dust mop or sweep floor. Submerge rag or sponge in with solution and clean surfaces beginning with touch areas on door and work clock or counterclockwise around the room. Surfaces are to be cleaned including wall smudges, light and call light and side tables, head/foot board/side rails of beds, windows. Clean the sink, around the light fixtures and dispensers. Clean inside and outside of the trash can. Let it air dry. Replace trash can liner. Clean bathroom using the same cleanser/disinfectant, wall smudges, lights, and call switches. Review of the facility's housekeeping job duties, undated, showed: -Duties: follow policy and procedures. The housekeeping process, morning walk-through, follow plan work, schedule for deep cleans, clean wash basins, mirrors, commodes, tubs, and showers daily, clean all air vents. 1. Observation of breakfast on 4/15/24 at 8:00 A.M., showed residents on the 300 hall and in the 300/400 assisted dining room were served meals on Styrofoam plates and bowls with plastic utensils. Observation of lunch on 4/16/24 at 12:40 P.M., showed residents on the 300 hall and in the 300/400 assisted dining room were served meals on Styrofoam plates and bowls with plastic utensils. Observation of dinner on 4/16/24 at 5:51 P.M., showed residents on the 300 hall and in the 300/400 assisted dining room were served meals on Styrofoam plates and bowls with plastic utensils. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #79's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/24, showed: -Cognitively intact; -Diagnoses included hemiplegia (paralysis to one side of the body) or hemiparesis (weakness to one side of the body), seizure disorder and depression. During an interview on 4/14/24 at 10:14 A.M., the resident said the facility has been serving meals on Styrofoam with plastic utensils for a long time now. He/She would not use Styrofoam and plastic utensils at home and he/she wants meals served with real dishes. Observations and interview on 4/15/24, showed: -At 8:27 A.M., the resident sat in bed in front of a divided Styrofoam plate containing a scoop of scrambled eggs, two pancakes and diced potatoes. With an unsteady left hand, he/she used a plastic fork to spear the pancakes on the Styrofoam plate. The fork was unable to fully penetrate the pancakes, which repeatedly slid across the Styrofoam plate. During an interview, the resident said the forks are cheap and break easily. He/She cannot eat his/her food with the plastic utensils and does not know why the facility is not using real utensils; -At 8:47 A.M., the resident sat in bed and was no longer eating. One pancake was untouched and one pancake had a bite mark in it and multiple stab marks from a fork. 85% of the potatoes and 80% of the scrambled eggs remained on the plate. During an interview, the resident said he/she was done eating because he/she could not get the food onto the plastic fork. 3. Review of Resident #125's quarterly MDS, dated [DATE], showed: -Totally dependent on staff for eating; -Diagnoses included stroke, dysphagia (swallowing disorder) following stroke, high blood pressure and diabetes. Observation on 4/15/24 at 9:00 A.M., showed Certified Nurse Aide (CNA) B sat next to the resident's bed and used a plastic fork to scoop food on the resident's Styrofoam plate. CNA B attempted to cut grits with the fork. The grits appeared rubbery and slid across the plate in a solid unit, unable to be separated with a fork. During an interview, CNA B said he/she was having a hard time cutting up the resident's grits. 4. Review of Resident #84's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included stroke and depression. During an interview on 4/14/24 at 11:03 A.M., the resident said meals are served on Styrofoam with plastic utensils. He/She did not know why food is served like this, but it did not feel homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 4/17/24 at 1:43 P.M., CNA B said he/she was not sure why meals were served on Styrofoam with plastic utensils and he/she is unsure how long it has been like this. Meals are prepared and wrapped by dietary, then brought to the floor. He/She would not consider the use of Styrofoam and plastic utensils to be homelike. 6. During an interview on 4/17/24 at 2:43 P.M., the Dietary Manager said it is not homelike for residents to use Styrofoam plates and plastic cutlery for a prolonged amount of time. She said residents have been using Styrofoam plates for at least two weeks. The dishwasher was currently fixed but residents were still using Styrofoam until she felt comfortable with the dishwasher. 7. During an interview on 4/18/24 at 2:08 P.M., the Administrator said it is absolutely not homelike for residents to be eating with Styrofoam and plastic cutlery when the dishwasher is working. 8. Review of Resident #102's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Mobility device used: manual wheelchair; -Dependent on staff for bed to chair transfers; -Diagnoses included diabetes, kidney disease, stroke and dementia. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has a history of stoke and requires dependent to maximum assistance with activities of daily living (ADLs); -Plan: Activity as tolerated and out of bed as tolerated; monitor and document mobility status. During observation and interview on 4/16/24 at 12:02 P.M., CNA I said he/she was going to change the resident's wheelchair out for a new one because the old one was leaning to one side. A new wheelchair was brought into the resident's room. The wheelchair had white crusty and reddish brown stains on the seat. The wheels on the wheelchair had dust and thick cobwebs. The resident was transferred from the broken wheelchair to the soiled chair without it being cleaned. During an interview on 4/17/24 at 2:40 P.M., CNA F said the night shift CNAs are responsible for cleaning the wheelchairs in the facility. There is a wheelchair cleaning schedule to follow. Wheelchairs are also to be cleaned as needed. During an interview on 4/18/24 at approximately 10:00 A.M., Certified Medication Technician (CMT) J said he/she observed the wheelchair that was brought into the resident's room and thought it looked pretty dirty and it should have been cleaned before giving it to the resident to use. During an interview on 4/18/24 at 1:41 P.M., the Director of Nurses (DON) said she expected staff to provide a clean wheelchair to the resident. 9. Review of Resident #130's admission MDS, dated , 3/18/24, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnoses of high blood pressure and obesity. During an interview on 4/14/24 at 10:37 A.M., the resident said his/her room is not cleaned enough by staff. He/She is distressed by the state of his/her room. Observation of the resident's room, showed: -On 4/15/24 at 8:10 A.M., the room had sticky floors with a dark liquid spill next to the resident's bed, dirty blinds with dust accumulation, dirty privacy curtains with various brown stains, a dirty air conditioning unit with dust accumulation on and inside the vents, and a fly catcher which hung by the sink, stuck to the mirror; -On 4/16/24 at 11:21 A.M., the room had a dirty mirror streaked with yellow liquid coming from the fly catcher, sticky floors with trash in various areas and debris, dirty privacy curtains with brown stains, dirty blinds with dust accumulation, and a dirty air conditioning unit with dust accumulation. 10. Observation of room [ROOM NUMBER], showed: -On 4/14/24 at 8:43 A.M., the room had an overwhelming musty smell, sticky floors with various debris, and dirty privacy curtains with brown stains; -On 4/15/24 at 1:35 P.M., the room had an overwhelming musty smell, floor sticky with debris and trash, dirty air conditioning vents with visible dust buildup, and dirty privacy curtains with brown stains; -On 4/16/24 at 11:17 A.M., the room had dirty sticky floors with trash debris, an overwhelming musty smell, dirty air conditioning vents with dust accumulation, and dirty privacy curtains. 11. Observation of room [ROOM NUMBER], showed: -On 4/14/24 at 9:03 A.M., the room had sticky floors with trash debris in various locations around the room; -On 4/15/24 at 7:52 A.M., the room had sticky floors with trash debris and a dirty air conditioning unit vent with dust accumulation; -On 4/16/24 at 11:49 A.M., the room had sticky floors with trash debris in various areas, dusty blinds, and a dirty air conditioning unit vent with dust accumulation. 12. During an interview on 4/17/24 at 8:24 A.M., Floor Tech Y said he/she cleans the floors in the facility daily. He/She said he/she looks at the residents' privacy curtains to make sure they are clean twice a week. He/She expected residents' rooms to have clean floors and privacy curtains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. During an interview on 4/17/24 at 8:29 A.M., Housekeeper X said he/she cleans two rooms on the 400 hallway a day. The floors are to be cleaned everyday along with the sink and mirror. He/She expected the residents' rooms to be clean. 14. During an interview on 4/17/24 at 2:02 P.M., the Housekeeping Supervisor said he expected residents' rooms to be cleaned daily including floors, mirrors, sinks, blinds and air conditioning units. He expected housekeepers to let the Maintenance Department know if air conditioning units needed to be cleaned on the inside of the vent. He expected residents' rooms to be clean and orderly. 15. During an interview on 4/18/24 at 2:10 P.M., the Administrator said she expected housekeeping to follow cleaning schedules to ensure residents' rooms are clean and orderly. 46888

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure each resident's care plan was updated and accurate to reflect the resident's needs. This failure affected three residents, whose care plans did not identify the residents' smoking status and one resident, whose care plan did not identify medication refusals (Residents #283, #65, #64 and #18). The sample was 26. The census was 133. Review of the facility's Comprehensive Care Plans and Baseline Care Plans policy, revised 1/19/22, showed: -A licensed nurse that has been designated by the facility administration will coordinate each assessment with the appropriate participation of health professionals among the Interdisciplinary Team (IDT); -A comprehensive care plan should be completed within 14 days of admission; -A baseline care plan should be completed within 48 hours of admission; -Information gathered to formulate care plans and assure accuracy of MDS includes but is not limited to: direct observation, communication with the resident/responsible party, direct care staff from all shifts, the resident's physician, and the resident's medical record; -Daily nursing meetings will occur Monday through Friday with a review of the resident's medical, functional, and psychological problems. From this meeting, information will be individualized to the resident's plan of care. 1. Review of Resident #283's medical record, showed diagnoses included high blood pressure, history of alcohol and substance abuse disorder, chronic obstructive pulmonary disease (COPD, a chronic narrowing of the pulmonary arteries and veins causing shortness of breath), and history of cerebral infarction (stroke, a blood clot in the brain cutting off oxygenated blood to one or several portions of the cerebrum). Review of the resident's progress notes, showed: -4/13/23, entered by the facility Nurse Practitioner during the resident's previous admission at the facility, the resident was a current, every day smoker while residing at the facility; -3/25/24, entered by the floor nurse after a smoking safety evaluation was completed on the resident, the resident currently utilizes tobacco products; -3/28/24, the Nurse Practitioner documented the resident utilized tobacco products and smoked approximately 1 pack of cigarettes per day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Minimum Data Set (MDS), a federally-mandated assessment instrument completed by facility staff, dated 3/25/24, showed: -Moderate cognitive impairment; -Section J1300, which addresses the use of tobacco products, was not completed. Review of the resident's care plan, in use at the time of survey, showed: -No entry in the care plan was made to identify the resident's smoking status. Observation on 4/14/24 at 9:36 A.M., showed the resident entered the smoking area at the facility after the breakfast meal. The resident smoked two cigarettes in the smoking area. Observation on 4/15/24 at 11:37 A.M., showed the resident entered the smoking area at the facility prior to the lunch meal. The resident smoked two cigarettes in the smoking area. Observation on 4/16/24 at 8:06 A.M., showed the resident entered the smoking area at the facility prior to the breakfast meal. The resident smoked two cigarettes in the smoking area. During an interview on 4/14/24 at 9:28 A.M., the resident said he/she smokes his/her cigarettes outside in the smoking area with the rest of the facility's residents. During an interview on 4/18/24 at 11:03 A.M., Certified Nurse Aide (CNA) H said the resident was admitted in March of this year, but had been a resident at this facility previously for a short time. CNA H said the resident is a smoker, and does not participate in many activities outside of smoking each day. CNA H said smoking should be included on residents' care plans to ensure staff are aware of each resident's specific health conditions, and smoking could contribute to them. During an interview on 4/18/24 at 11:07 A.M., Registered Nurse (RN) E said the resident was admitted in March of this year and does not participate in many activities outside of smoking times at the facility. RN E said smoking should be included on the resident's care plan, as care plans should be specific to each resident's needs and health conditions. 2. Review of Resident #65's medical record, showed diagnoses included hemiplegia (paralysis affecting one side of the body), pseudobulbar affect (episodes of sudden or uncontrolled emotion), multiple sclerosis (MS, a chronic disease of the central nervous system causing pain and loss of fine motor function) and high blood pressure. Review of the resident's MDS, dated [DATE], showed: -No cognitive impairment; -The resident requires moderate assistance from staff with dressing and bathing tasks; -The resident uses a wheelchair for locomotion. Review of the resident's progress notes, showed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/27/23 at 7:28 P.M., the resident refused all medications and supplements for the duration of the day, and had been refusing all medications since 11/26/23; -1/24/24 at 3:20 P.M., the resident refused his/her scheduled Baclofen (a neurologic medication used to treat MS) as he/she was not in pain. The resident was informed this is a scheduled medication for a chronic illness and continued to refuse the medication; -2/28/24 at 6:40 P.M., following re-admission from a hospital stay as a result of a fall at the facility, the resident refused to coordinate with Social Services in relation to follow-up appointments with neurology and his/her primary care physician; -3/21/24 at 12:44 P.M., the resident refused blood draws at the facility for an upcoming physician appointment, and continued to refuse blood draws while at the facility. Review of the resident's care plan, in use at the time of survey, showed: -The resident is a fall risk related to his/her diagnosis of MS. Interventions included following facility protocol and ensuring the resident's call light is within reach while encouraging the resident to use the call light when assistance is required; -The resident is at risk for alteration in musculoskeletal status related to his/her diagnosis of MS. Interventions included monitoring for falls, monitoring for fatigue, ensuring administration of prescribed analgesics, and ensuring the call light is within reach for the resident to use; -The care plan did not address medication or treatment refusals. During an interview on 4/14/24 at 9:04 A.M., the resident said the facility administered medications to him/her as ordered each day, but that he/she is on too many medications and tells the facility which ones he/she wants to take. The resident had no concerns about the administration of medications. During an interview on 4/18/24 at 11:03 A.M., CNA H said he/she was familiar with the resident, who has been a long-term resident at the facility for some time. CNA H said the resident has a history of medication and treatment refusals while at the facility, and expected that to be included on the care plan to direct staff approaches to the resident during treatment. During an interview on 4/18/24 at 11:07 A.M., RN E said he/she was familiar with the resident, and the resident often refuses medications and treatment, so much so that the resident's medication regimen has been vastly reduced over the last year due to refusals. RN E expected refusals and other behaviors to be included on the care plan to help direct staff approaches to the resident during medication administration and treatments. 3. Review of Resident #64's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses manual wheelchair; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included MS, seizures, anxiety, manic depression (a mood disorder), and schizophrenia (a mental disorder that is characterized by severely impaired thinking, emotions and behaviors). Review of the list of residents who smoke, provided by the facility, showed the resident listed as a smoker. Observation on 4/15/24 at 9:40 A.M. and on 4/16/24 at 1:35 P.M., showed the resident in the smoking area on the 100 hall, smoking a cigarette. Review of the care plan in use at the time of survey, showed it did not address the resident's smoking status. 4. Review of Resident #18's quarterly MDS, dated [DATE], showed: -The resident is rarely or never understood; -Uses a manual wheelchair; -Diagnoses include: Pneumonia, dementia, Alzheimer's disease, Parkinson's disease (a neurological condition that is characterized by tremors) and anxiety. Review of the list of residents who smoke, provided by the facility, showed the resident listed as a smoker. Observation on 4/15/24 at 9:40 A.M. and on 4/16/24 at 1:35 P.M., showed the resident in the smoking area on the 100 hall, smoking a cigarette. Review of the care plan in use at the time of survey, showed it did not address the resident's smoking status. 5. During an interview on 4/18/24 at 1:21 P.M., the facility MDS Coordinator, who also serves as the facility's Care Plan Coordinator, said care plans are developed in collaboration with CNAs, nurses, the resident, and their families if necessary to develop a specific care plan directed to address the resident's specific care concerns. The MDS Coordinator said a resident who smokes should have that information included on the care plan, and a resident with frequent behaviors such as medication refusals should have that included on the care plan as well. 6. During an interview on 4/18/24 at 1:37 P.M., the Director of Nursing (DON) and Administrator said a resident with medication refusals should have that information included on the care plan. They also said a resident who is a current smoker at the facility should have that information included on the care plan, as all care plans should be resident-specific to address each resident's unique health concerns. 44948

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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** 42795 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice when they did not obtain Peripherally Inserted Central Catheter (PICC, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) line orders and nephrostomy tube (a tube that is directly inserted into the kidney to drain urine) orders on admission, failed to ensure that suprapubic catheter (a tube that is inserted in the lower abdomen to drain urine) care orders were in place on the Treatment Administration Record (TAR), and failed to ensure a yearly electrocardiogram (EKG, a test to diagnosis heart irregularities) was completed for one resident (Resident #64). The sample size was 26. The census was 133. Review of the facility's Intravenous (IV) Catheter Care and Maintenance and Access Procedures policy, revised on 6/29/23, showed: -PICCs: -Frequency of dressing change: -Change the dressing 24 hours after insertion; -Transparent dressing: Change every 5-7 days unless soiled or loose; -Gauze dressing: change every two days or as needed if wet or soiled, or non-occlusive; -Flushing: use of heparin (a medication that prevents clots to be formed in the catheter line) flushes and the recommended concentration and frequency of flushing are determined in accordance with the manufacturer's instructions and per the treating clinician orders. Review of the facility's Urinary Catheter Care policy, revised on 6/29/23, showed: -The facility will ensure any resident with a urinary catheter will be maintained to prevent infection; -Residents who have a urinary catheter will have a physician order for the catheter, care and diagnosis; -Residents with indwelling catheters will receive catheter care every shift or as ordered by the physician. Review of the facility's Transcription of Orders and Following Physician Orders policy, revised 9/20/23, showed: -Purpose: The purpose of this policy is to outline procedures in accurately transcribing physician orders and to ensure that all physician orders are followed; That a process is in place to monitor nurses in accurately transcribing and following physician's orders; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Procedure: -Upon receiving a physician's order via telephone fax, written order, verbal order, transcribed order or other, it will be documented in the resident's electronic medical record; -Clarification of physician orders will be obtained in the event that the order is either unclear or the nurse is uncomfortable in implementation of the physician orders; -The Resident Care Coordinator (RCC)/Unit Director/designated nurse will review electronic Medication Administration Record (MAR) and electronic TARs daily to monitor medications that were not administered to the resident due to unavailability, refusal, or omission; -The Nurse or Certified Medication Technician (CMT) in charge of medicine administration must review all of their designated MARs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physician's orders and that all necessary interventions were taken in the event of an omission; -The RCC, Unit Manager, or designated nurse will review all electronic MARs and TARs and compare all medications available for each resident in the facility weekly to ensure availability. Review of Resident #64's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/24, showed: -Severe cognitive impairment; -Has an indwelling urinary catheter; -High risk drug class: antipsychotics (mood stabilizer), antidepressants and antibiotic; -Diagnoses include multiple sclerosis (MS, a neurological condition that causes muscle weakness), seizures, high blood pressure, multi-drug resistant organism (MDRO), anxiety, diabetes, urinary tract infection (UTI) in the last 30 days, manic depression and schizophrenia (severe mental disorder can result in hallucinations, delusions, and extremely disordered thinking and behavior). Review of the resident's progress notes showed: -On 3/6/24 at 3:43 P.M., the resident was readmitted from the hospital with an admitting diagnosis of UTI and bacteremia (infection that has spread to the blood stream); Current medication orders along with Ertapenem (antibiotic), intravenously (IV) for 3 days ending on 3/10/24, along with resuming previous meds were verified with the Nurse Practitioner (NP); Skin assessment noted skin intact with suprapubic catheter draining clear yellow urine; IV site in left inner upper arm with minimal redness noted around insertion site, nephrostomy in left lower back draining clear yellow urine; The resident has a follow up appointment for a cystoscopy retrograde pyelogram (a procedure to remove kidney stones) on 3/26/24; -On 3/26/24 at 2:06 P.M., the resident just returned from same day surgery; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/26/24 at 6:56 P.M., the resident returned alert and up in wheelchair; Midline IV port in left arm was removed and nephrostomy tube was also removed; A stent was placed in the penis, blood noted in catheter bag; The resident's suprapubic catheter was changed today. Review of the resident's Physician Order Sheets (POS), dated March, 2024, showed no orders for PICC line care or nephrostomy tube care. Review of the residents POS, dated March through April, 2024, showed an order: -Suprapubic catheter care every shift, cover with dry dressing and report any signs or symptom of infection; -Order status: active; -Start date: blank; -End date: blank; -Revision date: 2/2/23. Review of the resident's MAR and TAR, dated March, 2024 and April, 2024, showed no order for suprapubic catheter site care or documentation to show the treatment was completed. Observation on 4/14/24 at 10:17 A.M. and on 4/17/24 at 10 :37 A.M., showed the resident did not have a dressing located around his/her suprapubic catheter site. During an interview on 4/17/24 at 2:15 P.M., Licensed Practical Nurse (LPN) D said when the resident arrives from the hospital, there should be orders on how to care for the PICC, such as dressing changes and flushes from the hospital and if there are no orders, the nurse should ask the facility doctor for orders. If the resident returns from the hospital with a nephrostomy tube, there should also be orders obtained for care of the nephrostomy tube, such as cleaning and dressing changes. During an interview on 4/18/24 at 10:30 A.M., LPN O said he/she admitted the resident back into the facility on [DATE] and verified the resident had a PICC line, nephrostomy tube and suprapubic on admission. He/She said the orders for the suprapubic were probably placed in the computer incorrectly due to the tab for the order to be sent to the TAR was not selected. The orders did not show on the TAR to be completed by nursing staff. He/She was not sure what orders specifically needed to be obtained regarding the PICC line and nephrostomy tube. The resident had the PICC line and nephrostomy tube removed at the hospital when he/she went there for outpatient surgery on 3/26/24. Review of the residents POS, dated April, 2024, showed an order: -EKG yearly; -Status: active; -Start date: 4/5/22; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Revision date: 6/15/21. Review of the resident's diagnostic administration report, dated April, 2024, showed an order for a yearly EKG and on 4/5/24 the documentation box was blank. During an interview on 4/18/24 at 10:30 A.M., LPN O said the EKG company was currently backed up in their workload, therefore the resident's EKG was not completed. During an interview on 4/18/24 at 1:41 P.M., the Director of Nursing said she expected staff to place the orders in the computer correctly so the order would show on the TAR to be completed. She also expected staff to obtain orders related to the care for the resident's PICC line and nephrostomy tube. The EKG was not completed. The provider is backed up on orders. The resident is required to have the yearly EKG due to being on anti-psychotic medications. MO00233864

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADLs-bathing, dressing, toileting) received necessary services to maintain adequate personal hygiene when staff left one resident soiled for an extended period (Resident #44), and when staff did not shave and provide nail care for three residents (Residents #102, #64 and #18). The sample was 26. The census was 133. Review of the facility's ADL and Documentation Policy, last reviewed 10/18/23, showed: -All nurses, aides and other employees must follow nursing standard of practice of completing ADLs; -For independent residents, ADLs must be documented two times per week; -For all other residents who are not independent, ADLs must be documented daily; -All documentation is completed in the electronic medical charting system. 1. Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 2/23/24, showed: -Mild cognitive impairment; -Uses manual wheelchair; -No behaviors; -Occasionally incontinent of urine and continent of bowel; -Diagnoses included viral hepatitis (a liver disease), anxiety, manic depression (a mental disorder) and schizophrenia (a mental disorder that is characterized by severely impaired thinking, emotions and behaviors). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is incontinent of urine; -Interventions: -Clean peri-area (genital area) after each incontinent episode; -Ensure the resident has an unobstructed path to the bathroom; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor and document signs and symptoms of a urinary tract infection (UTI): pain, burning, blood-tinged urine, urine cloudiness, deepening in color of urine, no output from the catheter, increased pulse, increased temperature, foul smelling urine, chills, altered mental status changes, change in behavior, and change in eating habits. Review of the resident's behavior monitoring and intervention sheet, dated 3/19/24 through 4/16/24, showed no behaviors noted. Observation and interview on 4/16/24 at 11:04 A.M., showed upon entering the resident's room, a strong odor of urine present. The resident lay in bed with his/her eyes closed. The resident's maroon bedspread and thick blue blanket were saturated with urine. The resident said he/she was tired and didn't know when the last time was that he/she was assisted with getting his/her brief changed. The resident said he/she welcomed the assistance of staff and had some of his/her favorite staff members who help him/her get cleaned up. Certified Nursing Assistant (CNA) K entered the resident's room and removed the resident's bedspread and blanket. The resident's pants and lower part of his/her shirt was saturated with urine. CNA K assisted the resident in removing his/her brief. The resident's brief was completely saturated, and the brief lining had white balls formed and appeared to be disintegrating. CNA K raised the resident's pannus (abdominal fold) and the resident had a bright red and inflamed rash under his/her pannus. The resident's white sheet on his/her bed had a yellow ring on it. The CNA assisted to remove the resident's soiled brief and pulled up his/her soiled pants. The resident then walked to the shower room on 100 hall with his/her walker. During an interview on 4/16/24 at 11:10 A.M., CNA K said it was terrible and disgusting to leave someone wet like this for so long and it was obvious the resident was left wet the entire night and morning. CNA K said the resident required some reminders to get out of bed but normally never gave him/her any issues about getting up. CNA K did not know the last time the resident was changed. Staff are to check on and change incontinent residents at least every two hours. During an interview on 4/16/24 at approximately 1:00 P.M., Certified Medication Technician (CMT) J said he/she was familiar with the resident and said the resident can go to the bathroom him/herself and can clean him/herself when he/she is incontinent. The resident is encouraged to use the restroom during the shift but often has behaviors and refuses care from the staff. The nurse is notified of the resident's refusal of care and it is documented in the electronic chart. During an interview on 4/17/24 at 2:15 P.M., Licensed Practical Nurse (LPN) D said he/she was not aware of any refusals of care by the resident but expected staff to encourage the resident to be cleaned up and to document refusals. During an interview on 4/18/24 at 1:41 P.M., the Director of Nursing (DON) said staff is expected to change soiled residents in a timely manner and document any behaviors related to refusals of incontinence care. 2. Review of Resident #102's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for bed to chair transfers; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent on staff for bathing and showers and personal hygiene; -Diagnoses included diabetes, kidney disease, stroke and dementia. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has a history of stoke and requires dependent to maximum assistance with ADLs; -Plan: Activity as tolerated and out of bed as tolerated; Monitor and document mobility status. Observation on 4/14/24 at 10:17 A.M., on 4/15/24 at 8:39 A.M. and on 4/16/24 at 12:02 P.M., showed the resident sat in his/her wheelchair with an unshaven face and an approximately half-inch beard that had food particles in it. Both of the resident's hands had long jagged nails with brown matter underneath. 3. Review of #64's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses manual wheelchair; -Requires substantial to maximum assist from the sitting to standing position and with chair to bed transfers; -Requires substantial to maximum assist for bathing and showering; -Requires partial to moderate assist for personal hygiene; -Diagnoses included multiple sclerosis (MS, a neurological condition that causes muscle weakness) seizures, anxiety, manic depression and schizophrenia. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's ADL needs. Observation on 4/14/24 at 10:17 A.M., on 4/16/24 at 1:35 P.M., and on 4/17/24 at 10:37 A.M., showed the resident sat in his/her wheelchair with a greasy, shiny, unshaven face with an approximately one-half inch beard. Both of the resident's hands had long nails with dark matter underneath. 4. Review of Resident #18's quarterly MDS, dated [DATE], showed: -The resident is rarely or never understood; -Uses a manual wheelchair; -Diagnoses included pneumonia, dementia, Alzheimer's disease, Parkinson's disease (a neurological condition that is characterized by tremors) and anxiety. Review of the resident's care plan, in use at the time of survey, showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: The resident requires ADL assistance with bathing, dressing and hygiene; -Interventions: -Allow the resident time to complete the task and intervene as needed; -Monitor for a decline in function; -Provide assistance, set up, supervision, and cueing as needed. Observation on 4/14/24 at 9:55 A.M. and on 4/15/24 at 9:40 A.M., showed the resident unshaven with an approximately one-half inch beard. Both of his/her hands had long nails. 5. During an interview on 4/17/24 at 8:46 A.M., CNA K said staff are to shave residents on their shower days. The residents' nails have not been clipped on 100 hall because none of the staff could find any nail clippers. Staff are to inspect and trim residents' nails on their shower days and to clean and trim them when needed. 6. During an interview on 4/17/24 at 2:15 PM., LPN D staff are to complete residents' shaving and nail care with the residents' showers. 7. During an interview on 4/18/24 at 1:41 P.M., the DON said she expected staff to shave and provide nail care on the residents' shower days and as needed. MO00233864

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standard when staff failed to identify newly acquired skin issues and obtain treatment orders for two residents (Residents #64 and #44). The sample was 26. The census was 133. Review of the facility's Skin Integrity Assessment policy, revised on 6/30/23, showed: -The purpose of this policy is to ensure that all residents are being assessed for skin integrity issues or concerns weekly and changes being reported to the physician, legal guardian, family, interdisciplinary care plan team and the wound nurse consultant. Procedure: -All residents will be assessed for skin integrity concerns weekly by the Resident Care Coordinator (RCC), wound nurse, or licensed designee; -Any skin integrity concerns will be reported to the RCC, DON and physician for treatment orders as needed; -All pressure ulcers or skin integrity concerns will be marked on the assessment. 1. Review of #64's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 3/10/24, showed: -Severe cognitive impairment; -Uses manual wheelchair; -Requires substantial to maximum assist from the sitting to standing position and with chair to bed transfers; -Requires substantial to maximum assist for bathing and showering; -Requires partial to moderate assist for personal hygiene; -At risk for developing pressure ulcers (injury to underlying skin resulting from prolonged pressure of the skin); -Diagnoses include: multiple sclerosis (MS, a neurological condition that causes muscle weakness) seizures, anxiety, manic depression and schizophrenia. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's skin condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's skin assessment, dated 4/5/24, showed the resident had no skin issues. No further skin assessments were noted. During observation and interview on 4/14/24 at 10:17 A.M., the resident sat in his/her wheelchair in his/her room. Certified Nursing Assistant (CNA) G assisted the resident to bed to check his/her incontinence brief. CNA G removed the resident's incontinence brief. The resident had a round open area that was approximately one inch in diameter on the resident's right anterior (front) abdominal area. The open area was red with no drainage and had a pale white ring around it. CNA G observed the open area and said, I'm not sure what that is. During observation on 4/17/24 at 10:37 A.M., the resident sat in his/her wheelchair in his/her room. CNA I and CNA K pivoted the resident to his/her bed. At 10:47 A.M., Licensed Practical Nurse (LPN) O entered the resident's room to apply a dressing to the resident's suprapubic catheter (a tube that drains urine from the abdomen) site. CNA I and CNA K removed the resident's brief. The open area on the resident's right abdominal area remained present. The open area did not have a dressing. After completing the treatment to the resident's suprapubic catheter site, LPN O closed the resident's brief without addressing the resident's open area. Review of the resident's Physician Order Sheets (POS), dated April 2024, showed no treatment orders for the open area on the resident's abdomen. Review of the resident's progress notes, dated April 2024, showed no documentation of the open area on the resident's abdomen and no documentation that the physician was notified . During an interview on 4/18/24 at 10:30 A.M., LPN O said he/she was not aware of the open area on the resident's right abdomen. He/She did not observe it when he/she completed the suprapubic catheter treatment. 2. Review of Resident #44's, quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -No behaviors; -Occasionally incontinent of urine and continent of bowel; -Diagnoses included viral hepatitis (a liver disease), anxiety, manic depression (a mental disorder) and schizophrenia (a mental disorder that is characterized by severely impaired thinking, emotions and behaviors). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is incontinent of urine; -Interventions: -Clean peri-area (genital area) after each incontinent episode; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure the resident has an unobstructed path to the bathroom; -Monitor and document signs and symptoms of a urinary tract infection (UTI): pain, burning, blood-tinged urine, urine cloudiness, deepening in color of urine, no output from the catheter, increased pulse, increased temperature, foul smelling urine, chills, altered mental status changes, change in behavior, and change in eating habits. Review of the resident's skin assessment, dated 4/7/24, showed no skin issues. No further skin assessments were noted. Observation and interview on 4/16/24 at 11:04 A.M., showed upon entering the resident's room, a strong odor of urine present. The resident lay in bed with his/her eyes closed. The resident's maroon bedspread and thick blue blanket was saturated with urine. The resident said he/she was tired and didn't know when the last time he/she was assisted with getting his/her brief changed. The resident said he/she welcomed the assistance of staff and had some of his/her favorite staff members who help him/her get cleaned up. CNA K entered the resident's room and removed the resident's bedspread and blanket. The resident's pants and lower part of his/her shirt were saturated with urine. CNA K assisted the resident in removing his/her brief. The resident's brief was completely saturated, and the brief lining had white balls forming and appeared to be disintegrating. CNA K raised the resident's pannus (abdominal fold) and the resident had a bright red and inflamed rash under his/her pannus. The resident denied pain and was unaware the rash was present. Review of the resident's POS, dated April, 2024, showed no treatment order for the resident's pannus rash. Review of the resident's progress note, dated April, 2024, showed no documentation of the resident's rash or that the physician was notified. During an interview on 4/17/24 at 8:46 A.M., CNA K said the aides should inform the nurse of any new skin issues when they occur, including rashes. During an interview on 4/18/24 at 10:30 A.M., LPN O said the resident frequently gets rashes in his/her abdominal fold, but the resident usually will tell staff that he/she has a rash. 3. During an interview on 4/17/24 at 2:15 P.M., LPN D said skin checks are to be completed weekly by the nurses. The aides are to report any new skin issues to the nurse. Once the skin issue is assessed, the nurse should call the physician for new orders immediately. 4. During an interview on 4/18/24 at 1:41 P.M., the DON said the nurses are responsible for weekly skin assessments that are complete and accurate. She expected staff who observed the new skin issues to report it to the nurse immediately so new orders could be obtained.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to appropriately assess and investigate a series of falls resulting in head injuries, and to implement adequate interventions following the series of falls for one resident (Resident #36). The facility failed to ensure appropriate techniques and/or functional equipment were utilized during mechanical lift transfers for two residents (Residents #36 and #119), and to ensure staff applied and used gait belts properly during transfers or assisted ambulation for three residents (Residents #64, #102 and #39). In addition, the facility failed to ensure residents were routinely and accurately assessed for smoking safety for three residents (Residents #64, #18 and #107). The sample was 26. The census was 133. Review of the facility's Focus Risk Assessment Plan Scope/Severity of Falls (FRAPSS) policy, revised 6/29/23, showed: -Purpose: To assess all residents for potential for falls in the facility. To ensure a comprehensive interdisciplinary plan of care is established for all residents who are identified for increased risk of falls. To identify precipitating factors for fall risk and to be proactive in implementing interventions to prevent or reduce the incidence of further falls; -Procedure included: -1. Resident will be assessed using the FRAPSS form for fall risks upon admission, quarterly and in an acute situation where resident has fallen. The FRAPSS assessment guide measures areas of precipitating factors such as age, use of assistive devices, diagnoses, medical antecedents, history of previous falls, sensory deficits, medications, and resident compliance with prescribed orders. Every resident who has a fall including those without injury will be screened by the therapy department and nursing interventions will be put in place to reduce the risk of further falls; -2. The resident will be assessed by a Licensed Nurse and after the assessment is completed the resident will be scored accordingly and placed on the scope and severity level which outlines the plan of care and is denoted by different colors. The resident who is found to be at risk a score of 26 or greater or Level 3 or greater for falls will have an individualized interdisciplinary plan of care developed which will include nursing, therapy, physician, legal guardian (if applicable) and may include a pharmacist consult, dietician consult, and other outside agencies to consult; -3. The focus levels for fall risk, Scope and Severity Grid: --a. FRAPSS Level 1 score of 0-15 = Minimal risk, resident has had no falls in the last 30 days; --b. FRAPSS Level 2 score 16-25 = Potential for more than minimal harm, resident has had one fall in the last 30 days with no significant injury. Interventions will include all level 1 interventions and visual checks by nursing staff. Investigation by Registered Nurse (RN) or designee including monitoring of as needed (PRN) medications given to resident. Rule out of any medical antecedents; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--c. FRAPSS Level 3 score 26-34 = Potential for actual harm, resident has had 2 or more falls without significant injury. Interventions include all Level 1 and 2 interventions and intensive monitoring. The resident will be added to the high priority RN list and assessed by the Director of Nursing (DON) or designee including a meeting to establish a plan of care addressing the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) and care plans for the resident. In-servicing to all direct care staff on plan of care for resident's individual needs related to falls; --d. FRAPSS Level 4 score 35 and up = Immediate Jeopardy, 2 or more falls with 1 or more resulting in significant injury. Interventions will include all interventions of level 1-2-3 and may include based on the interdisciplinary team (IDT), other individualized plans of care as assessed by the IDT. The Administrator, DON and Therapy Director will meet and establish interventions and plan of care that will reduce the risk of resident falling and ensure that protective oversight of the resident is priority. The DON will continue to assess the resident as a high priority resident in the facility and the plan of care will be modified to ensure the highest level of safety is in place for the resident; -4. Nursing Interventions will be individualized and addressed on the care plan for the resident. These interventions can be added to any FRAPSS Level. The resident who reaches a level 3 will be placed on the High Priority list by the DON and assessed by the DON or designee; a plan of care will be initiated with the IDT and the care plan for the resident will be in-serviced to all direct care staff under the supervision of the DON/designee. Review of the facility's Precautionary Measures for Gait Belt Application and Usage, revised 6/29/23, showed: -Purpose: The purpose of this policy is to ensure precautionary and safe measures are taken during the application and use of gait belts; -Procedure: -Safe usage of a gait belt can prevent potential risk of injury to residents that could be caused by pulling on their arms, shoulders and wrists during ambulation, transfers or repositioning; -Safety Measure: Never transfer any resident by lifting them under their arms. Avoid the axillary area on the resident as this has the potential to cause nerve damage, shoulder dislocation, bruising, pain and fractures; -Never attempt to transfer a resident independently that cannot bear weight. A mechanical device/lift must be used in the plan of care for the resident that cannot bear weight; -The gait belt is a specialized device that is utilized to assist during transfers, ambulation or repositioning of the resident; -To ensure optimum comfort and safety for the resident, the gait belt will be utilized. This will also aid in minimizing the risk of injury to the resident as well as the staff; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bernard Care Center	4335 West Pine Blvd Saint Louis, MO 63108

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff will have better control and be able to facilitate the use of correct body mechanics to avoid injury of resident and staff; -Application of gait belt; --The gait belt is to be applied around the resident's waist below the ribs securely so that staff may grasp the belt which will prevent the belt from sliding above the resident's waist; --The gait belt buckle should be fastened securely in the front, away from the midline; -Transfer, ambulation and repositioning; --Always position fingertips pointing upward, grasping the belt from under; --Utilize proper body mechanics at all times. Review of the facility's Smoking Contraband policy, revised 4/3/24, showed: -Purpose: The purpose of this policy is to define what the facility classifies as smoking contraband and to provide safety and protective oversight to the residents and employees by monitoring the smoking contraband in the facility. It is the goal of the facility to provide a safe environment for all; -Procedure included: --Residents will be assessed for independent smoking upon admission/re-admission, quarterly and PRN. The resident must be approved per Legal Guardian and by the interdisciplinary care plan team to smoke unsupervised. This is determined by assessment of the resident's history and current plan of care. 1. Review of Resident #36's medical record, showed diagnoses included seizure disorder, unspecified intellectual disabilities (limits to a person's ability to learn at an expected level and function in daily life), schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder, drug-induced subacute (somewhat rapid change) dyskinesia (uncontrolled, involuntary muscle movement), ataxia (impaired coordination), abnormalities of gait and mobility, and generalized muscle weakness. Review of the resident's hospital after visit summary, dated 12/2/23, showed diagnoses included fall and injury of head. Review of the resident's FRAPSS fall assessment, dated 12/2/23, showed a score of 28.0 and category of Level 3. Review of the resident's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Upper extremity impairment on one side; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lower extremity impairment on both sides; -Use of wheelchair; -Mobility performance: Dependent (helper does all the effort) for sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer; -No falls since last assessment. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident requires total assistance with his/her activities of daily living (ADLs). Diagnoses of drug induced subacute dyskinesia and ataxia; -Problem: Resident is at risk for impaired cognitive function/dementia or impaired thought processes related to diagnoses of mental retardation and unspecified intellectual disabilities; -Problem: Resident is risk for falls related to unsteady balance and use of psychotropic medication; --Goal: Resident will not sustain serious injury through the review date; --Interventions, initiated 5/27/21, included: ---Anticipate and meet the resident's needs; ---Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; ---Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair; ---Follow facility fall protocol. Review of the resident's physician order sheet, active on 1/25/24, showed: -An order, dated 1/10/23, for haloperidol decanoate (antipsychotic medication) intramuscular (IM) solution, 50 milligrams (mg)/milliliters (ml), inject one ml IM one time a day every 14 days; -An order, dated 1/10/23, for haloperidol 2 mg tablet, give 2.5 mg by mouth (PO) once daily; -An order, dated 1/10/23, for haloperidol 2 mg tablet, give 7.5 mg PO in the afternoon; -An order, dated 2/19/23, for clonazepam (anxiolytic (anti-anxiety) medication) 0.5 mg, PO once daily; -An order, dated 4/23/23, for valproic acid (anticonvulsant medication) oral solution, give 1250 mg PO two times a day; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 7/9/23, for trazodone (antidepressant and sedative medication), give 75 mg PO in the afternoon; -An order, dated 7/9/23, for trazodone, give 75 mg PO in the morning; -An order, dated 7/9/23, for trazodone 100 mg, give one tablet PO at bedtime. Review of the resident's incident note, dated 1/25/24 at 4:55 P.M., showed staff documented the resident found lying next to his/her bed with blood coming from both the side of his/her face and the front. CNA came and notified nurse of the incident. The nurse noticed two, 2 centimeter (cm) lacerations to the resident's front forehead and right side of his/her face near his/her cheek. Resident could not inform nurse what he/she was trying to do. Patient demonstrated pain in each extremities and could not rate it or describe it due to his/her baseline. Nurse sent resident to hospital to be evaluated. Review of the resident's hospital after visit summary, dated 1/25/24, showed diagnoses of fall, facial laceration, and mental retardation. Review of the resident's FRAPSS fall assessment, dated 1/25/24, showed: -Category: Level 1, Score: 6.0; -Assistive devices checked: wheelchair; -Assistive devices not checked included: low bed and footwear; -Diagnoses/medications checked: heart failure; -Diagnoses/medications not checked included: unsteady gait, psychosis, falls, seizures, confusion, anticonvulsants, antipsychotics, sedatives/hypnotics, and anxiolytics; -Fall history: No falls in the past 30 days; -Sensory deficits checked: delirium and confusion; -Sensory deficits not checked included: agitation, anxiety, psychosis, extrapyramidal side effects (EPS, drug-induced movements); -Total score and implement the plan based on the system below for severity: --FRAPSS level implemented: Score 1-15 = Level 1. Review of the resident's physical therapy (PT) recertification, progress report, and updated therapy plan, signed by PT on 2/1/24, showed: -Precautions: Fall risk behavior - will lower him/herself to the floor; -Functional skills assessment of transfers: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Sit to stand = partial/moderate assistance; --Chair/bed-to-chair transfers = substantial/maximal assistance. Review of the resident's progress notes, dated 2/2/24, showed: -At 11:34 A.M., staff documented the resident is on incident follow up with neuro checks every 15 minutes. Resident slid out of wheelchair in dining room and hit the right side of his/her head on the arm of a chair. This was witnessed by staff. The nurse assessed the resident and sent him/her to the hospital; -At 2:44 P.M., staff documented the resident slid out of his/her wheelchair and hit his/her head on the metal handrails of the chair. No open areas, but sustained a bump on his/her right forehead. Review of the resident's hospital after visit summary, dated 2/2/24, showed diagnoses of fall and abrasion. Review of the resident's FRAPSS fall assessment, dated 2/2/24, showed: -Category: Level 3, Score: 33.0; -Assistive devices checked: wheelchair; -Assistive devices not checked included: low bed and footwear; -Diagnoses/medications checked: falls and severe mental retardation; -Diagnoses/medication not checked included: unsteady gait, psychosis, seizures, confusion, , antipsychotics, and sedatives/hypnotics; -Fall history: Two or more falls in the past 30 days without significant injury; -Sensory deficits checked: agitation; -Sensory deficits not checked included: delirium, confusion, anxiety, psychosis, and EPS; -Total score and implement the plan based on the system below for severity: --FRAPSS level implemented: Score 35 & up = Level 4. Review of the resident's incident note, dated 2/8/24 at 6:07 P.M., showed staff documented the nurse was called to assess the resident who slid on his/her wheelchair and hit his/her head on the floor. Open areas noted and bump on his/her right forehead. Resident was transported to the hospital. Review of the resident's hospital after visit summary, dated 2/8/24, showed diagnoses of fall, closed head injury, and abrasion of forehead. Review of the resident's FRAPSS fall assessment, dated 2/8/24, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Category: Level 4, Score: 42.0; -Assistive devices checked: wheelchair; -Assistive devices not checked included: low bed and footwear; -Diagnoses/medications not checked included: antipsychotics and sedatives/hypnotics; -Fall history: One or more falls in the last 30 days resulting in a significant injury; -Sensory deficits checked: psychosis; -Sensory deficits not checked included: delirium, agitation, confusion, anxiety, and EPS; -Total score and implement the plan based on the system below for severity: --FRAPSS level implemented: Score 35 & up = Level 4. Review of the resident's medical record showed no documentation of investigations regarding specific circumstances of falls occurring 1/25/24, 2/2/24, and 2/8/24, including potential behaviors exhibited at the time of falls or patterns observed related to falls. Further review showed no documentation of care plan meetings held to discuss fall interventions during this timeframe. Further review of the resident's care plan, in use at the time of survey, showed: -The care plan failed to identify the resident's transfer status, including requiring the use of a Hoyer (mechanical) lift; -The care plan failed to identify the resident's behavior of lowering him/herself to the floor; -The care plan failed to identify the resident's series of falls on 1/25/24, 2/2/24, and 2/8/24, in which injuries occurred involving the resident's head; -The care plan failed to identify updated resident-specific interventions following the resident's falls on 1/25/24, 2/2/24, and 2/8/24, including use of a low bed and fall mat. Observation on 4/14/24 at 8:37 A.M., showed the resident in his/her room, seated in a wheelchair on top of a Hoyer lift pad. The resident's wheelchair did not have foot rests. The resident wore socks without shoes, and his/her feet dangled from the wheelchair, approximately one inch from the floor. A fall mat was folded and against the wall, approximately ten feet from the resident. During an attempted interview, the resident was unable to respond to questions regarding falls. Observation on 4/15/24 at 7:18 A.M., showed Certified Nurse Aide (CNA) B and CNA N in the middle of transferring the resident in his/her room, using a Hoyer lift. The resident sat in a sling attached to the Hoyer lift, approximately four feet above a wheelchair. While CNA N operated the Hoyer lift, CNA B held the resident's wheelchair by the handles, keeping the chair tipped backward so the back of the chair rested against CNA B's body. The brake was not locked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/15/24 at 1:37 P.M., showed the resident on his/her back in bed, with the bed positioned low to the floor. The left side of the bed was flush to the wall and a fall mat was on the floor on the right side of the bed. A call light hung on the wall at the resident's feet, approximately five feet from the resident's reach. Observations on 4/16/24 at 10:10 A.M. and approximately 11:00 A.M., showed the resident in his/her room, seated in a wheelchair. The resident's wheelchair did not have footrests. The resident wore socks without shoes, and his/her feet dangled from the wheelchair, approximately one inch from the floor. The resident's catheter tubing wrapped around the front left wheel of his/her wheelchair. A fall mat was folded and against the wall, approximately ten feet from the resident. During an interview on 4/17/24 at 1:43 P.M., CNA B said the resident is confused at times. CNA B is not sure if the resident has a history of falls or is a fall risk. The resident used to wear a helmet, but does not wear it anymore and it is unknown how long ago this was. When in bed, the resident's bed gets positioned low and he/she gets a fall mat. CNA B knows to put the bed low and put out a fall mat because the nurse told him/her. The resident also has side rails for fall prevention. CNAs are made aware of fall interventions by the nurse. The resident cannot transfer him/herself and requires a Hoyer lift. When transferring the resident on 4/15/24, CNA B had the wheelchair tilted backward so when the resident was lowered into the chair, he/she would be positioned far back in the chair. The brakes of the wheelchair were not locked while CNA B held onto the wheelchair and propped it with his/her body. The brake should have been locked and the wheelchair should have been upright because the resident could have been dropped. During an interview on 4/17/24 at 2:21 P.M., CNA C said the resident has some confusion and has a history of falling out of bed. He/She gets a low bed and fall mat when he/she is in bed. Nurses communicate fall interventions to CNAs. The resident cannot transfer him/herself and requires a Hoyer lift. During a Hoyer lift transfer, staff should keep the wheelchair positioned upright. Staff should not tilt the wheelchair because they could drop the resident. During an interview on 4/17/24 at 2:45 P.M., Licensed Practical Nurse (LPN) D said the resident has poor short-term memory. He/She has a history of falls and his/her falls were more due to behaviors, like putting him/herself on the floor. He/She used to wear a helmet. Currently, he/she requires a floor mat and low bed. The Nurse Managers determine what interventions to implement for each resident. Fall interventions are documented as a progress note and on the resident's care plan. Care plans are updated by the MDS Coordinator and nurses can update them, too. The resident requires a Hoyer lift to transfer. During a transfer, staff should ensure the resident's wheelchair is upright and the brake is locked. It would not be appropriate for staff to tilt a resident's wheelchair and support the tilted wheelchair with the employee's body weight because the wheelchair could tip over and it is not safe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 9:06 A.M., the Residential Care Coordinator said the resident had a few falls recently. At the time, the resident had increased behaviors of climbing out of bed and flipping tables, and his/her falls were behavioral. At the time of the falls, the resident was using a low bed and he/she had fall mats. Shortly after the last fall, he/she went out to the hospital for a change in condition and was taken off all his/her psychotropic medications. Since he/she returned to the facility, he/she has not been exhibiting behaviors and has not had any falls. The Residential Care Coordinator is responsible for taking the lead on investigating the circumstances of resident falls. After a fall occurs, the nurse is responsible for completing a FRAPSS fall assessment. The assessment should be completed accurately. The score of the FRAPSS fall assessment determines the level of a resident's fall risk and the FRAPSS policy provides guidance for which interventions to implement at each level. Determining fall interventions is a team effort. At this time, there is no formal process for having IDT meetings to discuss interventions following a resident's fall. Once an intervention is identified, it goes onto the report sheet to get communicated to nursing staff. Interventions should be resident specific and should be documented on the resident's care plan. Care plans are updated by the nurse management team. During an interview on 4/18/24 at 12:21 P.M., the DON and Administrator said the resident's recent falls were due to behaviors. When he/she got angry, he/she acted out by doing things like flipping tables. The behaviors were normal for him/her and he/she fell with intention. He/She was recently hospitalized and was ultimately diagnosed with neuroleptic syndrome (life threatening reaction to antipsychotic drugs). His/Her medications were adjusted and he/she became stable. The neuroleptic syndrome might have been the cause of the resident's recent falls. The DON and Administrator expected the IDT to meet to discuss resident-specific interventions following a fall. After a fall occurs, the nurse is expected to fill out a FRAPSS fall assessment. The FRAPSS fall assessment should also be completed on admission and quarterly, and the assessment should be filled out accurately. Resident-specific fall interventions should be communicated to nursing staff in report and should be documented on the resident's care plan. Resident #36 is a Hoyer lift transfer. During a Hoyer lift transfer, it is expected that staff maintain the wheelchair in an upright position. The wheelchair should be locked and should not be tilted backward, for safety purposes. 2. Review of Resident #119's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses of multiple sclerosis (MS, neurological condition that causes muscle weakness), bipolar disorder (mood disorder) and muscle weakness. During an interview on 4/15/24 at 1:49 P.M., the resident said the sit to stand lift has been broken and staff continue to use it. He/She said the legs of the sit to stand lift do not work and there is a part visible on the bottom of the lift that is dragging. He/She said he/she does not feel safe on the lift. Observation on 4/18/24 at 10:44 A.M. showed CNA L and CNA M assisted the resident using the sit to stand lift. CNA L turned on the lift and pushed the button to spread the legs of the lift. The left leg of the lift spread while the right leg stayed in place. CNA M stood on the right side of the lift and used his/her foot to manually push the right leg of the lift open. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 11:06 A.M., CNA L said the sit to stand lift is broken. Staff have to kick the legs to open them because the remote doesn't work. He/She said he/she has used the lift at least twice on the resident and the lift was broken each time. He/She did not report the lift as broken to Maintenance or the Charge Nurse. During an interview on 4/18/24 at 11:08 A.M., CNA M said the lift has been broken for at least two weeks. He/She said the legs of the lift are broken and the lift is wobbly. He/She said CNAs are to let Maintenance and the Charge Nurse know when medical equipment is broken. He/She had not reported the lift being broken. During an interview on 4/18/24 at 11:12 A.M., LPN D said he/she was not aware the sit to stand lift was broken. He/She said he/she is to let Administration know if medical equipment is broken. He/She expected CNAs to let him/her know if equipment is broken. During an interview on 4/18/24 at 11:42 A.M., the Maintenance Director said he has taken the lift off the floor for repair. He said the legs are broken on the lift and he expected all staff to let him know if they see medical equipment that is broken. During an interview on 4/18/24 at 2:04 P.M., the Administrator said she expected medical lifts to be in working order. 3. Review of Resident #64's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Uses manual wheelchair; -Requires partial to moderate assistance from staff from sitting to lying position and lying to sitting to the side of the bed; -Requires substantial to maximum assistance from the sitting to standing position and with chair to bed transfers; -Diagnoses included MS, seizures, anxiety, manic depression (mood disorder) and schizophrenia. Review of the resident's care plan, in use at the time of survey, showed: -Problem: The resident is at risk for falls related to deconditioning, gait and balance problems, incontinence, poor communication, and unaware of safety needs; -Interventions: -Anticipate and meet the resident's needs; -Be sure the resident's call light is within reach; -Physical therapy to evaluate and treat as ordered and PRN; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident needs to be evaluated for and supplied appropriate adaptive equipment or devices PRN. Observation on 4/14/24 at 10:17 A.M., showed the resident in his/her room, sitting in his/her wheelchair. CNA G was in the resident's room and informed the resident that he/she was going to place the resident in the bed to check his/her incontinence brief. CNA G encouraged the resident to stand up out of his/her wheelchair. The resident was unable to stand on his/her own. CNA G lifted the resident under his/her arms. The resident was not able to stand up straight and held onto CNA G's waist as the resident pivoted to the bed. Staff did not use a gait belt for the transfer. Observation on 4/17/24 at 10:37 A.M., showed the resident sat in his/her wheelchair in his/her room. CNA I and CNA K explained to the resident they were going to get him/her into the bed. The resident was encouraged to stand but was unable to stand by trying to push off the arm rests on the wheelchair. CNA I and CNA K then lifted the resident under his/her arms. The resident was unable to stand up straight and CNA I and CNA K continued to hold the resident under his/her arms then pivoted the resident to his/her bed. Staff did not use a gait belt for the transfer. 4. Review of Resident #102's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Mobility device used: manual wheelchair; -Dependent on staff for sitting to lying, lying to sitting to the side of the bed, sit to stand, and bed to chair transfers; -Diagnoses included diabetes, kidney disease, stroke and dementia. Review of the resident's care plan, in use at the time of survey, showed: -Problem: The resident has a history of a stroke and is dependent to maximum assist with all ADLs; -Interventions: --Activity as tolerated and out of bed if tolerated; --Monitor and document mobility status; --Monitor and document resident's abilities for ADLs and assist as needed. Observation on 2/15/24 at 8:39 A.M., showed CNA T and CNA U informed the resident they were going to get him/her up to the chair. The resident was unable to sit in the upright position in the bed. CNA T and CNA U held the resident up by holding onto his/her arms and then shifted the resident to the edge of the bed by pulling on the bedsheet. CNA T and CNA U held the resident under the arms and rocked him/her out of the bed. The resident was unable to stand up straight or follow simple commands related to taking steps towards the wheelchair. CNA T and CNA U both held the resident by the waistband of his/her jeans and pivoted the resident into the chair. Staff did not use a gait belt for the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #39's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Upper extremity impairment on one side; -Lower extremity impairment on one side; -Use of wheelchair; -Mobility performance assessment: Supervision or touching assistance for sit to stand. Walking ten feet not attempted due to medical condition or safety concerns; -Diagnoses included stroke, seizure disorder, dementia and altered mental status. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident is at risk for falls related to decreased mobility, right sided weakness, and use of psychotropic medications; -Desired outcome: Resident will not sustain serious injury through the review date; -Interventions/tasks included PT evaluate and treat as ordered or PRN. Review of the resident's physical therapy recertification, progress report, and updated therapy plan, certification period 4/12/24 through 5/11/24, showed: -Diagnoses included unspecified sequelae (after effect of a disease, condition, or injury), unspecified abnormalities of gait and mobility, and generalized muscle weakness; -Goal: Patient will improve ability to safely transfer to a standing position from sitting in a chair, wheelchair or on the side of the bed with independence with ability to right self to achieve maintain balance and with implementation of compensatory strategies; --Current level of performance, as of 4/12/24: Supervision or touching assistance; -Goal: Patient will safely ambulate on level surfaces 30 feet using hemi-walker (walker designed for individuals with the use of only one hand) with supervision or touching assistance with adequate toe clearance, with adequate weight acceptance, with functional dynamic balance, with safety during turning and with use of righting reactions to facilitate increased participation in functional activity; --Current level of performance, as of 4/12/24: Partial/moderate assistance; -Prior equipment: Patient used a manual wheelchair prior to onset. Patient owns new right lower extremity (RLE) ankle foot orthoses (AFO) and hemi-walker; -Functional assessment: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Transfers, sit to stand = supervision or touching assistance; --Ambulation, walk 10 feet and walk 50 feet with two turns = partial/moderate assistance. Observation on 4/16/24 at 2:39 P.M., showed the resident sat in a wheelchair in the 300/400 dining room. CNA R placed a gait belt around the resident's waist and secured the belt, leaving it loose. The resident said the gait belt was tight and CNA R loosened the belt, leaving a gap of approximately 12 inches between the belt and the resident's abdomen. The resident propelled in his/her wheelchair to the hallway and CNA R stood behind the resident's wheelchair. The resident stood unsteadily and began walking unsteadily down the hall, using a hemi-walker with his/her left hand. CNA R followed behind the resident, pushing the resident's wheelchair approximately three feet behind the resident, not holding or touching the resident's gait belt. The right footrest of the wheelchair stuck straight out, not folded against the chair. The resident walked unsteadily, approximately 25 feet. CNA S walked down the hallway and stopped CNA R. CNA S said the resident's gait belt was too loose and he/she should be followed closely with the wheelchair. During an interview on 4/16/24 at 3:01 P.M., CNA S said the resident uses a wheelchair to ambulate and he/she is in therapy to work on mobility. At the time of the observation, CNA R

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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** 40290 Based on observation, interview and record review, the facility failed to ensure catheter bags (used to collect urine) remained positioned below the bladder of two residents with indwelling urinary catheters (thin tubes inserted into the bladder to drain urine), and to ensure catheter bags and catheter tubing remained off the floor. The facility's failure caused the potential for contamination and urinary tract infection. The facility identified six residents with catheters, all of whom were sampled, and problems were identified with two (Residents #64 and #36). The sample was 26. The census was 133. Review of the facility's Catheter Care policy, revised 6/29/23, showed: -Purpose: The facility will ensure any resident with a urinary catheter will be maintained to prevent infection; -Procedure included: -Keep the urinary drainage bag below the level of the bladder to prevent backflow of the urine; -Make sure the urinary drainage bag does not touch the floor. 1. Review of Resident #64's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/24, showed: -Moderate cognitive impairment; -Indwelling catheter; -Diagnoses included urinary tract infection (UTI) in the last 30 days, multiple sclerosis (MS, a neurological disease that causes muscle weakness), seizure disorder, anxiety, manic depression (a mood disorder), and schizophrenia (a mental condition that exhibits severely impaired thinking, emotions and behaviors). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is at risk for infection related to the resident having a supra-pubic catheter (a tube to drain urine that is inserted in the lower abdomen); -Interventions: -Monitor and document intake and output per facility policy; -Monitor signs of pain or discomfort related to the catheter; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor and record to the medical doctor (MD) signs and symptoms of a UTI: pain, burning, blood-tinged urine, urine cloudiness, deepening in color of urine, no output from the catheter, increased pulse, increased temperature, foul smelling urine, chills, altered mental status changes, change in behavior, and change in eating habits. Observation on 4/14/24 at 10:17 A.M., showed Certified Nurse Aide (CNA) G assisted the resident in the resident's room, to change the resident's clothing. While the resident lay in bed, CNA G adjusted the resident's urinary catheter tubing and bag through his/her pant leg. Once the catheter bag and tubing were freed from the resident's pant leg, CNA G raised the urinary catheter bag and catheter tubing that contained cloudy yellow urine, approximately 18 inches (in.) directly above the resident's waist. Cloudy urine in the catheter tubing flowed back towards the resident's abdomen. Observation on 4/17/24 at 10:37 A.M., showed the resident sitting in his/her wheelchair. CNA K freed the resident's catheter from the privacy bag that was located under the resident's wheelchair and emptied the resident's catheter while raising the catheter bag and tubing above the resident's waist. Cloudy yellow urine in the catheter tubing flowed back towards the resident's abdomen. 2. Review of Resident #36's admission MDS, dated [DATE], showed: -Resident rarely/never understood; -Lower extremity impairment on both sides; -Use of wheelchair; -Self-care admission performance: Dependent for toileting hygiene, upper and lower body dressing, and personal hygiene; -Indwelling catheter; -Diagnoses included seizure disorder, schizophrenia and anxiety disorder. Review of the resident's care plan, in use at the time of survey, showed: -Problem, initiated 3/22/24: Resident is at risk of infection and discomfort related to presence of urinary catheter; -Desired outcome: Resident will be/remain free from catheter-related trauma through review date. Resident will show no signs/symptoms of urinary infection through review date; -Interventions: Monitor and document intake and output as per facility policy. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to physician signs/symptoms of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/15/24 at 7:18 A.M., showed the resident positioned in a Hoyer (mechanical lift) sling, two feet above a wheelchair, with a catheter bag on his/her stomach. CNA N operated the Hoyer lift and lowered the resident into the wheelchair. Once the resident was lowered into the wheelchair, his/her catheter bag fell on to the floor. The top several inches of the catheter bag and approximately two feet (ft.) of catheter tubing lay directly on the floor. CNA N picked up the catheter bag, readjusted the protective covering, and placed it onto the resident's lap. Approximately sixteen inches of catheter tubing dragged on the floor while CNA B secured the catheter bag underneath the seat of the wheelchair. CNA B brought the resident in his/her wheelchair down the hall to the 300/400 hall dining room, with the resident's catheter tubing dragging along the floor for approximately 50 ft. CNA B positioned the resident in front of a table and left the room. Approximately 14 inches of catheter tubing was coiled on the dining room floor underneath the resident's feet. The dining room floor was covered with a light grey film and debris. Observations on 4/16/24, showed: -At approximately 10:10 A.M., the resident sat in a wheelchair in his/her room. Approximately eight inches of catheter tubing lay on the floor, around the front left wheel of his/her wheelchair; -At approximately 11:00 A.M., the resident sat in a wheelchair in his/her room. Approximately eight inches of catheter tubing lay on the floor, around the front left wheel of his/her wheelchair; -At 11:00 A.M., the resident sat in a wheelchair in the 300/400 hall dining room. Approximately eight inches of catheter tubing lay on the floor, behind the front left wheel of his/her wheelchair; -At 12:10 P.M., the resident sat in a wheelchair in the 300/400 hall dining room. Approximately eight inches of catheter tubing lay on the floor, behind the front left wheel of his/her wheelchair; -At 2:33 P.M., the resident lay on his/her back in bed. A fall mat was positioned on the floor to the right of the resident's bed. The fall mat had dark grey streaks of dirt. Approximately four inches of catheter tubing was coiled on top of the dark streaks on the fall mat; -At 4:43 P.M., the resident sat in a wheelchair in his/her room. Approximately eight inches of catheter tubing lay coiled on the floor beneath the resident's feet; -At 5:49 P.M., the resident sat in a wheelchair in the 300/400 hall dining room. The dining room floor was sticky and covered in debris and a grey film. Approximately eight inches of the resident's catheter tubing lay on the floor underneath his/her feet. During an interview on 4/17/24 at 1:43 P.M., CNA B said a resident's catheter bag should be positioned below their bladder. He/She was not sure why a catheter bag should be positioned below the bladder. During the resident's Hoyer transfer, CNA B should have tried to hang the catheter bag on the Hoyer pad strap and once the resident was in the wheelchair, CNA B should have moved the catheter bag so it was underneath the resident's wheelchair. Catheter bags should be in a protective covering and catheter tubing should be off the floor. Catheter tubing should be off the floor to reduce the risk of tripping and because the floors are dirty. If CNAs observe a resident's catheter tubing dragging on the floor, they should tell the nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 4/17/24 at 2:21 P.M., CNA C said catheter bags should be positioned below the resident's bladder to prevent urine from flowing from the tubing and back into the resident's bladder. Nursing staff is responsible for ensuring catheter tubing is floating above the floor due to contamination. If CNAs observe a resident's catheter tubing has come in contact with a contaminated surface, they should readjust the tubing so it is no longer in contact with the surface and then wipe it down to clean it. 4. During an interview on 4/17/24 at 2:40 P.M., CNA F and CNA H said when staff is providing care to any resident who has a catheter, the catheter should remain below the resident's knees to prevent the urine flowing back into the resident, causing an infection. 5. During an interview on 4/17/24 at 2:45 P.M., Licensed Practical Nurse (LPN) D said a resident's catheter bag should be positioned below the bladder to ensure urine does not reflux back into the bladder. During a Hoyer transfer, nursing staff should ensure a resident's catheter bag is maintained below the bladder. Nursing staff is responsible for ensuring catheter bags and catheter tubing is off the floor to avoid contamination. 6. During an interview on 4/18/24 at 8:44 A.M., Registered Nurse (RN) E said a resident's catheter bag should be positioned below their waist, including during a Hoyer transfer. Maintaining a catheter bag below the waist prevents urine from returning to the bladder. Nursing staff should ensure catheter tubing is off the floor for infection control. 7. During an interview on 4/18/24 at 12:21 P.M., the Director of Nurses (DON) and Administrator said they expected nursing staff to ensure a resident's catheter bag is positioned below the bladder so urine does not flow back into the bladder. During a Hoyer transfer, it is not appropriate for staff to place a resident's catheter bag on the resident's lap, and the catheter bag should be maintained below the bladder during the transfer. Nursing staff is responsible for ensuring catheter bags and catheter tubing are off the floor for infection control. If CNAs observe catheter tubing has come into contact with a contaminated surface, they should clean the catheter tubing or report it to the nurse. 42795

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 40290 Based on interview and record review, the facility failed to ensure residents had appropriate physician orders for assessment/monitoring of dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) access sites and to failed to maintain ongoing communication with dialysis centers for residents receiving dialysis treatment. Two residents were sampled for dialysis and problems were found for one resident (Resident #3). The sample was 26. The census was 133. Review of the facility's Dialysis policy, revised 3/18/22, showed: -Purpose: Ensure that residents who require dialysis receive such services as ordered by physician. The facility will ensure that residents who require dialysis receive such services, consistent with professional standards for practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility will ensure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including the: -Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified facility; -Ongoing assessment and oversight of the resident before and after dialysis treatments; -Ongoing communication and collaboration with the dialysis clinic, regarding dialysis care and services; -The nurse will monitor bruit (audible vascular sound) and thrill (vibration felt on the skin) every shift and document in treatment administration record (TAR); -Assess the vascular access for signs and symptoms of infection such as redness, warmth, tenderness, purulent drainage, open sores, or swelling. Patients with end-stage kidney disease are at increased risk of infection; -Assess for blebs (ballooning or bulging) of the vascular access that may indicate an aneurysm that can rupture and cause hemorrhage; -Document assessment findings, any interventions and patient response, patient teaching, and the patient's level of understanding. Review of the facility's Dialysis and Nursing Home Handoff Communication Tool, undated, showed: -Section to be completed by nursing home and sent with resident each treatment included code status, mental status, vital signs, allergies, current diet/fluid restrictions, type of access, signs and symptoms of infection, and medical problems, hospitalization s, medications, vaccinations, labs, and blood transfusions since last dialysis; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Section to be completed by dialysis and returned with resident each treatment included pre and post-dialysis weight, problems during dialysis, amount of fluid removed, post-dialysis vitals, labs drawn, updated physician orders, Dietician and Social Worker recommendations, food/fluid consumed during dialysis, medications given during dialysis, and vascular access condition. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/4/24, showed: -Moderate cognitive impairment; -Diagnoses included end stage renal disease (ESRD); -Dialysis received. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident receives dialysis on Monday, Wednesday, Friday related to diagnosis of ESRD; -Desired outcome: Resident will have immediate intervention should any signs/symptoms of complications from dialysis occur through the review date; -Interventions included: --Check and change dressing daily at access site; --Monitor/document/report as needed (PRN) any signs/symptoms of infection to access site (redness, swelling, warmth, or drainage); --Monitor/document/report PRN for signs/symptoms of renal insufficiency; --Monitory/document/report PRN for signs/symptoms of the following: bleeding, hemorrhage, bacteremia (presence of bacteria and infectious organisms in the blood stream), septic shock. Review of the resident's electronic Physician Order Sheet (ePOS) and TAR, showed: -An order, dated 8/23/23, for hemodialysis three times a week, Monday, Wednesday, and Friday; -No physician orders for pre and post-dialysis assessments. Review of the resident's electronic medical record (EMR), showed: -Blood pressure and pulse documented once on 2/23/24 and 4/15/24; -Temperature documented twice on 2/7/24, and once on 2/12/24, 2/14/24, 2/23/24 and 4/15/24; -No additional documentation of weights, blood pressure, pulse, or temperature obtained pre and post-dialysis in February, March and April 2024; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of pre and post-dialysis assessments of vascular access site in February, March and April 2024; -No documentation of communication with the dialysis center in February, March and April 2024. During an interview on 4/15/24 at 7:08 A.M., the resident said he/she goes to a dialysis center for treatment every Monday, Wednesday, and Friday. When he/she returns to the facility, he/she is not assessed by the nurse. During an interview on 4/16/24 at 10:48 A.M., the resident said he/she went to dialysis yesterday. When he/she returned to the facility, no one assessed his/her dialysis site or checked his/her vital signs. During an interview on 4/16/24 at 4:45 P.M., the resident said the facility does not send paperwork with him/her to give to the dialysis center. The dialysis center does not give him/her any paperwork to return to the facility staff. During an interview on 4/17/24 at 2:45 P.M., Licensed Practical Nurse (LPN) D said before a resident goes to dialysis, a weight should be obtained. The nurse is responsible for obtaining a full set of vital signs and assessing the resident's dialysis access site. Upon a resident's return to the facility, the nurse obtains another full set of vital signs and assesses the dialysis access site. Each resident on dialysis should have physician orders for pre and post-dialysis assessments, which populate on the TAR. Prior to last week, nurses documented their pre and post-dialysis assessments on the TAR. Now, nurses document their pre-dialysis assessments on a communication form that goes with the resident to dialysis. The dialysis center is supposed to fill out their portion of the form and send it back to the facility with the resident. There should be communication between the facility and the dialysis center documented in the resident's EMR. During an interview on 4/18/24 at 8:44 A.M., Registered Nurse (RN) E said nurses obtain a complete set of vital signs and assess the resident's dialysis access site before and after the resident goes to dialysis. Pre and post-dialysis assessments are documented on the resident's TAR. Residents receiving dialysis should have physician orders for pre and post-dialysis assessments. The facility does not use communication forms with the dialysis centers. The dialysis centers will call the facility if they have any updates or they will fax over labs completed during dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 2:13 P.M., the Director of Nurses (DON) said nurses should assess residents before and after dialysis. Until last week, pre and post-dialysis assessments were documented as a progress note in the EMR. There was no other place to document dialysis assessments. Last week, the facility started using forms to communicate with the dialysis center. The nurse is expected to obtain a full set of vital signs and to assess the dialysis access site. The nurse documents the assessment on the form, which also includes documentation of the resident's code status, allergies, medications, diet and fluid restrictions, and any changes since the last time the resident received dialysis, such as blood transfusions and new conditions, vaccinations, and labs. The nurse signs the form and gives it to the resident to bring to the dialysis center for them to fill out. The form has the facility's fax number at the bottom for them to send the form back to the facility. Once a form is received by the facility, it should be uploaded into the resident's medical record. When a resident returns to the facility from dialysis, the nurse should re-assess the resident. The nurse should also review the resident's pre and post-dialysis weights, amount of fluid removed, amount of food and fluid consumed, medications administered, and labs completed during dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 44948 Based on observation, interview and record review, the facility failed to ensure residents with side rails were appropriately assessed for safety in accordance with the facility's policy, for four residents (Residents #125, #36, #30 and #46). The facility identified 11 residents as utilizing side rails. The census was 133. Review of the facility's Bed Siderails Policy, revised 6/29/23, showed: -All residents using any size siderail device on their beds will have a Restraint/Entrapment Assessment completed to determine the restraining, enabling, or hazard effect of the device. The Assessment will occur upon initial use, quarterly, and as needed if there is a significant change in the resident's condition; -Each resident using a siderail device will have a detailed history documented including the symptoms or reasons for using a device; -Using any device requires a care plan. Use the Device Care Planning Process information in this policy when developing the plan. 1. Review of Resident #125's medical record, showed: -Diagnoses included stroke, abnormal posture, generalized muscle weakness, and memory deficit following stroke; -No entrapment or side rail assessments. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/13/24, showed: -Severe cognitive impairment; -Upper extremity impairment on one side; -Lower extremity impairment on one side; -Mobility performance: Dependent for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident has limited physical mobility related to diagnosis of stroke; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Problem: Resident has impaired cognitive function/through process; -Problem: Resident is a risk for falls related to confusion, deconditioning, and psychoactive drug use; -The care plan failed to identify the resident's use of side rails. Observation on 4/14/24 at 10:42 A.M., showed the resident on his/her back in bed. A half-length rail was raised on the right side at the foot of the bed. During an interview, the resident said he/she was unsure why the rail was raised. Observation on 4/15/24 at 7:41 A.M., showed the resident on his/her back in bed. A half-length rail was raised on the right side at the foot of the bed. Observation on 4/16/24 at 10:10 A.M., 2:27 P.M., 4:45 P.M., and 6:12 P.M., showed the resident on his/her back in bed. Half-length rails were raised on both sides at the foot of the bed. During an interview on 4/17/24 at 1:43 P.M., Certified Nurse Aide (CNA) B said the resident has side rails on both sides of his/her bed that never get lowered. He/She has the rails because he/she is a fall risk. Nurses tell CNAs which residents should have rails on their bed. During an interview on 4/17/24 at 2:21 P.M., CNA C said the resident required total assistance from staff with care and does not roll in bed on his/her own. CNA C is unsure why the resident has rails on his/her bed. Nurses tell the CNAs which interventions are in place for each resident. During an interview on 4/18/24 at 12:21 P.M., the DON and Administrator said the resident uses side rails for repositioning. 2. Review of Resident #36's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Upper extremity impairment on one side; -Lower extremity impairment on both sides; -Mobility performance: Substantial/maximal assistance for roll left and right, and dependent for sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer; -Diagnoses included schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), drug-induced subacute (somewhat rapid change) dyskinesia (uncontrolled, involuntary muscle movement), unspecified intellectual disabilities (limits to a person's ability to learn at an expected level and function in daily life), mild mental retardation, unspecified abnormalities of gait and mobility, and weakness; -Two or more falls since last assessment. Review of the resident's care plan, in use at the time of survey, showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Problem: Resident has a history of behavioral challenges that require protective oversight in a secure setting. Presents with diagnoses of schizophrenia, impulse control, mild mental retardation and bipolar disorder (mood disorder). Symptoms include verbal and physical aggression, paranoia, audio hallucinations, and isolative behaviors; -Problem: Resident requires total assistance with his/her activities of daily living (ADLs); -Problem: Resident is at risk for impaired cognitive function/dementia or impaired through processes related to diagnoses of mental retardation/intellectual disabilities; -Problem: Resident at risk for falls related to unsteady balance and use of psychotropic medication; -The care plan failed to identify the resident's use of side rails. Review of the resident's entrapment assessment, dated 2/22/24, showed: -Does the resident have cognitive and functional ability to remove the device: Yes; -Can the resident remove the device purposely: No; -Does the device allow the resident to do something that would improve their quality of life: Blank; -Is resident vulnerable to hazard: No; -Sections for diagnoses and identifying cause, care plan treatment and management, and monitoring: Blank; -How many rails does the resident's bed use: Two rails. Observation on 4/16/24 at 2:33 P.M., showed the resident on his/her back in bed. The bed was positioned to the floor and a U-shaped rail was raised on the right side at the head of the bed. During an attempted interview, the resident was unable to provide information regarding the rail. During an interview on 4/17/24 at 1:43 P.M., CNA B said the resident is confused at times. He/She has U-shaped rails on his/her bed for fall prevention. CNA B was unsure if the resident could move the U-rails. During an interview on 4/17/24 at 2:21 P.M., CNA C said the resident has some confusion. He/She has a history of falling out of bed and is on fall precautions. CNA C is not sure if the resident is supposed to have rails on his/her bed or not. During an interview on 4/18/24 at 12:21 P.M., the DON and Administrator said side rails were put on the resident's bed during a recent hospitalization in anticipation of him/her needing them due to a decline in health. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #30's medical record, showed his/her diagnoses included functional quadriplegia (the loss of motor function in all four extremities), myositis (a rare disease causing prolonged muscle fatigue and weakness) and spinal stenosis (narrowing of the spine causing stiffness and nerve pain). Review of the resident's Entrapment Assessments, found in the medical record, showed: -A quarterly assessment conducted on 5/23/23 showed the resident utilized bed rails for positioning and mobility, and was assessed to be safe for the use of these devices at that time; -No further assessments were conducted to evaluate the safety and appropriateness of the bed rails prior to the survey period. Review of the resident's quarterly MDS dated [DATE], showed: -No cognitive impairment; -The resident uses a wheelchair for locomotion; -The resident is dependent on staff for eating, oral hygiene, bathing tasks, dressing, and toileting hygiene. Review of the resident's care plan, in use at the time of survey, showed: -The resident utilizes two three-quarter rails to promote a sense of safety and security to resident as related to his/her significant physical impairment and requirement of total care by staff. Interventions included completing side rail assessments as required and to monitor for any change in condition and potential for improvement. Review of the resident's physician orders, showed an active order, dated 10/14/22 for three-quarter rails on both sides of the resident's bed for positioning and mobility. Observation on 4/14/24 at 8:43 A.M. showed the resident resting in bed. Side rails were assembled to the bed frame on both sides of the bed and were up in the mobility-assistance position. Observation on 4/16/24 at 2:38 P.M., showed the resident resting in bed with side rails up on both sides of the bed. The resident said he/she had utilized these rails for a very long time, and had no concerns with them. The resident said he/she was not sure if an assessment had been completed routinely to ensure the rails remained appropriate. Observation on 4/17/24 at 8:36 A.M., showed the resident resting in bed with side rails up on both sides of the bed. Observation on 4/18/24 at 9:01 A.M., showed the resident resting in bed with side rails up on both sides of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 11:03 A.M., CNA H said the resident has utilized side rails on both sides of the bed for a very long time and has reported no issues to staff. CNA H said residents are assessed for side rail use and appropriateness, but was not sure how often residents receive these assessments. During an interview on 4/18/24 at 11:07 A.M., Registered Nurse (RN) E said the resident utilized side rails for mobility and positioning, and residents are assessed for side rail usage and appropriateness upon admission and after a change in condition is reported. RN E expected for the usage of bed rails to be included on the care plan. 4. Review of Resident #46's medical record, showed his/her diagnoses included Type II diabetes, bilateral below the knee amputation (BKA, removal of the leg below the knee due to infection or injury), chronic kidney disease (CKD, a long-term condition in which the kidneys do not filter blood as efficiently as they should), and chronic atrial fibrillation (a-fib, a cardiac condition causing the atria to beat faster than normal, increasing the risk of blood clots). Review of the resident's assessments, showed: -A quarterly assessment conducted on 5/23/23 showed the resident utilized bed rails for positioning and mobility, and was assessed to be safe for the use of these devices at that time; -No further assessments were conducted to evaluate the safety and appropriateness of the bed rails prior to the survey period. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -The resident is dependent on staff for toileting and bathing tasks, and requires substantial assistance from staff with oral and personal hygiene; -The resident uses a wheelchair for locomotion. Review of the resident's care plan, in use at the time of survey, showed: -The resident uses two full side rails as requested for safety and positioning. Interventions included ensuring entrapment assessments were completed quarterly, and to evaluate safe use of the prescribed device. Review of the resident's physician orders, dated 5/24/23, showed an order for side rails at both sides of the bed for safety and positioning as requested by the resident. Observation on 4/14/24 at 8:37 A.M., showed the resident resting in bed. Side rails were assembled to the bed frame on both sides of the bed. The resident said he/she had been utilizing these rails for a year or so. The resident said he/she was not sure if an assessment had been completed routinely to ensure the rails remained appropriate. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/15/24 at 7:46 A.M., showed the resident resting in bed with side rails up on both sides of the bed. Observation on 4/17/24 at 7:43 A.M., showed the resident resting in bed with side rails up on both sides of the bed. During an interview on 4/18/24 at 11:03 A.M., CNA H said the resident utilized side rails on both sides of the bed since admission. CNA H said residents are assessed for side rail use and appropriateness but was not sure how often residents receive these assessments. During an interview on 4/18/24 at 11:07 A.M., RN E said the resident utilized side rails for mobility and positioning, and residents are assessed for side rail usage and appropriateness upon admission and after a change in condition is reported. RN E expected the usage of bed rails to be included on the care plan for all residents. 5. During an interview on 4/17/24 at 2:45 P.M., Licensed Practical Nurse (LPN) D said nurses are responsible for completing side rail assessments on admission. The assessment should be completed accurately to determine a resident's safety for the use of side rails. The care plan should be updated to reflect the resident's use of side rails. The MDS Coordinator and nurses can update care plans. 6. During an interview on 4/18/24 at 8:44 A.M., RN E said nurses are responsible for completing side rail assessments on admission and upon a change in condition. Side rail assessments should be completed accurately to assess a resident's safety for the use of side rails. The care plan should be updated to show a resident's use of side rails. Care plans are updated by nurses, Social Services, and the Director of Nurses (DON). 7. During an interview on 4/18/24 at 12:21 P.M., the DON and Administrator said nurses are responsible for assessing residents for the use of side rails. It is expected that side rail assessments are completed accurately. Side rail assessments should be completed on admission, quarterly, and if there are any changes with the resident's use of side rails. The care plan should be updated to show a resident's use of side rails. Care plans are updated by the MDS Coordinator.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42795 Based on interview and record review, the facility failed to establish a system of record for all controlled drugs with sufficient detail to enable an accurate reconciliation for two out of three medication carts reviewed. This had the potential to affect all residents with controlled substance orders. The census was 133. Review of the facility's Medication Storage and Destruction Policy, reviewed 1/5/23, showed: -Narcotic and controlled drug storage; -A manual end of shift narcotic count must be completed with the oncoming nurse counting and the outgoing nurse verifying; -Because the narcotics may be stored in a number of different carts, different pairs of nurses may be conducting counts at the different carts; -In the event the nurse must leave prior to the end of their shift, the nurse may count with another nurse and/or supervisor before leaving the facility, and then that nurse/supervisor will conduct the end of shift narcotic count; -Any nurse leaving the facility without properly conducting the narcotic count will receive disciplinary action, up to and including termination; -The Director of Nursing (DON) must ensure the end of shift narcotics count is occurring, and the records of all items dispensed is current, with no missing signatures, and correctly counted. 1. Review of the controlled substance count sheet for the 400 hall, dated 3/1 through 3/31/24, showed a manual end of shift narcotic count was not completed and documented per facility policy when: -Four out of 31 days, staff counted one out of three shifts; -Thirteen out of 31 days, staff counted two out of three shifts; 2. Review of the controlled substance count sheet for the 400 hall, dated 4/1 through 4/15/24, showed a manual end of shift narcotic count was not completed and documented per facility policy when: -One out of 15 days, staff counted one out of three shifts; -Ten out of 15 days, staff counted two out of three shifts; 3. Review of the controlled substance count sheet for the 300 hall, dated 4/1 through 4/15/24, showed a manual end of shift narcotic count was not completed and documented per facility policy when: -Six out of 15 days, staff counted one out of three shifts; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nine out of 15 days, staff counted two out of three shifts. 4. During an interview on 4/16/24 at 10:41 A.M., Certified Medication Technician (CMT) J said the narcotic count is to be completed with one oncoming staff member and one off-going staff member every shift, every day. 5. During an interview on 4/17/24 at 2:15 P.M., Licensed Practical Nurse (LPN) D said the nurses and the CMTs are to check the narcotic count with one oncoming staff member and one off-going staff member on every shift, every day. If a nurse or CMT leaves before the shift ends, that person is still required to count the narcotics before they leave for the day. 6. During an interview on 4/16/24 at 12:50 P.M., the DON said she expected CMTs and nurses to count the narcotics every day on every shift. The count should be completed with one oncoming staff member and one off-going staff member.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 46888 Based on observation, interview and record review, the facility failed to ensure food delivered to residents was palatable and at required temperatures for four residents (Residents #125, #84, #130 and #119) and additional residents who ate in their rooms on the 300 and 400 hallways. The sample was 26. The census was 133. Review of the facility's dietary food preparation policy, dated 7/5/23, showed: -Food temperatures: foods will be served at proper temperature to ensure food safety; -Acceptable serving temperatures are: meat should be higher than 135 degrees Fahrenheit (F) but preferably 160-175 degrees F, potatoes should be higher than 135 degrees F but preferably 160-175 degrees F; -Food tasting: the cook or Dietary Manager will taste food prepared before serving. 1. Review of Resident #125's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/13/24, showed: -Dependent (helper does all of the effort) on assistance with eating; -Diagnoses included stroke, dysphagia (swallowing disorder) following stroke, high blood pressure and diabetes. Observation on 4/15/24 at 9:00 A.M., showed Certified Nurse Aide (CNA) B sat next to the resident's bed, using a plastic fork to scoop food on the resident's Styrofoam plate. CNA B attempted to cut the grits with the fork. The grits appeared rubbery and slid across the plate in a solid unit, unable to be separated with a fork. During an interview, CNA B said he/she was having a hard time cutting up the resident's grits. The resident said the food did not look good. Observation on 4/16/24 at 6:08 P.M., showed CNA A brought a plate of food to the resident's room. The plate contained a beige pureed food, a dark green pureed food, and a scoop of mashed potatoes. CNA A said the beige pureed food appeared to be a meat product, but he/she was not sure what it was. CNA A used a spoon to scoop some of the beige pureed food and held the spoon to the resident's mouth. The resident took a bite, grimaced, and shook his/her head no. The resident said he/she wanted a health shake. During an interview, the resident said the food was not good and had no flavor. 2. Review of Resident #84's quarterly MDS, dated [DATE], showed: -Setup or clean up assistance needed with eating; -Diagnoses included stroke, dysphagia, high blood pressure, diabetes and depression. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/14/24 at 11:03 A.M., the resident said the food served at the facility is nasty. He/She is hungry because he/she cannot eat the food. He/She does not get to choose what he/she eats and cannot ask for anything else. Observation on 4/16/24 at 12:49 P.M., showed the resident sat in his/her room next to a bedside table containing a plate of food. The plate had a scoop of dark green cooked vegetables, a scoop of mashed potatoes, and diced beige meat in a dark brown, oily sauce. During an interview, the resident said the food does not look good. He/She is not sure what the meat is and he/she does not want to eat it. He/She is not given a choice on what to eat at meals. 3. Review of Resident #130's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses of essential hypertension and obesity. During an interview on 4/14/24 at 10:59 A.M., the resident said he/she usually eats in his/her room. He/She said his/her food is frequently lukewarm or cold by the time it is served to him/her. 4. Review of the Resident #119's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses of multiple sclerosis, bipolar disorder, and muscle weakness. During an interview on 4/14/24 at 11:21 A.M., the resident said the food is decent but does not always taste good. He/She said the food temperatures are not always consistent and sometimes his/her meal is cold when delivered. 5. Observation on 4/16/24 at 1:00 P.M. of lunch trays served on the 400 hallway, showed: -Fried chicken measured at 135 degrees F; -Mashed potatoes measured at 127 degrees F, and the taste was bland; -Green beans measured at 130.6 degrees F, and the taste was bland. 6. Observation on 4/17/24 at 1:00 P.M. of lunch trays served on the 300 hallway, showed: -Mushroom steak measured at 120.2 degrees F; -Mashed potatoes measured at 125.0 degrees F. The taste was bland; -Corn measured at 125.0 degrees F. 7. During an interview on 4/17/24 at 2:37 P.M., the Dietary Manager said she expected food served to be palatable and at the required temperatures. She expected for food to look and taste good. She said she does not always taste mechanical food once it is prepared. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview on 4/18/24 at 2:07 P.M., the Administrator said she expected for food served to residents to be palatable and at the proper temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46888 Based on observation, interview and record review, the facility failed to keep the kitchen floor, walk in refrigerator, and appliances clean, and failed to ensure the ice machine had an air gap. The sample was 26. The census was 133. Review of the facility's daily and weekly cleaning schedule, undated, showed: -The floors are to be swept and mopped daily; -The food storage bins are to be cleaned weekly; -The storage racks are to be cleaned weekly; -The kitchen appliances are to be cleaned daily/weekly. 1. Observation on 4/14/24 at 8:16 A.M., showed the following: -The bulk storage room had water pooling on the ground, various trash and food debris littered the floor and beneath the area of the storage rack, and all three bulk bins had dirty lids with a powder substance; -The walk in refrigerator had caked on grime and food debris on the floor and shelves in various areas, and wrapper trash under the storage rack; -The floor in the main part of the kitchen and pots room had food debris and various dried liquid stains. 2. Observation on 4/16/24 at 10:52 A.M., showed the following: -The floors in the main area of the kitchen, bulk storage area, and pots room had various trash items, food debris, and a white powder substance in various areas; -The oven doors were streaked with dried liquid matter. The deep fryer was caked with sticky grease spills on the front and sides; -The walk in refrigerator had caked on food debris on the rack shelves and on the ground in various spots, with trash and wrappers under the racks; -The bulk bin room had trash and a white powder substance on the ground, and the three bulk bins had a powder substance on the lids. 3. During an interview on 4/17/24 at 2:25 P.M., Dietary Aide Q said all dietary staff are in charge of deep cleaning the walk-in refrigerator, floors, and the bulk bin room. He/She said the cook is in charge of cleaning the deep fryer after each use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 4/17/24 at 2:33 P.M., the Dietary Manager said all dietary staff are responsible for daily cleaning of the floors and bulk bins. She said the kitchen appliances should be cleaned daily and weekly depending on the level of need. She expected the kitchen and kitchen appliances to be clean. 5. During an interview on 4/18/24 at 2:05 P.M., the Administrator said she expected kitchen staff to follow facility policies and cleaning schedules. She expected the kitchen and appliances to be clean. 6. Observation on 4/14/24 at 8:27 A.M., showed the ice machine in the kitchen did not have an air gap. The piping went straight into the drain. During an interview on 4/17/24 at 7:50 A.M., the Maintenance Director said he was not aware the ice machine in the kitchen did not have an air gap. He expected the ice machine to have an air gap to prevent possible contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to follow acceptable infection control standards when providing peri-care (cleansing of the genitals and anal area) for one resident (Resident #102) and when providing treatment for a supra-pubic catheter (a tube to drain urine that is inserted in the lower abdomen) for one resident (Resident #64) The sample size was 26. The census was 133. Review of the facility's Using Gloves policy, revised 6/29/23, showed: -When gloves are indicated, disposable single-use gloves should be worn; -When to use gloves: -When touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin; -Gloves need to be used during removal of wound dressings; -Gloves are changed and hands are washed, new gloves donned before a clean dressing is applied; -When the employee's hands have any cuts, scrapes, wound, chapped skin, or dermatitis; -When cleaning up spills or splashes of blood or body fluids; -When cleaning potentially contaminated items; -Whenever in doubt. Review of the facility's Peri-care policy, revised 6/29/23, showed: -Procedure: Gather necessary equipment; Wash hands; Explain what you are going to do; Provide privacy; Fill basin with warm water; Cover the resident with a towel or sheet; Cleanse peri-area; Pat area dry; Remove towel or sheet; Remove and dispose of gloves; Remove, clean and store equipment; Wash hands; Make the resident comfortable; and record observations and report anything unusual to the nurse. 1. Review of Resident #102's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/31/24, showed: -Severe cognitive impairment; -Always incontinent of bowel and bladder; -Dependent on staff for toileting and personal hygiene; -Diagnoses included diabetes, kidney disease, stroke and dementia. (continued on next page)

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	265500	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bernard Care Center	4335 West Pine Blvd Saint Louis, MO 63108

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, in use at the time of the survey, showed: -Problem: The resident has a history of a stroke and is dependent to maximum assist with all Activities of Daily Living (ADL); -Interventions: -Activity as tolerated and out of bed if tolerated; -Monitor and document mobility status; -Monitor and document resident's abilities for ADLs and assist as needed. Observation on 4/15/24 at 8:39 A.M., showed Certified Nursing Assistant (CNA) T provided peri-care with gloved hands to the resident while the resident lay in bed. After providing peri-care, CNA T removed a clean brief off the resident's dresser and applied the clean brief with the same gloved hands. CNA T then went into the resident's closet while wearing the same gloves, touched the clothing in the closet and retrieved clean clothing for the resident. CNA T dressed the resident, still while wearing the same gloves. Once the resident was dressed, CNA T observed the bottoms of the resident's feet were crusted with dark matter. CNA T washed the resident's feet, while he/she still wore the same gloves. CNA T applied socks to the resident and then opened the resident's door, touching the door handle, and stepped into the hallway to find another staff member to assist him/her get the resident out of bed. CNA T and CNA U assisted the resident into his/her wheelchair. CNA T continued to wear the same gloves during the transfer. CNA T removed his/her gloves after getting the resident into the wheelchair. During an interview on 4/17/24 at 8:47 A.M., CNA K said staff should change gloves and perform hand hygiene after providing peri-care. Soiled gloves should not be used to touch the residents' clean clothing or items in their room. Gloves should be changed when going from dirty to clean. During an interview on 4/18/24 at 10:30 A.M., Licensed Practical Nurse (LPN) O said staff should remove gloves and perform hand hygiene after providing peri-care, and not touch other things in the room with soiled gloves on. During an interview on 4/18/24 at 1:41 P.M., the Director of Nurses (DON) said she expected staff to remove their soiled gloves and perform hand hygiene after providing peri-care, then reapply new gloves before touching anything that is clean in the resident's room. 2. Review of #64's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Has indwelling urinary catheter; -High risk drug class: antipsychotics (mood stabilizer), antidepressants, and antibiotic; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included multiple sclerosis (MS, a neurological condition that causes muscle weakness) seizures, high blood pressure, multi drug resistant organism (MDRO), anxiety, diabetes, urinary tract infection (UTI) in the last 30 days, manic depression, and schizophrenia (a severe mental disorder that can result in hallucinations, delusions and extremely distorted thinking and behaviors). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is at risk for infection related to the resident having a supra-pubic catheter; -Interventions: monitor and document intake and output per facility policy; -Monitor signs of pain or discomfort related to the catheter; -Monitor and record to the medical doctor (MD) signs and symptoms of a UTI: pain burning, blood-tinged urine, urine cloudiness, deepening in color of urine, no output from the catheter, increased pulse, increased temperature, foul smelling urine, chills, altered mental status changes, change in behavior, and change in eating habits. Review of the resident's Physician Order Sheets (POS), dated April, 2024, showed an order for suprapubic catheter care every shift, cover with dry dressing and report any signs or symptoms of infection. Observation on 4/17/24 at 10:47 A.M., showed LPN O entered the resident's room with wound care supplies. He/She laid a pair of scissors on the resident's bathroom sink located in the resident's room. LPN O prepared an area on the resident's bedside table with a drape and laid the supplies on the drape. LPN O cleansed the resident's suprapubic with normal saline and opened a wound dressing package labeled border gauze (a specialized dressing). LPN O then removed the scissors that were located on the resident's bathroom sink and cut a slit in the border dressing and then applied the dressing to the resident's suprapubic catheter site. LPN O did not clean the scissors prior to cutting the border gauze dressing. During an interview on 4/18/24 at 10:30 A.M., LPN O said he/she should have cleaned the scissors with a bleach wipe or antibacterial wipe prior to cutting the dressing and applying it to the resident. During an interview with on 4/18/24 at 1:41 P.M., the DON said she expected staff to practice good infection control practices during catheter care and the nurse should have cleaned the contaminated scissors with a cleansing antibacterial wipe prior to cutting the dressing and applying it to the resident.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44948 Based on observation, interview and record review, the facility failed to ensure all call lights in the facility were in working order, including a visual notification above the door and audible notification at the nurse's station. Concerns were noted in one of 17 resident rooms surveyed, affecting one of 26 sampled residents (Resident #65). The census was 133. Review of Resident #65's medical record, showed diagnoses included hemiplegia (paralysis affecting one side of the body), pseudobulbar affect (episodes of sudden or uncontrolled emotion), multiple sclerosis (MS, a chronic disease of the central nervous system causing pain and loss of fine motor function) and hypertension. Review of the resident's quarterly Minimum Data Set (MDS), a federally-mandated assessment instrument completed by facility staff, dated 1/11/24, showed: -No cognitive impairment; -Required moderate assistance from staff with dressing and bathing tasks; -Wheelchair for locomotion. Review of the resident's care plan, in use at the time of survey, showed: -The resident is a fall risk related to his/her diagnosis of MS. Interventions included following facility protocol and ensuring the resident's call light is within reach while encouraging the resident to use the call light when assistance is required; -The resident is at risk for alteration in musculoskeletal status related to his/her diagnosis of MS. Interventions included monitoring for falls, monitoring for fatigue, ensuring administration of prescribed analgesics, and ensuring the call light is within reach for the resident to use. Observation on 4/14/24 at 9:04 A.M., showed the resident resting in his/her bed. The resident pressed the call button hooked to his/her bed, and said the light had been off for about three weeks and had not been working. The notification light above the door to the room did not illuminate and a small light on the wall that would indicate normal functioning when lit also did not illuminate. The resident said staff were aware of this but were ignoring it. Observation on 4/16/24 at 5:39 P.M., showed the resident resting in his/her bed. The resident pressed the call light, and the notification light above the door did not illuminate. A small light on the wall that would indicate normal functioning when lit was also did not illuminate. Observation on 4/17/24 at 2:09 P.M., showed the resident resting in his/her bed. The resident pressed the call light, and the notification light above the door did not illuminate. A small light on the wall that would indicate normal functioning when lit also did not illuminate. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 11:03 A.M., CNA H said a call light was reported to be non-functioning on the 200 hall that morning, and staff had reported it to maintenance. CNA H was not aware the call light in room [ROOM NUMBER] was not functioning properly, and said nursing staff are expected to report non-functioning call lights to maintenance when observed. During an interview on 4/18/24 at 11:07 A.M., Registered Nurse (RN) E said a call light was reported as non-functioning today on the 200 hall, but he/she was not aware of the call light in room [ROOM NUMBER] not working. RN E said nursing staff were expected to contact Maintenance when a call light was noticed as non-functioning so that it could be fixed. During an interview on 4/18/24 at 12:21 P.M., the Maintenance Director said he/she was made aware of a non-functioning call light on the 200 hall today, but had not been made aware of any call light not working prior to today. All call lights should function normally in resident rooms. The Maintenance Director expected nursing staff to notify the Maintenance staff of non-functioning call lights as soon as possible, as nursing staff have the most interaction with resident call systems. During an interview on 4/18/24 at 1:37 P.M., the Director of Nursing (DON) and Administrator said they expected all resident call lights in the facility to function normally, and all lights should provide an audible alarm at the nurse's station as well as a visual notification above the resident's door.