STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265523	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Skilled Nursing and Rehabilitation Center	3201 Parkwood Lane Maryland Heights, MO 63043

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 40290 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity when staff spoke to one resident in a disrespectful manner regarding the resident's hygiene and failed to provide care to promote his/her dignity (Resident #9), staff failed to provide one resident with grooming and feeding assistance (Resident #168) and staff entered one resident's room without knocking (Resident #34). In addition, staff failed to wear name badges to identify themselves to residents. The sample was 17. The census was 67. Review of the facility's Resident's Rights, provided to residents upon admission, showed the right to be treated with respect and dignity. Review of the facility's undated Resident Privacy/Dignity/Customer Service policy, showed: -Staff will always aim to communicate with residents in a manner which respects their individuality and needs, taking their view and needs into account; -Staff will protect the dignity, particularly modesty, of very ill or confused patients who may act inappropriately and present challenging behavior while the root cause of the problem is ascertained and treated. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/9/24, showed: -Diagnoses included Alzheimer's disease; -Moderately impaired cognition; -Substantial/maximal assistance required for toileting hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, in use at the time of the survey, showed: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At risk for problems with elimination. Frequently incontinent of bowel and bladder and requires extensive assistance with toileting and perineal care (care to the surface area between the thighs, extending from the pubic bone to tail bone); -Interventions included: Assist with toileting before and after meals, at hour of sleep, and as needed. Monitor bowel movements daily. Provide perineal care after each incontinent episode. Observation on 8/26/24 at 2:06 P.M., showed the resident in his/her room in bed, on his/her back. He/She brought his/her hands out from under his/her blanket. The resident had a brown substance on his/her hands and under his/her nails. A strong odor of bowel movement was present in the room. At 2:20 P.M., Certified Nursing Assistant (CNA) A entered the resident's room and asked the resident why you doing that. The resident said he/she cannot help it. CNA A said give me your hands. He/She wiped the resident's hands with a paper towel, told the resident he/she was going to tell his/her CNA, and then exited the room and walked down the hall. No perineal care was provided. At 2:55 P.M., the resident remained in bed on his/her back. The smell of bowel movement permeated the room. At 3:09 P.M., the resident self-propelled in a wheelchair out of his/her room and down the hall. The room continued to have a strong smell of bowel movement. The resident propelled him/herself into the television area near the nurse's station. The resident had brown matter on his/her hands and under his/her nails. A smell of bowel movement was noted when standing close to the resident. At 4:04 P.M., CNA A told the resident to head to the elevator for dinner. The resident propelled away towards the elevator. No personal care was provided. The resident's hands appear soiled. During an interview on 8/26/24 at 4:07 P.M., the Administrator said if a resident is observed to put his/her hands in stool, he expected staff to address this immediately. The resident's hands should be cleaned and care provided. He would deal with this right now. The Administrator went and talked with CNA A. Observation on 8/26/24 at 4:09 P.M., showed CNA A got on the elevator to head down to the dining room. He/She said CNA B was the resident's CNA today. Shift change is at 3:00 P.M., so he/she was not sure who the resident's CNA was now. CNA A went to the main dining room and told the resident I have to wash your hands cause you was being nasty. The resident looked down and said oh. The resident had two other residents at his/her side when this was said. The CNA took the resident to the shower room on the first floor and assisted the resident to wash his/her hands at the sink. 2. Review of Resident #168's medical record, showed: -admitted [DATE]; -Diagnoses included injury of neck, pain in hand and vertigo (dizziness). Observation on 8/26/24 at 10:59 A.M., showed the resident sat in a wheelchair in his/her room. The resident's hair was in a disheveled ponytail, with sections of hair loose and outside of the ponytail. During an interview, the resident said he/she was admitted to the facility three days ago for therapy. He/She just had surgery on the discs in his/her neck and does not have full use of his/her arms. Staff has not helped him/her brush his/her hair since he/she was admitted . Staff dropped of his/her breakfast tray this morning and left it there without helping him/her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/27/24 at 8:45 A.M., showed the resident in a wheelchair in his/her room. CNA K delivered a tray of breakfast to the resident's room, said he/she would come back to feed the resident, and left the room. During an interview, the resident said staff do not offer to help him/her. He/She is doing the best he/she can to fend for him/herself. The staff lack compassion. The resident became tearful during the interview. At 9:13 A.M., the resident remained seated in his/her room with the breakfast tray untouched. During an interview, the resident said the facility staff lack compassion and care. It makes him/her sad and he/she does not want to ask them for help. He/She is sitting in his/her wheelchair with his/her pants not fully pulled up, leaving his/her bottom uncovered on the wheelchair, because he/she cannot lift his/her pants up all the way. At 12:13 P.M., the resident remained seated in his/her wheelchair with pants not pulled up all the way. During an interview on 8/28/24 at 9:11 A.M., the resident said staff come into his/her room without knocking on the door or telling him/her who they are. Sometimes they are not wearing name badges and they don't tell him/her their names. 3. Review of Resident #34's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnosis of depression. Observation on 8/26/24 at 11:42 A.M., showed the resident in bed in his/her room. During an interview, CNA A entered the resident's room without knocking or announcing him/herself. He/She was not wearing a name badge. CNA A asked the resident if his/her call light was on and the resident said no. CNA A left the room. The resident said staff do this all the time. Staff just walk right on in his/her room without knocking first. 4. Observation on 8/29/24 at 10:01 A.M., showed Licensed Practical Nurse (LPN) E with no name badge while working at the nurse's station. During an interview, LPN E said staff should wear name badges while working. He/She never got around to getting a badge. Staff should knock and announce themselves when entering resident rooms because this is their home. 5. During an interview on 8/28/24 at 10:58 A.M., CNA A said staff should knock and announce themselves when entering a resident's room so the resident knows who is coming into their room. Staff are required to wear name badges while working. 6. During an interview on 8/29/24 at 12:50 P.M., with the Director of Nursing (DON) and LPN L/Unit Manager, they said residents should be treated with dignity and respect. Staff should not scold the residents. Staff are expected to knock and announce themselves before entering a resident's room for dignity and respect. Staff are expected to wear name badges while they are working. The DON did not wear a name badge during the interview. 7. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected staff to knock upon entering a resident's room. This is a privacy and resident rights issue. He expected staff to wear name badges in the facility during their shift. He expected residents to be treated with dignity and respect. MO00239684 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00240891 MO00240930

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42795 Based on observation, interview and record review, the facility failed to follow acceptable nursing practice when staff left medication in one resident's room, who did not have a physician order for self-administration or medications to be left at the bedside (Resident #27). The sample was 17. The census was 67. Review of the facility's Medication Administration policy, dated 6/1/18, showed: -Purpose: To administer oral medication in a safe, accurate, and effective manner; -Procedure: Administer medication and remain with the resident while medication is swallowed; Do not leave medications at bedside, unless specifically ordered by the prescriber. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/20/24, showed: -Cognitively intact; -Required maximum assistance from staff for oral hygiene, toileting, personal hygiene, bathing and upper and lower body dressing; -Diagnoses included high blood pressure, anemia (low levels of iron in the blood) and depression. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's medications could be left at bedside or that the resident could self-administer his/her medications. Review of the resident's Physician Order Sheets (POS), dated August, 2024, showed no order that the resident's medications may be left at bedside or that the resident may self-administer medications. Review of the resident Medication Administration Record (MAR), dated August, 2024, showed: -An order, with a start date 5/20/24, Cymbalta (anti-depressant) 30 milligrams (mg), give one capsule, twice daily, scheduled doses 8:00 A.M. and 5:00 P.M.; -An order, with a start date 1/3/24, lisinopril (used to treat high blood pressure) 5 mg, give one tablet daily, scheduled dose 8:00 A.M.; -An order, with a start date 1/3/24, metoprolol succinate extended release (ER) (used to treat high blood pressure) 25 mg, one tablet daily, scheduled dose 7:00 A.M., -An order, with a start date 3/9/22, multivitamin, give one tablet daily, scheduled dose 7:30 A.M.; -An order, with a start date 1/24/24, sertraline (anti-depressant) 150 mg, give one capsule, daily, scheduled dose 7:30 A.M.; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, with a start date 3/20/24, vitamin C 500 mg, give one tablet daily, scheduled dose 7:30 A.M.; -On 8/26/24, A.M. doses of Cymbalta, lisinopril, metoprolol succinate ER, multivitamin, sertraline and vitamin C were documented as administered. During observation and interview on 8/26/24 at 10:40 A.M., the resident lay in his/her bed with his/her bedside table positioned over the bed in front of the resident. The resident appeared drowsy. There were multiple pills in a clear medication cup on the resident's bedside table. There was no staff member in the room. The resident said staff will leave his/her medication at his/her bedside so he/she can take them when he/she is more awake. He/She did not know the names of his/her medications but thought he/she took something for his/her blood pressure. During an interview on 8/28/24 at 6:58 A.M., Certified Medication Technician (CMT) U said there are no residents in the facility who have physician orders to self-administer medications or that medications can be left at the bedside. The staff member administering the medication should wait for the resident to swallow the medications. No medications are to be left unattended at the bedside. During an interview on 8/29/24 at 9:40 A.M., Licensed Practical Nurse (LPN) C said medications are not to be left unattended by staff at the resident's bedside. Staff are to stay with the resident until the resident takes the medication. If the resident will not take the medications, then staff should document refused or try again later. There should be physician orders if medications can be left at the resident's bedside. During an interview on 8/29/24 at 12:40 P.M., the Director of Nursing (DON) said there is no resident in the facility who has a physician order to self-administer medications or that medications can be left at the bedside. Staff are expected to remain with the resident until all medications are taken. Medications are expected not to be left unattended at the bedside for the resident to take later.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 40290 Based on observation, interview and record review, the facility failed to ensure resident requests for less than $100.00 ($50.00 for Medicaid residents) are honored within the same day, and the facility failed to ensure resident funds in excess of $100.00 (or $50.00 for Medicaid residents), were held in an interest-bearing account. This affected 40 residents whose funds were handled by the facility. The census was 76. 1. During a group interview on 8/29/24 at 10:04 A.M., seven residents, whom the facility identified as cognitively intact, said requests for personal funds are limited to $20.00. If a resident wants more than $20. 00, they have to wait. During an interview on 8/29/24 at 11:03 A.M., the Business Office Manager (BOM) said she handles requests for cash made by residents who have funds held by the facility. She usually only does $20.00 for cash withdrawals. She prefers to do smaller amounts like $20.00, in case the resident misplaces their money. Years ago, she was told residents could only get $20.00 per day, unless they go out of the facility, at which point they can request more money. The BOM was not aware requests for up to $49.00 should be honored by the facility within 24 hours for Medicaid residents. 2. Observation on 8/29/24 at 11:03 A.M., showed the BOM counted the petty cash amount on hand, totaling $4,938.17. She was not aware that cash on hand had to be limited to $50.00 for Medicaid residents, and $100.00 for Medicare residents, and that any overage must be in an interest-bearing account. Review of the facility's balance report and census, showed: -The facility holds funds for 36 Medicaid residents. The total amount of cash on hand for the residents should be $1800.00; -The facility holds funds for four non-Medicaid residents. The total amount of cash on hand for the residents should be $400.00. 3. During an interview on 8/29/24 at 2:55 P.M., the Administrator said it has always been the facility's policy to provide up to $20.00 when residents request personal funds. If a resident wants more than $20.00, the facility will ask the resident what they are purchasing and might contact their loved one to run the request by them. They don't want to chance the resident losing their money. He expected funds held in excess of $50. 00 for Medicaid residents, or $100.00 for non-Medicaid residents, to be held in an interest bearing account.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 32847 Based on observation, interview and record review, the facility failed to have the most recent annual survey's plan of correction and statements of deficiencies with the corresponding plans of correction completed for any abbreviated survey completed since the most recent annual survey, available to residents and visitors at all times without them having to be requested. The sample was 17. The census was 67. Review of the facility's Resident's Rights, provided to residents upon admission, showed the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and receive information from agencies acting as client advocates, and to be afforded the opportunity to contact these agencies. Review of a sign posted near the main entrance, reviewed on 8/27/24 at 7:41 A.M., showed: -State inspection survey located at the reception desk; -Available Monday through Friday, 8:00 AM through 5:00 PM; -Survey results located at the entrance to the suites during all hours of operation. Observation on 8/27/24 at 7:45 A.M., showed a survey binder located on the suites' side entrance. Review of the survey binder, showed: -The statement of deficiencies for the annual survey completed on 4/21/23: -No plan of correction for the annual survey completed on 4/21/23; -No statement of deficiencies or plan of correction for the abbreviated survey completed on 10/4/23; -No statement of deficiencies or plan of correction for the abbreviated survey completed on 1/23/24. Observation on 8/27/24 at 8:00 A.M., showed the survey binder located at the front office, behind the desk and on an upper shelf. The staff at the desk were able to obtain the binder upon request. The binder was not accessible without requesting assistance from staff. During an interview on 8/29/24 at 10:02 A.M., seven residents who represent the resident council, said they would like to see the survey binder. They believed it was at the front desk. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected the most recent statements of deficiencies and plans of corrections from the most recent annual survey and abbreviated surveys completed since the annual survey, to be available without the residents or visitors having to request the records. 46888

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 40290 42795 46888 Based on observation, interview, and record review, the facility failed to ensure residents' rooms and medical equipment and resident common areas were clean and homelike, affecting 13 of 17 sampled (Residents #9, #24, #43, #69, #32, #55, #27, #2, #50, #4, #269, #47 and #45). The facility also failed to ensure the 200 veranda hallway had clean floors. The census was 67. Review of the facility's housekeeping disinfecting cleaning schedule, revised 2/24/23, showed: -Housekeeping staff is responsible for the cleaning and disinfection of resident's room. Staff have responsibilities that are scheduled on a daily, weekly, and monthly basis. Housekeepers are responsible for every resident room on their halls which includes suites, gardens and terrace; -Disinfects bathrooms toilet and rails. Wipe sink and clean mirrors with Spic and Span. If nursing staff has to change sheets make sure the bed is disinfected with chemicals depending if the room is a deep clean or vacant room make sure bed is made. Sweep rooms starting from the top of the rooms to the outside room. Check privacy curtains to see if it needs to be laundered and put back up in the room before the end of the day. Clean Air Conditioning(AC) units and wall are cleaned. Make sure all furniture nightstands bed side tables are wiped off and cleaned. Make sure toilet tissue paper towels and soap is stocked in the room before mopping from top to bottom. After mopping room make sure wet floor sign is outside the door. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/9/24, showed: -Diagnosis of Alzheimer's disease; -Moderately impaired cognition; -Required substantial/maximal assistance for toileting hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, in use at the time of the survey, showed: -At risk for problems with elimination. Frequently incontinent of bowel and bladder and requires extensive assistance with toileting and perineal care (care to the surface area between the thighs, extending from the pubic bone to tail bone); (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions included: Assist with toileting before and after meals, at hour of sleep, and as needed. Monitor bowel movements daily. Provide perineal care after each incontinent episode. Observation on 8/26/24 at 2:06 P.M., showed the resident in his/her room in bed, on his/her back. He/She brought his/her hands out from under his/her blanket. The resident had a brown substance on his/her hands and under his/her nails. A strong odor of bowel movement in the room. At 2:20 P.M., Certified Nursing Assistant (CNA) A entered the resident's room, wiped the resident's hands with a paper towel, and then exited the room and walked down the hall. On 8/26/24 at 2:55 P.M., the resident remained in bed on his/her back. The smell of bowel movement permeated the room. Observation on 8/26/24 at 5:59 P.M., showed CNA A entered the resident's room and assisted the resident to be cleaned. A strong odor of bowel movement permeated the room. Observation showed brown matter smeared on the sheets, blankets, pillow, and on the wall. CNA A changed the resident's linen. The wall was not cleaned. Observation of the floor under the bed, showed several small balls of brown matter along the wall on the right side of the bed and near the head of the bed. A plastic cup, used gloves, and paper towels were also under the bed. Observation on 8/27/24 at 6:46 A.M., showed a strong odor of bowel movement in the room. The trash that had been on the floor under the bed was no longer present. The balls of brown matter remained on the floor under the bed. At 12:13 P.M., the balls of brown matter had been cleaned up, but smears of brown matter were still visible under the bed. On 8/28/24 at 6:21 A.M. and 8/29/24 at 9:22 A.M., the resident lay in bed, asleep. The smears of brown matter remained under the bed. During an interview on 8/28/24 at 10:58 A.M., CNA A said housekeeping cleans rooms once a day, but they do not mop under furniture. The resident throws his/her poop. The CNAs pick it up, they can clean up the big messes and do the best they can. They need housekeeping to clean up the rest but housekeeping does not clean. 2. Review of Resident #24's significant change MDS, dated [DATE], showed: -Diagnoses included manic depression and schizophrenia(mental illness that affects how people think, feel, and behave); -Cognitively intact. Observation and interview on 8/26/24 at 10:24 A.M., showed the resident lay in bed. The floor in the resident's room appeared dirty with debris, dirt, and dried spills throughout. Behind the resident's head of bed, were large gashes in the wall, vertically up and down the wall. The resident said it bothers him/her to have the wall so scratched up. 3. Review of Resident #43's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Dependent on assistance with toileting; -Diagnoses included hemiplegia (paralysis on one side of the body) or hemiparesis (weakness on one side of the body), depression, and anxiety. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #69's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Required substantial/maximum assistance with toileting; -Diagnoses included hemiplegia or hemiparesis and anxiety. During an interview on 8/27/24 at 1:11 P.M., Residents #43 and #69 said the toilet in the bathroom they share runs all the time and it is annoying. Resident #43 said the bathroom door has to stay shut at night or it will keep him/her awake. Both residents said the water in their bathroom sink does not get hot. The residents require staff assistance when they become soiled and staff clean them up with cold water. Resident #69 said the water has not been getting hot for a long time. When he/she tells staff, they say there is nothing that can be done. Observation on 8/27/24 at 1:50 P.M., showed the residents' toilet ran intermittently while not in use. The hot water faucet turned on and ran continuously for two minutes. The hot water measured 86.6 degrees Fahrenheit (F). During an interview on 8/28/24 at 1:54 P.M., Licensed Practical Nurse (LPN) C said the sink's water has been like this for a long time and he/she has told management. Observation on 8/28/24 at 6:57 A.M., showed the residents' toilet ran intermittently while not in use. The hot water faucet turned on and ran continuously for two minutes. The hot water measured 82.4 degrees F. During an interview on 8/28/24 at 10:58 A.M., CNA A said the residents' toilet runs and Resident #43 prefers the bathroom door to be shut because of this. The water in the residents' sink does not get hot. The toilet and sink have been this way for two years. All resident rooms should have hot water. During an interview on 8/29/24 at 2:20 P.M., the Maintenance Director said he has been working with the facility for 10 days. He was not aware of any concerns with the toilet running or the water temperature in the residents' room. He expected water temperatures to be within range. He does not routinely check water temperatures in resident rooms. He expected staff to fill out a work order for these issues. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected staff to report issues with the environment, such as running toilets and sinks without hot water, to himself or the Maintenance Director. He expected water temperatures to be within the appropriate range. He expected residents to be provided with a comfortable environment. 4. Review of Resident #32's admission MDS, dated [DATE], showed: -Resident rarely/never understood; -Dependent for assistance with mobility; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included dementia and depression. Review of Resident #55's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Dependent for assistance with all activities of daily living; -Diagnosis included stroke. Observations on 8/26/24 at 11:54 A.M 12:34 P.M., 1:28 P.M., and 4:29 P.M., and on 8/27/24 at 7:13 A.M. and 12:16 P.M., showed splatters of a dried beige substance on top of Resident #55's oxygen concentrator, fall mat, and floor underneath the resident's tube feeding pole. Dirt and debris were on the floor with three tube caps on the floor underneath the head of Resident #32's bed. Observations on 8/28/24 at 6:39 A.M. and 8:15 A.M., and on 8/29/24 at 7:11 A.M., showed splatters of a dried beige substance on top of Resident #55's oxygen concentrator, fall mat, and floor underneath the resident's tube feeding pole. 5. Review of Resident #27's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses include high blood pressure and depression. Observation and interview on 8/26/24 at 10:40 A.M., and on 8/27/24 at 9:15 A.M., showed the resident lay in bed. The resident's bedside table was cluttered with old food wrappers, medication cups and an empty soda bottle. Behind the resident's bed were multiple food wrappers, a white and blue pill, food crumbs and dead roaches. The resident's bathroom had brown roaches crawling on the door and wall of the bathroom. The resident said he/she thought someone cleaned his/her room daily but wasn't sure. During an interview on 8/27/24 at 9:15 A.M., a family member said he/she has not seen anyone deep clean the resident's room in several months. The family member he/she normally cleans the resident's room. 6. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included heart failure, renal (kidney) failure, dementia and depression. Observation on 8/26/24 at 10:30 A.M. and 3:30 P.M., and on 8/28/24 at 6:45 A.M., showed the resident in his/her wheelchair in his/her room. The resident's bed was positioned against the wall. Behind the resident's bed and dresser were an empty water cup, crumbs, a white dried liquid and dead roaches. The resident's overhead bedside table was covered with a sticky substance. The resident's bathroom had brown roaches crawling on the walls of the bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 8:15 A.M., Housekeeper V said housekeepers move the furniture and beds out to deep clean with sweeping and mopping about once or twice a month. Housekeeping can clean the resident's bedside tables off when needed. 7. Review of Resident #50's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnoses of acute kidney failure and major depressive disorder. Observations on 8/26/24 at 1:03 P.M., 8/27/24 at 12:13 P.M., and 8/28/24 at 10:18 A.M., showed the resident's room to have sticky floors with debris, the AC unit had dust accumulation and debris on the inside and out, and a dirty privacy curtain with various brown stains. 8. Review of Resident #4's quarterly MDS, dated [DATE], showed the following: -Cognitively intact. -Diagnoses of anxiety disorder and major depressive disorder. Observations on 8/26/24 at 10:54 A.M., and 8/28/24 at 10:25 A.M., showed the resident's AC unit had dust accumulation and debris on the inside and out. 9. Review of Resident #269's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition. -Diagnosis of acute respiratory failure. Observations on 8/26/24 at 10:34 A.M., 8/27/24 at 6:57 A.M., and 8/28/24 at 10:18 A.M., showed the resident's room with sticky floors with dark splattered matter on the resident's fall mat and surrounding floor. Dust build up was on the inside and outside of the AC unit. 10. Review of Resident #47's quarterly MDS, dated [DATE], showed the following: -Cognitively intact. -Diagnosis of end stage renal disease. Observations on 8/26/24 at 11:24 A.M., 8/27/24 at 7:38 A.M., and 8/28/24 at 10:18 A.M., showed brown smears on the wall by the resident's bed. The AC unit had dust and debris accumulation on the inside and outside. 11. Review of Resident #45's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included major depressive disorder, anxiety disorder and Alzheimer's disease. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/26/24 at 11:12 A.M., 8/27/24 at 10:45 A.M., and 8/28/24 at 10:17 A.M., showed the resident's floor was sticky with various debris and liquid spills. The resident's closet had dead bugs on the ground, along with cobwebs. The wall behind the resident's bed had dust build up and cobwebs. The AC had dark speckled matter that covered the top of the unit and on the windowsill. 12. Observation of the 200 hall TV area, showed: -On 8/26/24 at 4:04 P.M., crumbs and debris on the floor throughout the area. An area of light brown substance smeared near the entrance to the B200 hall. Dried spills with dirt and debris stuck to the spill scattered throughout the area; -On 8/27/24 at 6:51 A.M., some of the loose debris had been swept up. The smeared brown substance and dried spills with stuck on debris remained; -On 8/28/24 at 8:13 A.M., crumbs and debris on the floor throughout the area. An area of light brown substance smeared near the entrance to the B200 hall. Dried spills with dirt and debris stuck to the spills, scattered throughout the area; -On 8/29/24 at 9:22 A.M., crumbs and debris on the floor throughout the area. An area of light brown substance smeared near the entrance to the B200 hall. Dried spills with dirt and debris stuck to the spill scattered throughout the area. 13. Observation of the B200 and C200 halls, on 8/26/24 at 4:04 P.M., 8/27/24 at 6:51 A.M., 8/28/24 at 8:13 A.M., and 8/29/24 at 9:22 A.M., showed several dried spills and debris throughout the floor. Dust and debris stuck to the various spills. Crumbs and debris gathered near the edges of the halls. 14. Observation of the front entrance walkway, sitting area and down the A200 hall, showed: -On 8/26/24 at 10:00 A.M. and 8/27/24 at 7:48 A.M., several areas with speckled dried spills, with dust and debris stuck to the spills, throughout the front entrance and extended through the A200 hall. The sitting area near the entrance had several pinkish reds dried spots/spills scattered around on the floor, the drips were approximately the size of dime to penny sized. Blue debris was stuck to the floor that appeared to be small pieces, smaller than dime size, of painter's tape, stuck on various areas of the floor; -On 8/28/24 at 8:13 A.M., the front entrance appeared to be mopped. The blue bits of what appeared to be painter's tape remained stuck to the floor; -On 8/29/24 at 9:22 A.M., the blue bits of what appeared to be painter's tape remained stuck to the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. During an interview on 8/28/24 at 10:58 A.M., CNA A said housekeeping staff is shorthanded. CNAs pitch in to help clean. Housekeeping staff clean resident rooms once a day, but they don't mop under furniture. Resident #9 throws his/her feces and CNAs pick it up, clean up the big messes and do the best they can, but they need housekeeping staff to help too, but housekeeping staff don't clean. There is no housekeeping staff working in the evenings. When housekeeping leaves around 3:00 P.M., they lock up their cleaning supplies and nursing staff do not have access to the cleaning supplies if they need them. Housekeeping staff come in at 7:00 A.M. A lot of messes can be made between 3:00 P.M. and 7:00 A.M. The facility needs housekeeping staff to work later to help keep things clean. 16. During an interview on 8/29/24 at 8:28 A.M., Housekeeper R said housekeeping staff work 7:00 A.M. to 3:00 P.M. He/She wishes there was housekeeping staff in the evenings because it would help keep the facility cleaner. A lot happens between 3:00 P.M. and 7:00 A.M., and the rooms are a mess when day shift comes in. If housekeeping worked in the evening, the rooms would not be so horrible. Some rooms require more attention and time because some of the residents are [NAME]. Resident rooms are cleaned daily. The daily routine is to empty trash cans, clean toilets, wipe counters and tables, stock toilet paper and paper towels, sweep, and mop. Housekeeping staff should mop underneath furniture. There is no deep cleaning schedule. If staff notice a room requires deep cleaning, they mark it on a board in the basement and the Housekeeping Supervisor addresses it. If rooms are cleaned properly, they won't need to be deep cleaned. 17. During an interview on 8/29/24 at 12:36 P.M. with the Director of Nurses (DON) and Licensed Practical Nurse (LPN) L/Unit Manager, they said staff should clean up spills, such as tube feeding formula. Housekeeping staff should clean resident rooms daily. Housekeeping staff work day shift and do not work in the evenings. 18. During an interview on 8/29/24 at 2:20 P.M., the Maintenance Director/Housekeeping Supervisor said the prior Housekeeping Supervisor left on the 19th of this month, so he was assigned the position. There are five housekeeping staff employed at the facility. They work day shift, 7a-3p. Then, no one from housekeeping is at the facility until the next morning. Housekeeping staff do not leave any cleaning supplies out when they leave for the day. They will take care of spills before the end of the shift. If there is a spill that happens overnight, it might have to wait until the next day, unless nursing staff decide to help out. There are typically three housekeeping staff working per day. One on the 100 halls, one on the 200 halls, and a floor tech. The floor tech is responsible for all halls, common areas, shower rooms, dining room, etc. The other staff are responsible for resident rooms on their halls. The floor tech should clean the floors throughout the common areas, daily. The housekeeping staff assigned to a floor should clean each room daily. Cleaning the rooms includes cleaning the floors, sweeping and mopping. This includes mopping under the furniture and beds and moving the furniture if needed, wiping down tables, sinks, vents, AC units, and cleaning the bathroom and toilets. Privacy curtains should be observed for stains. Maintenance concerns are reported via a work slip. These are given to him and he handles them from there. If needed, he will consult the administrator to develop a plan. Staff should fill out a work order for gouges in the walls. The turn around time depends on how bad the issue is. MO00238869 MO00239680 MO00240930

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 32847 Based on interview and record review, the facility to develop a policy for and complete background checks for all newly hired employees, to include the Nurse Aide (NA) Registry (checks for Federal Indicators (FI) given to individuals found guilty of abuse, neglect, and misappropriation of resident property) for thee of five newly hired employees sampled. The census was 67. Review of the facility's Policy on Background Checks, revised 8/29/24, showed: -The facility will conduct background checks on all employees before they start working at the facility; -Upon hire background checks will be completed two days prior to the employee start date; -Human Resources (HR) will conduct an annual Family Care Safety screening and quarterly Employee Disqualification List (EDL) screening; -The policy failed to identify which background checks will be completed prior to hire; -The policy failed to require the NA Registry check for all staff to ensure the staff has no Federal Indicators. Review of Dietary Aide P's employee file, showed: -Date of hire 6/6/24; -No NA registry check. Review of Licensed Practical Nurse (LPN) O's employee file, showed: -Date of hire 7/5/24; -No NA registry check. Review of Housekeeping Aide N's employee file, showed: -Date of hire 2/23/24; -No NA registry check. During an interview on 8/27/24 at 1:04 P.M., the Human Resources/Staffing Coordinator said employee background checks include the Family Care Safety Registry (FCSR) and Employee Disqualification List (EDL) check. The NA registry is only checked for the Certified Nursing Assistants, Nursing Assistants, Certified Medication Technicians, and nurses. She was not aware that the NA registry needed to be checked on all staff to check for federal indicators.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 32847 Based on interview and record review, the facility failed to ensure the resident assessment was coded accurately to include a life expectancy of less than 6 months for all residents on hospice for one of one resident investigated for hospice (Resident #24). The census was 67. Review of Resident #24's medical record, showed the resident admitted to hospice on 5/10/24. Review of the resident's significant change Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 5/21/24, showed: -Received hospice care; -Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months: No. During an interview on 8/27/24 at 1:00 P.M., the MDS Coordinator said she does not indicate a life expectancy of less than 6 months just because a resident is on hospice. It is only marked if the resident is actively dying. She was not aware that any resident admitted into hospice has a certification of terminal illness certifying a life expectancy of less than 6 months.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 32847 Based on observation, interview, and record review, the facility failed to coordinate assessments for the pre-admission screening and resident review (PASARR) program under Medicaid with the appropriate state-designated authority, to ensure that individuals with a mental disorder receive care and services in the most integrated setting appropriate to their needs for one of eight residents investigated for the preadmission screening. Of those eight, only one indicated a level II screening was required and the level II assessment for the resident was not completed (Resident #5). The census was 67. Review of Resident #5's medical record, showed: -The resident resided in a Medicaid certified bed; -A DA-124c form, dated 2/29/07, showed: -Section B: Level 1 screening criteria for serious mental illness; -Question #4: Has the person had serious problems in levels of functioning in the past 6 months: Yes; -This completes the level 1 screening. If you checked yes in #4 or #5 in section B, a level II screening is indicated for serious mental illness; -No documentation of a level II screening completed. Review of the resident's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 4/10/24, showed: -Cognitively intact; -Diagnoses included dementia, manic depression (a mental illness characterized by manic highs and depressed lows), and reoccurring major depressive disorder; -Received antipsychotic and antidepressant medications; -Received Medicaid benefits. Observation on 8/26/24 at 10:37 A.M., showed the resident in his/her room in a wheelchair. He/She said he just got back from dialysis and has no care concerns. During an interview on 8/27/24 0 at 8:32 A.M., the Social Service Manager said she was not here when the resident's level I screen was done. She looked through her records, but she does not have records of a level II requested or completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32847 42795 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate, and individualized care plans to address the specific needs of three of 17 sampled residents (Residents #9, #45, and #2). The census was 67. Review of the facility's Care Planning Policy and Procedure, dated 1/17/20, showed: -Objective: The facility's standard is to perform quality of care that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices; -A care plan will be developed upon admission. It will be update quarterly, and annual to ensure that there is a continuity of care and is in accordance with the individual's needs. Care plan will also be updated with a significant change of condition; -The care plan must be based upon the resident assessment, choices and advance directive, if any. As the resident's status changes, the facility, attending practitioner and the resident representative, to the extent possible, must review and/or revise the care plan goals and treatment choices. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/9/24, showed: -Diagnoses included Alzheimer's disease; -Moderately impaired cognition; -Substantial/maximal assistance required for toileting hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, in use at the time of the survey, showed: -At risk for problems with elimination. Frequently incontinent of bowel and bladder and requires extensive assistance with toileting and perineal care; -Interventions included: Assist with toileting before and after meals, at hour of sleep, and as needed. Monitor bowel movements daily. Provide perineal care after each incontinent episode; -The resident's behavior of playing in his/her stool not included in the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/26/24 at 2:06 P.M., showed the resident in his/her room in bed, on his/her back. He/She brought his/her hands out from under his/her blanket. The resident had a brown substance on his/her hands and under his/her nails. A strong odor of bowel movement was in the room. At 2:20 P.M., Certified Nursing Assistant (CNA) A entered the resident's room and asked the resident why you doing that. The resident said he/she cannot help it. CNA A said give me your hands. He/She wiped the resident's hands with a paper towel, told the resident he/she was going to tell his/her CNA, and then exited the room and walked down the hall. No perineal care was provided. At 3:09 P.M., the resident self-propelled in a wheelchair out of his/her room and down the hall. The room continued to have a strong smell of bowel movement. The resident propelled him/herself into the television area near the nurse's station. The resident had a brown substance on his/her hands and under his/her nails. At 4:04 P.M., CNA A told the resident to head to the elevator for dinner. The resident propelled away towards the elevator. The resident's hands appear soiled. During an interview on 8/26/24 at 4:07 P.M., the Administrator said if a resident is observed to put his/her hands in stool, he expected staff to address this immediately. The resident's hands should be cleaned, and care provided. During an interview on 8/28/24 at 10:58 A.M., CNA A said the resident throws his/her poop. The CNAs pick it up, they can clean up the big messes and do the best they can. During an interview on 8/29/24 at 12:50 P.M., with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) L/Unit Manager, they said playing in stool is a behavior for the resident. This behavior should be included in the care plan. 2. Review of Resident #45's quarterly MDS, dated [DATE], showed the following: -Diagnoses included major depressive disorder, anxiety disorder, and Alzheimer's disease; -Cognitively intact. Review of the resident's care plan, in use at the time of survey, showed: -Resident is not care planned for refusal to allow staff to clean his/her room; -Resident is not care planned for storing food in his/her room. Observation on 8/26/24 at 11:24 A.M., of the resident's room, showed: -Multiple bugs in the three drawers by the resident's sink. Various food trash and packages were in the drawers; -Two bugs observed crawling on the resident's pillow. During an interview on 8/29/24 at 12:53 P.M., the DON said the resident has a history of refusing to let staff into his/her room to clean. The resident also frequently brings food into his/her room and stores it in his/her drawers. She expected the resident's care plan to reflect interventions for cleaning the resident's room and interventions for preventing bugs due to the resident's refusal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 3:01 P.M., the Administrator said he expected the resident's care plan to reflect interventions for cleaning the resident's room and interventions for preventing bugs due to the resident's refusal to allow staff in his/her room and for storing food in his/her room. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Requires maximum assistance from staff for lower body dressing and putting on or taking off footwear; -Diagnoses include heart failure, renal (kidney) failure, dementia, and depression. Review of the resident's Medication Administration Record, dated August, 2024, showed: -An order, dated 1/29/24 at 6:00 A.M., to apply Tubi grips (an elastic tubular dressing that reduces swelling) to left lower limb and remove at 6:00 P.M.; Diagnosis: cellulitis (infection of the skin and tissue beneath the skin). Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's leg edema (swelling), cellulitis and Tubi grip application with goals and interventions. Observation and interview on 8/27/24 at 10:36 A.M., showed the resident sat in his/ her wheelchair in his/her room. CNA S removed both the resident's shoes and socks and lifted the resident's pant legs up, exposing the resident's lower extremities. The resident had moderate edema to both lower extremities. Indentations were visible in the resident's bilateral (both) calf areas from the resident's socks. The right leg appeared red and more edematous than the left lower extremity. CNA S said the resident has always had swelling to both his/her legs. CNA S was not aware of any special treatment to the resident's legs for his/her leg swelling or interventions to reduce swelling. During an interview on 8/29/24 at 12:40 P.M., the DON said resident's leg edema, cellulitis and Tubi grips are expected to be on the care plan. 46888

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Parkwood Skilled Nursing and Rehabilitation Center	3201 Parkwood Lane Maryland Heights, MO 63043

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32847 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming, and personal hygiene. Resident #9 was not provided care after having a bowel movement and getting that bowel movement on his/her hands. In addition, the resident was not checked for incontinence or cleaned, resulting in the resident's brief being saturated through his/her pants (Resident #9). One resident was not provided showers or hair washing for an extended period of time and the hair care that was provided was not sufficient to cleanse the hair, resulting in the resident's hair becoming matted in a hard thick clump (Resident #32). In addition, staff failed to provide basic activities of daily living to include brushing residents' hair, providing feeding assistance, providing baths and/or showers, and providing nail care for four residents (Residents #168, #269, #29, and #16). The sample was 17. The census was 67. Review of the facility's Activity of Daily Living (ADL) policy, dated 8/17/20, showed: -It is the standard of the facility to promote the highest level of health and hygiene for the residents residing at the facility, while promoting the utmost independence. In order to adhere to this standard, it is the policy that any resident that is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal oral hygiene; -Assistance with the bathroom: Refers to the residents ability to use the toilet room, transfer on/off the toilet, clean themselves, change absorbent pads or briefs, and adjust clothes; -Assistance with ADLs will be performed if the ADLs cannot be performed independently by the resident. The level of assistance with ADLs provided by staff are based on the residents ability to maintain highest level of health and hygiene. Review of the facility's Peri Care (perineal care, care to the surface area between the thighs, extending from the pubic bone to tail bone) policy, dated 1/5/20, showed: -Purpose: To clean the perineum and to prevent infection and odor; -Wash hands, put on cloves, drape the resident for privacy; -Wipe the resident from front to back thoroughly cleaning the genitals. Repeat process until disposable wipe is free of soiling and discard; -Remove gloves, wash hands, apply gloves; -Wipe the peri rectal area from front to back. Repeat until disposable wipe is free of soiling and discard. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/9/24, showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included Alzheimer's disease; -Moderately impaired cognition; -Substantial/maximal assistance required for toileting hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, in use at the time of the survey, showed: -At risk for problems with elimination. Frequently incontinent of bowel and bladder and requires extensive assistance with toileting and perineal care; -Interventions included: Assist with toileting before and after meals, at hour of sleep, and as needed. Monitor bowel movements daily. Provide perineal care after each incontinent episode. Observation on 8/26/24 at 2:06 P.M., showed the resident in his/her room in bed, on his/her back. He/She brought his/her hands out from under his/her blanket. The resident had a brown substance on his/her hands and under his/her nails. A strong odor of bowel movement in the room. At 2:20 P.M., Certified Nursing Assistant (CNA) A entered the resident's room and asked the resident why you doing that. The resident said he/she cannot help it. CNA A said give me your hands. He/She wiped the resident's hands with a paper towel, told the resident he/she was going to tell his/her CNA, and then exited the room and walked down the hall. No perineal care provided. At 2:55 P.M., the resident remained in bed on his/her back. The smell of bowel movement permeated the room. At 3:09 P.M., the resident self-propelled in a wheelchair out of his/her room and down the hall. The room continued to have a strong smell of bowel movement. The resident propelled him/herself into the television area near the nurse's station. The resident had a brown substance on his/her hands and under his/her nails. A smell of bowel movement was noted when standing close to the resident. At 4:04 P.M., CNA A told the resident to head to the elevator for dinner. The resident propelled away towards the elevator. No personal care was provided. The resident's hands appear soiled. During an interview on 8/26/24 at 4:07 P.M., the Administrator said if a resident is observed to put his/her hands in stool, he expected staff to address this immediately. The resident's hands should be cleaned, and care provided. He will deal with this right now. The Administrator went and talked with CNA A. Observation on 8/26/24 at 4:09 P.M., showed CNA A got on the elevator to head down to the dining room. He/She said CNA B was the resident's CNA earlier today. Shift change is at 3:00 P.M., so he/she was not sure who the resident's CNA is now. CNA A went to the main dining room and took the resident to the shower room on the 1st floor. He/She assisted the resident to wash his/her hands at sink. There was a large amount of brown debris under the resident's nails and on his/her hands and fingers. CNA A assisted to wash the resident's hands using three different scrubs in order to get all of the dried debris off of the resident's hands. CNA A brought the resident to the table in in the main dining room. No perineal care was provided. CNA A said when he/she went into the resident's room earlier, he/she was playing in his/her stool. He/She cleaned his/her hands at that time, but he/she did not provide perineal care. He/She told the resident's CNA the resident needed care. This behavior of playing in stool is a normal for the resident and is why he/she does not have a roommate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/24 at 4:22 P.M., showed the resident remained in the dining room and waited for dinner. Observation on 8/26/24 at 5:49 P.M., showed the resident returned to the second floor from the main dining room. He/She self-propelled around at the nurse's station. CNA A then told the resident to go in to his/her room and he/she was going to clean him/her. The resident propelled to his/her room and transferred him/herself to bed. At 5:59 P.M., CNA A entered the resident's room with supplies. He/She asked the resident to stand up and sit back in his/her wheelchair so he/she could change the bed. As the resident stood and pivoted, the back of the resident's pants appeared very wet near the buttocks area and between the legs. A strong odor of bowel movement permeated in the room. Observation showed stool smeared on the sheets, blankets, pillow, and on the wall. CNA A placed gloves on and made the resident's bed, changing his/her gloves and sanitized his/her hands after touching the soiled linen and before placing the clean linen on the bed. CNA A assisted the resident to stand, removed his/her pants, and lowered his/her brief. The brief was saturated with dark colored urine and stool. As the resident started to stand, the resident began to have another bowel movement. CNA A assisted the resident into the bathroom and onto the toilet. During an interview on 8/29/24 at 12:50 P.M., with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) L/Unit Manager, they said the aide or any nursing staff can clean a resident's hands if they appear soiled. Residents should be cleaned if they are known to have a bowel movement. Residents who are incontinent should be checked every two hours and cleaned up before meals. 2. Review of Resident #32's admission MDS, dated [DATE], showed: -admitted [DATE]; -Resident is rarely/never understood; -Rejection of care behavior not exhibited; -Upper extremity impairment on both sides, lower extremity impairment on one side; -Dependent for assistance with personal hygiene; -Diagnoses included dementia, Parkinson's disease (brain disorder causing unintended or uncontrolled movements), depression, and generalized muscle weakness. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident has a self-care deficit; -Goals: Resident will maintain or improve self-care area of dressing, grooming, hygiene, and bathing. Resident will accept assistance with area of dressing, grooming, hygiene, and bathing; -Interventions included provide assistance with self-care as needed; -The care plan failed to identify the resident's individual needs and preferences related to bathing, including the resident's dependence on staff for assistance with personal hygiene and grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's shower schedule, undated, located in the shower binder at the nurse's station, showed the resident scheduled to receive showers during day shift on Wednesdays and Saturdays. Review of the resident's shower sheets for July and August 2024, showed: -On 7/10/24 and 7/24/24, shower sheets completed and signed by a CNA and a nurse. No notes regarding the resident's hair; -On 8/1/24, shower sheet completed and signed by a CNA. Not signed by a nurse. No notes regarding resident's hair; -No other shower sheets completed. Observations on 8/26/24 at 11:12 A.M., 12:34 P.M., 1:28 P.M., 4:29 P.M., and 6:19 P.M., showed the resident on his/her back in bed. His/Her hair was disheveled and in a ponytail at the top of his/her head. Large chunks of white flakes were throughout the resident's hair, from the crown of his/her head to the end of his/her ponytail. Observations on 8/27/24 at 7:13 A.M. and 8:49 A.M., showed the resident on his/her back in bed with his/her hair in a disheveled ponytail. Large chunks of white flakes were throughout the resident's hair, from the crown of his/her head to the end of his/her ponytail. Observation on 8/27/24 at 11:00 A.M., showed the resident on his/her back in bed with his/her hair in a disheveled ponytail. The back of his/her head was bald with clumps of hair on his/her pillow. His/Her hair was matted into a large clump on the side of his/her head. During an interview, the resident shook his/her head no when asked if his/her hair had been washed recently. Observation on 8/28/24 at 6:54 A.M., showed CNA D entered the resident's room. The resident lay on his/her back. CNA D uncovered the resident and unsecured his/her brief. CNA D assisted the resident to his/her left side. The resident's hair was matted and stuck straight out from the left side of his/her head in a large clump. Large chunks of white flakes stuck in the matted hair. During an interview on 8/28/24 at 10:58 A.M., CNA A said staff follow a shower schedule at the nurse's station. When a shower or bed bath is completed, staff fill out a shower sheet and put it in the binder at the nurse's station. Staff should mark any observed issues on the shower sheet and report it to the nurse, including flakes in a resident's hair. The resident requires total assistance from staff with his/her care needs. He/She does not get out of bed and screams when touched. CNA A is not sure why the resident screams or if it is due to pain. The resident gets bed baths. Staff use a wet washcloth to wash the resident's hair. They have tried using regular shampoo in the past. CNA A does not know how the resident's hair got the way it has. His/Her hair has been this way for about a month. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/29/24 at 8:48 A.M., showed the DON entered the resident's room. The resident lay on his/her back in bed. The DON lifted the resident's head and observed the resident's hair matted into a large clump. Large chunks of white flakes were throughout the resident's hair. The DON explained to the resident that his/her hair was matted and needed to be cut. The resident said he/she wanted staff to try brushing his/her hair first. The DON asked CNA K to look at the resident's hair and CNA K entered the resident's room and observed the resident's hair. CNA K said he/she has tried to get the resident to wash his/her hair, but the resident says no. CNA K said while giving bed baths, he/she has been wetting a washcloth and rubbing it on top of the resident's head. During an interview on 8/29/24 at 8:52 A.M., CNA K said the resident was admitted to the facility a couple of months ago with his/her hair in a ponytail. CNA K tried to wash the resident's hair, but the elastic band holding the ponytail wouldn't come out and the resident's hair started pulling away from his/her scalp. CNA K left the elastic band in the resident's hair and thought someone else would try to get it out. CNA K has given the resident several bed baths and uses a wet washcloth to push the resident's hair back and wipe the flakes out of his/her hair. CNA K told one of the nurses about the flakes in the resident's hair. The resident does not have a medicated shampoo. During an interview on 8/29/24 at 10:01 A.M., LPN E said the resident is total care, receives bed baths, and does not like to get up. He/She is in pain all the time and does not like to be touched. Yesterday, LPN E heard the resident's hair was matted. The resident lays toward one side all day, so LPN E can see how his/her scalp would get like this. He/She would have expected staff to notify the nurse if they observed flakes in the resident's hair. The nurse could notify the physician to get a medicated shampoo. If staff observe the resident's hair is matted so severely it cannot be brushed, they should report it to the nurse. The nurse would notify the family about the resident's hair to see if there is anything they can do or get consent to cut the resident's hair. Because of the resident's pain, staff could make sure the resident gets a Tylenol or pain medication before getting a shower to stay ahead of the pain. During an interview on 8/29/24 at 9:03 A.M., the DON said the resident's hair did not get like this overnight. She expected staff to have reported the resident's matted hair, flakes, and refusals to have his/her hair washed. She expected staff to get the resident's family involved if the resident has been refusing. She expected the nurse to notify the resident's physician about the flakes in the resident's hair so an order could be obtained for a medicated shampoo or topical treatment. 3. Review of Resident #168's medical record, showed: -admitted [DATE]; -Diagnoses included unspecified injury of the neck, pain in unspecified hand, and vertigo (dizziness). Review of the resident's care plan, in use at the time of survey, reviewed 8/26/24, showed: -Care area/problem: Resident has a self-care deficit; -Goals included: Resident will maintain or improve self-care area of dressing, grooming, hygiene, and bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions included provide assistance with self-care as needed. Observation on 8/26/24 at 10:59 A.M., showed the resident sat in a wheelchair in his/her room. The resident's hair was in a disheveled ponytail, with chunks of hair loose and outside of the ponytail. During an interview, the resident said he/she was admitted to the facility three days ago for therapy. He/She just had surgery on the discs in his/her neck and does not have full use of his/her arms. Staff has not helped him/her brush his/her hair since he/she was admitted . Staff dropped off his/her breakfast tray this morning and left it there without helping him/her. Observations on 8/26/24 at 12:21 P.M. and 1:14 P.M., showed the resident sat in a wheelchair in his/her room. His/Her hair was in a disheveled ponytail, which had chunks of hair loose and outside of the ponytail. During an interview at 1:14 P.M., the resident said his/her hair is a mess and he/she does not like it that way. Being disheveled makes him/her very uncomfortable. Review of the resident's Occupational Therapy (OT) evaluation, dated 8/26/24, showed: -Goal: Patient will complete all activities of daily living (ADL)/self-care tasks with independence. Baseline, as of 8/26/24: Dependent; -Functional skills assessment: Substantial/maximal assistance with eating. Dependent with personal hygiene and dressing. Observation on 8/27/24 at 8:45 A.M., showed the resident in a wheelchair in his/her room. CNA K delivered a tray of breakfast to the resident's room, said he/she would come back to feed the resident, and left the room. During an interview, the resident said staff do not offer to help him/her. He/She is doing the best he/she can to fend for him/herself. The staff lack compassion. The resident became tearful during the interview. At 9:13 A.M., the resident remained seated in his/her room with breakfast tray untouched. During an interview, the resident said the facility staff lack compassion and care. It makes him/her sad and he/she does not want to ask them for help. He/She was sitting in his/her wheelchair with his/her pants not fully pulled up, leaving his/her bottom uncovered on the wheelchair, because he/she cannot lift his/her pants up all the way. At 12:13 P.M., the resident remained seated in his/her wheelchair with his/her pants not pulled up all the way. Observation on 8/28/24 at 9:11 A.M., showed the resident sat in wheelchair. His/Her hair was in a disheveled bun and said his/her friend put his/her hair in a bun yesterday. Staff have not offered to help him/her brush his/her hair or to assist him/her in taking a bath or shower since he/she was admitted to the facility. During an interview on 8/28/24 at 10:58 A.M., CNA A said the resident is a new admission. Staff should get report from the nurse about what type of assistance is needed. The resident needs some assistance from staff with eating and brushing his/her hair. Staff should offer and provide this assistance as needed. During an interview on 8/29/24 at 10:01 A.M., LPN E said the resident is a new admission to the facility. When he/she first arrived at the facility, his/her arms were not really mobile at all. Now, he/she can use his/her lower arms. Staff still need to help him/her with some things and should provide assistance, like brushing the resident's hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 12:36 P.M. with the DON and LPN L/Unit Manager, they said they expected staff to provide assistance to the resident as needed. 4. Review of Resident #269's quarterly MDS, dated [DATE], showed the following: -Diagnosis of acute respiratory failure; -Moderately impaired cognition. Review of the resident's care plan, dated 6/24/24 and in use at the time of the survey, showed: -Focus: Resident has a self-care deficit. He/She requires extensive assist with most of his/her ADL care. He/She is not ambulatory at this time; -Goal: Utilize interventions to help resident become as independent as possible while making sure his/her needs are met; -Interventions: Encourage resident to participate in ADLs and praise accomplishments and give resident as many choices as possible about care. Observation on 8/26/24 at 10:32 A.M., 8/27/24 at 6:50 A.M., and 8/28/24 at 12:40 P.M., showed the resident's finger nails to be at various lengths with dark matter underneath the nails. During an interview on 8/29/24 at 7:51 A.M., CNA S said CNAs are responsible for trimming residents' nails during showers or as needed. He/She expected residents' nails to be trimmed and clean. During an interview on 8/29/24 at 12:50 P.M., the DON said all nursing staff are able to trim residents' nails. She said nurses are responsible for trimming the nails of residents with diabetes. She expected residents to have clean, trimmed nails. 5. Review of Resident #29's quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -Requires maximum assistance from staff with personal hygiene and bathing; -Diagnoses include heart disease and stroke. Review of the resident's care plan, in use at the time of survey, showed: -Care area: Self-care deficient; -Interventions: Give the resident as many choices as possible. Encourage the resident to complete as much self-care as possible independently or as possible. Provide assistance with self-care as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/26/24 at 10:50 A.M., showed the resident lay in bed with fingernails on both hands that were approximately one-fourth inch long, with jagged edges and with brown matter underneath. The resident said he/she did not like his/her nails that long and thought they looked dirty. During observation and interview on 8/29/24 at 9:30 A.M., the resident said he/she received a shower the evening before, but the staff did not trim his/her nails. He/She could not trim his/her nails by him/herself. The resident's fingernails on both hands were approximately one-fourth inch long, with jagged edges, and with brown matter underneath. During an interview on 8/27/24 at 9:15 A.M., CNA S said nail care is part of the residents' routine showers and bathing care. 6. Review of Resident #16's, admission MDS, dated [DATE], showed: -Cognitively intact; -No rejection in care; -Requires maximum assist from staff for bathing, upper body dressing and personal hygiene; -Dependent on staff for lower body dressing; -Diagnosis included: diabetes, peripheral vascular disease (PVD, constricts the blood flow to lower extremities) and lung disease. Review of the resident's care plan, in use at the time of survey, showed: -Care Area: Self- care deficient related to the resident has an above the knee amputation (AKA) and requires maximum assistance with transfers, turning, grooming, positioning, and dressing. -Interventions: Occupational therapy (OT) and physical therapy (PT) evaluation as needed. Provide self-care as needed. During observation and interview on 8/26/24 at 10:25 A.M. and 4:07 P.M., 8/27/24 at 1:15 P.M., 8/28/24 at 8:40 A.M., and 8/29/24 at approximately 9:00 A.M., the resident lay in bed with a yellow facility gown and a blue cardigan sweater. The resident's hair was frizzy and had small knots of hair at the back of his/her head. The resident said he/she would like to get out of bed, look in the mirror, and be able to fix his/her own hair because he/she used to be a beautician. He/she gets a bed bath from staff but is normally just cleaned after he/she is incontinent. His/Her clothing does not get changed. He/She would like to get his/her clothing changed. During an interview at 8/27/24 at 1:15 P.M., the resident's family member said he/she visits the resident about once a week and has never seen the resident out of bed. The resident always wears a hospital gown and never wears any of his/her own personal clothing. The resident also has his/her own wheelchair with chair cushion. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 8/28/24 at 8:40 A.M., Wound Clinic Nurse F said it is important for the resident to get out of bed to promote circulation and off load pressure. During an interview on 8/29/24 at 7:50 A.M., CNA S said the resident should be getting his/her clothing changed daily but the resident will refuse at times to get out of bed. During an interview on 8/29/24 at 9:45 A.M., LPN C said the resident would benefit from at least two hours a day getting out of bed and should be getting his/her clothing changed daily. During an interview on 8/29/24 at 12:40 P.M., the DON said she expected the resident to have his/her clothing changed daily and to get out of his/her of bed if the resident will allow staff to do so. 7. During an interview on 8/28/24 at 10:58 A.M., CNA A said some residents have their own hairbrushes, but the facility only supplies combs for the rest of the residents. There is a shared hairbrush used for residents who do not have their own individual hairbrush. CNA pointed at a hairbrush in the common area by the nurse's station, and said it was used this morning on several residents seated in the common area. 8. During an interview on 8/29/24 at 10:01 A.M., LPN E said residents should be provided with showers or bed baths in accordance with the facility's shower schedule and the resident's needs and preferences. When staff assist in completion of a shower or bed bath, they should document it on a shower sheet. The shower sheet should be given to the nurse for them to review and sign. Once reviewed by the nurse, the shower sheet goes in the binder at the nurse's station, which is reviewed by the DON. Staff should document any observed issues on the shower sheet and immediately report the issues to the nurse. 9. During an interview on 8/29/24 at 12:36 P.M. with the DON and LPN L/Unit Manager, they said the facility does have a sufficient supply of hairbrushes. Each resident should be provided with their own individual hairbrush. It would not be acceptable to use a shared hairbrush on all residents. CNAs are responsible for trimming residents' nails and cleaning residents' hands. Staff should document all bed baths and showers on shower sheets. Any area of concerns should be indicated on the shower sheet. If a resident refuses a shower or bed bath, staff should document this on the shower sheet and notify the nurse. The nurse should notify the family and physician. Ongoing refusals should be documented on the residents' care plan. MO00234383 MO00239684 MO00238437 MO00238869 MO00239680 MO00240891 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00240930 40290 42795 46888

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 40290 Based on observation, interview and record review, the facility failed to provide individual activities designed to meet the interests of and to support the psychosocial well-being of each resident, in accordance with needs and preferences for three residents (Residents #32, #9, and #55). The census was 67. 1. Review of Resident #32's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: -Resident rarely/never understood; -Dependent on assistance for mobility; -Somewhat important to resident to have books, newspapers, and magazines to read; -Somewhat important to resident to go outside to get fresh air when the weather is good; -Somewhat important to resident to participate in religious services or practices; -Very important to resident to listen to music he/she likes; -Very important to resident to do things with groups of people; -Very important to resident to do his/her favorite activities; -Diagnoses included dementia, Parkinson's disease (brain disorder causing unintended or uncontrolled movements), and depression. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding the resident's needs and preferences related to activities. Review of the resident's medical record, showed no activity assessments. Review of the Activity Director's activity documentation from July and August 2024, showed: -On 8/1/24, staff documented the resident participated in Resident Photo List activity; -No other documentation of other activities offered to the resident in July or August 2024. Observations on all days of the survey, from 8/26/24 through 8/29/24, showed the resident in bed in his/her room. No observations of 1:1 activities offered or provided to the resident. No observations of the resident out of his/her room and participating in group activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/24 at 12:16 P.M., the resident nodded and shook his/her head to respond to questions and nodded his/her head yes when asked if he/she was bored. 2. Review of Resident #9's annual MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included Alzheimer's disease; -Interview for activity preferences: -How important is it to you to listen to music you like: Somewhat important; -How important is it to you to be around animals such as pets: Somewhat important; -How important is it to you to keep up with the news: Somewhat important; -How important is it to you to do things with groups of people: Somewhat important; -How important is it to you to do your favorite activities: Somewhat important; -How important is it to you to go outside to get fresh air when the weather is good: Very important. Review of the resident's care plan, in use at the time of the survey, showed: -Prefers to participate in individual activities/self-directed activities; -No goals for activities specified; -Interventions: Encourage participation and positive feedback and praise. Explore and obtain past interest and potential re-motivation. Offer activity cart/wellness on wheels supplies: Games, reading materials, audio books, music supplies, health/wellness, education, cognitive games, spiritual materials. Provide a schedule of events to post in his/her room. Provide materials, equipment or supplies for preferred activity pursuits. Provide one-on-one interventions, to include music therapy, maintenance program, health education, and sensory stimulation. Review of the resident's Activity Interest and Initial Assessment, dated 3/6/22, showed: -Activity interests and initial assessment: Bingo, books, listening to music, sitting outside for fresh air, movies, news, other TV/Internet activity interests; -Activity environment preferences: Day room/activity room; -Activity preferences that are very important to the resident: Listening to music. Participating in favorite activities. Reading books, newspapers, or magazines. Spending time outdoors; -Cognitive adaptions and interventions: Needs reminders of activities. One-on-one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record, showed only one, one-on-one activity documented since admission. No further activity participation documented. Review of the resident's one-on-one visit, dated 4/2/24, showed: -Sensory stimulation, snack/hydration, nail care; -Duration: 20 minutes; -Location: In room; -Response: Resident enjoys nail care and decorations added to his/her room. Resident likes to explore with activity direction, but easily loses track of activity/attention. Activity director paints resident's nails and helps decorate the room with his/her instruction of how they want it set up. Review of the resident's Activities Quarterly/Annually Assessment, dated 7/17/24, showed: -Preferred activity setting: In-room, dining room, other. Resident roams building when not stationed in his/her room or in the dining hall; -Cognitive status: Disorganized thinking; -Behavior: Wanders intrudes on others; -Resident will roam if not supervised or informed on where to go. Resident likes being stationed at a table or by a window to enjoy nature scene; -Participates in individual leisure activities: No; -Resident likes to be near television, but does not focus on what is on/easily distracted; -Other: Listening to music, socializing with others, visiting the beauty shop, crafts; -Staff to provide: one-on-one interventions: Encouragement, provide schedule of programs; -Staff to provide activity cart visits, verbal reminders, assistance to and from groups. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/24 at 2:06 P.M., showed the resident in his/her room in bed, on his/her back. The resident had a brown substance on his/her hands and under his/her nails. A strong odor of bowel movement was in the room. No activity calendar was posted in the resident's room. At 2:20 P.M., Certified Nursing Assistant (CNA) A entered the resident's room and asked the resident why you doing that. The resident said he/she cannot help it. CNA A said give me your hands. He/She wiped the resident's hands with a wipe, told the resident he/she was going to tell his/her CNA, and then exited the room and walked down the hall. At 2:55 P.M., the resident remained in bed on his/her back. At 3:09 P.M., the resident self-propelled in a wheelchair out of his/her room and into the television area near the nurse's station. At 4:04 P.M., CNA A told the resident to head to the elevator for dinner. The resident propelled away towards the elevator. At 4:22 P.M. , the resident remained in the dining room and waited for dinner. At 5:49 P.M., the resident returned to the second floor from the main dining room. He/She self-propelled around at the nurse's station. CNA A then told the resident to go in to his/her room and he/she is going to clean him/her. The resident propelled to his/her room and transferred him/herself to bed. Observation on 8/27/24 at 6:46 A.M., showed the resident in a wheelchair near the 200-hall nurse's station. Observation on 8/28/24 at 6:21 A.M., showed the resident in bed, asleep. No observations of staff interacting with the resident or providing mental stimulation outside of routine resident care. 3. Review of Resident #55's medical record, showed diagnoses included stroke and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke. Review of the resident's activity assessment, dated 3/18/24, showed: -Interest in games: Bingo; -Interest in arts and crafts: Coloring, drawing, painting; -Specify any types of reading/writing that patient prefers: Resident expressed interest in simple reads, such as magazines; -Interest in music: Listening to music; -Interest in socializing with others: Phone calls, social visits; -Interest in outdoor activities: Sitting outside; -Interest in TV/Internet: Game shows, movies; -Interest in other areas: Resident does not mind trying out simple activities, but prefers to be offered options to pick through; -Activity environment preferences: Day room/activity room, self-directed, resident prefers to be offered options and picks through what he/she wants; -Chooses not to participate in group activities; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Types of activities patient participates in: Activity Director brings activity cart to resident's room to pick through; -Participation level in activities: Behaviors in activities is appropriate, responsive to one to one visits; -Activity schedule preference: Afternoon, evening; -Activity preferences that are very important to resident: Listening to music, participating in favorite activities, reading books, newspapers, or magazines; -Physical adaptations and interventions: Activity Director does room visits with this resident; -Cognitive adaptions and interventions included one to one activities. Review of the resident's significant change MDS, dated [DATE], showed: -Moderate cognitive impairment; -Dependent on assistance for mobility; -Somewhat important to resident to do his/her favorite activities; -Somewhat important to resident to get outside to get fresh air when the weather is good; -Very important to resident to have books, newspapers, and magazines to read; -Very important to resident to listen to music he/she likes. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident has a need for/prefers socialization activities; -Goal and interventions: Blank; -The care plan failed to identify the resident's specific needs and preferences related to activities. Review of the Activity Director's activity documentation from July and August 2024, showed: -On 8/2/24, staff documented the resident participated with assistance in Nail Care activity; -On 8/6/24, staff documented the resident taken already, for Room Visit activity; -On 8/8/24, staff documented the resident's name on the list of Room Visits. Participation level was not indicated; -No other documentation of other activities offered to the resident in July or August 2024. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on all days of the survey, from 8/26/24 through 8/29/24, showed the resident in bed in his/her room. No observations of 1:1 activities offered or provided to the resident. No observations of the resident out of his/her room and participating in group activities. 4. During an interview on 8/29/24 at 12:11 P.M., the Activity Director said she has been working with the facility since February 2024. She does not have a specific list of residents who receive 1:1 activities. There is no set schedule for residents to receive 1:1 activities. Residents #32 and #55 are bed bound. She sees them in their rooms, but not on a specific schedule. When residents do not come to the group activities, she tries to see them later in that day. She does not have any additional documentation of activities provided to Residents #32 and #55. She needs to work on her documentation and getting more structure for the residents at the facility. She does not do formal activity assessments. She does do some activity assessments in the electronic medical record (EMR) when residents are newly admitted . She checked the EMR and verified there is no activity assessment for Resident #32. Residents need activities for their quality of life. 5. During an interview on 8/29/24 at 12:36 P.M. with the Director of Nurses (DON) and Licensed Practical Nurse (LPN) L/Unit Manager, they said it is hard to keep Resident #9's attention, but he/she enjoyed watching others do puzzles and interactions with staff. Activity staff should learn about the residents to see what activities they would benefit from. Residents #32 and #55 are total care and they are in bed most of the time. It is very painful for resident #32 to move. It is expected that Residents #32 and #55 receive 1:1 activities. 1:1 activities should be offered to residents who cannot or do not want to attend group activities. It is expected that all residents be offered activities in line with their needs and preferences. Activities can help improve the quality of a resident's life. Activities can help decrease behaviors. It is expected for residents at risk of social isolation to be offered activities. 6. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expects residents who are unable or unwilling to attend group activities to be offered/provided 1:1 activities. He expects the Activity Director to have a schedule/routine for providing activities to residents who are risk of social isolation.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 40290 Based on interview and record review, the facility failed to ensure the activity program was directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional. The census was 67. Review of the facility's Facility Assessment Tool, updated 11/2/23, showed: -Facility resources needed to provide competent support and care for the resident population every day and during emergencies included: -Therapy services (e.g., activities professionals); -In addition to nursing staff, other staff needed for behavioral healthcare and services included Activity Director; -Staff training/education and competencies: Upon hire, all staff go through formal orientation for education and competency testing; -No documentation regarding the training requirement for a qualified Activity Director. During an interview on 8/29/24 at 12:11 P.M., the Activity Director said she began working in her position with the facility in February 2024. During an interview on 8/29/24 at 2:13 P.M., the Activity Director said she had no training in activities when she began working with the facility. The Director of Nurses (DON) helped train her a little bit. She is not licensed, registered, or certified as an Occupational Therapist or in activities. This is her first job as an Activity Director. She has expressed interest in taking Activity Manager classes and this has been discussed with the facility's owner, but she has not been signed up for classes or received a certification, yet. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expects the facility to employ a qualified Activity Director. The Activity Director had some training with the previous Activity Director. There are plans for the Activity Director to get certified, but she has not signed up for classes, yet.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards. Staff failed to follow physician orders and apply a Tubi grip (elastic tubular dressing that reduces swelling) to one resident's lower extremity (Resident #2), who has a medical history of chronic (long term) edema (swelling) and cellulitis (infection of the skin and tissue below the skin) and apply a dressing to one resident's (Resident #269) gastrostomy tube (g-tube, a tube that is surgically inserted into the abdomen and used for liquid nutrition and medications) site. The sample was 17. The census is 67. Review of the facility's physician order policy revised, 6/21/20, showed: -Policy: To transcribe and follow-physician orders accurately; -Procedure: Orders received by the physician are to be followed as prescribed. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/23/24, showed: -Mild cognitive impairment; -No behaviors; -Required maximum assistance from staff for lower body dressing and putting on or taking off footwear; -Diagnoses included heart failure, renal (kidney) failure, dementia and depression. Review of the residents Medication Administration Record (MAR), dated August, 2024, showed: -An order, dated 1/29/24, at 6:00 A.M., apply Tubi grip to left lower limb and remove at 6:00 P.M., diagnosis: cellulitis; -On 8/26, 8/27, and 8/28/24 the treatment was documented as completed. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's leg cellulitis and Tubi grip application. Observation on 8/26/24 at 3:30 P.M., showed the resident sat in his/her wheelchair. The resident lifted his/her pant legs up and exposed both lower legs. The resident was not wearing a Tubi grip. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 8/27/24 at 10:36 A.M., showed the resident sat in his/her wheelchair in his/her room. Certified Nursing Assistant (CNA) S removed both the resident's shoes and socks and lifted the resident's pant legs up, exposing the resident's lower extremities. The resident had moderate edema to both lower extremities. Indentations were visible in the resident's bilateral (both) calf area from the resident's socks. The right leg appeared red and more edematous than the left lower extremity. The resident was not wearing a Tubi grip. CNA S said the resident has always had swelling to both his/her legs. CNA S was not aware of any special treatment to the resident's legs for his/her leg swelling. Observation on 8/28/24 at 6:45 A.M., showed the resident sat in the dining room and self-propelled him/herself to his/her bathroom on the Garden Unit. The resident was not wearing a Tubi grip. During an interview on 8/29/24 at 9:45 A.M., Licensed Practical Nurse (LPN) C said the resident has chronic issues with leg swelling and cellulitis. LPN C was not aware of the Tubi grip order but thought it was a good idea to help with the resident's swelling. LPN C said he/she wasn't even sure if the facility had a Tubi grip supply. Treatments are not to be documented as completed if they are not. During an interview on 8/29/24 at 12:40 P.M., the Director of Nursing (DON) said she expected staff to follow physician orders and apply the resident's Tubi grip. Treatments are expected to be documented accurately. 2. Review of Resident #269's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Diagnoses of acute (short term) respiratory failure and dysphasia (difficulty swallowing). Review of the resident's Physician's Order Summary (POS), showed: -An order, dated 8/3/24, to cleanse g-tube site with wound cleanser and pat dry; Apply 4 x 4 split gauze to site and secure with tape. Observation on 8/26/24 at 10:32 A.M., showed no dressing at the resident's g-tube site. The resident's skin surrounding the g-tube site was reddened. Observation on 8/27/24 at 6:49 A.M., showed no dressing at the resident's g-tube site. The resident's skin surrounding the g-tube site was reddened with darker red drainage. During an interview on 8/27/24 at 12:32 P.M., the Nurse Practitioner (NP) observed the resident's g-tube site and said there was a presence of bloody drainage. He/She said there should be a dressing on the site if ordered by the physician. During an interview on 8/29/24 at 9:17 A.M., the Wound Nurse said nurses are responsible for putting dressings on the resident's g-tube site. He/She said dressings should be placed per physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 12:36 P.M., the DON said the night shift nurses are responsible for g-tube dressing changes. She expected the physician's orders to be followed. She expected the resident to have a dressing on his/her g-tube site. 46888

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32847 40290 Based on observation, interview and record review, the facility failed to ensure one resident, identified by the facility as dependent with mobility and high risk for development of pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction) was routinely turned and repositioned by staff. The resident developed a new pressure ulcer to his/her coccyx (tailbone area) and upon identification of the pressure ulcer, staff failed to report it to the nurse, in accordance with the facility's policy (Resident #32). The sample was 17. The census was 67. Review of the facility's Policy and Procedure for Skin Protocol, dated 1/5/24, showed: -In order to prevent skin breakdown and promote the health of our residents, it is the policy of the facility to perform skin assessments on a weekly basis. Skin assessments are to be performed by a registered or Licensed Practical Nurse (LPN); -Procedure: The LPN or Registered Nurse (RN) are to visually inspect all areas of the body and note/document any abnormalities. If any abnormalities are found, the LPN or RN performing the skin assessment is to notify the physician, resident and/or resident representative, and Director of Nursing (DON). This will be performed weekly; -The Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), Certified Medication Technicians (CMTs) are to monitor skin during bathing and clothing change and notify the nurse of any changes so that they can be assessed; -Residents may develop various types of skin alterations. At the time of the assessment and diagnosis of skin ulcer/wound, the clinician is expected to document the clinical basis which permit differentiate the ulcer type, especially if the ulcer has characteristics consistent with pressure ulcer but is determined not to be one. Review of Resident #32's medical record, showed: -Diagnoses included Parkinson's disease (brain disorder causing unintended or uncontrolled movements), dementia and depression; -A pressure ulcer risk assessment, dated 6/15/24, showed the resident at high risk for developing pressure ulcers; -A physician order, dated 6/24/24, to apply barrier cream to coccyx area as needed with each incontinent episode. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident rarely/never understood; -Upper extremity impairment on both sides, lower extremity impairment on one side; -Dependent on assistance with mobility; -Resident at risk of developing pressure ulcers. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident at risk for/actual breakdown present. Resident is dependent with bed mobility, transfers, and toileting hygiene. He/She is incontinent of bowel and bladder. He/She had noted redness to coccyx upon admission and moisture barrier cream to be applied. He/She also has a wound to left great toe with treatment in place; -Interventions included: -Apply protective/moisture barrier cream after episodes of incontinence and as needed; -Assist resident to turn and reposition frequently; -Inspect skin daily with care and bathing, and report any changes to charge nurse -Position resident properly, use pressure-reducing or pressure-relieving devices (e.g. pillows, positioning wedges, and alternating pressure mattress) if indicated; -Position with pads and cushions to prevent pressure; -No documentation regarding the resident's refusal to be turned and/or repositioned, or the resident screaming when touched. Review of the resident's skin assessment, dated 8/26/24, showed: -Status: Skin color normal, dry; -Rash/redness: No; -Wound: No. Observations on 8/26/24 at 11:12 A.M., 11:54 A.M., 12:23 P.M., 12:58 P.M. and 1:28 P.M., showed the resident on his/her back in bed with his/her legs bent at the knee and positioned toward the right side of the bed. No cushions or pillows were underneath the resident's body. During an interview at 1:28 P.M., the resident said he/she was comfortable. He/She was unable to answer further questions regarding his/her skin care. Observation on 8/26/24 at 4:29 P.M., showed the resident on his/her back in bed with his/her legs bent at the knee and positioned toward the right side of the bed. No cushions or pillows were underneath the resident's body. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 8/27/24 at 7:38 A.M., 8:49 A.M., 11:00 A.M., 12:16 P.M., 1:13 P.M., and 1:34 P.M., showed the resident on his/her back in bed with his/her legs bent at the knee and positioned toward the rights side of the bed. No cushions or pillows were underneath the resident's body. Observation on 8/28/24 at 6:54 A.M., showed CNA D entered the resident's room. The resident lay on his/her back. CNA D uncovered the resident and unsecured his/her brief. CNA D assisted the resident to his/her left side. Observation of the resident's buttocks, showed a small open area to the coccyx. The skin around the open area appeared mushy and white and extended out to an approximate quarter size. CNA D pointed to the open area. The resident had stool in the buttocks' crack. CNA D cleansed the resident, removed his/her gloves and washed his/her hands. CNA D then assisted the resident to be repositioned to his/her back and covered him/her, then said he/she gets off work at 7:00 A.M. The resident did not resist or scream during care. During an interview on 8/28/24 at 9:16 A.M., Wound Clinic Nurse F said the resident is seen for his/her toe wound. It is healing well. The resident was currently eating breakfast, so they would come back to do the treatment later. Observation on 8/28/24 at 9:22 A.M., Wound Clinic Nurse F and the facility Wound Nurse entered the resident's room and provided care to the resident's toe. Wound Clinic Nurse F said he/she was not aware of any other open areas on the resident. The Wound Nurse said no one told her of any new open areas on the resident. The Wound Nurse assisted the resident to his/her right side. Wound Clinic Nurse F observed the area to the resident's coccyx and said the area is opened and presents as a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.) pressure ulcer and measured approximately 0.1 x 0.1 x 0.1 centimeters (cm). He/She instructed the Wound Nurse to clean the area, apply betadine (used to clean minor wounds), and apply a Mepilex dressing (foam dressing with adherent edges). Wound Clinic Nurse F said the opened area was caused by the resident laying on his/her back too much. The Wound Nurse cleaned the area, applied betadine, and covered it with a Mepilex dressing. The Wound Nurse said this should have been reported to her so she could assess the area and get an order. During an interview on 8/28/24 at 9:48 A.M., LPN E said he/she is the resident's nurse for day shift today. When night shift left, neither the nurse nor CNA reported any new open areas to the resident's buttocks. They should have, so he/she could follow up. During an interview on 8/29/24 at 9:50 A.M., CNA K said while providing care to the resident earlier this week, he/she noticed a small area on the resident's buttocks. He/She reported it to the nurse. The resident is total care and he/she is at high risk for skin breakdown. The resident is in bed all the time. Residents need to be turned and repositioned every two hours to get the pressure off their skin so it won't break down. The resident refuses to be turned and repositioned at times. During an interview on 8/28/24 at 10:58 A.M., CNA A said the resident has not been on his/her assignment this week, but he/she knows the resident well. The resident does not get out of bed and is very constricted. He/She does not like to get up and screams when touched. He/She requires total assistance from staff. He/She needs to be turned and repositioned by staff throughout the day, at least at every meal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record, showed no documentation of a new skin issue noted to the resident's coccyx in the week preceding the identification of the Stage II pressure ulcer on 8/28/24. There was no documentation of his/her refusal to be turned and repositioned and no documentation of the resident screaming when touched. During an interview on 8/29/24 at 12:36 P.M. with the DON and LPN L/Unit Manager, they said residents should be turned and repositioned every two hours because long-term positioning can cause skin breakdown. The resident requires total assistance from staff and he/she is at high risk for skin breakdown. He/She is very contracted (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement) and it is very painful for him/her to move. It is very painful for him/her to be turned on his/her left side and they probably need to get him/her something for pain. He/She did not have a pressure ulcer on his/her coccyx upon admission. The DON was just notified today of the resident's new Stage II pressure ulcer on his/her coccyx. When staff identify a new skin issue, they are expected to communicate this to nurse management as soon as possible. The nurse should document the change and notify the physician to obtain orders for treatment. MO00236984

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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. 40290 Based on observation, interview and record review, the facility failed to ensure one resident received tube feeding in accordance with physician orders to support adequate nutritional intake (Resident #32). The facility identified eight residents receiving tube feedings, three of which were sampled and problems were found with one. The sample was 17. The census was 67. Review of the facility's Specific Medication Administration procedures policy, dated 6/1/18, showed: -Guidance for staff to administer medications via feeding tube; -No any other guidance for staff related to the technical aspects of feeding tubes, including verification of functionality and feeding tube care. Review of Resident #32's medical record, showed diagnoses included dysphagia (swallowing disorder), heart failure and dementia. Review of the resident's electronic Physician Order Sheet (ePOS), showed: -An order, dated 6/24/24, to turn off tube feeding at 8:00 A.M.; -An order, dated 6/30/24, for Jevity 1.5 cal (calorie-dense tube feeding formula) oral liquid, 65 milliliters (ml), gastrostomy tube (g-tube, tube that is placed directly into the stomach through an abdominal wall incision for administration of foods, fluid, and medications) at bedtime, turn feeding on at 8:00 P.M. and turn off at 8:00 A. M. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: -Resident rarely/never understood; -Feeding tube while a resident; -Proportion of total calories the resident received through tube feeding: 51% or more. Observation on 8/27/24 at 7:13 A.M., showed the resident on his/her back in bed. The resident's tube feeding machine was off with no tube feeding container on the pole next to the resident's bed. Observation on 8/28/24 at 6:36 AM., showed the resident on his/her back in bed with the tube feeding machine off. A container of Jevity 1.5 cal hung on the pole next to the resident's bed, dated 8/27 at 8:00 P.M. , with 800 ml left in the container. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 8:18 A.M., Licensed Practical Nurse (LPN) E said the resident's tube feeding is already off for the day. The night nurse told LPN E that the resident said he/she was full this morning and asked the night nurse to turn the tube feeding off. The resident has orders to receive tube feeding from 8:00 P.M. to 8:00 A.M. He/She also eats pureed food during the day, so it makes sense that he/she gets full. The resident is hard to understand, but can make his/her needs known. When the nurse cuts off a resident's tube feeding early, the nurse does not need to document anything in the resident's medical record. Observation on 8/29/24 at 7:11 A.M., showed the resident on his/her back in bed. The resident's tube feeding machine was off with no tube feeding container on the pole next to the resident's bed. Review of the resident's medical record, reviewed 8/29/24, showed no documentation regarding the resident's tube feeding being turned off early on 8/27//24, 8/28/24 and 8/29/24. During an interview on 8/29/24 at 8:48 A.M., the resident said his/her stomach does not hurt. He/She is not hungry or full. He/She does not know why his/her tube feeding was turned off early. During an interview on 8/29/24 at 10:01 A.M., LPN E said the resident has orders for tube feeding to be on at 8:00 P.M. and off at 8:00 A.M. It is not a requirement to notify the physician if a resident's tube feeding needs to be cut off early. This is similar to if a resident refuses breakfast, which would not be reported to the physician. If the resident's tube feeding is cut off early, he/she is still getting adequate nutrition during the day. When nursing staff turn the tube feeding off for the day, they should disconnect the tube and remove the container of formula. It would be particularly helpful for the resident's tube feeding to be removed since he/she won't get it back on for about 10 hours and he/she will need to be turned and changed during this time. When staff handle a container of tube feeding formula, they should write the date and time on the container. Containers cannot be reused. During an interview on 8/29/24 at 12:36 P.M. with the Director or Nurses (DON) and LPN L/Unit Manager, they said the resident has physician orders for his/her tube feeding to be on at 8:00 P.M. and off at 8:00 A.M. The tube feeding should be on during the entire time, from 8:00 P.M. to 8:00 A.M. If the tube feeding runs during the entire time like it is supposed to, there should not be a large amount of formula left in the container when it is turned off in the morning. A new bottle should be hung when the tube feeding goes back on, and the container should be labeled with the date, time and resident's name. If a tube feeding is turned off early, the container should be removed and the tubing should be disconnected. Staff should document the reason why the tube feeding was turned off early and notify the physician. During an interview on 8/29/24 at 2:52 P.M., the DON said the facility does not have a specific policy regarding tube feeding care. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected residents to receive diets in accordance with physician orders. He expected physician orders for tube feeding to be followed. He expected staff to notify the physician if orders cannot be followed for whatever reason. MO00240891

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure side rails were accurately assessed as a necessary device prior to installation and use. The facility failed to obtain physician orders for the use of side rails and to document side rail use on care plans for four residents (Residents #32, #55, #47 and #50). The facility identified 47 residents with side rails in use. The census was 67. Review of the facility's Restraints/Side Rails policy, dated 4/28/17, showed: -Restraint Evaluation and Utilization Guideline: -The facility does not typically utilize restraints, however if a restraint is utilized to treat a resident's medical symptoms, to prevent injury and promote the highest practicable level of independence, careful evaluation will precede this decision; -The least restrictive device will be used; -The Interdisciplinary Team (IDT) will discuss the predisposing factors that resulted in the conclusion that restraint evaluation and utilization may be needed; -The need for the use of the restraint will be discussed with the resident and/or family representative. The facility will obtain a signed consent for the use of the restraint. The consent form will be placed in the medical record; -The facility will obtain a physician's order for the least restrictive device. The physician's order must include the medical symptoms for which device is to be used, type of device to be used; -The purpose of the Side Rail Utilization may be to: -Remind the resident not to get out of bed when medically contraindicated and/or medical equipment is attached to the resident; -Aid in turning and repositioning in the bed; -Providing a hand-hold for getting in or out of bed; -Assessment and documentation: -Assessment is completed to identify potential benefits from utilizing side rails and minimize risks; -If side rails are being considered, assessment will be completed at that time with ongoing reassessment (at least quarterly); (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Care plan interventions are implemented when side rails are utilized and reviewed at least quarterly. 1. Review of Resident #32's medical record, showed: -Diagnoses included Parkinson's disease (brain disorder causing unintended or uncontrolled movements), dementia and depression; -No physician order for the use of side rails; -No signed consent for the use of side rails. Review of the resident's side rail evaluation, dated 6/25/24, showed: -Can resident independently get in and out of bed safely: No; -Has resident requested the use of side rails for their own comfort and safety: No; -Is the resident having problems with balance or poor trunk control: Yes; -Does the resident use the side rails for positioning, mobility or support: No; -No final determination made for use of side rails. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: -Resident rarely/never understood; -Dependent on assistance for mobility. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident is at risk for falls. Resident is not ambulatory. His/Her left leg is contracted (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement); -No documentation related to the use of side rails. Observation on 8/26/24 at 1:28 P.M., showed the resident on his/her back in bed with U-shaped rails raised on both sides of the bed, at the head of the bed. During an attempted interview, the resident was unable to respond to questions regarding the side rails. Observations on 8/27/24 at 8:49 A.M. and 12:16 P.M., on 8/28/24 at 7:59 A.M., and on 8/29/24 at 7:11 A.M., showed the resident on his/her back in bed with U-shaped rails raised on both sides at the head of the bed. During an interview on 8/29/24 at 10:01 A.M., Licensed Practical Nurse (LPN) E said he/she is not sure why the resident has side rails because he/she cannot use his/her arms. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #55's medical record, showed: -Diagnoses included seizures, stroke, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke; -No physician order for the use of side rails; -No signed consent for the use of side rails. Review of the resident's side rail evaluation, dated 2/29/24, showed type of side rail not indicated. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Upper and lower extremity impairment on one side; -Dependent on assistance to roll left and right. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident is at risk for falls. Resident requires total assist of two with bed mobility. He/She had a recent stroke with left sided hemiparesis and recently diagnosed with seizures; -No documentation related to the use of side rails. Observation on 8/26/24 at 12:58 P.M., showed the resident on his/her back in bed, on a low air loss mattress (mattress that provides a constant flow of air in the mattress). U-shaped rails were raised on both sides of the bed, at the head of the bed. The resident used his/her right arm to pull the right rail. During an interview, the resident said he/she was trying to use the rail to pull him/herself to move the pillow on his/her right leg. Observations on 8/27/24 at 7:13 A.M., 12:16 P.M., and 1:13 P.M., showed the resident in bed with U-shaped rails raised on both sides at the head of the bed. Observation on 8/28/24 at 8:15 A.M., showed the resident using his/her right arm to pull the right side rail. During an interview, the resident said he/she was trying to get out of bed. Observation on 8/29/24 at 7:11 A.M., showed the resident in bed with U-shaped rails raised on both sides at the head of the bed. During an interview on 8/29/24 at 10:01 A.M., LPN E said the resident can move one arm and can use the side rail on one side of the bed. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnosis of end stage renal disease (ESRD, kidney failure); -Cognitively intact. Review of the resident's Physician Order Sheet (POS), showed no order for bilateral enabler rails. Observation on 8/27/24 at 7:38 A.M., and 8/28/24 at 10:18 A.M., showed the resident on his/her back in bed with bilateral enabler rails raised on both sides at the head of the bed. 4. Review of Resident #50's quarterly MDS, dated [DATE], showed: -Diagnoses of acute kidney failure and major depressive disorder; - Cognitively intact. Review of the resident's POS, showed no order for bilateral enabler rails. Observation on 8/26/24 at 1:03 P.M. and 8/27/24 at 10:18 A.M., showed the resident on his/her back in bed with bilateral enabler rails raised on both sides at the head of the bed. 5. During an interview on 8/29/24 at 9:15 A.M., the Wound Nurse said the nurses assess residents for the use of side rails. He/She said maintenance staff are responsible for installment of side rails and inspections of side rails. He/She expected staff to obtain a physician's order for the usage of side rails. 6. During an interview on 8/29/24 at 10:01 A.M., LPN E said the use of any type of side rails should be assessed by the nurse. The nurse assesses for side rails upon admission. He/She doesn't think a consent needs to be obtained, but a physician order is required. The use of side rails should be on the resident's care plan. 7. During an interview on 8/29/24 at 12:36 P.M. with the Director of Nurses (DON) and LPN L/Unit Manager, they said bed changes may result in some residents having side rails who should not have them. The facility needs to implement an audit system. Resident #32 cannot grip or use his/her side rails. Resident #55 has some stiffness in his/her upper body and side rails may not be effective for him/her. His/Her side rails may be more of a boundary for him/her and may be beneficial on one side. Resident #47 uses enabler rails to transfer to and from bed. Nurses should assess residents for the use of side rails within the first five days of admission. The facility does not obtain consents for the use of side rails. A physician order should be obtained for the use of side rails and should indicate what type of device is used. Side rail use should be indicated on the resident's care plan. 8. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected nurses to assess residents for the use of side rails. He expected physician orders to be obtained for the use of side rails. 46888

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42795 Based on observation, interview and record review, the facility failed to establish a system of record for all controlled drugs with sufficient detail to enable an accurate reconciliation for three out of three medication carts reviewed. This had the potential to affect all residents with controlled substance orders. The census was 67. Review of the facility's Narcotic Count Change of Shift Policy, dated 1/4/23, showed: -Narcotics must be counted with the nurse or Certified Medication Technician (CMT) at the change of shift; The nurse and CMT must count the total number or cards and packages and note total on count sheet; Each care and package must be counted to ensure that the total number of narcotics is accurate and matches that total number of narcotics in the card or package; The nurse or CMT arriving for their shift and leaving their shift must initial the change of shift count sheet; If any discrepancies are noted at the change of shift the nurse or CMT are to notify the Director of Nursing (DON) or nursing management immediately. 1. Observation on 8/26/24 at 11:35 A.M., showed the Garden Unit nurses cart did not have a narcotic count sheet dated August, 2024. 2. Observation and interview on 8/26/24 at 11:40 A.M., showed the Garden Unit CMT cart did not have a narcotic count sheet dated August, 2024. CMT M said someone must have taken it because it was in the book earlier. During an interview on 8/29/24 at 11:50 A.M., the DON said the Garden Unit narcotic sheets dated August, 2024 could not be located. 3. Review of the Terrace Unit, Controlled Substance Shift Change Count Check Sheet, dated August, 2024, showed: -26 out of 50 shifts did not have a total number of packages noted; -Eight out of 50 shifts with no staff initials for the shift change count; -16 out of 50 shifts had only one staff initial for the shift change count. During an interview on 8/28/24 at 6:58 A.M., CMT U said the narcotic count is to be completed with one on-coming staff member and one off-going staff member every shift, every day. During an interview on 8/29/24 at 9:45 A.M., Licensed Practical Nurse (LPN) C said the narcotic sheets are to be available on each cart that has narcotics. The sheets should indicate the number of packages and initials of the staff counting. The narcotic count is to be completed with one on-coming staff member and one off-going staff member every shift, every day. The nurses and CMTs work twelve hour shifts. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 8/29/24 at 11:50 A.M., the DON said it is expected for CMTs and nurses to count the narcotics every day on every shift. The count should be completed with one on-coming staff member and one off-going staff member. The number of packages counted is expected to be written on the shift count sheet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42795 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals stored in a medication room refrigerator had a temperature log in one of two medication rooms observed. In addition, staff failed to keep a medication cart locked when left unattended. The census was 67. Review of the facility's Medication Storage policy dated, 6/1/18, showed: -Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier; -Procedures: All medications are maintained within the temperature ranges noted in the United States Pharmacopoeia (USP, an organization that sets standard for health care products) and the Centers for Disease Control (CDC); Medications and biologicals are stored at their appropriated temperatures and humidity according to the USP guidelines for temperature ranges; The facility should maintain a temperature log in the storage area to record temperatures at least one a day; Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1. Observation and interview on 8/27/24 at 8:25 A.M., showed the Garden Unit medication room with a small black refrigerator. The refrigerator had multiple insulin pens and insulin vials. A thermometer hung on the inside of the refrigerator door. The refrigerator temperature logs were not available for review. Certified Medication Technician (CMT) M searched in the medication room and the nurses station but could not locate any temperature logs. CMT M said the Unit Manager checks the temperatures. During an interview on 8/29/24 at 12:40 P.M., the Director of Nurses (DON) and Licensed Practical Nurse (LPN) L/Unit Manager said temperatures are expected to be checked by nursing staff on the night shift every day. The temperature logs for the Garden Unit medication room refrigerator could not be located. 2. Observation on 8/28/24 at 9:12 A.M., showed the nurses' medication cart on Garden Unit was unlocked. There were multiple residents returning from breakfast, ambulating with walkers and self-propelling in wheelchairs past the unlocked medication cart. The nurse was not near the medication cart. At 9:25 A.M., LPN Y returned to the medication cart and then locked the medication cart. During an interview on 8/28/24 at 11:46 A.M., CMT T said the medication cart should be locked every time the staff member walks away from the cart. It is to ensure residents don't get into the medications cart and remove something they shouldn't. There are many confused residents on the Garden Unit and locking the medication cart ensures resident safety. During an interview on 8/29/24 at 9:45 A.M., LPN C said the medication cart is to be locked every time the staff member walks away. Locking the medication cart ensures resident safety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 12:40 P.M., the DON said all medication carts are expected to be locked when the staff leave the cart. The DON expected all medication carts to always be locked when not in use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 46888 Based on observation, interview and record review, the facility failed to provide residents food that is palatable and at a safe and appetizing temperature for two residents (Residents #24 and #45) and residents on the Veranda hall. The sample was 17. The census was 67. Review of the facility's meal service temperatures policy, revised January 2019, showed: -Purpose: to ensure appropriate food temperatures during meal service and to ensure appropriate food holding temperatures. To comply with federal and state regulations governing food meal service; -Policy: meals temperatures shall be monitored by the dietary manager and the cooks on a daily basis. Hot food shall be cooked or heated to a temperature above 165 degrees. Cold food shall be chilled to a temperature below 40 degrees. 1. Review of Resident #24's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/21/24, showed: -Cognitively intact; -Diagnoses included manic depression and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 8/26/24 at 10:24 A.M., the resident said he/she eats meals in his/her room. He/She said the food is not good and the temperature is usually too cold. 2. Review of Resident #45's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included major depressive disorder, anxiety disorder and Alzheimer's disease. During an interview on 8/26/24 at 11:14 A.M., the resident says the food is not good and is sometimes cold. 3. Observation on 8/28/24 at 9:10 A.M., of breakfast trays served on the Veranda hallway, showed the following: -Pancakes measured at 105.2 degrees Fahrenheit (F); -Sausage measured at 99.5 degrees F. 4. Observation on 8/28/24 at 1:02 P.M., of lunch trays served on the Veranda hallway, showed the following: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mashed potatoes measured at 100.4 degrees F; -Chicken fried steak measured at 107.4 degrees F; -Cooked carrots measured at 95.7 degrees F. 5. During an interview on 8/29/24 at 7:25 A.M., Dietary Aide G said food should be served to residents at a safe and palatable temperature. He/She said this is important to keep residents from getting sick. 6. During an interview on 8/29/24 at 7:29 A.M., the Food Service Manager said she expected food to be delivered to residents at a safe and palatable temperature. She said this is important so residents get their food while it is still hot. 7. During an interview on 8/29/24 at 1:00 P.M., the Director of Nursing (DON) said she expected food to be delivered at the correct and palatable temperature. 8. During an interview on 8/29/24 at 3:01 P.M., the Administrator said he expected food to be delivered at a safe and palatable temperature. MO00240930

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure one resident received nectar-thick liquids (Resident #269) and one resident received a mechanical-soft diet (Resident #32) in accordance with physician orders. The sample was 17. The census was 67. 1. Review of Resident #269's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/9/24, showed: -Diagnoses of acute respiratory failure and dysphagia (difficulty swallowing); -Moderately impaired cognition. Review of the resident's Physician's Order Sheet (POS), showed an order, dated 7/9/24, for nectar thickened liquids. Review of the resident's care plan, in use at the time of the survey, showed: -Problem: resident receives a mechanical soft diet with nectar thickened liquids; -Goal: utilize interventions to help maintain weight and skin integrity; -Interventions: monitor oral intake of food and fluid, allow eating at own pace. Review of the resident's dietary order and communication slip, dated 7/9/24, showed the resident should receive mechanical texture food and nectar thickened liquids. Observation on 8/27/24 at 7:58 A.M., showed Certified Medication Technician (CMT) M administered medication to the resident. CMT M poured regular water from a pitcher into a cup and gave it to the resident. Upon the resident's request for more water, CMT M took the cup from the resident, filled it with more regular water, and gave it back to the resident. Observation on 8/28/24 at 12:49 A.M., showed Certified Nurse Aide (CNA) X delivered a lunch tray to the resident's room. CNA X placed regular lemonade onto the resident's tray and placed the tray in front of the resident to eat. 2. Review of Resident #32's medical record, showed diagnoses included dysphagia (swallowing disorder) and dementia. Review of the resident's admission MDS, dated [DATE], showed: -Resident rarely/never understood; -Mechanically altered diet received while a resident. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident is at risk for altered nutritional status. Resident receives a pureed diet fed by staff. He/She receives tube feeding from 8:00 P.M. to 8:00 A.M. due to poor appetite; -Interventions included provide diet as prescribed; -The care plan failed to reflect the resident's diet upgrade to mechanical soft texture, as assessed by Speech Therapy (ST) on 7/10/24. Review of the resident's ST treatment encounter note, dated 7/10/24, showed: -Precautions: Mechanical soft texture (upgraded via bedside on 7/10/24); -Educated nursing and kitchen staff on diet upgrade with voiced understanding. Review of the resident's POS, showed an order, dated 7/10/24, for mechanical soft diet with thin liquids. Review of the resident's dietary slips, in use at the time of survey, showed pureed diet for breakfast, lunch and dinner. Observation on 8/26/24 at 12:58 P.M., showed CNA K fed the resident a pureed brown food, a pureed orange food, and mashed potatoes. During an interview on 8/26/24 at 1:28 P.M., the resident said he/she ate lunch and is not hungry. He/She was unable to answer questions regarding his/her diet. Observation on 8/27/24 at 9:08 A.M., showed CNA K fed the resident pureed biscuits and gravy. During an interview, CNA K said the resident receives tube feeding at night and pureed food during the day. Observation on 8/27/24 at 1:28 P.M., showed CNA A fed the resident pureed food. During an interview on 8/28/24 at 8:18 A.M., Licensed Practical Nurse (LPN) E said the resident receives a pureed diet during the day. He/She eats really well. LPN E is not sure why the resident's diet is pureed. The resident is not an aspiration risk. During an interview on 8/28/24 at 10:58 A.M., CNA A said the resident receives tube feeding and a pureed diet. He/She needs assistance from staff to eat. Nursing staff know what type of diet the resident receives by checking the dietary slip that comes out with their meal trays. During an interview on 8/29/24 at 10:01 A.M., LPN E said if therapy makes a change to a resident's diet, therapy gives nursing a diet sheet, the nurse signs off on it, then tells dietary about the change. It is important for residents to receive their diets as ordered to ensure they don't choke. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 12:36 P.M. with the Director of Nurses (DON) and LPN L/Unit Manager, they said ST gave one of the nurses the new order for the resident to receive a mechanical soft diet, and the nurse entered the order in the medical record. The nurse should have filled out a diet order change slip when he/she put the order in. The diet order change slip would have been copied, with one copy going into the resident's chart and the other copy going to dietary so dietary could update the resident's dietary slip. 3. During an interview on 8/29/24 at 7:29 A.M., the Food Service Manager said she expected residents to receive their food and drinks according to their POS. 4. During an interview on 8/29/24 at 8:22 A.M., LPN L/Unit Manager said he/she expected staff to double check when passing room trays to residents to ensure they receive the proper food and drinks according to the resident's POS. 5. During an interview on 8/29/24 at 12:36 P.M. with the DON and LPN L/Unit Manager, they said they expected all residents to receive diets in accordance with physician orders. If staff is unsure about a resident's diet order, they should check the dietary slip that comes out with the resident's tray. Diet consistency, including liquids, should be reflected in the resident's physician orders. 6. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected residents to receive diets in accordance with their physician orders. He expected nursing staff to communicate with dietary staff about any changes made to a resident's diet orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46888 Based on observation, interview and record review, the facility failed to follow hair restraint policies while preparing food, keep the kitchen equipment clean and floors free of trash and grime. This had the potential to affect all residents who eat from the facility kitchen. The census was 67. Review of the facility's food service policy, undated, showed: -The facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes; -Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. Review of the facility's dietary cleaning schedule, undated, showed: -Items to be cleaned: walk in refrigerator are to be swept and mopped, the fryer is to be cleaned inside and out. 1. Observation on 8/26/24 at 10:10 A.M., 8/27/24 at 8:38 A.M., and 8/29/24 at 6:38 A.M. of the kitchen, showed: -The deep fryer had sticky liquid streaks on the sides of the fryer; -The dry storage room had food debris and various trash wrappers on the ground; -The walk-in refrigerator had food debris and trash wrappers on the ground under the racks. 2. Observation on 8/27/24 at 8:31 A.M., showed: -The Administrator and Maintenance Aide W walked into the kitchen during breakfast preparations. Maintenance Aide W did not wear a hairnet or beard net and walked up to the oven where eggs were being cooked. His/Her beard was approximately 1 inch long; -Dietary Aide G walked up to the steam table where the cook was dishing out breakfast plates with a hair net on that did not cover all his/her hair. His/Her hair hung out of the hairnet in the back and was approximately 10 inches long. Observation on 8/28/24 at 7:56 A.M., showed Food Service Assistant J stood over the steam table with uncovered food. His/Her hair net was pulled back and exposed approximately 1 inch of uncovered hair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 8/29/24 at 7:25 A.M., Dietary Aide G said hairnets should be worn in the kitchen and anytime staff are around food. This is important for sanitation. All kitchen staff are responsible for cleaning the floors in the kitchen, dry storage room, and walk in refrigerator. 4. During an interview on 8/29/24 at 7:29 A.M., the Food Service Manager said she would expect any staff member who comes in the kitchen during meal prep times to wear hair restraints. This includes hair nets and beard nets. Hair restraints should be worn correctly. All kitchen staff are responsible for sweeping the floors in the kitchen. The cook is responsible for cleaning the fryer. 5. During an interview on 8/29/24 at 3:01 P.M., the Administrator said he would expect the kitchen and appliances to be clean. He would expect for staff to be wearing hair restraints properly when in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32847 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with central lines to include dialysis access sites and centrally inserted intravenous (IV) lines, urinary catheters, wounds requiring treatment, and tube feedings administered via a feeding tube surgically inserted into the stomach through the abdomen, for nine of nine residents sampled for EBP (Residents #68, #32, #269, #55, #16, #29, #62, #69, and #5). The facility also failed to follow proper infection control practices during medication administration when staff touched the residents' medications and stuck their fingers into stock medication bottles to dig out medication, for two residents (Residents #269 and #45). In addition, the facility failed to ensure newly hired employees had their first step purified protein derivative (PPD, used to determine the presence of tuberculosis) read prior to starting at the facility and that the PPD results were read within 24 to 48 hours after administered, for four of five newly hired employees sampled. The sample was 17. The census was 67. Review of the facility's Matrix for Providers CMS form 802, provided during the annual survey, showed: -The facility identified seven residents as receiving tube feedings: -Of those seven, five were investigated for EBP (Residents #68, #32, #269, #55, and #29) -The facility identified one resident as having a urinary catheter: -Of the one, the resident was investigated for EBP (Resident #62); -The facility identified three residents as receiving dialysis: -Of the three, two were investigated for EBP (Residents #69 and #5); -The facility identified one resident as having intravenous access: -Of the one, the resident was investigated for EBP (Resident #68). Review of the most recent pressure ulcer/wound report, dated 8/21/24, showed six residents identified as having wounds. Of those six, two were included in the sample (Residents #32 and #16). Review of CMS memo QSO-24-08-NH, dated March 20, 2024, showed: -Subject: Enhanced Barrier Precautions in Nursing Homes; -CMS is issuing new guidance for State Survey Agencies and long-term care (LTC) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facilities on the use of EBP to align with nationally accepted standards; -EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status (MDROs); -The new guidance related to EBP is being incorporated into F880 Infection Prevention and Control; -EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; -Examples of chronic wounds include, but are not limited to, pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction), diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers; -Indwelling medical device examples include central lines, urinary catheters, and feeding tubes; -EBP should be used for any residents who meet the above criteria, wherever they reside in the facility; -For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: -Dressing; -Bathing/showering; -Transferring; -Providing hygiene; -Changing linens; Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter, feeding tube; -Wound care: any skin opening requiring a dressing; -Effective Date: April 1, 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation during all days of survey, from 8/26/24 through 8/29/24, showed no EBP signs posted on any resident doors and no PPE besides gloves available to staff for any resident room in the facility. 1. Review of Resident #68's medical record, showed: -An order dated 8/3/24, custom order night shift cleanse gastrostomy tube (g-tube, feeding tube) incision site with wound cleanser and pat dry. Apply 4x4 split gauze to site and secure with tape; -An order dated 8/16/24, for vancomycin (antibiotic) 1.25 gram IV solution 275 milliliter (ml) IV every 12 hours. Observation on 8/27/24 at 9:18 A.M., showed the resident in his/her room, in bed, and covered with a blanket. At 9:26 A.M., Licensed Practical Nurse (LPN) C entered the room, put on gloves, and exposed a single lumen peripherally inserted central catheter (PICC, intravenous access line inserted into a central vein) line and said this was the IV access site used for the resident. No EBP sign was posted on the door and no gown available to staff or worn. Observation on 8/28/24 at 6:25 A.M., showed the resident lay in bed. A phlebotomist with the lab company stood at the resident's side and drew blood from the resident's left-hand. The phlebotomist wore gloves. No EBP sign was posted on the door and no gown available to the phlebotomist or worn. 2. Review of Resident #32's medical record, showed: -An order dated 6/25/24, for Peg-tube (a type of feeding tube) dressing one time per day. Cleanse PEG site with warm water, pat dry and apply split gauze. Secure with tape. Document any signs and symptoms of infection; -An order dated 8/14/24, custom order, day shift cleanse left great toe wound with wound cleanser and pat dry. Apply Mupirocin (antibiotic) ointment to open area. Cover with 2x2 gauze and wrap with small piece of Coband (wrap). Wrap with just enough to wrap around wound one time. Treatment to be done every day. Observation on 8/28/24 at 6:54 A.M., showed Certified Nursing Assistant (CNA) D entered the resident's room. The resident lay on his/her back with his/her tube feeding connected to the g-tube, but turned off. CNA D uncovered the resident and unsecured his/her brief. CNA D assisted the resident to his/her left side. Observation of the resident's buttocks showed an open area to the coccyx (tailbone area). The opened area appeared reddened and had no dressing in place. CNA D pointed to the open area. The resident had stool in the buttocks crack. CNA D cleansed the resident, removed his/her gloves, and washed his/her hands. He/She wore no gown. CNA D then assisted the resident to be repositioned to his/her back and covered. No EBP sign was located on the resident's door or gowns available to staff for use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Skilled Nursing and Rehabilitation Center	3201 Parkwood Lane Maryland Heights, MO 63043

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/28/24 at 9:22 A.M., showed Wound Clinic Nurse F and the facility Wound Nurse entered the resident's room. The Wound Nurse cleaned the resident's bedside table with a bleach wipe and placed a clean barrier down. Both staff sanitized their hands and the Wound Nurse applied gloves. Wound Clinic Nurse F said the area to be treated is to the toe and is a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed) and is healing well. The Wound Nurse set out the supplies to provide care to the left toe. No gown was worn. Wound Clinic Nurse F uncovered the resident. The resident's tube feeding was connected to the g-tube but turned off. Wound Clinic Nurse F placed a towel under the resident's foot. He/She wore no gloves. No other PPE was worn. Wound Clinic Nurse F said he/she was not aware of any other open areas on the resident. The Wound Nurse said no one had told her of any new open areas on the resident. The Wound Nurse cleaned the resident's toe and applied the ordered treatment. As the area was treated, both staff leaned over the resident and their lab coats hung on the resident and the resident's bed. The Wound Nurse then wrapped the residents' foot with the wrap and said this helps keep the dressing on. The Wound Nurse removed her gloves and washed her hands with soap and water. The wound nurse assisted the resident to his/her right side. Wound Clinic Nurse F observed the area to the resident's coccyx and said the area is opened and presents as a stage II. He/She instructed the Wound Nurse to clean the area, apply betadine, and apply a Mepalex dressing (foam dressing with adherent edges). Wound Clinic Nurse F said the opened area was caused by the resident laying on his/her back too much. The Wound Nurse cleaned the area, applied betadine, and covered with a Mepalex dressing. The Wound Nurse removed her gloves and washed her hands. The Wound Nurse applied gloves and both staff assisted to position the resident onto on his/her right side with pillows. No EBP sign was located on the resident's door or gowns available to staff for use. 3. Review of Resident #269's medical record, showed an order dated 8/3/24, custom order, night shift cleanse g-tube site with wound cleanser and pat dry. Apply 4x4 split gauze to site and secure with tape. Observation on 8/27/24 at 7:39 A.M., showed Certified Medication Technician (CMT M) entered the resident's room and covered him/her with a blanket. He/She then grabbed the resident's arm to put a blood pressure cuff on the resident's right wrist. The resident's blood pressure was measured and the CMT F removed the blood pressure cuff. CMT M then assisted the resident to reposition in bed by grabbing his/her hands and assisting to move his/her legs. He/she wore no gown. No EBP sign was located on the resident's door or gowns available to staff for use. 4. Review of Resident #55's medical record, showed an order dated 5/1/24, for Jevity 1.5 Cal (liquid meal replacement) 70 ml per hour. At 6am start continuous feeding, at 6am to 10pm. 200 water flush every 4 hours. Observation on 8/26/24 at 1:04 P.M., showed CNA K entered the resident's room and assisted to feed the resident pureed food. No gown or gloves were worn. No EBP sign was located on the resident's door or gowns available to staff for use. On 8/27/24 at 9:18 A.M., CNA K entered the resident's room and assisted to feed the resident pureed food. No gown or gloves were worn. No EBP sign located on the resident's door or gowns available to staff for use. At 12:14 P.M., the resident lay in bed. Tube feeding Jevity 1.5 infused at 70 ml per hour. No EBP sign located on the resident's door or gowns available to staff for use. 5. Review of Resident #16's medical record, showed a wound clinic note, dated 8/21/24: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Evaluate and treat multiple pressure wounds to the right foot, right lateral (outer) foot, and sacrum (tailbone area), below the knee amputation to the left leg; -Goal: Resolve open pressure wounds with weekly visits until closure. Observation and interview on 8/28/24 at 8:40 A.M., showed the resident lay in his/her bed on his/her right side and the Wound Nurse and the Wound Clinic Nurse F stood on each side of the resident's bed with gloved hands. The Wound Clinic Nurse F said they had just completed the resident's coccyx dressing. The resident was repositioned on his/her left side by the Wound Nurse and the Wound Clinic Nurse F. The Wound Nurse removed the resident's right heel protector, and the resident's right foot and heel dressing. Wound Clinic Nurse F cleaned the resident's right foot and heel wound with a dry gauze and measured the resident's wounds. The Wound Nurse leaned over the resident's bed and cleaned the resident's right foot and heel wound with wound cleanser and redressed the resident's wounds. The Wound Nurse's name badge and uniform top touched the resident's leg and bedding while cleaning and redressing the resident's wound. The resident's heel protector was reapplied by Wound Clinic Nurse F. The Wound Nurse and the Wound Clinic Nurse covered the resident with a bed sheet and blanket. The Wound Nurse and the Wound Clinic Nurse F did not wear a gown during the resident's treatment. No EBP sign located on the resident's door or gowns available to staff for use. 6. Review of Resident #29's medical record, showed an order dated 2/6/24, for peg-tube dressing, night shift change dressing to peg tube insertion site daily, monitor for signs and symptoms of infection, notify physician of any changes. Observation on 8/27/24 at 9:15 A.M., showed the resident lay in his/her bed. CNA S applied gloves and assisted the resident to turn to his/her left side. CNA S removed the resident's brief, and the resident was checked for incontinence. The resident was dry and was repositioned by CNA S to his/her back. The resident's bed sheets were adjusted and pulled up over the resident. No gown was worn during the resident's care. No EBP sign located on the resident's door or gowns available to staff for use. 7. Review of Resident #62's medical record, showed an order dated 6/20/24, for Foley (brand of urinary catheter) and suprapubic catheter (a urinary catheter surgically inserted through the abdomen and into the bladder) every 2 shift, cleanse peri-area and catheter tubing with warm soap and water. Observation on 8/28/24 at 7:47 A.M., showed the resident in his/her room and sat in a chair. He/She wore long pants and said he/she does have a urine bag attached to his/her leg. The urine drains from a tube inserted into his/her abdomen. No EBP sign located on the resident's door or gowns available to staff for use. 8. Review of Resident #69's medical record, showed an order dated 12/18/20, for every 2 shift, monitor shunt/graft/fistula (different types of dialysis access sites) for signs and symptoms of infection and adequate circulation. Observation on 8/27/24 at 1:15 P.M., showed LPN C donned gloves and pulled the resident's gown down at the neck of and said the resident used to have a dialysis access site in his/her arm, then he/she had a blockage and now his/her dialysis site is in her upper right chest. He/She now has a double lumen central main line access site. LPN C wore gloves but no gown worn. No EBP sign located on the resident's door or gowns available to staff for use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of Resident #5's medical record, showed an order dated 11/16/22, custom order every 2 shift, check bruit and thrill (the sound made and vibration felt as blood passes through the shunt) left forearm atrial venous (AV). Observation and interview on 8/26/24 at 11:01 A.M., showed the resident in his/her room in a wheelchair. A dressing was intact to his/her left arm, just above the elbow near the bicep area. The resident said this was his/her dialysis access site. Staff monitor it when he/she returns from dialysis. The dialysis company applies the dressing while at dialysis. It is a shunt. He/She just got back from dialysis. He/She has no concerns with care and is very happy. No EBP sign was located on the resident's door or gowns available to staff for use. 10. During an interview on 8/29/24 at 9:50 A.M., CNA K said he/she did not know what EBP is. 11. During an interview on 8/29/24 at 9:12 A.M., the Wound Nurse and unit manager said she did not know what EBPs are. She has not received any training on it. 12. During an interview on 8/29/24 at 7:51 A.M., CNA S said he/she did not know what EBP was and has received no training on it, but there is personal protective equipment (PPE) in central supply. 13. During an interview on 8/29/24 at 9:45 A.M., LPN C said he/she had no idea what EBP was, and he/she had not received any education or in-servicing on EBP. 14. During an interview on 8/29/24 at 12:50 P.M., with the DON and LPN L/Unit Manager, they said the administrator had approached them a while back about a new requirement for gowns and other PPE during routine care. They did not believe it applied to them, so it was not implemented. 15. During an interview on 8/29/24 at 2:55 P.M., the administrator said regarding the requirement for enhanced barrier precautions, he did bring it to the DONs attention, and she said she did not feel it was relevant to them. Nothing has been implemented. 16. Review of the facility's Medication Administration policy, dated 6/1/18, showed; -Oral medication administration; -For solid medications: Pour or push the correct number of tablets or capsules into the souffle' (medication) cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. 17. Review of Resident #269's face sheet, undated, showed diagnoses that included: respiratory failure, gastro-esophageal reflux disease (heartburn, GERD), anxiety disorder, high blood pressure and kidney disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/27/24 at 7:45 A.M., showed CMT M prepared to pass medications for residents on the Garden Unit CMT cart. CMT M removed one acid reducer 20 milligram (mg) tablet and one renal (kidney) vitamin 0.8 mg tablet out of the facility stock bottle by placing his/her ungloved fingers into the bottle to retrieve the medications and then placed the medication into a clear medication cup. CMT M removed one amlodipine (used to treat high blood pressure) 10 mg tablet; one apixaban (blood thinner) 5 mg tablet; one benztropine (used to treat muscle tremors) 0.5 mg tablet; one buspirone (used to treat anxiety) 15 mg tablet; one clonidine (used to treat high blood pressure) 0.1 mg tablet; and one escitalopram (used to treat depression and anxiety)10 mg tablet by popping the medication out of the medication bubble card into his/her ungloved hand and then placing it into the clear medication cup. CMT M then placed the medication in a clear sleeve and crushed medications. CMT T then mixed the crushed medication in pudding and administered the medications to the resident. 18. Review of Resident #45's face sheet, undated, showed diagnosis that included: Alzheimer's disease, depression, and anxiety. Observation on 8/27/24 at 7:54 A.M., showed CMT M removed one loratadine (medication used to treat allergy symptoms) 10 mg tablet out of the facility floor stock bottle with ungloved fingers, placed it in a clear medication cup and administered the medication to the resident. 19. During an interview on 8/28/24 at 11:46 A.M., CMT T said medications that are in the facility stock bottles are to be dispensed by shaking the medication into the lid of the bottle and then place it in the medication cup. The medications should not be dispensed by placing fingers in the medication bottle. The bubble pack medications are to be popped directly into the medication cup. The medications should not be placed in the staff's hand first. The resident's medication should never be touched prior to administration. It is poor infection control practices. 20. During an interview on 8/29/24 at 9:45 A.M., LPN C said the medication should be directly placed into the medication cups. Staff should not be touching the medication prior to giving it to the resident. If they do have to touch the medications, then they should be wearing gloves. 21. During an interview on 8/28/24 at 12:50 P.M., the DON said that staff are expected to use proper infection control practices and not directly touch the resident's medication prior to administration. 22. Review of the facility's undated PPD Tuberculosis Testing and Screening policy for employees, showed: -A two step PPD skin test is to be administered on all new employees prior to employment with the first step being completed prior to start date, unless the test was performed within the past month; -If the initial test is negative after 48 to 72 hours, the second PPD test is to be given. Review of Staff AAA's employee file, showed: -Date of hire 10/2/23; -First step PPD administered on 10/2/23; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-First step PPD read late on 10/6/23. Staff BBB's employee file, showed: -Date of hire 6/6/24; -First step PPD administered on 6/5/24; -First step PPD read negative on 6/8/24. Staff CCC's employee file, showed: -Date of hire 7/5/24; -First step PPD administered on 7/5/24; -First step PPD read negative on 7/8/24. Staff DDD's employee file, showed: -Date of hire 11/30/23; -First step PPD administered on 11/30/23; -First step PPD read late on 12/4/24. During an interview on 8/27/24 at 1:04 P.M., the HR/Staffing Coordinator said the first date working in the facility does not necessary correspond to the date of hire. She will provide the first date worked for the sampled staff. Nursing staff is responsible for new employee PPDs. Review of the list of staff first date worked, showed Staff AAA, Staff BBB, Staff CCC, and Staff DDD's date of hire was the same as their first date worked. During an interview on 8/29/24 at 12:50 P.M., with the DON and LPN L/Unit Manager, they said they way they have done it, is make sure the first step is given by date of hire, but they are not reading it before the staff start. They were not aware of the requirement that the first step be read prior to starting. PPDs should be read within 2-3 days. 40290 42795

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure staff completed routine inspections of bed/side rails as part of a regular maintenance program to identify possible areas of entrapment to reduce the risk of accidents for four residents (Residents #55, #32, #47, and #50). The facility identified 47 residents with side rails in use. The census was 67. Review of the FDA (Federal Drug Administration) guidance, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, showed: -It is suggested that facilities and manufacturers determine the level of risk for entrapment and take steps to mitigate the risk. Evaluating the dimensional limits of the gaps in hospital beds is one component of an overall assessment and mitigation strategy to reduce entrapment; -The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement; -Bed rails (commonly used synonymous terms are side rails, bed side rails, grab bars and safety rails), may be an integral part of the bed frame or they may be removable and at times are used either as a restraint, a reminder or an assistive device; -There are seven potential entrapment zones in hospital beds. Review of the facility's Restraints/Side Rails policy, dated 4/28/17, showed: -Side Rail Guideline: -The assessment and documentation also includes measuring the gaps between the rail(s) themselves and the gaps between the side rail and the mattress. A visual review is performed to assess that the mattress does not shift/slide allowing for an increased gap between the bed and the side rail; -The policy failed to provide guidance for routine inspections of side rails after installation, as part of a regular maintenance program. 1. Review of Resident #55's medical record, showed diagnoses included seizures, stroke, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke. Review of the resident's side rail evaluation, dated 2/29/24, showed: -Type of side rail not indicated; -No documentation of maintenance inspection for gap measurements. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/6/24, showed: -Cognitively intact; -Upper and lower extremity impairment on one side; -Dependent on assistance to roll left and right. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident is at risk for falls. Resident requires total assist of two with bed mobility. He/She had a recent stroke with left sided hemiparesis and recently diagnosed with seizures; -No documentation related to the use of side rails. Observation on 8/26/24 at 12:58 P.M., showed the resident on his/her back in bed, on a low air loss mattress (mattress that provides a constant flow of air in the mattress). U-shaped rails were raised on both sides of the bed, at the head of the bed. The resident used his/her right arm to pull the right rail, which moved several inches as the resident pulled. During an interview, the resident said he/she was trying to use the rail to pull him/herself to move the pillow on his/her right leg. Observation on 8/28/24 at 8:15 A.M., showed the resident using his/her right arm to pull the right side rail. The rail moved back and forth approximately five inches. During an interview, the resident said he/she was trying to get out of bed. 2. Review of Resident #32's medical record, showed diagnoses included Parkinson's disease (brain disorder causing unintended or uncontrolled movements), dementia, and depression. Review of the resident's side rail evaluation, dated 6/25/24, showed: -Type of side rail not indicated. Review of the resident's admission MDS, dated [DATE], showed: -Resident rarely/never understood; -Dependent on assistance for mobility. Review of the resident's care plan, in use at the time of survey, showed: -Care area/problem: Resident is at risk for falls. Resident is not ambulatory. His/Her left leg is contracted (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement); -No documentation related to the use of side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/24 at 1:28 P.M., showed the resident on his/her back in bed with U-shaped rails raised on both sides of the bed, at the head of the bed. During an attempted interview, the resident was unable to respond to questions regarding the side rails. Observations on 8/27/24 at 8:49 A.M. and 12:16 P.M., on 8/28/24 at 7:59 A.M., and on 8/29/24 at 7:11 A.M., showed the resident on his/her back in bed with U-shaped rails raised on both sides at the head of the bed. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed: -Diagnosis of end stage renal disease (ESRD, kidney failure); -Cognitively intact. Observation on 8/26/24 at 11:23 A.M., showed the resident's bed with bilateral enabler rails. Review of the resident's medical record, showed no documentation of side rail inspections to identify areas of entrapment. 4. Review of Resident #50's quarterly MDS, dated [DATE], showed: -Diagnoses of acute kidney failure and major depressive disorder; -Cognitively intact. Review of the resident's medical record, showed no documentation of side rail inspections to identify areas of entrapment. Observation on 8/26/24 at 1:13 P.M., showed the resident's bed with bilateral enabler rails. 5. During an interview on 8/29/24 at 10:01 A.M., Licensed Practical Nurse (LPN) E said Maintenance is responsible for installing and inspecting side rails for safety. 6. During an interview on 8/29/24 at 12:36 P.M. with the Director of Nurses (DON) and LPN L/Unit Manager, they said Maintenance installs and inspects side rails. 7. During an interview on 8/29/24 at 2:28 P.M., the Maintenance Director said he has worked with the facility for 10 days and does not have a system in place for side rail inspections, yet. Maintenance staff installs side rails on resident beds. Side rails should be measured for safety. Side rails should be inspected routinely because they can get loose over time. Side rails should be secure to prevent the risk of entrapment. 8. During an interview on 8/29/24 at 2:55 P.M., the Administrator said he expected side rails to be inspected by Maintenance on a routine basis. Side rails should be inspected to reduce the risk of entrapment. 46888

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 40290 42795 46888 Based on observation, interview and record review, the facility failed to ensure the facility's pest control program was effective in preventing roaches, which affected eight of 17 sampled residents (Residents #45, #27, #2, #46, #43, #168, #34 and #67). The census was 67. Review of the facility's pest control policy, revised 4/22/23, showed: -Parkwood has a contract with CES Pest Control Company. CES will come out every 2 weeks to spray for bugs and use traps for both bugs and other pests. If additional spraying is needed Parkwood will call CES to come out and spray. A log book is in the front office for CES to sign whenever staff indicates a certain area needs attention for spraying. Any staff member can write a request in the log book for CES to spray or put down traps. If a resident room needs more then the CES spraying Parkwood will move the resident(s) in that room temporarily so that the room can be bug bombed. Clothes will be sent down to laundry and beds and drawers will be cleaned. 1. Review of the facility's pest control logs, showed the company initialed treatments as completed on 6/13/24 in a resident's room for roaches, 6/27/24 in a resident's room for roaches, 7/11/24 in a resident's room for roaches, 8/8/24 in a resident's room for roaches and 8/22/24 in a resident's room for roaches. The pest control company did not document recommendations for facility staff. There were no entries by staff for areas that needed attention for spraying. 2. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/7/24, showed: -Cognitively intact; -Diagnoses included major depressive disorder, anxiety disorder and Alzheimer's disease. Observation on 8/27/24 at 10:43 A.M., of the resident's room, showed: -Two red roaches crawling on the resident's sink; -A dead red roach inside a box of gloves stored on resident's sink; -Three sink drawers with various dead and living roaches. Drawer number one had food trash and opened packages of cookies. Dead red roaches were on the resident's wash cloths. Three live red roaches crawled in the drawer. The drawer had dark, brown tiny specked matter in various areas. The second and third drawer had various live red roaches crawling in the drawer. The drawer had dark, brown tiny specked matter in various areas. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265523	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Skilled Nursing and Rehabilitation Center	3201 Parkwood Lane Maryland Heights, MO 63043

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The top drawer of the resident's nightstand had two live roaches crawling on the resident's masks; -One live red roach was on the resident's pillow. Observation on 8/28/24 at 10:15 A.M., of the resident's room, showed: -One red roach crawling on the resident's sink; -A dead red roach inside a box of gloves stored on resident's sink; -Three sink drawers with various dead and live roaches. Drawer number one had food trash and opened packages of cookies. Dead red roaches were on the resident's wash cloths. Two live red roaches crawled in the drawer. The drawer had dark, brown tiny specked matter in various areas. The second and third drawer had various live red roaches crawling in the drawer. The drawer had dark, brown tiny specked matter in various areas. -The top drawer of the resident's nightstand had two live roaches crawling on the resident's masks; During an interview on 8/27/24 at 10:45 A.M., the resident said seeing all the bugs in his/her room makes him/her feel sick. He/She said housekeeping staff have not cleaned his/her room for at least six months. He/She eats most of his/her meals in his/her room. During an interview on 8/29/24 at 12:53 P.M., the Director of Nursing (DON) said the resident has a tendency to store food in his/her room and has not allowed staff to come into his/her room to clean. She expected interventions to be put in place for staff to follow in order to keep the resident's room clean and free from bugs. She said the state of the resident's room is unacceptable. She expected the resident's room to be clean and free from bugs. 3. Review of Resident #27's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnosis included high blood pressure and depression. During observation and interview on 8/26/24 at 10:40 A.M., the resident's bathroom had approximately 12 brown roaches crawling on the door and wall of the bathroom. The resident insisted the door be closed immediately so the roaches do not come in his/her room. He/She has seen the roaches for many months and doesn't like it. Sometimes he/she will see someone spray the room but it is obvious that whatever is sprayed is not working. During observation and interview on 8/27/24 at 9:15 A.M., the resident had a personal stainless steel pink cup with a lid on his/her bedside table. In the bottom of the cup, there were two dead brown roaches. A family member was sweeping the resident's room as a brown roach crawled up the resident's wall. The family member hit the roach with the broom. The resident's family member said the roaches are everywhere and he/she has seen them in the resident's room for several months. The resident's bathroom door also had multiple roaches crawling in and out of a small hole at the top of the door. 4. Review of Resident #2's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnoses included heart failure, renal (kidney) failure, dementia and depression. Observation on 8/28/24 at 6:45 A.M., showed the resident sat in the dining room and self-propelled him/herself to his/ her bathroom on the Garden Unit. The resident turned the light on in the bathroom and three brown roaches were crawling on the wall of the bathroom. The resident then used the restroom. The resident was not aware of the roaches on the bathroom wall. 5. Review of Resident #46's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included depression, anxiety and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 8/26/24 at 1:19 P.M., the resident said he/she has seen bugs in his/her room. Observation on 8/27/24 at 9:10 A.M., showed a full trash can in the middle of the resident's room. Two cockroaches crawled in and out of the trash can. One cockroach crawled out of the trashcan and into a hole in the back of the resident's dresser. During an interview on 8/27/24 at 9:11 A.M., Certified Nursing Assistant (CNA) K said there are a lot of cockroaches in the resident's room. 6. Review of Resident #43's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included depression and anxiety. During an interview on 8/26/24 at 11:26 A.M., the resident said he/she has seen roaches in his/her room. Someone comes around the facility and sprays for them. Observation on 8/27/24 at 1:54 P.M., showed a pile of clothing on the floor in the middle of the resident's room. Two cockroaches crawled in and out of the clothing. 7. Review of Resident #168's medical record, showed diagnoses included unspecified injury of neck and vertigo (dizziness). Observation on 8/26/24 at 10:59 A.M., showed a bait trap underneath the sink in the resident's bathroom. The bait trap was full of bugs. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/24 at 10:59 A.M., the resident said he/she was admitted to the facility three days ago. He/She just had surgery on his/her spine and cannot move his/her arms very well. Cockroaches crawl all over the wall in his/her room and it freaks him/her out. Cockroaches crawl around the floor in his/her bathroom and he/she has to lift his/her feet when he/she is on the toilet because if they get on him/her, he/she cannot move his/her arms to knock them off. 8. Review of Resident #34's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnosis included depression. During an interview on 8/26/24 at 11:42 A.M., the resident said there are cockroaches in his/her room. They crawl on him/her at night. He/She has seen someone spray the halls for bugs, but they do not spray in the resident's room. 9. Review of Resident #67's care plan, in use at the time of the survey, showed resident has a self-care deficit: Resident has chronic obstructive pulmonary disease (COPD, lung disease) and is on continuous oxygen. He/She needs limited assistance with toileting, dressing, grooming and transfers. Gets easily exerted. During an interview on 8/26/24 at 10:24 A.M., the resident said his/her only concern is all the roaches. He/She sees them in his/her room. 10. During an interview on 8/27/24 at 10:42 A.M., CNA S said all management is aware of the roach problem and the number of roaches in the residents' rooms is out of control. 11. During an interview on 8/28/24 at 10:58 A.M., CNA A said there are cockroaches throughout the facility. An exterminator comes out the facility twice a month, but the cockroaches are still everywhere. 12. During an interview on 8/29/24 at 8:15 A.M., Housekeeper V said he/she was aware of the brown roaches. There is a insect spray in the housekeeping closet they can use as needed. The residents have too many opened food items that attract the roaches. 13. During an interview on 8/29/24 at 9:50 A.M., CNA K said the cockroaches in the facility have been getting worse. Someone comes out to the facility to spray for them, but they spray the halls and trash room, but not really the resident rooms. Nursing staff do what they can to help by stepping on the bugs, buying their own bug spray, keeping food out of resident rooms, and encouraging residents to eat in the dining room instead of their rooms. 14. During an interview on 8/29/24 at 2:28 P.M., the Maintenance Director said he has seen an issue with pests in the facility. During his first week working at the facility, he removed all items in one resident room and had housekeeping deep clean it, then spray it for pests. The bugs came back. An outside pest control company comes to the facility every other week. The pest control company does not meet with him after their visits and he did not know if they made any recommendations to help with pest control. (continued on next page)

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