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	12/19/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' code status with Cardiopulmonary Resuscitation (CPR, an emergency procedure consisting of chest compressions if the heart stops beating or the person stops breathing) or Do Not Resuscitate (DNR, does not want CPR) were verified upon admission and documentation maintained in the medical record for 13 out of 29 sampled residents (#2, #5, #7, #9, #12, #14, #15, #20, #35, #113, #115, #120, #138). The facility census was 131.Review of the facility's Communication of Code Status policy, revised [DATE], showed:-Purpose: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance with these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information;-Policy: The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive;-When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to: Full Code and Do Not Resuscitate;-The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record;-In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code;-The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services;-The Social Services Director shall maintain a list of residents who have an Advance Directive on file;-The resident's code status will be reviewed at least quarterly and documented in the medical record. 1. Review of Resident #2's medical record, reviewed on [DATE], showed:-admitted [DATE];-An order dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 2. Review of Resident #5's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 3. Review of Resident #7's medical record, reviewed [DATE], showed:-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 4. Review of Resident #9's medical record, reviewed on [DATE], showed-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 5. Review of Resident #12's medical record, reviewed on [DATE], showed: -admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 6. Review of Resident #14's medical record showed, reviewed on [DATE], showed:-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 7. Review of Resident #15's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 8. Review of Resident #20's medical record, reviewed on [DATE], showed: -admitted on [DATE];-An order, dated [DATE], for full (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265500	A. Building B. Wing	12/19/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	code;-The medical record contained no documentation of the resident's signed advanced directive. 9. Review of Resident #35's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order dated [DATE];-The medical record contained no documentation of the resident's signed advanced directive. 10. Review of Resident #113's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order for full code;-The medical record contained no documentation of the resident's signed advanced directive. 11. Review of Resident #115's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 12. Review of Resident #120's medical record, reviewed on [DATE], showed:-admitted on [DATE];-An order, dated [DATE], for full code;-The medical record contained no documentation of the resident's signed advanced directive. 13. Review of Resident #138's medical record, reviewed on [DATE], showed:-admitted on [DATE];-No orders for code status;-The medical record contained no documentation of the resident's signed advanced directive. 14. During an interview on [DATE] at 2:20 P.M., the Social Worker said the residents' code status should be reviewed and signed annually. The medical record should contain a signed code status form. On [DATE] at 3:19 P.M., the Social Services Director said she was under the impression that there was a code form within the admission contract and scanned in the medical record. The residents signed either full code or DNR. It was not until yesterday that she found out the code status form had to be separated from the admission contract. She could not find the code status forms for the residents. 15. During an interview on [DATE] at 1:00 P.M., the Administrator said she would expect all the residents to have a code status form in the medical record. The form is a part of the admission contract. The code status is expected to be reviewed annually.

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	12/19/2025

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 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** Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment throughout the facility. The facility failed to ensure noise levels were comfortable when the overhead announcements were too loud and the door to the smoking area slammed, for two residents (Residents #108 and #79). One resident (Resident #4) had soiled briefs on the bathroom floor. One resident had a clogged toilet (Resident #11). In addition, the facility failed to provide clean and well-maintained walls, floors, doors, and windows for the 400 locked unit, 300 hall, 100 hall, 200 hall, lobby, hospitality room, and Southern dining room. The facility census was 131.Review of the facility's Safe and Homelike Environment Policy, last reviewed on 6/5/25, showed:-Purpose: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the residents to use his or her personal belongings to the extent possible;-Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas;-A homelike environment is one that deemphasizes the institutional character of the setting, to the extent possible, and allows the residents to use those personal belongings that support a homelike environment;-Comfortable sound levels means levels that do not interfere with the resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is required. Review of the facility's Housekeeping-Deep Cleaning policy, last reviewed on 6/29/23, showed:-Deep cleaning is to be completed as scheduled. This includes floor cleaning (scrubbing and waxing included), windows to be cleaned and ensure no spider webs, floors at closets and doorways are free from was/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. Review of the facility's Daily Cleaning Checklist for resident rooms, undated, showed:-Resident room:--Pick up all paper, trach, etc., and dispose into cleaning cart;--Use high duster for dusting high places (vents and ceiling, corners);--Clean window edges and all furniture tops and sides;--Glass cleaner, clean windows, mirrors,-Resident Bathroom: Clean inside and outside and sides and base of toilet;-Mopping Residents' room:--Mop entire room, working your way out of the room, dip mob 2-3 times;--In heavy odor rooms, use odor counter at base of toilet;--As you move to the next room, clean the handrails and bumper base;--Clean front of the door. 1. Observation and interview on 12/15/25 at 11:50 A.M., showed Resident #108 walked out of the smoke room. As the resident was speaking, an overhead announcement began. The resident quit talking until the announcement was over. The resident said he/she could not talk over the loudspeakers. The overhead announcements did not always bother him/her so long as he/she could hear what was going on. Observation and interview on 12/16/25 at 11:09 A.M., showed Resident #79 sat in the hallway outside the smoke room. As the resident was speaking, staff came out of the smoke room. The door closed with a loud bang. The resident scrunched his/her eyes and said the door slamming bothered him/her. The smoke room door opened and closed again with a loud bang. The resident said that was a super slam! Boom! It could wake up the dead! Between 11:10 A.M. and 11:13 A.M., the door slammed shut seven times. During an interview on 12/19/25 at 8:59 A.M., the Administrator said there have been issues with the door slamming and they have had it fixed multiple times. She has received reports from residents that the door was broken, but they were not necessarily complaints. She can hear the door slam shut in her office. She has not received any complaints about the overhead speakers. 2. Observation in Resident #4's room on 12/15/25 at 10:50 A.M., showed one soiled brief on the floor in the corner of the bathroom. On 12/16/25 at 8:12 A.M., 8:39 A.M., 9:59 A.M., and 11:12 A.M., two soiled briefs lay on the floor in the corner of the bathroom. During an interview on 12/17/25 at 12:15 P.M., the resident said staff (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructed him/her not to place soiled briefs in the trash cans. Residents are expected to ask for a trash bag from the staff to place the soiled brief in. During an interview on 12/19/25 at 12:50 P.M., Certified Medical Technician (CMT) B said staff give the residents on the 100 hall a trash bag to place their soiled briefs in. Staff will take the bagged soiled briefs from the residents and dispose of them in the locked soiled linen and trash room. If the resident is cognitively impaired, nursing staff should check the resident rooms and bathrooms for soiled briefs. Housekeeping will not pick up any trash that contains soiled briefs, and they will not pick up soiled briefs in the resident bathrooms. During an interview on 12/19/25 at 2:30 P.M., the Director of Housekeeping said normally nursing staff put soiled briefs in the dirty utility closet on the 100 hall. Residents were supposed to tell nursing staff if they needed to throw away a brief. During an interview on 12/19/25 at 1:00 P.M., the Administrator and the DON said staff are expected to check residents' rooms and bathrooms for soiled briefs and dispose of them in a timely manner. 3. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/4/25, showed:-Diagnoses included major depressive disorder, schizoaffective disorder, and epilepsy;-Moderately impaired cognition. Observation and interview on 12/15/25 at 11:28 A.M., showed the resident's toilet filled with toilet paper and feces. The toilet seat dirty with smeared brown matter. The resident said the toilet had been dirty since the day before and he/she had not been able to use it. On 12/16/25 at 8:19 A.M., the resident's toilet filled with toilet paper and feces. The toilet seat dirty with smeared brown matter. A strong feces odor permeated in the bathroom and the resident's room. On 12/16/25 at 11:58 A.M., the resident's toilet filled with toilet paper and feces. The toilet seat dirty with smeared brown matter. A strong feces odor permeated in the bathroom and the resident's room. During an interview on 12/19/25 at 1:00 P.M., the Administrator and DON said they would expect toilets to be clean and in working condition. 4. Observations of the 400 Secured Unit on 12/15/25 at 11:25 A.M., 12/16/25 at 10:31 A.M. and 12/17/25 at 9:20 A.M., showed:-The hallway floors with a buildup of dirt throughout hall. A buildup of dirt at cove bases throughout hall. A blackish buildup on both sides of thresh holds to resident rooms and in corners near the thresholds;-The locked doors to the unit had large areas of paint missing that revealed brownish metal under the windows and streaks and dried drips on the kickplates;-The wood railings on both sides of the doorway to the dining room had multiple areas of chipped paint;-A broken clock hung in the dining room;-Streaks and dried drips on the dining room door kickplate;-A blackish buildup around the threshold of the dining room;-Visible dust and dirt spots on the dining room windows;-Visible streaks and dried drips on the door kickplates of all resident rooms;The wall vent between rooms [ROOM NUMBERS] with a plastic food wrapper inside and visible dust on the slates;-Missing cove base around the perimeter of the toilet area of the shower room;-Baseball sized gouge in the wall above the cove base behind the shower room door;-The cove bases pulled away on both sides of the corner on the left side of the shower stall;-Missing 1 x 1 foot tiles on the right side of the shower stall. Observation on 12/15/25 at 11:42 A.M., of the bathroom for rooms [ROOM NUMBERS], showed the air vent cover was out of the wall, lying on the floor. A light bulb was exposed in the vent. Observation on 12/17/25 at 7:04 A.M., of the bathroom for rooms [ROOM NUMBERS], showed the air vent cover out of the wall and lay on the floor. A light bulb was exposed in the vent. Observation on 12/18/25 at 7:39 A.M., of the bathroom for rooms [ROOM NUMBERS], showed the air vent cover out of the wall lying on the floor. A light bulb was exposed in the vent. During an interview on 12/19/25 at 1:00 P.M., the Administrator said she would expect maintenance staff to ensure vents are in working order. 5. Observations of the 300 hall on 12/15/25 from 4:27 P.M. to 4:34 P.M. and 12/16/25 at 11:18 A.M. and 1:25 P.M., showed:-The plastic railing outside room [ROOM NUMBER] with a 6 inch x 4 inch crack in middle;-The plastic railing near room [ROOM NUMBER] with cracks along the seam at the top of the railing;-Blackish buildup at cove bases outside the clean utility closet and shower room across from room [ROOM NUMBER];-The shower room had a blackish buildup at the threshold and corners of the doorway. The shower room did not have any cove bases around the perimeter of the room. The door (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had paint scratches and chipped paint. The ceiling had black spotted areas above the orange pipes along the perimeter of the entry way into the shower room;-A strong musty odor in the shower room;-An approximate 6 inch crack and 2 inch gouge on the railing between the fire door and room [ROOM NUMBER];-Two used band aids on floor outside room [ROOM NUMBER];-The railings below the survey book sign across from room [ROOM NUMBER] cracked with exposed metal;-Chipped paint on the baseboards between rooms [ROOM NUMBERS];-Cracked and discolored ceiling around the vent by the utility closet;-The plastic railing across from room [ROOM NUMBER] had an approximate 6 inch by 3 inch crack in the middle and along the edges;-Blackish buildup at the cove bases on both sides, along the length of the hallway;-The floors towards the end of the 300 hall at the 200 hall entrance had black stains by the scale that extended the width of the hallway;-Approximately 4 feet of missing cove base on the left side at the end of the 300 hall across from room [ROOM NUMBER]. 6. Observations of the 100 unit on 12/16/25 from 8:13 A.M. to 8:36 A.M., showed:-Dried drops of varying sizes and colors and numerous black streaks across the dining room floor;-A heavy blackish build up at the cove base near the threshold of the dining room door;-Dust on the ceiling outside the dining room;-The windows in the dining room had a milky film;-Dried brown splatter and drops outside the dining room doorway;-Dark scuffs on the floor tiles throughout the hall;-Dust and black buildup at the cove bases on both sides along the length of the hallway from outside the dining room to the exterior exit door;-A tile with a 4 x 2 inch crack, outside of room [ROOM NUMBER];-At 8:22 A.M., housekeeping staff finished mopping in room [ROOM NUMBER]. The mop bucket had brownish water. Black discoloration and debris remained on the floor. The threshold to the room and the corners near the door had a visible black buildup of gunk;-A basketball sized area of white plaster on the wall outside the nurse's station;-Chipped edges and a strip of paint hung off the railing by room [ROOM NUMBER];-No threshold piece in the doorway of room [ROOM NUMBER];-Visible dust on ceiling near the nurse's station;-Exposed subfloor the size of a metal strip across the width of the floor between the fire doors by room [ROOM NUMBER];-Multiple chipped areas on the door of room [ROOM NUMBER]. 7. Observation of the 200 Hall on 12/16/25 from 1:40 P.M. to 2:00 P.M., and 12/18/25 at 10:03 A.M., showed:-The wall across from room [ROOM NUMBER] had brownish dried drips above and below the railing;-Heavy brown and black buildup of gunk on both sides of the threshold of the women's and men's bathroom;-Cracks in the ceiling paint around the vent outside room [ROOM NUMBER];-The door kickplate for room [ROOM NUMBER] had dried streaks and drips, gouges and chipped paint on the doorframe;-Visible dust and debris buildup on the baseboards on both sides for the length of the hallway, including the nurse's station;-Three gouges on the wall of the nurses' station facing the dining room;-The kickplates on the doors for rooms 200 through 212 including the tub/shower room and women's bathroom had streaks and dried drips;-The threshold for room [ROOM NUMBER] had a heavy buildup of brownish gunk on the metal piece;-The tinted windows in the dining room had multiple horizontal scratches and visible dust and dirt making the surfaces rough to the touch;-The shower room ceiling had cracked paint above the door and visible rust on the lower right corner of an empty metal sharps container on the wall;-Numerous smears and scratches on all three windows of the nurse's station. 8. Observation of the lobby on 12/18/25 at 8:39 A.M., showed:-An approximately 2 feet x 18 inches area of white putty above the vent over the receptionist's desk;-Visible dust and dirt spots on the windows throughout the lobby;-Paint chipped from the ceiling above the entrance to the 100 hall;-A broken outlet on the floor by the aviary with visible capped wires and an accumulation of debris and dust;-A large black smoker with two broken legs on the right side, slanting to the ground on the patio visible from the lobby. 9. Observation of the Hospitality Room on 12/17/25 at 8:33 A.M., showed:-Six residents ate breakfast;-Brownish/rusty stains approximately 3 feet x 6 inches and chipped paint on the ceiling over the sink;-Brown splatter on the ceiling near the snack machine;-Exposed wire in a light fixture outlet above the table where residents ate;-A beach ball sized area of chipped paint above the ceiling where residents ate;-Multiple areas of chipped areas exposing metal, aqua paint, yellow paint, pink paint and green paint on the doorframe. 10. Observation (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the Southern Kitchen on 12/17/25 at 8:30 A.M., showed five residents ate breakfast. The floor to ceiling windows had a buildup of dust and dirt and various spots. 11. During an interview on 12/18/25 at 9:30 A.M., Certified Nurse Aide (CNA) B said the resident rooms and halls should be cleaner than they were. Due to short staffing, deep cleaning of resident rooms and the hallways were not being completed. The baseboards and floors needed attention, and a fresh coat of paint would be nice. CNA B had never seen anyone clean the insides or outside of the windows. During an interview on 12/18/25 at 9:54 A.M., CNA A said he/she frequently saw buildup at the cove bases in the hallways and thresholds to resident rooms. The floors did not look clean. 12. During an interview on 12/17/25 at 8:50 A.M., Laundry Aide (LA) C said he/she also works in housekeeping. Employees in the laundry and housekeeping departments had to cover the other department when they were short staffed. LA C said resident rooms should be cleaned every day. This included wiping down the bathroom sink, dressers and tables, and sweeping and mopping the floors. Housekeeping/Laundry staff selected three rooms every week on each hall to deep clean. Deep cleaning required all furniture to be moved out, wipe down the walls, wipe down every surface, mop and sweep. The Floor Technician swept and mopped the hallways and common areas. The floors were stripped, but he/she was not sure how frequently. He/She looked at the entrance to room [ROOM NUMBER] and said the floor looked very dirty and like it had not been cleaned in a while. The baseboards should be cleaned every two days. He/She did not think the baseboards looked clean. Broken handrails and chipped paint will be reported to the Maintenance Director. This is done by either by filling out a form by the time clock or telling the Maintenance Director in person. 13. During an interview on 12/17/25 at 8:59 A.M., Housekeeper D said he/she also worked in laundry. Housekeeping staff moved around and did not always clean the same hall. When he/she cleaned a resident room, he/she wiped down the overbed light, the front of the air conditioner, the call light, walls and baseboards. He/She also swept and mopped the floors and cleaned the resident bathrooms as well. Housekeeper D wiped down the sink and swept and mopped around the toilet and cleaned the toilet. The hallway baseboards should be cleaned three to four times a week. They have been short-staffed, so they must focus on the biggest issues first. The baseboards and floors in the hallway did not look like they had been cleaned. If something was damaged or needed repair, he/she would tell the Maintenance Director. Report forms were by the time clock. 14. During an interview on 12/18/25 at 10:05 A.M. and 2:30 P.M., the Director of Housekeeping and Laundry said they used to have four designated housekeepers and two floor technicians. That was cut back to three housekeepers and one floor technician. There were a few months when there were only two housekeepers, so staff would be pulled from laundry when they were short staffed. They hired another housekeeper yesterday. The floor technician was in an accident and has been out for the last three weeks. The elevator has also been broken which complicates staff ability to do their jobs. They have not been able to do their jobs to his expectations. He has been helping out to cover for laundry and housekeeping as well. They usually do not have issues, but the last seven to eight months have been a challenge. Some things were not getting done. The floor technician was responsible for cleaning the cove bases and thresholds. All housekeeping staff were responsible for wiping down the handrails and dusting the baseboards. The ceilings were not frequently dusted. He was aware the smoker was broken. When staff tried to move it, the legs broke. He thought maintenance was going to fix it. Housekeeping staff were supposed to clean the inside of the windows in resident rooms. He cleaned the windows, on the outside. Staff selected the rooms they would deep clean. There was not a set schedule. Staff were doing their best to provide a clean, comfortable and homelike environment for the residents. 15. During an interview on 12/18/25 at 10:43 A.M., the Administrator said they were in the process of replacing handrails. Residents were hard on the environment. The basketball sized patch was from a resident punching the wall but should have been painted. Residents in wheelchairs bumped into walls and doorframes. If staff saw something that needed to be repaired or replaced, they were supposed to put in a maintenance request or use the walkie/talkie to alert the Maintenance Director. Sometimes the housekeeping staff could only get the (continued on next page)

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	12/19/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	basics accomplished when cleaning resident rooms. Some rooms were more challenging than others. The floor technician was responsible for emptying the trash for the whole building and maintaining the floors for the whole building which included stripping, waxing, buffing and shining. The floor technician has been out for three weeks. They were trying to provide a clean and comfortable homelike environment for their residents. 1710443

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	12/19/2025

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 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** Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were updated and accurate to reflect resident needs for 3 of 29 sampled residents (Residents #5, #6, and #100). The census was 131. Review of the facility's Comprehensive Care Plan policy, dated 10/21/24, showed:-Purpose: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;-Procedure: The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed;-The comprehensive care plan will be developed within seven days after the completion of the comprehensive Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff). All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 1. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease) and dementia;-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed the care plan did not address the resident's dementia diagnosis. During an interview on 12/19/25 at 1:20 P.M., the Director of Nursing (DON) said she expects the care plan to include if a resident has dementia. She expects goals and interventions to be placed on the care plan in order for the resident to receive appropriate care relating to their dementia. 2. Review of Resident #6's significant change MDS, dated [DATE], showed:-Diagnoses included diabetes, acute kidney failure, muscle weakness and dementia;-Severe cognitive impairment. Review of the resident's physician's order summary (POS) dated 12/2025, showed an order, dated, 5/6/24 admitting the resident to hospice care. Review of the resident's care plan, in use at the time of the survey, showed the care plan did not address the resident's hospice care. During an interview on 12/19/25 at 1:20 P.M., the DON said she expects the resident's care plan to include hospice care. 3. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Used a wheelchair for mobility;-History of falls;-Diagnoses included uterine cancer, protein calorie malnutrition, Alzheimer's disease, depression, unsteadiness on feet and wandering. Review of the resident's fall risk evaluation, dated 9/29/25 at 4:29 P.M., showed:-History of falls: 1-2 in the past 3 months;-Level of consciousness: intermittent confusion;-Resident is ambulatory and incontinent;-Clinical suggestions: blank Review of the progress notes, showed:-On 10/2/25 at 4:40 P.M., the resident readmitted to the facility following a surgical repair to the femur;-On 10/9/25 at 4:00 A.M., the resident experienced an unwitnessed fall in his/her room and stuck his/her head. First aid provided, the physician notified. The resident was sent to the hospital for evaluation and treatment;-On 10/9/25 at 4:20 A.M., a fall risk evaluation note showed three or more in the last three months. Mental status: disoriented at all times. Balance problem when walking and standing;-On 10/12/25 at 5:10 P.M., the resident re-admitted to the facility. Resident diagnosed with a urinary tract infection (UTI) and administered a treatment. The resident was moved closer to the nurse's station for closer observation;-On 10/15/25 at 7:20 A.M., the resident noted to be on the floor of his/her room after an unwitnessed fall. Assessment completed no injuries noted. Various stages of bruising noted from previous falls. Physician notified orders given to send to emergency room for evaluation and treatment;-On 10/15/25 at 9:17 P.M., a nurse note: the resident (continued on next page)

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	12/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	re-admitted to the facility and bed alarm and floor mat in place for safety. Review of the resident's care plan, updated on 10/15/25, showed:-Problem: Had an unwitnessed fall and sustained a left hip fracture;-Outcome: Provide oversight and remain free from severe injury;-Interventions: Assessed for injury and pain to the left leg. Sent to the hospital for evaluation and treatment;-The care plan did not address the prior falls or the interventions put in place. During an interview on 12/18/25 at 11:32 A.M., the DON said the resident had multiple falls while at the facility. He/She often attempted to self-transfer out of bed or the wheelchair. Part of the facility interventions included frequent monitoring and bed and chair alarms. The care plan should have reflected the resident's falls and interventions put in place.

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	12/19/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were followed by failing to obtain yearly electrocardiograms (EKG, a test that records the heart's electrical signals to check the rate, rhythm, and overall function) as ordered for eight residents (Residents #4, #13, #14, #16, #35, #75, #83 and #115). In addition, the facility did not ensure recommendations were followed for a palliative care referral for one resident (Resident #120). The sample was 29. The census was 131. Review of the Following Physician's Orders policy, revised 5/18/24, showed:-Purpose: To ensure that all physician's orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician orders;-Procedure:--Upon receiving a physician order, it will be documented in the electronic medical record (EMR) in the orders section;--After diagnostic testing and other services are ordered, the nurse will document orders in the medical record and fill out the corresponding requisition for the specific services to be obtained. 1. Review of Resident #4's medical record showed:-Diagnoses include major depressive disorder (a mental disorder that causes persistent sadness and loss of interest in activities) and schizoaffective disorder (a mental disorder that causes disorganized thinking, mood swings and hallucinations);-A physician order, dated 5/28/24, for EKG yearly for long-term psychiatric medication use;-No documentation of EKG completed. 2. Review of Resident #13's medical record, showed:-Diagnoses include bipolar disorder (mood disorder that can cause intense mood swings), major depressive disorder, diabetes, and schizoaffective disorder;-A physician order, dated 2/10/22, for EKG yearly, starting on the 22nd of the month;-No documentation of EKG completed in 2025. 3. Review of Resident #14's medical record showed:-Diagnoses include cognitive communication deficit, schizophrenia (a mental disorder that distorts reality) and schizoaffective disorder;-A physician order, dated, 6/4/24, for EKG yearly for long-term psychiatric medication use;-No documentation of EKG completed. 4. Review of Resident #16's medical record, showed:-Diagnoses include lung disease, diabetes, stroke, adjustment disorder with mixed anxiety and depressed mood;-A physician order, dated 4/28/21, for yearly EKG, every day shift, every 12 months;-No documentation of EKG completed in 2025. 6. Review of Resident #35's medical record, showed:-Diagnoses include schizophrenia, diabetes, and anxiety;-A physician order, dated 9/3/21, for yearly EKG, starting on the 16th of the month; -No documentation of EKG completed in 2025. 7. Review of Resident #75's medical record, showed:-Diagnoses include lung disease, paralysis, chronic kidney disease, high blood pressure, and stroke;-A physician order, dated 1/5/24, for yearly EKG, every day shift, every 12 months;-No documentation of EKG completed in 2025. 8. Review of Resident #83's medical record, showed:-Diagnoses include diabetes, schizoaffective disorder, and multiple sclerosis (MS, autoimmune disease of the central nervous system);-A physician order, dated 4/28/21, for yearly EKG, starting on the 15th of the month;-No documentation of EKG completed in 2025. 9. Review of #115's medical record, showed:-Diagnoses include schizophrenia, dementia, high blood pressure, irregular movements, and diabetes;-A physician order, dated 4/29/24, for yearly EKG, once every 12 months;-No documentation of EKG completed. 10. Review of Resident #120's medical record, showed:-Diagnoses include anemia, heart failure, hypertension (high blood pressure), peripheral vascular disease (PVD, circulatory problem causing numbness/weakness), kidney failure, diabetes, hyperkalemia (too much potassium in the blood), hyperlipidemia (high cholesterol), aphasia (language disorder), cerebrovascular accident (CVA, stroke), hemiplegia (paralysis on one side of the body), seizure disorder, malnutrition, and depression. Review of the resident's hospital record for hospitalization 11/19/25 through 12/2/25, showed:-Intensive Care Unit course: admitted [DATE] for hyperosmolar hyperglycemic state (HHS, extremely high blood sugar), diabetic ketoacidosis (DKA, lack of insulin), septic shock, respiratory failure due to right upper lung (RUL) pneumonia, and severe hypernatremia (high sodium levels). In context of poor prognosis, appear to have transitioned to Do Not Resuscitate (DNR)/Do Not Intubate (DNI) on 11/22/25, pending (continued on next page)

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	12/19/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	continued discussion of hospice;-Floor course: Goals of Care (GOC) conversation with palliative care with family. DNR/DNI and will follow up with palliative care. No hospice at this time;-Discharge details: --Active issue requiring follow up: Palliative care, outpatient referral. Review of the resident's progress notes, dated 12/2/25 through 12/16/25, showed no documentation of a referral for palliative care. Review of the resident's physician order sheet (POS) for December 2025, showed no physician's order for palliative care evaluation/referral. 11. During an interview on 12/19/25 at 1:06 P.M., the Director of Nursing (DON) said there was an issue with the previous EKG company not receiving reimbursement. The facility then decided in April 2025 on purchasing an EKG machine and the facility Medical Director and their associate would complete the EKGs at the resident's bedside. The facility has not purchased an EKG machine, and the Medical Director has not provided any EKGs at the facility. The DON expects the yearly EKGs to be competed as ordered. All physician orders should be followed for hospice, palliative services or outside referrals.

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	12/19/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the restorative nursing program (RNP) policy and ensure residents who had limited mobility received restorative nursing services to promote and maintain the residents' highest practical wellbeing (Residents #3, #16, #75 and #83). In addition, the facility did not have a functional restorative nursing program to ensure recommended restorative nursing exercises were provided on a continual basis. The facility did not have a system in place to ensure residents received assessments and referrals for restorative therapy. The sample was 47. The census was 131. Review of the restorative nursing program policy, reviewed 4/30/24, showed:-Purpose: To provide maintenance and restorative services designated to maintain or improve a resident's abilities to the highest practicable level;-Definition: The restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safety as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning;-Policy: -Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols; -The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's comprehensive assessment, goals and preferences; -Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to: -Maintaining proper positioning and body alignment; -Encouraging and assisting resident, as needed in turning and position changes; -Encouraging residents to remain active and assisting with any exercises according to the plan of care; -Promote independence in activities of daily living (ADL, the level of assistance needed to complete daily tasks), performing tasks for residents only as needed (PRN) to ensure completion of tasks; -Assisting residents in adjustment to their disabilities and use of any assistive devices; -Assisting residents with range of motion (ROM) exercises, performing passive range of motion (PROM) for residents who lack active range of motion (AROM); -Promoting continence with various toileting and/or bowel and bladder training activities; -All residents will receive maintenance nursing services as described, PRN by certified nurse aides (CNAs); -The restorative nurse and restorative aides receive additional training on restorative nursing program activities upon hire and PRN; -Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services, these services include PROM or AROM, splint or brace assistance, bed mobility training and skill practices, training and skill practice in transfers, walking, dressing and/or grooming, eating and/or swallowing, amputation/prosthesis care and communication training and skill practice; -Residents may receive restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy; -Potential candidates for restorative nursing services may be identified through one or more of the following processes such as physical assessment, minimum data set (MDS, a federally mandated assessment instrument completed by facility staff) assessments, specialized rehabilitation assessment, and in-house referral due to unusual occurrence/events; -The restorative nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented; -A resident's restorative nursing plan will include: -The problem, need, or strength the restorative tasks are to address; -The type of activity to be performed, the frequency and duration of activities; -Measurable goal and target date; -The discharging therapist, restorative nurse or designated licensed nurse will communicate to the appropriate restorative aide, (continued on next page)

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	12/19/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the provisions of the restorative nursing plan, providing any necessary training to carry out the plan; -Restorative aides will implement the plan for a designated length of time, performing the activities, and document in the electronic health record; -The restorative nurse, or designated licensed nurse will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly; -When restorative nursing services are no longer warranted, or the resident is appropriate for being transferred to nursing assistants, the restorative aide, restorative nurse, and/or designated licensed nurse will train the appropriate nursing assistants on the maintenance care or activities that need to be provided on an ongoing basis;-Documentation: The facility maintains complete, accurate, and organized documentation of restorative treatments and the response to those treatments; -The need for restorative nursing services will be documented in the medical record, and indicated on the resident's plan of care. Documentation shall include the problem, need, or strength that is being addressed, measurable goal with a target date, the specific interventions/treatments to be provided, the frequency and durations of interventions/treatments; -Treatment provided as part of a restorative nursing program will be documented on a daily basis by the restorative aide, or other trained individual providing the treatment; -The treatment as described in the resident's care plan will be written on the designated restorative flowsheet; -The specific treatment provided will be initiated daily, or as specified by the care plan; -The number of minutes the treatment was performed will be recorded; -If the treatment is refused or withheld, a narrative note will be written explaining why; -If any unusual incident occurs during a treatment (fall, pain, swelling, skin breakdown), document in the narrative note and report to the resident's change nurse; -A weekly progress note will be written by the restorative aide and countersigned by a licensed nurse. The progress note shall include, but not limited to treatment provided, specific distance or repetitions, assistive devices, endurance and tolerance level and the amount of assistance needed and why; -The restorative nurse will document an evaluation monthly. The evaluation will include the problem, need, strength that is addressed, the resident's progress towards goals, tolerance or response to the treatment, any complication or risks associated with the restorative interventions, and a determination regarding the need for continued restorative services or rationale for discontinuing restorative services; -The resident's plan of care will be updated at routine intervals and as indicated. 1. Review Resident #3's physician order sheet (POS), showed an order, dated 8/11/25: admit to skilled therapy services. Review of the nursing restorative care program, November 2025, showed:-Frequency of restorative therapy (RT): Three times a week;-Plan of care: Blank;-Goal: Maintain bilateral lower extremity (BLE) ROM;-Approaches: BLE PROM and gentle stretching, all planes for 10 repetitions;-Update to plan of care: Blank. Review of the medical record, showed:-re-admitted [DATE];-Moderate cognitive impairment;-Used a wheelchair for locomotion;-Needs full staff assistance for oral hygiene, toileting, bathing, dressing, applying footwear and personal hygiene;-Did not receive restorative services or skilled therapy in November or December 2025;-Diagnoses included gastronomy tube (GT, hollow tube inserted into the stomach used when swallowing is not possible), protein calorie malnutrition, respiratory failure, abnormal posture, right and left knee contractures (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement), muscle wasting, abnormal posture, and altered mental status. Review of the care plan, revised 10/15/25, showed:-Problem: Unwitnessed fall from bed, no injury;-Desired outcome: Staff provide oversight and free from injury;-Interventions: Resident assessed AROM/PROM, staff educated for repositioning devices and bolster placed on the bed;-Problem: Limited physical mobility, unable to walk and uses a wheelchair for locomotion. Staff provide locomotion and full care; -Desired outcome: Remain free of complications related to immobility; -Interventions: Staff monitor, document and report any signs or symptoms of immobility worsening. Staff provide supportive care and assistance with mobility, referrals to physical and occupational therapy PRN;-The care plan did not address supportive devices or RT services. Review of the restorative nursing screen, dated 12/2/25, showed:-Reason for evaluation: Admission;-Self-care: Code the resident's need for assistance with (continued on next page)

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	12/19/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing, dressing, using the toilet, or eating prior to the current illness: dependent, a helper completed all the activities for the resident;-Indoor mobility: Need for assistance with walking from room to room: Dependent, helper completed all the activities for the resident;-Stairs: Need for assistance with internal/external stairs: Dependent;-Functional cognition: Assistance with planning regular tasks, shopping or medications: Dependent;-Device used: Manual wheelchair;-Currently prescribed to wear a splint/brace: No;-Able to effectively communicate: Yes;-Current situation: Currently receiving formalized rehabilitation therapy and expected to continue;-Eating: Not attempted due to medical condition;-Hygiene: Dependent with oral, toileting, bathing, dressing upper and lower body, transfers and personal hygiene;-Upper and lower extremity ROM: No impairments;-Walking not attempted due to medical condition or safety concerns;-Care planning: No interventions were selected. Review of the physical and occupational therapy evaluation, dated 12/3/25, showed:-Physical therapy assessment summary: -Communication: Sometimes understood, sometimes able to understand others; -Cognition: Moderate impairment; -Reason for therapy: Evaluation only, not applicable (N/A) for skilled therapy at this time; -Complexities: Limited daily assistance available, multiple medical conditions and medications; -Intervention modes: Can interventions be provided using treatment modes other than individual: No;-Occupational therapy summary: -Reason: Chart reviewed and evaluation completed. Patient not appropriate for skilled therapy. He/She is dependent for all ADLs and unable to follow simple commands. He/She can be resistive to PROM at times for severe contractures all extremities. He/She had poor rehabilitation potential and hospitalized frequently due to unstable medical conditions. 2. Review of Resident #16's medical record, showed: -Severe cognitive impairment;-Physical impairment upper and lower extremities one side;-Used a wheelchair for locomotion;-Staff provide assistance for eating, personal hygiene, transfers, dressing;-Diagnoses included lung disease, diabetes, aphasia (difficulty speaking), stroke, right sided paralysis, arthritis, lower back pain and protein malnutrition. Review of the POS, showed no orders for skilled or restorative therapy. Review of the physical therapy discharge summaries, dated 7/7/25, showed:-Discharge reason: Maximal potential achieved, referred for RNP;-Restorative programs: RNP established/trained, restorative ambulation program;-Ambulation program: Ambulated using hallway rail 15 feet, minimal cues. Review of the care plan, in use during the survey, showed:-Problem: Required assistance from staff with grooming, personal hygiene due to stroke and right sided weakness;-Desired outcome: Increase the level of independence with grooming and hygiene;-Interventions: Staff allow rest breaks between tasks, break tasks into smaller tasks, place supplies on bedside, praise when a grooming hygiene task, provide protective oversight and assist when needed;-The care plan did not address the RNP exercises. Observation and interview on 12/16/25, showed:-At 7:20 A.M., the resident in the hallway in his/her wheelchair. His/Her right arm was in a sling. The resident said he/she wore the sling daily;-At 12:22 P.M., the resident said he/she wore the sling due to a stroke, he/she cannot use his/her right arm well. He/She had not received therapy for several months and would like to have exercises to keep his/her muscles loose. Staff do not provide additional stretching, exercises or walking. Review of the medical record, showed no restorative nursing assessment, no orders for the sling and no restorative nursing orders. 3. Review of Resident #75's medical records, showed:-Cognitively intact;-Used a wheelchair for locomotion;-Staff assistance needed for dressing, hygiene, transfers and mobility;-Diagnoses included lung disease, stroke, paralysis or the right side, depression, kidney disease, high blood pressure, and vitamin deficiencies. Review of the care plan, in use during the survey, showed:-Problem: Requires assistance with daily care related to stroke affected the right side;-Desired outcome: Needs will be met;-Interventions: Allow time to complete tasks, monitor for decline in functions, provide assistance and cues, therapy to screen quarterly and PRN. Review of the POS in use at the time of the survey, showed no orders for skilled therapy or the RNP. Review of the medical record, showed no RNP assessments, or therapy interventions on the care plan. Observation and interview on 12/16/25 at 1:26 P.M, showed the resident up in the wheelchair. His/Her right arm appeared weak, and no splints (continued on next page)

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	12/19/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were in place. The resident said he/she experienced a stroke years ago, and his/her right arm and right leg had been affected. He/She said he/she had received therapy previously. He/she received therapy several months ago, then therapy stopped due to insurance coverage. He/She had not received skilled therapy or restorative therapy. He/She would like to participate in the RNP to maintain strength. 4. Review of Resident #83's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes, schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder, and Multiple Sclerosis (MS, autoimmune disease of the central nervous system);-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: Resident has limited physical mobility. Resident needs assistance with ADLs and transfers. Resident is unable to walk;-Goal: Resident will remain free of complications related to immobility through the next review date;-Interventions: Therapy as ordered and as needed. Review of the POS in use at the time of the survey, showed no orders for restorative therapy. Review on 12/18/25 at 8:40 A.M., of the resident's electronic medical record (EMR), showed:-No skilled or restorative therapy received. -No RT assessments noted in the record. 5. During an interview on 12/18/25 at 8:51 A.M., the Interim Regional Director of Rehabilitation Services said she had been overseeing the rehabilitation services at the facility since the beginning of 12/2025. Residents should receive a therapy assessment when re-admitted from the hospital, if a fall occurred or if the resident or staff express a change in status. The nursing department should send a referral email to the therapy department. The facility should have an RT program. When a resident is discharged from therapy, the therapy department should complete an RNP recommendation form and provide the form to the Director of Nursing (DON). She is not aware if the facility had a functional RNP in place. The facility had recently undergone management changes. Any resident who has a contracture, weakness from stroke or illness should be assessed for therapy for the RNP, there are likely many residents that need RNP. She has not had any discussions with management about the RNP. 6. During an interview on 12/18/25 at 11:02 A.M., the DON said the facility should have a RNP in place. The RNP has not been functional for several months due to budget cuts and staffing shortages. The facility had two restorative aides and now have one. That aide is also used for transportation outings with residents and is often pulled to the floor for staffing shortages. The DON said a RNP is important to help residents maintain current function or improve mobility. There is no system in place to ensure restorative therapy is provided to residents who need it. Normally, the RNP aide would document in the RNP binder for the residents who receive restorative nursing. The binder is not up to date and the Restorative Nursing Aide had been working in other areas. The DON planned to work with the Director of Therapy to discuss how to get the program functional. All residents should be assessed to receive RNP and the assessment should be in the medical record and in the care plan.

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	12/19/2025

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account and by not reconciling each month. The facility also failed to ensure resident accounts did not have negative balances for three residents (Residents #88, #80 and #55). The facility managed funds for 105 residents. The facility census was 131.1. Review of the facility maintained attempted reconciliation forms for the period of 12/1/24 through 11/30/25, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of reconciliation:-December 2024: -Ending balance per bank statement: $190,580.09; -Current balance per trust report: $167,812.94; -January 2025: -Ending balance per bank statement: $184,920.61; - Current balance per trust report: $114,518.60; -February 2025: -Ending balance per bank statement: $119,205.92; -Current balance per trust report: $97,453.71; -March 2025: -Ending balance per bank statement: $126,266.97; -Current balance per trust report: $108,864.75;-April 2025: -Ending balance per bank statement: $143,411.86; -Current balance per trust report: $128,859.85;-May 2025: -Ending balance per bank statement: $145,713.62; -Current balance per trust report: $131,083.97;-June 2025: -Ending balance per bank statement: $143,864.05; -Current balance per trust report: $133,879.96; -July 2025: -Ending balance per bank statement: $140,728.59; -Current balance per trust report: $127,210.36; -August 2025: -Ending balance per bank statement: $135,527.17; -Current balance per trust report: $127,771.77; -September 2025: -Ending balance per bank statement: $124,880.87; -Current balance per trust report: $128,398.49; -October 2025: -Ending balance per bank statement: $163,303.77; -Current balance per trust report: $165,744.39; -November 2025: -Ending balance per bank statement: $185,685.05; -Current balance per trust report: $168,871.93. During an interview on 12/19/25 at 11:40 A.M., the Business Office Manager (BOM) said the corporate BOM audited the resident trust fund reconciliations. There were outstanding checks and reimbursements owed by the corporation which had not been paid. She was not able to resolve those issues. This would need to be addressed with corporate BOM. During an interview on 12/19/25 at 2:29 P.M., the Administrator said the bank statements should reconcile with the resident trust fund balance. She was not aware there were reimbursements owed by the corporation. During an interview on 12/19/25 at 3:02 P. M., the corporate BOM said she was aware of the outstanding checks and owed reimbursements. She had made numerous requests for the reimbursements, but the Accounts Payable department was slow and had not provided the reimbursement money. 2. Review of Resident #88's most recent quarterly resident trust statement from 6/30/25 to 9/30/25, showed:-An opening balance of $50.07;-On 8/13/25 a balance of -$17.92;-On 9/26/25 a balance of -$111.92;-A closing balance of -$111.91. Review of the resident's 10/1/25 through 12/19/25 trust transaction history, showed:-An opening balance of -$111.91;-On 10/3/25 a balance of -$156.91;-On 10/10/25 a balance of -$145.91;-On 10/31/25 a balance of -$145.91. During an interview on 12/19/25 at 11:40 A.M., the BOM said the resident's account had negative balances because the resident's Medicaid check was less than the amount the resident was charged for room and board at the facility. 3. Review of Resident #80's most recent quarterly resident trust statement from 6/30/25 to 9/30/25, showed:-An opening balance of $$27.00;-On 7/15/25 a balance of -$700.00. During an interview on 12/19/25 at 11:40 A.M., the BOM said the resident had a negative balance because his/her Medicaid check was less than the amount the resident was charged for room and board. 4. Review of Resident #55's most recent quarterly resident trust statement from 6/30/25 to 9/30/25, showed:-An opening balance of $1,961.89;-On 8/7/2 a balance of $246.91;-On 8/12/25 a balance of -$35.09;-On 8/135 a balance of -$45.09;-On 8/19/25 a balance of -$0.09. During an interview on 12/19/25 at 11:40 A.M., the BOM said she didn't know why the resident's account had negative balances. The Activity Director (AD) oversaw petty cash, but didn't have access to the residents' account balances. She gave the AD a (continued on next page)

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	12/19/2025

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ledger with a $50.00 balance for each resident at the beginning of the month. The resident may have withdrawn money he/she did not actually have in his/her account. During an interview on 12/19/25 at 1:06 P.M. the AD said he was responsible for handing out petty cash to residents. He keeps a receipt book and logs the transactions on the ledger provided by the BOM. He did not know how much money residents had in their trust accounts. 6. During an interview on 12/19/25 at 2:29 P.M., the Administrator said resident trust accounts should never have negative balances. There should be a daily accounting of the balance for each resident's account. The BOM was responsible for the management of the residents' trust accounts.

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	12/19/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to complete an annual Minimum Data Set (MDS, a federally mandated comprehensive assessment instrument completed by facility staff) assessment for one resident (Resident #20) timely as required. The sample was 29. The facility census was 131.Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, Assessments for the RAI, showed the following information: -The annual assessment is an OBRA (Omnibus Budget Reconciliation Act of 1987) comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA (Significant Change in Status Assessment) or an SCPA (Significant Correction to Previous Assessment) has been completed since staff completed the most recent comprehensive assessment; -The annual assessment ARD is the ARD of previous OBRA comprehensive assessment plus 366 calendar days, and ARD of previous OBRA Quarterly assessment plus 92 days. 1. Review of Resident #20's face sheet, showed he/she was admitted on [DATE]. Review of the resident's medical record, showed: -A quarterly MDS dated [DATE];-A quarterly MDS dated [DATE];-A quarterly MDS dated [DATE];-A quarterly MDS dated [DATE];-A quarterly MDS dated [DATE]; -No comprehensive assessment completed after August 2025. During an interview on 12/19/25 at 1:00 P.M., the administrator said she would expect MDS to be completed timely and to be accurate. She would staff to accurately complete the correct type of MDS.

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	12/19/2025

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to assess residents using the quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, no less frequently than once every 92 days as directed by the Resident Assessment Instrument (RAI) manual for one resident (Residents #120) out of 29. The facility census was 131. Review of the Resident Assessment Manual (RAI), dated 10/1/17, showed the Quarterly assessment is an Omnibus Budget Reconciliation Act of 1987 (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The Assessment Reference Date (ARD) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type. Review of Resident #120's medical record, showed:-A quarterly MDS dated [DATE];-A significant change MDS dated [DATE];-A late quarterly MDS, due August 2025, showed an ARD date of 9/22/25. During an interview on 12/19/25 at 1:00 P.M., the administrator said she would expect MDS to be completed timely and to be accurate. She would expect staff to accurately complete the correct type of MDS.

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	12/19/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure the resident's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflected the resident's status of having a life expectancy of less than 6 moths when they received hospice services (a service provided when a resident has a condition indicating a life expectancy of less than 6 months as certified by the hospice physician) for one of one hospice resident investigated for hospice services (Resident #6). The census was 131. Review of the facility's MDS policy, dated 11/6/23, showed Section J (Health Conditions) is to be completed by Nursing Staff. This section addresses any condition that impacts the resident's quality of life and functional status. Used to identify the number of health conditions that impact the resident's functional status and quality of life. Other areas in this section to assess are, dyspnea (difficulty breathing, tobacco use, prognosis, problem conditions and falls. Review of Resident #6's initial certification of terminal illness, dated 5/1/24, showed:-Written certification: based on my clinical judgement, I certify that this patient is terminally ill with a life expectancy of 6 months or less if the terminal disease runs its normal course;-The document was signed by the physician on 5/3/25. Review of the resident's significant change MDS, dated [DATE], showed:-Diagnoses included type two diabetes, acute kidney failure, muscle weakness and dementia;-Severe cognitive impairment;-Section J, does the resident have a life expectancy of 6 months or less: No. During an interview on 12/19/25 at 1:19 P.M., the Director of Nursing (DON) said she would expect the MDS to be accurate and reflect if the resident has a life expectancy of 6 months or less.

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	12/19/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure residents with a mental health disorder and/or individuals with intellectual disabilities had a DA-124 Level One Screen (used to evaluate for the presence of psychiatric conditions to determine if a Preadmission Screening/Annual Resident Review (PASARR) Level Two Screen was required), as required for one of three residents sampled (Resident #113) for PASARR. The sample was 29. The census was 131.Review of Resident #113's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/28/25, showed:-Entry date: 6/24/14;-readmitted : 2/4/14;-Diagnoses included depression, psychotic disorder and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's face sheet, showed diagnosis of other specified mental disorders due to known physiological condition. An on-set date, 5/8/24, showed diagnoses of major depressive disorder and disorganized schizophrenia. Review of the resident's medical records, showed:-No DA-124 Level one screen;-No PASARR Level two screen. During an interview on 12/18/25 at 3:19 P.M., the Social Services Director said resident PASARR assessments are uploaded in the medical record. On 12/19/25 at 10:50 A.M., the Social Services Director said the resident was admitted during a period when they did not need a PASARR. She did not know what the plan was for residents that were admitted prior to the PASARR, but they were grandfathered in. She was not aware of a new psych diagnosis since admission. Review of an email, dated 12/19/25, showed:-At 10:55 A.M., Department of Health and Senior Services (DHSS) asked Central Office Medical Review Unit (COMRU, the organization responsible for completion of level 2 PASARR assessments) to provide a PASARR for the resident;-At 11:10 A.M., COMRU replied, I am sorry, but I cannot provide a copy. The last one completed was in 11-1997. The Skilled Nursing Facility (SNF) will need to complete a new online application and indicated reason for submitting Replacement Form. During an interview on 12/19/25 at 1:00 P.M., the Administrator said COMRU said the residents that were at the facility prior to PASARR documents would be grandfathered in. She would expect the DA-124 to be completed upon admission or before.

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	12/19/2025

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 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** Based on observation, interview, and record review, the facility failed to ensure dependent residents received activities of daily living (ADL) care for four sampled residents (Residents #27, #120, #5, and #6). The sample was 29. The census was 131.Review of the facility's Nail Care policy, revised 6/26/24, showed:-Purpose: The purpose of this procedure is to provide guidelines for the provision of care to resident's nails for good grooming and health;-Policy: Assessment of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences. Report unusual or abnormal conditions of the nails to the physician and the responsible party (curling, color changed, separation form the nail bed, redness, bleeding, pain, odor, infection). Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease (PVD, a lack of blood flow in the legs caused by narrowing of the blood vessels), heart failure, kidney disease, or stroke. Routine cleaning and inspection of the nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. The resident's care plan will identify: The frequency of nail care to be provided, type of nail care provided and the person responsible for providing nail care to the resident;-Principles of nail care: Nails should be kept smooth to avoid skin injury. Only licensed nurses shall trim or file fingernails with diabetes. 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 9/5/25, showed:-Moderate cognitive impairment;-No rejection of care behavior exhibited;-Requires supervision with bathing and personal hygiene;-Diagnoses include schizophrenia (a mental disorder that distorts reality) and diabetes. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is at risk for self-care deficit related to bathing;-Interventions: Provide assistance with ADLs as needed;-The care plan did not address refusal of care by the resident. Observation on 12/15/25 at 10:55 A.M., showed the resident in his/her room. His/Her fingernails on both hands approximately 0.5 inches (in.) long. The nails were jagged with dark matter underneath the nails. During an interview, the resident said his/her nails need to be cleaned and trimmed. Observation on 12/16/25 at 8:15 A.M., showed the resident in the dining room, eating breakfast and touching his/her food with his/her hands. His/Her fingernails on both hands were long, jagged, and with dark matter underneath the nails. During an interview with on 12/19/25 at 8:30 A.M., Certified Medicine Technician (CMT) B said the resident occasionally refuses showers and nail care. Nail care should be done anytime a resident requires it. If a resident refuses, then the staff should attempt again later. 2. Review of Resident #120's quarterly MDS, dated [DATE], showed:-Mild cognitive impairment;-Diagnoses include anemia, heart failure, hypertension (high blood pressure), PVD, kidney failure, diabetes, hyperkalemia (too much potassium in the blood), hyperlipidemia (high cholesterol), aphasia (language disorder), cerebrovascular accident (CVA, stroke), hemiplegia (paralysis on one side of the body), seizure disorder, malnutrition, and depression;-Moderate assistance required with oral hygiene, toileting, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. Review of the resident's care plan, in use during survey, showed:-Problem: Resident requires assistance with his/her ADL functions including transfer and dressing. He/She can perform many of his/her tasks with set up and supervision;-Interventions included provide assistance, supervision, and set up as needed. Observation on 12/16/25 at 1:38 P.M., showed the resident's fingernails were long with dirt underneath the nail bed. Observations on 12/17/25 at 9:19 A.M., 12/18/25 at 10:50 A.M., and 12/19/25 at 11:00 A.M., showed the resident's fingernails were approximately 1/3 in. long in with dirt underneath the nail bed. The resident's right thumb was thick and curved forward. During an interview on 12/19/25 at 12:30 P.M., Certified Nurse Aide (CNA) Q and CNA R said the resident normally does not refuse care. The resident will sometimes ball up his/her hands during nail care. If staff explain to the resident what care they are providing, the (continued on next page)

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	12/19/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident is compliant. Any care that is refused by the resident is reported to the nurse right away. During an interview on 12/19/25 at 1:15 P.M., the Director of Nursing (DON) said the resident's nails are expected to be cleaned and trimmed on shower days and as needed. Refusals of care are expected to be documented on the care plan and the resident's medical record. 3. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease) and dementia;-Moderately impaired cognition;-Staff supervision required for bathing and personal hygiene. Review of the resident's care plan, in use at the time of the survey, showed the care plan did not include the resident's ADL care needs. Observation on 12/15/25 at 2:15 P.M., showed a strong odor coming from the resident. His/Her beard was disheveled. During an interview, the resident said he/she wanted the beard shaved off. Observation on 12/16/25 at 8:18 A.M., showed the resident in the dining room. His/Her beard long and disheveled. A sweat odor was coming from the resident. 4. Review of Resident #6's significant change MDS, dated [DATE], showed:-Diagnoses include diabetes, acute kidney failure, muscle weakness, and dementia;-Severe cognitive impairment;-Dependent on staff for showering and personal hygiene. Review of the resident's electronic medical record (EMR) profile photo, from the time of admission, showed the resident's hair was short and his/her face was clean shaven with no beard. Observations on 12/16/25 at 8:23 A.M. and 12/18/25 at 7:42 A.M., showed the resident with long, stringy hair, and an unkempt beard. During an interview on 12/19/25 at 8:58 A.M., LPN A said the resident's hair was long and he/she needs a haircut. Staff are responsible for setting up appointments for the resident to go to the barber. He/She expects staff to use their professional judgement when deciding if a resident needs their beard shaved, if the resident cannot communicate their needs. Any nursing staff can assist with shaving. Residents can also make an appointment to go to a barber. 5. During an interview on 12/19/25 at 1:23 P.M., the Director of Nursing (DON) said any nursing staff can assist residents with shaving their beard. The facility also has a part-time barber with whom residents can make appointments. She expects resident care plans to reflect ADL needs and interventions.

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	12/19/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received proper treatment and care to maintain mobility and good foot health for five residents (Resident #128, #105, #45, #17 and #1). The sample was 29. The census was 131.Review of the facility's Podiatry (foot) Services policy, revised, 5/14/24, showed:-Purpose: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health;-Policy: Foot care that is provided in the facility, such as toenail clipping for residents without complication disease processes, shall be provided by staff who have received education and training to provide this service. Residents requiring foot care who have complication disease processes will be referred to qualified professional such as a podiatrist (foot doctor). Employees should refer an identified need for foot care to the Social Worker (SW) or designee. The SW or designee will assist residents in making appointments. Review of the facility's Nail Care policy, revised 6/26/24, showed:-Purpose: The purpose of this procedure is to provide guidelines for the provision of care to resident's nails for good grooming and health;-Policy: Assessment of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences. Report unusual or abnormal conditions of the nails to the physician and the responsible party (curling, color changed, separation form the nail bed, redness, bleeding, pain, odor, infection). Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease (PVD, a lack of blood flow in the legs caused by narrowing of the blood vessels,) heart failure, kidney disease, or stroke. Routine cleaning and inspection of the nails will be provided during activities of daily living (ADL) care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. The resident's care plan will identify: The frequency of nail care to be provided, type of nail care provided and the person responsible for providing nail care to the resident.-Principles of nail care: Nails should be kept smooth to avoid skin injury. Toenails of residents with diabetes or circulation problems shall be filed only. 1. Review of Resident #128's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/20/25, showed:-Moderate cognitive impairment;-No rejection of care behavior exhibited;-Diagnoses include schizophrenia (a mental disorder that distorts reality);-Requires supervision or touching assistance with lower body dressing, putting on and taking off footwear, personal hygiene and bathing. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is independent with ADLs but requires cueing at times for hygiene needs;-Interventions: Remind the resident of good hygiene. Provide protective oversight and assist when needed. Review of the resident's physician order sheet (POS), showed an order, dated 4/29/21, for may see podiatrist. Review of the resident's medical record, reviewed during the survey from 12/15/25 through 12/19/25, showed no documented podiatry visits or consults. Observation on 12/15/25 at 11:13 A.M., showed the resident wore slide-on sandals with his/her toes exposed. His/Her toenails on both feet approximately an inch long, thick, jagged and curled under. Both feet extremely dry with large flakes of dry skin. 2. Review of Resident #105's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care behavior exhibited;-Diagnoses include diabetes and schizophrenia;-Requires partial to moderate assist putting on and taking off footwear and lower body dressing;-Requires supervision or touching assistance with personal hygiene and bathing. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is at risk for alteration in health related to diabetes;-Interventions: Refer to podiatrist or foot care nurse to monitor and document foot care needs and to cut long nails. Review of the resident's POS showed an order, dated 5/14/21, for may see podiatrist. Review of the resident's medical record, reviewed during the survey from 12/15/25 through 12/19/25, showed no documented podiatry visits (continued on next page)

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	12/19/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or consults. Observation on 12/17/25 at 10:00 A.M., showed the resident wore gray slipper socks that were brown on the bottom of the sock. The socks had large holes exposing the resident's heels. Certified Medicine Technician (CMT) B removed the resident's socks and a large of amount of white flakes fell out of the socks. The resident's toenails were approximately 0.5 inches (in) long, thick, and jagged. 3. Review of Resident #45's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care behavior exhibited;-Diagnoses include anxiety, depression and schizophrenia;-Requires supervision or touching assistance with putting on and taking off footwear, lower body dressing, personal hygiene and bathing. Review of the resident's care plan, in use at the time of survey, showed:-Plan: The resident is independent with ADLs but does require supervision and cues to maintain hygiene;-Intervention: Protective oversight and provide assistance where needed. Review of the resident's POS, showed an order dated, 4/27/21, for may see podiatrist. Review of the resident's medical record, reviewed during the survey from 12/15/25 through 12/19/25, showed no documented podiatry visits or consults. Observation on 12/17/25 at approximately 10:05 A.M., showed the resident lay in bed with his/her feet exposed. His/Her feet extremely dry with large flakes of dry skin falling off his/her feet. The resident's toenails thick and jagged. During an interview, the resident said he/she would like to have his/her feet moisturized and toenails groomed. 4. Review of Resident #17's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care behavior exhibited;-Diagnoses include PVD and schizophrenia;-Requires supervision or touching assistance with putting on and taking off footwear, lower body dressing, personal hygiene and bathing. Review of the resident's care plan, in use of the time of survey showed:-Plan: The resident is independent with ADLs;-Intervention: Protective oversight and provide assistance where needed.Observation on 12/16/25 at 8:39 A.M., showed the resident sat at the bedside. His/Her ankles and feet slightly edematous (swollen). Both feet extremely dry with large flakes of skin coming off. During an interview, the resident said he/she thought his/her feet were dry and needed lotion. During an interview on 12/17/25 at 10:15 A.M., CMT B said many residents on the resident's hall shower and get dressed independently. Most of the residents do not refuse ADL care. If the podiatrist is in the building during smoke time, the resident will refuse the visit because he/she does not want to miss out on smoking. 5. Review of Resident #1's POS, showed an order, dated 3/10/23, for may see podiatrist; Review of the resident's care plan, revised 7/25/25, showed:-Problem: The resident requires assistance with ADLs due to pain;-Desired outcome: The resident will improve level of function;-Interventions: Encourage participation to fullest extent. Staff monitor and report any changes. Review of the resident's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Uses a wheelchair for mobility;-Staff provide supervision to touching assistance for hygiene needs;-Diagnoses include lung disease, obesity, high blood pressure, lower spine dysfunction, heart disease, chronic pain, and osteoporosis. Review of the resident's medical record, reviewed during the survey from 12/15/25 through 12/19/25, showed no documented podiatry visits or consults. Observation on 12/16/25 at 10:23 A.M., showed the resident asleep in bed. His/Her feet were exposed and his/her right big toenail was thick, dark yellow, and approximately 1.0 in long. During an interview on 12/17/25 at 9:15 AM the resident said he/she had a very long toenail and the nail rubs on his/her slipper. He/She had not seen the podiatrist for the toenail. The staff had not offered the podiatrist to see him/her. A doctor should cut the long toenail. Staff assists him/her with bathing. He/She would like to have a doctor look at his/her toenails to get the long nail trimmed. During an interview on 12/17/25 at 1:43 P.M., the Social Service Designee (SSD) said the resident has not been seen by a podiatrist and does have a history of refusals. 6. During an interview on 12/17/25 at 10:15 A.M., CMT B nursing staff are expected to notify the Director of Nursing (DON) or Assistant Director of Nursing (ADON) if residents require toenail trimming. Moisturizing a resident's feet can be done anytime by any nursing staff member. If a resident is unable to apply lotion to their feet, then the facility will supply them with some type of moisturizer. Staff should change a resident's socks if they are soiled or have holes in them. If a resident refuses any type of care staff should let (continued on next page)

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	12/19/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse know and document the refusals. 7. During an interview on 12/18/25 at 8:15 A.M., Licensed Practical Nurse (LPN) F said the nurses complete weekly skin assessments on the residents. The assessment includes removing the resident's socks and examining the resident's feet. Podiatry is consulted for diabetics and for residents that have extremely thick toenails. The nurse can trim or file toenails for residents who are not diabetic. 8. During an interview on 12/17/25 at 8:30 A.M., the DON said some residents refuse to have foot care completed by staff and the podiatrist. The podiatrist comes to the facility about every two to three months. If a resident refuses foot care, staff is expected to document this in the medical record and on the care plan. She expects staff to moisturize the resident's feet on their shower days and as needed. She expects staff to notify her or the charge nurse if the resident needs their toenails trimmed. She expects staff to change the resident's socks if soiled or if there are holes in the socks. 9. During an interview on 12/17/25 at 1:43 P.M., the SSD said staff notifies her of residents that need to be seen by the podiatrist. She will obtain a consent and schedule the resident to be seen. The aides are responsible for notifying the nurses of a resident's toenail needs and the nurses should assess and determine if the residents need to be seen by the podiatrist. Refusals should be documented in the resident's medical record. 2686150

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	12/19/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure physician orders were obtained for feeding tube water flushes and to ensure staff documented the date and time tube feeding formula was hung for one of two residents sampled with feeding tubes (Resident #120). The facility census was 131. Review of the facility's Following Physician's Orders policy, revised 5/18/24, showed:-Procedure: Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in the Orders section;-Clarification of physician's orders will be obtained if the order is either unclear or the nurse is uncomfortable in implementation of the physician's orders;-The nurse in charge of medication administration must review all their designatedMedication Administration Records (MARs) and Treatment Administration Record (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 order and that all necessary interventions were taken in the event of an omission;-The Resident Care Coordinator (RCC)/Unit Manager/designated nurse will review all electronic MARs/TARs and compare all medications to the medications available for each resident in the facility weekly to ensure availability;-The physician is expected to sign all of their orders electronically in the Electronic Health Record;- Medical Records Coordinator/designee will audit electronic signatures by running report weekly on orders pending electronic signatures. The Director of Nursing (DON) and Administrator are to be notified of physician orders still needing signatures. The physicians who have orders that need to be electronically signed, will be contacted requesting they sign the orders. Review of Resident #120's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/22/25, showed:-Mild cognitive impairment;-Diagnoses included anemia, heart failure, hypertension (high blood pressure), peripheral vascular disease (PVD, circulatory problem causing numbness/weakness), kidney failure, diabetes, hyperkalemia (too much potassium in the blood), hyperlipidemia (high cholesterol), aphasia (language disorder), cerebrovascular accident (CVA, stroke), hemiplegia (paralysis on one side of the body), seizure disorder, malnutrition, and depression;-Moderate assistance with oral hygiene, toileting, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene;-Weighs 103 pounds;-Has feeding tube. Review of the resident's care plan, in use at the time of survey, showed:-Problem: Resident is at risk for aspiration;-Interventions included: Diet provided as ordered (continuous tube feeding);-Problem: The resident has dehydration or potential fluid for deficit related to nothing by mouth (NPO) diet;-Interventions: Administer water flushes per orders (per pump). Review of the resident's hospital record, dated 12/2/25, showed:-admitted : 11/19/25;-discharged : 12/2/25;-Intensive Care Unit (ICU) course: Admit 11/19/25, transferred out 11/24/25. Reason for admission: hyperosmolar hyperglycemic state (HHS, extremely high blood sugar)/diabetic ketoacidosis (DKA, lack of insulin) septic shock/respiratory failure due to right upper lung (RUL) pneumonia, severe hypernatremia (high sodium levels;-Hospital course: He/She was found to have severe hypernatremia and cystic fibrosis sepsis, aspiration pneumonia, admitted to ICU for brief intubation, insulin drip, hypernatremia management, now extubated, transitioned to floor. He/She underwent gastronomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) replacement on 12/1/25 after his/her g-tube was dislodged. He/She will be discharged back to nursing facility;-discharged on continuous tube feed rate 55 milliliters (ml) per (/) hour (hr), Glucerna (calorie dense formula) 1.5 cal;-No documentation of water flushes, rate or frequency. Review of the resident's physician orders sheet (POS), for December 2025, showed:-An order, dated 12/2/25, NPO diet related to dysphagia;-An order, dated 12/2/25, Glucerna 1.5, 55 ml per/hour for 22 hours every shift for supplement;-An order, dated 11/4/25, 150 cubic centimeters (cc) water flush via g-tube every four hours;-An order, dated 12/2/25, to discontinue 150 cc water flush (continued on next page)

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	12/19/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	via g-tube every four hours;-An order, dated 12/16/25, enteral feed order every four hours related to hyperkalemia, 150 cc free water every four hours, auto infuse via pump. Observation on 12/15/25 through 12/19/25, showed:-On 12/15/25 at 4:07 P.M., showed the resident in bed, with g-tube infusing at 55 ml/hr. The formula bottle showed no documentation of the time it was hung and started infusing;-On 12/16/25 at 12:50 P.M., the resident in bed. His/Her g-tube infused at 55 ml/hr. G-tube pump showed the water flush set at 100 cc every hour;-On 12/17/25 at 9:19 A.M., the resident in bed. G-tube infused at 55 ml/hr. G-tube pump showed the water flush set 150 cc every four hours;-On 12/18/25 at 10:50 A.M., the resident in bed. G-tube infused at 55 ml/hr and water flush set at 150 cc. The formula bottle showed no documentation of the time it was hung and started infusing;-On 12/19/25 at 11:00 A.M., the resident in bed with eyes closed. The g-tube infused at 55 ml/hr. G-tube pump showed the water flush set at 150 ml. The formula bottle showed no documentation of the time it was hung and started infusing. During an interview on 12/19/25 at 1:00 P.M., the Director of Nursing (DON) said she expected staff to ensure the resident had physician's orders for water flushes. She expected staff to follow physician's orders. She expected staff to document the date, time, infuse rate, and formula type on the bottle. When the resident returned from the hospital, he/she was on 100 ml water flush.

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	12/19/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure pain management was provided for one of 29 sampled residents who experienced pain and reported it to staff per their policy. In addition, the facility failed to report the resident's pain to the nurse (Resident #120). The census was 131.Review of the facility's Pain Management policy, revised 6/26/24, showed:-Purpose: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences;-Policy: The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain;-Recognition of pain: In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated; Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences;-Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain;-Pain Management and Treatment: Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission;-The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal;-The interdisciplinary team and the resident and/or the resident's representative will collaborate to arrive at pertinent, realistic and measurable goals for treatment. Review of Resident #120's quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 9/22/25, showed:-Mild cognitive impairment;-Diagnoses included heart failure, high blood pressure, peripheral vascular disease (PVD, circulatory problem causing numbness/weakness), aphasia (language disorder), stroke, hemiplegia (paralysis on one side of the body), seizure disorder, and depression;-Moderate assistance with toileting, upper body dressing, lower body dressing, and personal hygiene;-No pain in the last five days. Review of the resident's care plan, in use during survey, showed:-Problem: Acute pain;-Intervention: Evaluate pain;-Utilize non-medication interventions for pain relief. Review of the resident's electronic Physician's Orders Sheet, dated December 2025, showed:-An order dated 9/17/25, for Acetaminophen (Tylenol) tablet 500 milligram (mg), give two tablets via gastric tube (g-tube, feeding tube used to provide food, fluid and nutrition for individuals who had difficulty swallowing) every six hours as needed for elevated temperature;-An order dated 12/3/25, for Aspirin 81 mg oral tablet, give one tablet via g-tube one time a day related to stroke. Review of the resident's Medication Administration Record (MAR), dated December 2025, showed:-Acetaminophen tablet 500 mg, give two tablets via g-tube every six hours as needed: No documentation it was administered;-Aspirin 81 mg oral tablet, give one tablet via g-tube one time a day related to stroke, showed: -On 12/15/25 through 12/19/25, staff documented pain level 0; -Staff documented the administration of Aspirin 81 mg on 12/15/25 through 12/19/25. Observation on 12/17/25 at 10:18 A.M., showed Certified Nurse Aide (CNA) G and CNA P entered the resident's room and put on gowns and gloves, raised the bed, unfastened the resident's brief, and tucked it down between the resident's legs. The resident cried out. When staff asked if his/her legs were hurting, the resident said yes. CNA G told the resident that he/she would let the nurse know after they get him/her up. When positioned onto his/her back, CNA G provided personal care and then CNA P assisted to turn the resident to his/her left side. CNA G provided personal care. The CNAs then turned the resident to his/her to right side and provided personal care. The resident cried out each time staff moved him/her. Staff straightened the brief under the resident and fastened the brief, then CNA G (continued on next page)

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	12/19/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed groves and washed his/her hands. CNA G placed pants and shirt on the resident and placed the mechanical lift pad under the resident. The resident said he/she had pain to his/her left hip, legs, and buttock that was increase when laying. At 10:45 A.M., CNA G put socks on the resident. The resident continued to moan and cry out with facial grimacing. Staff used the Hoyer lift (full body mechanical lift) to transfer the resident. The resident's legs curled up and his/her knees in front of the Hoyer bar. CNA G pushed the resident's legs under bar, scraping the resident's left knee. CNA G rubbed the knee after. CNA G asked the Resident to straighten his/her legs. The resident was then transferred from bed to the chair with his/her legs scrunched up. The resident continued to moan out with facial grimacing. CNA G propelled the resident out to the hall and positioned him/her in his/her chair against the wall. Observation showed the CNAs walked down hall and did not go to the nurse to report the pain. During an interview on 12/18/25 at 11:00 A.M., the Assistant Director of Nursing (ADON) said the resident does have pain at times. If he/she has pain, he/she will typically rub his/her leg and that is how staff know. He/She gets Tylenol as needed (PRN). Staff will report it to the nurse. During an interview on 12/19/25 at 9:34 A.M., Licensed Practical Nurse (LPN) J said he/she worked on 12/17/25 and staff did not report the resident was having pain. He/She does not have pain often but when he/she does, he/she will verbalize it. If he/she tells staff he/she is hurting, LPN J would expect staff to tell him/her. LPN J would get his/her PRN Tylenol. LPN J would have expected them to stop and come get him/her to assess the resident first in case there was an injury. During an interview on 12/19/25 at 9:46 A.M., CNA P said he/she was new and still getting to know the residents. He/She was unsure if he/she told the nurse of the resident's pain. During an interview on 12/18/25 at 2:58 P.M., the resident said he/she did not believe staff brought him/her any pain medication on 12/17/25. When he/she is in pain and staff are aware, they do not normally bring him/her anything. During an interview on 12/19/25 at 1:00 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to report complaints of pain to the nurse. They would expect staff to stop and assess if the resident complained during care.

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	12/19/2025

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 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. Based on observation, interview and record review, the facility failed to ensure one resident's arterial venous (AV) fistula (a surgically created connection between an artery and a vein that is accessed during hemodialysis, an invasive procedure that cleanses the blood of impurities) was assessed by a licensed nurse, for one out of one dialysis resident sampled (Resident #101). The census was 131.Review of the facility's Hemodialysis policy, last revised, 5/14/24, showed:-Purpose: The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the residents' goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis;-Care for the resident on dialysis: The nurse will monitor and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications. Review of the Resident #101's quarterly minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/29/25, showed:-Diagnoses included kidney failure;-The resident is receiving hemodialysis. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident requires hemodialysis related to kidney failure;-Interventions: Check and change dressing daily at access site; Monitor any signs or symptoms of infection at the access site (redness, warmth, swelling or drainage); Monitor new or worsening peripheral edema (swelling of arms and legs). Review of the resident's medication administration record (MAR), dated 12/1 through 12/15/25 showed:-An order dated 10/30/25, to check bruit (a whooshing sound heard with a stethoscope) and thrill (a vibration felt by touching) of AV fistula every shift, days and nights;-Documented as completed by a Certified Medication Technician (CMT) on: 12/1 through 12/15/25, for day shift;-Documented as completed by a CMT on: 12/1 through 12/15/25 for night shift;-A licensed nurse did not document the resident's bruit and thrill assessment as completed. Observation and interview on 12/16/25 at 11:10 A.M., showed the resident lay in bed. The resident had an undated dressing over his/her AV fistula site to his/her left upper arm. CMT B said he/she only checks the resident's left arm AV fistula site to ensure it is not bleeding. CMT said he/she will sometimes hold his/her hand over the residents AV fistula site. CMT B was not sure what the exact assessment was for a bruit and thrill and was signing it off on the MAR as completed. If CMT B notices anything abnormal about the resident's AV fistula then he/she will call for the nurse. During an interview on 12/17/25 at 8:30 A.M., Certified Nursing Assistant (CNA) K said the resident was moved to the 300 hall so a nurse could assess the resident's dialysis site. During an interview on 12/19/25 at 10:00 A.M., Licensed Practical Nurse (LPN) J said only a nurse should be completing the bruit and thrill assessment on the resident's AV fistula. It would be out of a CMTs scope of practice to complete the assessment. The AV fistula needs to be checked to ensure it is not clotted. If the AV fistula becomes clotted, hemodialysis could not be completed. The assessment should not be documented as completed when the staff member is not sure what the assessment is. During an interview on 12/19/25 at 1:00 P.M., the Director on Nursing (DON) said only a nurse is expected to assess the resident's AV fistula for bruit and thrill to ensure its patency. The nurse is expected to document the assessment as completed on the MAR. The CMTs should not be assessing the AV fistula or documenting that they did so.

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	12/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain medications identified as to be destroyed in the 300 hallway medication room in a safe and secure location inaccessible by unauthorized staff. This affected one of two observed medication storage rooms. The census was 131.Review of the Medication Destruction policy, revised [DATE], showed:-Purpose: To ensure that medications that cannot be returned to the dispensing pharmacy are destroyed;-Policy: -Any medication that is to be destroyed is to be locked in a separate cabinet and labeled to be destroyed. No other items, medications or treatments are allowed to be stored in the to be destroyed cabinet;---Medications should not be in an unsecured area to be handled at a later time. It must be immediately placed in the to be destroyed cabinet or destroyed:--For example, a single use vial may contain two milliliters (ml) of a drug and the resident is only prescribed 1 ml. In this case, the 1 ml must be destroyed;--Another example is an oral medication prepared for a resident and the resident is unable or unwilling to take the medication. The medication must be destroyed;--Destruction shall be completed as soon as practicable;--When items are placed in the to be destroyed cabinet, they shall be placed by a minimum of two employees licensed to dispense medication and shall consist or one Registered Nurse (RN)/Licensed Practical Nurse (LPN) and one Certified Medication Technician (CMT) or two licensed nurses (excluding the Director of Nursing (DON). When the medication is placed in the cabinet, both the dispensing record and the signed Medication to be Destroyed Record must be attached. The medication to be destroyed record must be fully completed with the date, medication name and dosage, residents name, and both authorized signatures;-All medications must be destroyed in the presence of two health care providers who are licensed to dispense drugs. At least one must be an LPN or RN. Disposal cannot be done by two CMTs. The DON may not be involved in the destruction of medication;-Medications are to be destroyed weekly if possible but a minimum of monthly;-All medications will be destroyed in accordance with the federal guidelines to proper pharmaceutical disposal:--Medications that cannot be returned to the pharmacy are to be destroyed by the facility, including medication that is expired or medication for residents who are permanently discharged ;--If the medication is in pill form, the designated nurses will gather all medications and liquify them by adding water. The liquified medication will then be added to a kitty litter mixture, or other approved medication destruction product, then placed in a trash bag or biohazard and discarded;--If the medication is in liquid form, the designated nurses will pour the liquid directly into the kitty litter and discard the litter in the trash bag and discard;-The two health care providers handling the destruction include one designated to destroy and one designated as the witness for the destruction/disposal of medications. These two health care providers must reconcile the medication to be destroyed record with the specific dispensing record, and the actual medications to be destroyed, prior to the medication destruction. If a discrepancy is noted the DON will be notified immediately and will begin an investigation;-Whomever destroys and witnesses the destruction/disposal of medications must sign and date the medication destruction record;-The medication destruction record will provide the following information:--Resident name;--Date medication destroyed;--The name, strength, prescription number (if any), dispensing pharmacy name;--The quantity destroyed, method of destruction and reason;--Signature of witnesses;-The two health care providers who complete and witness the medication destruction and complete the medication destruction record will turn in the completed log to the medical records coordinator for secure record keeping. A copy of the destruction log is also given to the DON and must be kept in a locked cabinet in the DON's office or other secured area. The form must be available for inspection by the Department of Health investigators upon request;-Completed medication destruction records will be withheld by the facility for at minimum of two years;-Before discarding any medication cards or prescription bottles with labels, ensure that all (continued on next page)

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	12/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident information is removed or scratched/blacked out;-The DON is responsible for ensuring that the medications that are no longer needed are being kept securely and destroyed properly. Observations on [DATE] of the 300 unit medication room, located within the 300 nurses station, showed:-At 6:40 A.M., the medication room door was ajar and rested loosely on the door frame. The door noted to have button keypad. On the medication room counter lay a red plastic bin with an open plastic bag containing eight bottles of liquid risperidone (antipsychotic medication) 1 ml, and 28 various medication cards containing various discontinued medications. An ice cooler on a wheeled cart noted in the medication room;-At 6:50 A.M., three Certified Nurse Aides (CNAs) walked into the medication room without using the keypad. The staff placed personal belongings on the medication room counter and left the medication room. The door to the medication room remained loosely ajar. During an interview on [DATE] at 6:58 A.M., LPN O said the medication room door does not close completely and the keypad code is broken. Staff frequently store the ice cooler and personal belongings in the medication room. The nurse and the CMT should be the only staff able to access the medication room. The nurse does not remain in the nurse's station at all times and they are frequently away to care for residents and the door is not monitored. During an interview on [DATE] at 11:02 A.M., the DON said all medication room doors should be closed and secured. The doors have a keypad for access. The DON, nurses, and CMTs who work the units have the access codes to the applicable medication rooms. Staff should not keep personal belongings in the medication rooms. If the medication room door or the door code is not working, nursing staff should notify the DON and Maintenance staff immediately. Unlicensed staff should not have access to the med room. All discontinued medications should be secured in the medication room and not left accessible on the counter. The DON is notified when the red bin has discontinued medications and she destroys the medications.

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	12/19/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and record review, the facility failed to ensure pharmacy recommendations were followed up on in a timely manner for one of five sampled residents reviewed for pharmacy recommendations (Resident #2). The facility census was 131. Review of the facility's Medication Regimen Review (MMR) policy, revised 6/26/24, showed:-Purpose: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart;-Timelines and responsibilities for Medication Regimen Review: The consultant pharmacist shall schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete all required activities;-The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review;-If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON or designee is informed verbally;-The pharmacist will complete the MRR, and ensure this is documented into the electronic health record;-For residents experiencing a change in condition and the nurse deems a MRR is necessary outside the routine visit, the facility will notify the pharmacy provider:--The pharmacist will complete the MRR and ensure documentation of the MRR is in the electronic health record;-The pharmacist shall forward to the facility's Consultant Pharmacist for follow up, if indicated;-Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Review of Resident #2's face sheet, showed:-Diagnoses included hypertension (high blood pressure) and chronic atrial fibrillation;-A physician order, dated 4/21/25, for losartan potassium oral tablet 50 milligram (mg), give one tablet by mouth, one time a day for hypertension. Review of the resident's care plan, in use during survey, showed:-Problem: Resident is at risk for altered cardiovascular status related to diagnosis of chronic atrial fibrillation;-Interventions: Monitor, document, report as needed (PRN) any signs and symptoms of chronic atrial fibrillation. Resident, family, caregiver teaching to include: nature of disease, risk factors such as hypertension. Review of the resident's blood pressure record, showed on 10/8/25, blood pressure of 148/78. Review of the resident's Pharmacy Review, dated 10/15/25, showed resident's blood pressure remains elevated. Consider increasing losartan to 100 mg daily. Review of the resident's blood pressure record, showed on 11/5/25, blood pressure of 152/92. Review of the resident's Pharmacy Review, dated 11/12/25, showed resident's blood pressure remains elevated. Consider increasing losartan to 100 mg or starting a beta blocker like carvedilol due to pulse being elevated as well. Review of the resident's Medication Administration Record (MAR), for December 2025, showed:-Losartan potassium oral tablet 50 mg, one time a day, documented as administered on 12/1/25 through 12/16/25;-No new or revised orders for losartan. During an interview on 12/19/25 at 8:26 A.M., the resident said staff stopped taking his/her blood pressure. They said he/she did not need it, but he/she did not know why. At 8:30 A.M., the resident gave permission for the nurse to take his/her blood pressure. Observation on 12/19/25 at 8:45 A.M., showed the resident lay in bed in his/her room. Licensed Practical Nurse (LPN) N entered the resident's room and placed blood pressure cuff on the resident's right arm, then used a stethoscope to manually measure the resident's blood pressure. The resident's blood pressure read 160/78. At 8:50 A.M., LPN N measured the resident's pulse, which showed 78. LPN N asked the resident if he/she had coffee this morning. During an interview, LPN N was asked if the resident's blood pressure was considered elevated. LPN N said when the resident is laying down, his/her blood pressure would be 120 or 130. When the resident goes out and returns, the blood pressure is elevated. He/She also drinks soda. LPN N said he/she would contact the physician since the resident is on blood pressure medication. During an interview on 12/19/25 at 1:00 P.M., the Director of Nursing (DON) said the Assistant Director of Nursing (ADON) and herself take care of the pharmacy recommendations and communicate with the physician and document it in the record. They have changed the pharmacy, so there is a new group of (continued on next page)

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	12/19/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	people doing it and they are sending in three recommendations a day and the physician is expected to respond in three days. The DON expects a response from the physician at this point regarding the resident's pharmacy recommendation.

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	12/19/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was served at a palatable and appetizing temperature during tray service by failing to maintain the temperature of hot food at least at 120 degrees Fahrenheit (F) and failed to ensure food was palatable for two of 29 sampled residents (Residents #11 and #13). The census was 131. 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: eggs should be between 135 degrees F and 155 degrees F. Meat should be 135 degrees F;-If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution and discarded out of temperature range foods. 1. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/4/25, showed:-Diagnoses included major depressive disorder, schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder), and epilepsy (seizure disorder);-Moderately impaired cognition. During an interview on 12/17/25 at 11: 29 A.M., the resident said the food is not good. The food is not always warm, and the taste is bad. 2. Review of Resident #13's annual MDS, dated [DATE], showed:-Diagnoses included bipolar disorder (mood disorder that can cause intense mood swings), major depressive disorder, type two diabetes, and schizoaffective disorder;-Cognitively intact. During an interview on 12/15/25 at 2:00 P.M., the resident said the food tastes okay but could be better. The food is cold a lot. 3. Observation on 12/17/25 at 8:08 A.M., of the breakfast meal service on the 300 hall, showed:-Sausage patty measured 93 degrees F and felt cold. The sausage tasted rubbery;-Scrambled eggs measured 115.9 degrees F and felt cold. 4. Observation on 12/17/25 at 12:45 P.M., of the lunch meal service on the 100 hall, showed:-The plate covered with plastic wrap and contained 3 chicken strips, a slice of white bread, green beans and mashed potatoes;-The chicken strips had a piece of sliced bread on top. The bread was limp and damp;-The chicken strips tasted rubbery;-The mashed potatoes tasted very dry, bland, and powdery. The mashed potatoes did not have gravy. 5. During an interview on 12/19/25 at 9:22 A.M., the Food Service Manager said food should be palatable and taste good. He would expect food to be served at a safe and palatable temperature. He said the reason the food temperatures are not good is because the elevator breaks frequently so dietary staff have to carry the food up the stairs, which takes longer. 6. During an interview on 12/19/25 at 1:15 P.M., the Administrator said she would expect food to be served at a safe and palatable temperature. She would expect food to be palatable. 17104431710440

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	12/19/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer and vaccinate eligible residents for the pneumococcal (pneumonia caused by bacteria) vaccine for two out of five residents sampled for immunizations (Resident #28 and Resident #18). The census was 131.Review of the facility's Influenza and Pneumococcal Immunizations policy, last revised on 5/14/24, showed:-The purpose of this policy is to ensure that all residents residing in the facility are offered influenza and pneumococcal immunizations to prevent infection and the spread of communicable disease;-As part of the admission process, the resident and/or the resident's legal representative will be provided education on the benefits and potential side effects of both the influenza and pneumococcal immunizations;-The resident or their legal representative will be informed that the pneumococcal immunization will be offered upon admission or per the Centers for Disease Control and Prevention (CDC) guidelines. The pneumococcal immunization will not be given in the immunization is medical contraindicated, the facility has evidence to support the resident received the immunization, or the resident or their legal representative has refused the immunization;-The pneumococcal immunization will be offed upon admission and a second pneumococcal immunization may be recommended after five years from the first immunization. The pneumococcal immunization will be given unless the immunization is medically contraindicated, the facility has evidence the resident has already been immunized during this time-period, or the resident or their legal representative has refused the immunization. 1.Review of Resident #28's medical record, showed:-Diagnosis included: diabetes, schizophrenia (mental disorder that distorts reality), anxiety, high blood pressure and kidney disease;-No documentation that resident was screened or received a pneumococcal vaccine. 2. Review of Resident #18's medical record, showed:-Diagnosis include: impulsiveness, anxiety, schizophrenia and high blood pressure;-No documentation that resident was screened or received a pneumococcal vaccine. 3. During an interview on 12/19/25 at 1:00 P.M., the Director of Nursing (DON) said she was responsible for ensuring the residents are receiving recommended vaccines. Social service is also involved in getting the consents for the vaccines. The DON said she would expect the residents to receive the appropriate vaccines per CDC guidelines. Refusal of the vaccines are documented in the medical record.

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	12/19/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain essential equipment in a safe and operable working condition by not maintaining a consistently operating elevator. This deficient practice had the potential to affect all residents. In addition, one resident (Resident #2) did not have access to his/her wheelchair while being repaired because the repair needed to occur in the lower level of the facility, and the resident did not have access to an alternate wheelchair during the repair. The sample size was 29. The facility census was 131.Review of Resident #2's face sheet, showed:-admitted on [DATE];-Diagnoses included high blood pressure, chronic atrial fibrillation (irregular heart rhythm), acquired absence of right leg below the knee, and acquired absence of left leg below the knee.Review of the resident's care plan, in use during survey, showed:-Problem: Resident has limited physical mobility and needs assistance with Activities of Daily Living (ADLs). He/She needs encouragement to get out of bed. He/She needs total assistance with care. He/She uses an electric wheelchair for locomotion. He/She is a bilateral knee amputee;-Interventions: Monitor/document/report as needed (PRN) any signs or symptoms of immobility, contractures (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement) forming or worsening, thrombus (blood clot) formation, skin breakdown, and fall related injury;-Provide supportive care, assistance with mobility as needed. Document assistance as needed;-Problem: Resident is at risk for psychosocial problems related to depression and acceptance surrounding his/her diagnosis, specifically the loss of his/her legs. He/She is working on getting prosthetics and if often frustrated about the process. Resident complains daily to staff about his/her wheelchair and other issues;-Interventions: Anticipate and meet the resident's needs;-Administer medications as ordered. Monitor/document for side effects and effectiveness;-Explain all procedures to the resident before starting and allow the resident time to adjust to changes;-Praise any indication of the resident's progress/improvement in behavior.Observation and interview on 12/16/25 at 8:53 A.M., showed the resident sat in his/her wheelchair. The resident has bilateral knee amputations (BKA). The tilted electric wheelchair was missing the support limb for the right thigh. The resident said it broke two weeks ago. Someone is coming to fix it on 12/18/25.Observation and interview on 12/19/25 at 8:26 A.M., showed the resident in bed. The resident said he/she was upset because his/her wheelchair was in the basement to get repaired, but the elevator was out of service. At 8:45 A.M., the resident told Licensed Practical Nurse (LPN) N that he/she wanted to get his/her wheelchair. He/She is having company. and Christmas is next week. The resident said he/she likes to come and go and does not like being in bed. He/She was once in bed for four months because of a wound, and he/she did not want to do that anymore. The resident said, if God gives me the strength, I will get up. During an interview on 12/19/25 at 8:59 A.M., the Administrator said the elevator stopped working yesterday. In the last year, it has broken more times than ever. As soon as the company comes out, it will be fixed. They have been called but there is no estimated time of when they will arrive. During an interview on 12/19/25 at 1:00 P.M., the Director of Nursing (DON) said she spoke to the resident. The company had to use the basement to repair the wheelchair; they could not use the resident's room or hallway. The resident likes to leave and go around to the store. The wheelchair may be fixed, but it is in the basement. She believed the resident was offered a geri-chair (medical reclining chair), but the resident has no trunk control, and she did not believe they had anything that reclines or had a seatbelt that would keep the resident positioned well. 1710443

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	12/19/2025

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 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation, interview and record review, the facility failed to maintain an appropriate exhaust system to remove cigarette smoke from the facility's indoor smoke room. This affected all residents who sat in the 300 Hall dining room or walked from the 300 Hall to the 400 Hall. The facility census was 131.Review of the facility's Safe and Homelike Environment policy, last revised on 6/5/25, showed:-Purpose: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment;-Environment refers to any environment the facility that is frequented by residents, including hallways and dining rooms;-General considerations: Have adequate outside ventilation by means of windows, or mechanical ventilation or a combination of the two. 1. Observations of the smoke room on 12/15/25 at 11:50 A.M. and 6:00 P.M., 12/16/25 at 11:06 A.M.,1:24 P.M. and 3:41 P.M., 12/17/25 at 7:45 A.M., 8:49 A.M., and 3:00 P.M., 12/18/25 at 9:59 A.M. and 4:00 P.M. and 12/19/25 at 7:30 A.M. showed:-Multiple residents and staff entered and exited the smoke room;-Multiple residents sat in the smoke room to smoke;-The smoke odor began at the entrance from the lobby and could be smelled to the end of the hallway at the top of the 400 Hall and inside and outside the 300 Hall dining room;-Two floor fans not turned on;-Two garage fans not turned on.2. Observation of the 300 Hall outside the smoke room on 12/15/25 at 6:00 P.M., showed a visible haze of smoke.3. During an interview on 12/17/25 at 9:15 A.M., a resident who lived on the 400 Hall said he/she could smell smoke when the door to his/her room was open.4. During an interview on 12/17/25 at 8:59 A.M., Housekeeper D said there was a strong smoke odor outside the smoke room and in the 300 Hall dining room. It smelled more when there were more residents smoking inside the smoke room.5. During an interview on 12/18/25 at 9:54 A.M. Certified Nurse Aide A said he/she had seen smoke in the hallway outside the smoke room. He/She wouldn't want his/her house to smell like smoke. He/She did not smoke. 6. During an interview on 12/18/25 at 10:23 A.M., the Maintenance Director said it smelled like smoke outside the smoke room. The ceiling tiles in the hallway outside the smoke room had yellowed due to the smoke. The fans in the smoke room should be on, but residents turned them off. He installed two new garage fans, but there was a power issue, and they did not work. 7. During an interview on 12/18/25 at 10:43 A.M., the Administrator said she did not like the smoke odor, and she could smell it in her office. There were exhaust fans, but they were broken. The smell was worse in the colder weather when more residents sat inside to smoke. The other fans were used in the warmer weather to cool down the smoke room.

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	12/19/2025

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all corridors had handrails and failed to ensure existing handrails were securely affixed to the wall. The census was 131.Review of the Facility Area Audit, Preventative Maintenance Inspection, undated, showed handrails listed as an item for staff to inspect. 1. Observation of the 100 Hall on 12/16/25 at 8:16 A.M., showed:-No railings between room [ROOM NUMBER] and the 100 hall dining room;-No railings around the perimeter of the 100 hall nurse's station;-Broken railing that pulled away from the wall outside of room [ROOM NUMBER]. 2. Observation of the 400 Hall on 12/16/25 at 10:42 A.M., showed:-No railing outside the enclosed nurse's station;-Loose railing to the right of the nurse's station window;-Loose railing outside of room [ROOM NUMBER];-Loose railing pulled away from the wall between rooms [ROOM NUMBERS]. Observation on 12/16/25 at 11:05 A.M., showed a staff member stood next to a resident who held on to the handrail outside the 400 hall dining room. 3. Observation of the 300 hall on 12/16/25 at 11:18 A.M., showed:-No railings between the doors to the lobby and the Director of Nurse's (DON) office;-No railings between the DON's office and the women's restroom;-No railings between the men's restroom and staff office;-No railings from the staff office to the end of the wall extending approximately 13 feet. 4. Observations of the 200 hall on 12/16/25 at 1:37 P.M., showed:-No railings on either side of a hallway leading to a designated exit door by the nurses' station;-No railings around the perimeter of the enclosed nurses' station;-No railings between rooms [ROOM NUMBERS]. 5. During an interview on 12/18/25 at 10:23 A.M. the Maintenance Director said he checked the status of the facility's handrails every three months. He was aware there were handrails that needed to be replaced or were missing. He did not have the needed replacement parts because the current handrails were plastic. [NAME] railings were being used to replace the plastic handrails. Some handrails had been completely removed around the beginning of the month but had not yet been replaced. He knew handrails needed to be firmly affixed to the wall. He was not aware handrails were needed outside the nurses' stations and on both sides of all corridors used by residents. If staff noticed something needed to be repaired or replaced, they would either tell him directly or fill out a maintenance request form. 6. During an interview on 12/18/25 at 10:44 A.M., the Administrator said they were in the process of replacing and repairing handrails throughout the facility. Orders were placed to replace the handrails. Old fashioned wood railings were being used because they did not know where the plastic handrails were ordered from. She knew handrails needed to be firmly affixed to the wall and on both sides of the hall. She was not aware they needed to be located outside the nurses' stations or in the hallway near the lobby or the designated exit door on the 200 hall.