STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265586	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Place Health and Rehabilitation	2600 Redman Road Saint Louis, MO 63136

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35394 Based on interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity and respect for one sampled resident (Resident #59). The sample size was 18. The census was 85. The facility was notified of past non-compliance on 8/3/24. Facility staff immediately intervened, separated the resident and staff, reported the incident, and began their investigation. The investigation consisted of written statements, interviews from witness, and other staff and residents on the unit. Staff were in-serviced on abuse and neglect prevention and promoting/maintaining resident dignity. The deficiency was corrected on 7/2/24. Review of the facility's Promoting/Maintaining Resident Dignity policy, dated 7/2/24, showed: -Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality; -Compliance Guidelines: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights; -During interactions with residents, staff must report, document and act upon information regarding resident preferences; -Interview results will be documented; the provision of care and care plans will be revised, if appropriate, based on information obtained from resident interviews; -The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences; -When interacting with a resident, pay attention to the resident as an individual; -Respond to requests for assistance in a timely manner; -Explain care or procedures to the resident before initiating the activity; (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused and resident centered; -Groom and dress residents according to resident preference; -Speak respectfully to residents; avoid discussions about residents that may be overheard; -Respect the resident's living space and personal possessions; -Maintain resident privacy; -Assist residents to participate in activities of choice; -Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source; -Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy. Review of Resident #59's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/27/24, showed: -Cognitively intact; -Diagnoses include neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem), wound infection, quadriplegia (paralysis of all four limbs), malnutrition, and depression; -Dependent with eating, oral hygiene, toileting, shower/bath, and personal hygiene; -No behaviors. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has an Activity of Daily Living (ADL) self-care performance deficit; -Goal: Resident will maintain/improve level of functioning; -Interventions: Bathing/Showering: Avoid scrubbing and pat dry sensitive skin; -The resident is totally dependent on one staff for personal hygiene and oral care. Review of the resident's progress notes, showed: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/29/24 at 12:00 P.M., this nurse assisted Certified Nurse Aide (CNA) with cleaning and dressing patient for the day. Upon departure from room, this nurse went into adjacent room to wash hands. When coming out of room this nurse began to hear some yelling and cursing. He/She then approached this patient's room and CNA appeared to have been washing patient's face, but then tossed towel onto patient and proceeded to walk out of the room, stating that he/she was unable to work with patient because he/she is rude. This nurse then asked patient what occurred. Patient stated, all he/she asked him/her to do was to get the towel off of his/her bed. He/She then stated, you can at least say please. Patient states that he/she then replied, You didn't give me a chance to finish my sentence. Patient states that CNA then started saying things like You can't say anything to us, and you are so rude, while using profanity. Patient states that CNA then proceeded to wash his/her face with a washcloth but was very rough when doing so. Patient states that he/she then threw the towel on top of his/her head and walked out of the room. This nurse immediately had patient and CNA separated and informed CNA that he/she is not to return to patient's room or communicate with him/her. This nurse educated CNA on therapeutic communication and providing care with ease while caring for patients. CNA sent home pending investigation. Patient has no distress or injuries noted; -On 6/29/24 at 1:00 P.M., patient phoned his/her parent following verbal altercation informing him/her of incident. Patient's parent then arrived to the facility and came to the nursing station. This nurse spoke with patient's parent and informed that CNA was sent home, and informed him/her that there will be a full investigation conducted. Patient's parent eventually calmed down and visited with patient. Director of Nursing (DON) and administrator informed of verbal altercation. Review of the facility's investigation, showed: -Date/time alleged incident occurred: 6/29/24 at 12:15 P.M.; -Summary of interview with person(s) reporting the alleged incident: Resident reported that CNA L was cursing at him/her and while wiping his/her face with the towel was rough and smashing his/her face. He/she denies cursing at CNA L during the interaction; -Summary of interviews with witnesses: Licensed Practical Nurse (LPN) K had been assisting CNA L with the resident and had left the room to assist someone else. He/She was in the adjacent room when he/she heard cursing coming from the resident's room. LPN K states that he/she heard both CNA L and the resident say the F word but could not hear the interaction. When he/she entered the room, he/she saw CNA L toss the towel on his/her head. It was on his/her forehead/top of his/her head. Upon assessment there were no visible marks; -Summary of interviews with staff: CNA L stated that he/she and the nurse went to assist the resident and everything was fine until the nurse left the room. He/She stated that the resident became disrespectful and stated the staff is to come when he/she calls them. He/She stated that he/she was calling staff names. CNA L stated that he/she told him/her that he/she cannot talk to people like that and he/she said, F you. At which time he/she responded, F me? He/She denies ever cursing at him/her but did say she/he was only repeating what he/she said to him/her. CNA L denies ever being rough while wiping his/her face and that he/she tossed the towel onto his/her forehead/top of his/her head as he/she always has a towel around his/her head. He/She stated that he/she had never had any prior negative interactions with the resident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Summary of investigators findings: It is the determination of the facility that abuse cannot be substantiated. A thorough investigation was completed including interviews of staff and residents. While a negative interaction occurred between resident and CNA L, it cannot be said that abuse occurred; -Outcome of the investigation and any interventions/changes to plan of care/corrective actions (if appropriate) taken: A post trauma assessment was completed with resident with no negative psychosocial impacts noted. He/She has continued his/her normal daily routine since the incident. His/her care plan has been updated as needed. Education with staff on abuse/neglect as well as resident rights/dignity to be completed. Review of CNA L's written statement, dated 6/29/24, showed: myself and LPN K was in the resident's room to change his/her dressing. As we were finishing up, he/she was being very disrespectful by saying he/she was tired of the place and we CNAs/nurses are supposed to come when he/she calls, and he/she can talk to me the way he/she wants to. He/she asked for his/her towel and I said hold up and that is when he/she responded by saying you are lazy, your job is to do whatever I ask, no matter how he/she says it. CNA L then said who are you talking to like that, you cannot talk to people like that. The resident said F you, then CNA L said, F me, really? F me? CNA L then walked out and asked the nurse to remove him/her from his/her assignment. He/She did not feel comfortable. Review of CNA L's telephone interview, dated 7/3/24, showed: -Was LPN K in there the whole time: He/She was in there until he/she finished his/her dressing and stepped out; -Was there any negative interaction between you and him/her while the nurse was in there? No, he/she was just frustrated that he/she had to wait a little while to get his/her wounds done. We got him/her up and then he/she wanted repositioned in his/her chair, so we did that and the nurse left; -Did you curse directly at him/her: No, I repeated what he/she had said to me; -Did you wash his/her face with the towel: He/she had sweat on his/her forehead, and I wiped it off; -Did he/she make any comments while you were wiping his/her forehead: No, he/she was fine and didn't say anything; -Did you wipe his/her face in a rough manner or did he/she say anything to the affect that you were hurting him/her? No; -When you were done wiping his/her face, what did you do with it: Placed it on his/her forehead because that is where he/she always has it; -Have you ever had any negative interactions with the resident: No. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN K's written statement, dated 6/29/24, showed this nurse along with CNA L had gotten the resident out of bed for the day. Once patient was in his/her wheelchair, this nurse went into adjacent room to wash hands. Upon leaving the room, I could hear loud cursing coming from this patient's room. He/She then reapproached the room and asked, What happened, what is going on? CNA L tossed the towel that he/she was using onto patient's head and proceeded to walk out the room, stating he/she cannot work with him/her, he/she is too rude. When he/she asked patient what transpired, he/she stated he/she asked him/her to get the towel off the bed and he/she said, you could at least say please. They began to go back and forth with profanities. Patient stated that he/she was wiping his/her face forcibly. I did hear patient stating you can stop now several times as I was approaching the room. When I asked CNA what occurred he/she stated that he/she thinks that he/she can talk to people any kind of way, and he/she admitted to using profanities when speaking with him/her. Review of LPN K's telephone interview, dated 7/2/24, showed: -When you entered the room, did you witness him/her toss the towel on his/her head: Yes; -Where did the towel land: Forehead/top of head; -Was it in any way covering his/her eyes, nose, or mouth: No; -Did you clearly hear what the cursing was: No, just could hear the F word from both of them; -Did you notice any agitation prior to incident while you were in the room: No. Review of the resident's follow up interview, dated 6/29/24, showed they were getting the resident up. CNA entered the room. CNA to wipe resident's face, CNA responded you could say please. Resident say you did not give me a chance and it's your job. CNA said you're rude, he/she then took the towel covered his/her face with the towel, wiped hard like smashing his/her face. The nurse walked up to the resident room in the doorway and saw the CNA had the towel over the resident's face. The nurse then took the resident outside to calm him/her down. Resident denies cursing at CNA. Review of the resident's progress notes, showed on 6/30/24 at 11:22 P.M., resident noted to be in wheelchair and in good spirits. Found to be joking with other residents. States he continues to feel safe and has not had any ill feelings since the incident. No pain or open skin in facial area. Investigation follow up (IFU) continues. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 12:41 P.M., the resident said he/she remembered the incident that occurred with the CNA. He/She did not know the CNA's name. The CNA got mad because he/she did not say please when he/she asked the CNA to clean his/her face. He/She told the CNA that he/she did not give the resident a chance, and even if I did not, it's his/her job. The aide mushed the towel on the resident's face after asking to wipe it. The resident clarified and said the aide pushed the cloth into his/her face. Instead of wiping his/her face, the aide pushed the towel in his/her face. The resident said it felt aggressive and it was an assault. The resident said the CNA continued to mush him/her. The resident said the CNA did not cuss at him/her. The aide covered the resident's face with the towel when the nurse came in. The nurse came in and asked what was going on. The CNA walked out of the room leaving the towel over the resident's face. It was the first time having interaction with the aide and first time seeing her/him. The aide told the resident he/she was demanding. The resident said he/she was not demanding but was just telling him/her what he/she needed. The resident never had problems with anyone here. Everyone gives him/her love and maybe that aide just had a bad day. During an interview on 8/5/24 at 8:28 A.M., CNA L said he/she had worked at the facility for three weeks. He/She never took care of the resident on his/her own. On that day, he/she assisted the resident, and he/she was upset with the nurse. He/She wanted to get his/her wounds done so he/she could go out to smoke. When the nurse was able to go in there it was 11:00 A.M. Nurse asked CNA L to go in and the resident was irritated. Once the resident sat in the chair, the nurse walked out of the room and the resident said these lazy Bs. CNA L could not remember exactly how it went, but the resident said, I'm so tired of these lazy Bs and these MFs. CNA L asked the resident, who he/she was talking to. The resident said I am talking to you. CNA L said you cannot talk to me like that. The resident said he/she can talk to him/her however the F he/she wants and F you. CNA L said F me, really? The resident cursed at CNA L and then asked CNA L to wipe his/her forehead. He/She wiped his/her forehead and around the same time the nurse entered the room and asked what was going on. CNA L said I cannot assist him/her. CNA L also spoke to someone from corporate. He/She reported that he/she only repeated what the resident said. He/She did not curse or hit him/her. He/She wiped the sweat from the resident's face. He/She did not do anything to him/her. CNA L wanted to be removed from the assignment. CNA L also found out they had a meeting about the resident's behavior the week before. When asked to describe how he/she wiped the resident's face, CNA L said he/she patted the resident's face. He/She patted his/her face from side to side, never smooshed his/her face into the towel. CNA L lay the towel on his/her forehead because he/she goes around the building like that since he/she sweats. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/01/24 at 1:18 P.M., LPN K said he/she was across the hall when he/she heard the CNA and the resident cursing. The CNA had not worked at the facility long and LPN K did not know his/her name. When LPN K entered the resident's room, the resident was overheard saying you can stop now to the CNA. The CNA stood in front of the resident and tossed a towel on top of the resident's head and said he/she could not work with the resident. The towel was not on his/her face, just on top of his/her head. After the aide tossed the towel, he/she walked out of the room. LPN K asked the CNA what happened. The resident asked her/him to wipe his/her face and he/she asked for a specific towel on the bed. The resident was rude and aggressive. There was an issue with the resident telling the CNA what to do instead of asking him/her, or it was a rude manner in the way the resident said it. The CNA told the resident, you could at least say please and they started going back and forth from there. LPN K heard the resident say don't f'ing touch me and the CNA said the F word also, but LPN K could not remember what was said. The resident was asked what happened and he/she said the same thing. He/She asked for a specific towel and the CNA started being rude and said he/she needed to talk to him/her different. The resident told the aide, you need to wash my face, but the aide was rude, so the resident started cussing at him/her. LPN K said the resident reported the aide pushed the towel into his/her face, wiping vigorously in a rough manner. The CNA denied being rough. The resident reported the aide cussed at him/her. The aide reported whatever the resident said to him/her, he/she repeated it back to the resident. LPN K said the resident has behaviors at times, but it is because he/she wanted things at a certain time. He/She can be demanding. He/She is a smoker, so he/she does not like to stay in bed. The resident becomes upset related to getting out of bed at a certain time to smoke. The CNA was new and only at the facility for a week. He/She worked with him/her on one or two shifts. There were no issues between the aide and other residents. There were no reports of physical abuse. Review of CNA L's employee file, received on 8/1/24, showed he/she was terminated on 7/1/24 for violation of policy and procedure. During an interview on 8/02/24 at 9:07 A.M., the Administrator said she would expect all residents to be treated with dignity and respect. MO00238305

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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 Based on observation, interview, and record review, the facility failed to provide residents a safe, clean, comfortable and homelike environment. One resident's air conditioning unit leaked into the room, causing puddles under the bed and a wet feel and smell in the room (Resident #78). One resident's call light indicator, above his/her room door, did not work resulting in a delay in staff answering the call light (Resident #16). In addition, staff failed to provide a homelike environment on the 300 hall when there were floor tiles chipped, baseboard and transition strips chipped and broken along the floor, and the door frame for room [ROOM NUMBER] pulled away. The census was 85. The sample was 18. Review of the facility's Nursing Home Residents' Rights, provided to residents upon admission to the facility, showed: -Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination; -Right to a dignified existence: A homelike environment, and use of personal belongings when possible. 1. Review of Resident #78's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/6/24, showed: -Cognitively intact; -Diagnoses included anxiety disorder, depression, and asthma. During an interview on 7/29/24 at 12:38 P.M., the resident said his/her air-conditioning until is leaking water. Staff are aware. It started a couple weeks ago. Maintenance staff came in, took the cover off, and said they were going to fix it. They left the room and never came back. This was a week ago. Observation showed the air-conditioning/heating unit cover leaned against the wall near the resident's head of bed. The inner workings of the unit visible. The room with a wet smell and feel. A small puddle noted near the wall under the unit. Observation and interview on 7/30/24 at 6:29 A.M., showed the resident lay in bed. The bed located on the far side of the room near the window. An air-conditioning/heating unit installed into the wall under the window. The cover of the unit leaned against the wall near the resident's head of bed. The inner workings of the unit visible. A large puddle of water pooled under the resident's bed. A wet blanket saturated, lay under the bed on the floor. The puddle extended out from under the bed. The resident said staff put the blanket down to soak up the water. Observation on 7/31/24 at 7:37 A.M., showed the resident in bed asleep. A puddle approximately a foot and a half pooled under the bed, extending from the unit. The unit cover remained off an leaned against the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/1/24 at 9:28 A.M., showed a small amount of water under the bed. The unit cover remained off and leaned against the wall. A smell of moisture noted in the room. The resident said maintenance had not been by recently. 2. Review of Resident #16's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included: heart failure, high blood pressure, diabetes, stroke, and lung disease. Observation and interview on 7/29/24 at 4:22 P.M., showed the resident lay in bed and said when he/she turned the call light on, staff do not always come timely. Staff told the resident they do not always know he/she had his/her call light on. The resident pushed the button on the call light. The red light for the call light lit up on the wall in the resident's room. The light in the hall above the door did not light up. At approximately 4:53 P.M. the residents call light remained lit in the room and no staff had responded to the light. A beeping sound was heard out in the hall by the nurse's station. An staff member at the nurses station said the beeping sound was the call bells and he/she could tell which room was ringing by looking at the call bell panel located at the nurse's station. He/She looked at the panel and named the residents room number as ringing. 3. Observation of the 300 hall, on 7/29/24 at 12:00 P.M., on 7/30/24 at 6:19 A.M., on 7/31/24 at 7:30 A.M., and on 8/1/24 at 9:20 A.M., showed scuffs and stains noted on the floor throughout the hall. An orange stain on the floor at the top end of the hall, on the right-hand side. Areas of chipped and missing tile, one area approximately the size of a softball located near the top left side of the hall. Another area of chipped tiles near the top left-hand side of the hall, approximately 4 inches by 2 inches. The cove base near the bottom of the doors throughout the hall, chipped with a buildup of a dark blackish brown substance along the edges. Paint on the wall near the medication room peeled off near the ground, an area approximately 5 inches by 4 inches and irregular shaped. An area of paint peeled on the wall in long strips near the 300 central bath, approximately 2 feet by 1 inch and 1.5 feet by 1 inch. At 6:25 A.M., room [ROOM NUMBER] room door closed. The door frame edges pulled away from the wall on the right side of the doorframe, with jagged edges. 4. During an interview on 7/31/24 at 11:35 A.M., the Maintenance Director said paper request slips are available on the wall at the nurse's station for staff to fill out if they identify maintenance issues. He picks them up when he gets to work and reviews them. He is aware of the leaking air-conditioning/heating unit. He became aware earlier this week. The drain line just needs to be cleaned out. Chipped paint, broken cove base, chipped floor tiles and broken doorframes are the responsibly of maintenance. Some hall floors were just replaced. The 300 hall was not done and it is not scheduled to be replaced at this time. He was not aware of the broken doorframe. Staff should have reported it. He was not aware of the broken call light. It is probably just a bulb that needs to be replaced. 5. During an interview on 7/30/24 at 11:04 A.M., the Administrator said when owned by the prior corporation, they started the remodel of some of the halls. Then when the current corporation purchased the facility the work was stopped. The 300 hall floor needs stripped because it does appear the stains were waxed over; therefore, housekeeping would not be able to clean it up. MO00238123 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42247

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to provide services based on acceptable standards of practice by not obtaining a physician order for one resident who was using a Bi-level positive airway pressure (bi-pap, helps with breathing) machine (Resident #16) and for failing to complete neuro check documentation for one resident who fell (Resident #63). The sample was 18. The census was 85. Review of the facility's Medical Provider Orders Policy, dated 9/1/21, showed: -Policy: this facility shall use uniform guidelines for ordering and following medical providers orders; -Medications and/or treatments should be administered only upon the signed order of a person lawfully authorized to prescribe. Review of the facility's Fall Prevention Program Policy, dated 9/1/21, showed: -Policy: each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; -Definitions: fall: an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere; -When any resident experiences a fall, the facility will: -Assess the resident; -Complete a post fall assessment; -Complete an incident report; -Notify physician and family; -Review the resident's care plan and update as indicated; -Document all assessments and actions; -Obtain witness statements in case of injury. Review of the facility's neurological checks (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status) flowsheet, showed: (continued on next page)

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	265586	A. Building B. Wing	08/02/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Neuro checks should be completed for unwitnessed falls or fall in which head was hit. Complete initial, then every 15 minutes times four, every 30 minutes times two, every hour times two and every shift for 72 hours. 1. Review of Resident #16's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/18/24, showed: -Cognitive intact; -Diagnoses included obstructed sleep apnea (OSA, when something blocks part or all your upper airway while you sleep); -Used Bi-pap on admission. Review of the care plan, in use at the time of survey, showed: -Focus: resident used a continuous positive airway pressure machine (CPAP machine, used for the treatment of sleep apnea) for sleep apnea; -Goal: The resident will use their c-pap/bi-pap nightly with minimal risk for complications; -Intervention: bi-pap/c-pap titrate pressure at settings as ordered. Provide preferred and ordered equipment. Review of the progress notes, dated 7/12/24 through 7/29/24, showed: -On 7/12/24 at 3:15 P.M., the patient arrived back to facility from hospital, accompanied by 2 transporters. The patient had a history of OSA. The nurse set up patient's bi-pap for tonight's use for patient on nightstand; -On 7/20/24 at 4:30 A.M., uses c-pap machine while sleeping. Review of the after-visit summary, dated 7/4/24 through 7/12/24, showed: -Other instructions: bi-pap with all sleep. Observation on 7/29/24 at 1:30 P.M., showed the resident lying in bed with his/her bi-pap on. Review of the physician order summary, dated 7/30/24, showed: -There was no physician order for the bi-pap. During an interview on 7/31/24 at 3:10 P.M., Central Supply Employee D said the resident used a bi-pap machine. During an interview on 8/2/24 at 9:00 A.M., the Director of Nursing (DON) said the resident should have a physician order for the bi-pap. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #63's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included high blood pressure, stroke with hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm, or face) and seizure disorder. Review of the care plan, in use at the time of survey, showed: -Focus: resident is at risk for falls. 6/17/24, rolled out of bed; -Goal: resident will not sustain serious injury through next review; -Intervention: Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance; follow facility fall protocol. Review of the progress notes, dated 6/17/24 through 6/20/24, showed: -On 6/17/24 at 6:21 A.M., the resident was observed lying on the floor at his/her bedside, resident states that he/she rolled out of bed. Resident observed lying on his/her back on the floor. Resident assessed for injuries, none noted. Neuro-checks within normal limits; -On 6/17/24 at 7:26 P.M., the resident observed lying in bed resting quietly at this time with his eyes closed. Neuro-checks within normal limits at this time; -On 6/19/24 at 3:26 A.M., resident observed resting quietly in bed with eyes closed. Neuro checks within normal limits. Review of the neuro check flowsheet dated 6/17/24 through 6/20/24, showed: -Level of Consciousness: six out of 18 opportunities were blank; -Movement/ROM: three out of 18 opportunities were blank; -Hand grasp: three out of 18 opportunities were blank; -PERL (pupil equal and reactive to light): three out of 18 opportunities were blank; -Pupil response right: three out of 18 opportunities were blank; -Pupil size right: three out of 18 opportunities were blank; -Pupil response left: three out of 18 opportunities were blank; -Pupil size left: three out of 18 opportunities were blank; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Speech: three out of 18 opportunities were blank; -Pain: three out of 18 opportunities were blank; -Pulse: six out of 18 opportunities were blank; -Respirations: six out of 18 opportunities were blank; -Blood pressure: six out of 18 opportunities were blank; -Nurse initials: three out 18 opportunities were blank. 3. During an interview on 8/2/24 at 7:55 A.M., Licensed Practical Nurse (LPN) G said if a resident fell , he/she would assess the resident, notify the medical doctor and the family, document the fall in risk management and do neuro checks. Post fall documentation should be done every shift for 3 days. 4. During an interview on 8/2/24 at 9:00 A.M., the Director of Nursing (DON) said if a resident fell , she expected staff to stay with the resident and call for the nurse. The nurse should assess the resident. If the resident is ok to get up, staff would assist the resident up and document the fall, notify the medical doctor and the family or if the resident needed to be sent out, the facility would send them out. For an unwitnessed fall, staff should do neuro checks per the neuro check sheet form and monitor the resident for 72 hours. The DON expected the neuro sheets to be completed. Neuro checks are not part of the facility's policy, but the facility did them because it is best nursing practice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32847 Based on observation, interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance to prevent accidents. One resident was not positioned in an upright position during meals, resulting in a coughing episode (Resident #6). In addition, staff failed to adequately monitor smoke breaks to ensure residents followed facility protocol for safe smoking for two of three smoke breaks observed (Residents #33, #82, and #41). The census was 85. The sample was 18. 1. Review of Resident #6's care plan, in use at the time of the survey, showed: -Diagnoses included dementia and dysphagia (difficulty swallowing); -Focus: Current functional performance Hoyer (mechanical lift) and new recliner wheelchair: -Goal: Will progress towards personal discharge goals; -Interventions included: Eating: independent/set-up help only. Transfer: Total assist/one-person physical assist; -Focus: Activity of daily living self-care performance/limited physical mobility deficit related to cognitive deficit with impaired safety awareness with lower extremity weakness due to spinal stenosis (when there is too little space between the bones of the spin, resulting in decreased mobility): -Goal: Activities of daily living needs will be met; -Interventions included: Requires 1-2 staff for bed mobility and transfers. Monitor for safety/positioning in wheelchair. Is able to feed self with set up assist and supervision. Review of the resident's Speech Therapy Plan, for certification period of 7/23/24 through 9/5/24, showed: -Treatment diagnoses: Dysphagia, oral phase (difficulty swallowing); -Impairments: Decreased oral motor coordination and control; -Continued skill: Reason for skilled services- Patient presents with oral dysphagia which necessitates skilled services for dysphagia to assess/evaluate for safety level of oral intake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the lunch meal service in the main dining room on 7/29/24 at 11:38 A.M., showed staff already served desert and drinks to the residents who had arrived. The resident was positioned in a tilt-back wheelchair, tilted to an approximate 60 degrees, and slid down with his/her buttocks near the end of the seat of the wheelchair. An empty desert plate sat in front of the resident. At 11:52 A.M., staff served the resident what appeared to be broccoli rice with beef and gravy. The resident remained at an approximate 60-degree angle when staff served the tray and walked away. The resident began to feed him/herself. Staff did not assist the resident to sit up. The resident fed him/herself with his/her left hand. The resident spilled his/her drink. Speech Pathologist A assisted the resident with a drink but did not assist the resident to sit up. He/She then walked away. The resident struggled to get a bite of food to his/her mouth as the food fell off the tilted fork before reaching his/her mouth. After taking a couple bites, the resident started coughing a very wet cough. Three staff rushed over, to include Speech Pathologist A, who gave the resident a drink, despite the resident actively coughing. This resulted in the resident coughing more. Staff attempted to assist the resident to sit up in his/her chair. The position of the resident's buttocks on the seat was readjusted so it was closer to the back of the chair, but the resident's wheelchair remained tilted back. Staff again went to give the resident a drink while he/she was coughing. The resident was breathing heavy and making attempts to clear his/her throat. Staff assisted the resident back up to the table, wiped food from his/her face, then went and refilled the resident's drink. The resident continued to feed him/herself with a tilted back wheelchair. During an interview at this time, Speech Pathologist A said the resident is receiving speech therapy. He/She slides down in his/her chair and will sometimes put too much food in his/her mouth. That is what speech therapy is working with him/her on. During an interview on 7/30/24 at 10:53 A.M., Speech Therapist E said the resident has difficulty swallowing and is being followed by speech therapy to make sure he/she is on the least restrictive diet. He/She should be upright, near 90 degrees, for meals. Staff should sit him/her up for meals. Nursing staff who serve the food tray or who are present in the dining room should ensure proper positioning when eating. He/She can feed him/herself once served. No one reported to him/her that the resident had a coughing episode. Review of the resident's Speech Therapy treatment encounter note, date of service 7/29/24, completed date 7/30/24, showed Speech Therapy was present in the dining room to see a different resident when this resident was noted to be coughing during the meal. Speech Therapy asked for help to reposition the resident to an upright position and was able to change position. Resident was still struggling to clear food from pharyngeal cavity (a hollow, muscular tube inside the neck that starts behind the nose and opens into the esophagus) so Speech Therapy implemented compensatory techniques including hard throat clear and coughing until no more signs and symptoms of aspiration, including wet voice, were present. Resident was instructed then to take small sips of liquids and three bites of mechanical soft food and Speech Therapy observed to ensure no more signs and symptoms of aspiration with current position. During an interview 8/2/24 at 9:06 A.M., the Administrator and Director of Nursing (DON) said residents should be in an upright position when eating. If they are not, staff should assist them to sit upright prior to serving food. 2. Review of the facility's Resident Smoking policy, last reviewed/revised on 6/25/24, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents; -Safety measures for the designated smoking area will include, but not limited to: Provision of ashtrays made of noncombustible material and safe design. Accessible metal containers with self-closing covers into which ashtrays can be emptied; -Residents who smoke will be further assisted, using the smoking assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all; -All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan; -If a resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional safety measures; Review of the facility's Resident Smoking List, showed 26 residents identified as smokers to include Residents #33, #82, #41, and #10. Review of the posted smoke break schedule, showed scheduled cigarette times and responsible departments: -7:00 A.M. Activities; -9:00 A.M. Housekeeping; -11:00 A.M. Maintenance; -1:00 P.M. Activities; -3:00 P.M. Dietary; -5:30 P.M. Reception- Certified Nursing Assistant (CNA); -7:00 P.M. Nursing. 3. Review of Resident #33's medical record, showed: -Diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke; -A smoking assessment, dated 6/14/24, resident is a smoker, can light own cigarette, requires supervision; -A care plan in use at the time of the investigation, the resident is a smoker. The resident will follow all facility smoking rules. The resident requires supervision while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's medical record, showed: -Diagnoses included high blood pressure and chronic obstructive pulmonary disease (COPD, lung disease); -A smoking assessment, dated 5/22/24, resident is a smoker, can light own cigarette, requires supervision; -A care plan in use at the time of the investigation, resident is dependent on tobacco. The resident will have minimized risk of injury from unsafe smoking practices. The resident requires supervision while smoking. Observation of the 1:00 P.M. smoke break on 7/29/24 at 1:12 P.M., showed an overhead page announcing smoking time. Approximately 16 residents sat in the smoking area. No staff were present. There was one dietary staff member cleaning the dining room, but the staff member was not in view of the smoking area. A resident sat at the door waiting to come in. The resident opened the door and exited the smoking area. He/She was followed by a resident actively smoking. As the resident approached the door, he/she flicked his/her cigarette into the grass. Another resident who smoked a cigarette also flicked the cigarette into the grass as he/she exited the smoking area. Observation of the smoking area, showed a lit cigarette lay on the ground near the facility entrance, and several other cigarette butts scattered around on the ground. A plastic trash can sat on the patio with cigarettes inside, on top of trash. A red ash can was approximately 10 percent full of cigarette butts and a wire mesh over the top and a chip bag and empty cigarette pack sat on top of the mesh. There was a second red ash can with wire mesh on top with a paper plate, napkins, empty cigarette packs, and a kitchen hair net on top of the mesh. Numerous cigarettes lay in the grass and on the patio. The Activity Director arrived to the smoking area and assisted a resident to leave by propelling his/her wheelchair. No staff remained in the smoking area after the Activity Director left. The Activity Director returned to the area as another resident prepared to leave. The resident held a cigarette and flicked the cigarette onto the grass as the Activity Director held the door. The Activity Director did not educate or redirect the resident on safe smoking practices. Resident #33 smoked with a smoking apron on throughout the observation, including during unsupervised times. Resident #82 also smoked throughout the observation, including during times of no supervision. 4. Review of Resident #41's care plan, in use during survey, showed: -Focus: Resident smokes tobacco. Resident has a history of begging for cigarettes; -Goal: Resident will adhere to the tobacco/smoking policies of the facility; -Interventions: Conduct smoking safety evaluation on admission and as needed (PRN). Educate resident/responsible party on the facility's tobacco/smoking policy(s). Review of the resident's admission smoking assessment, dated 5/22/24, showed: -Smoking status: Resident is a smoker; -Safety: Resident need for adaptive equipment: Supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 7/29/24 at 3:19 P.M., showed the resident sat outside smoking a cigarette. There was no staff outside or in view of the smoking area. He/She said they are able to smoke every 1.5 hours. He/She did not have any issues with not being able to smoke. The resident smoked independently. 5. During an interview on 8/2/24 at 9:06 A.M., the Administrator and DON said if a resident requires supervision with smoking, staff should provide continuous supervision. The staff responsible for the smoke break is responsible to pass out cigarettes, help residents light the cigarettes if necessary, help with proper disposal of ashes and cigarettes, and ensure safety. If a resident is observed not practicing safe cigarette handling or disposal, staff should correct them. 6. During an interview on 7/31/24 at 9:51 A.M., the Activity Director said she has one other activity staff that works under her. For the scheduled smoke breaks that the activity department is responsible for, if the staff under her is not available, she will supervise the smoke break. She is responsible to pass out the cigarettes and go out with the resident as they smoke. If a resident requires a smoking apron, they assist the resident to put one on. When residents are done smoking, they let them in. If she sees a resident with unsafe smoking practices, she will inform the DON. If residents are not safely disposing the cigarettes, she will reeducate them and make sure the cigarette is completely out. 35394

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32847 Based on interview and record review, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week during the most recent available quarterly payroll-based journal (PBJ) staffing report. The sample was 18. The census was 85. Review of the facility's PBJ Staffing Data Report, dated for Quarter 2 20204 (January 1- March 31), showed: -This staffing data report identifies areas of concern that will e triggered (e.g., requires follow-up during the survey); -One star staffing rating: Triggered; -No RN hours: Triggered; -Infraction dates: Thursday 3/21, Friday 3/22, Saturday 3/23, Sunday 3/24, Saturday 3/30, Sunday 3/31. During an interview during the entrance conference, on 7/29/24 at 10:27 A.M., the Administrator said Corporate Staff B is responsible for the PBJ reports. During an interview on 7/30/24 at 7:50 A.M., Corporate Staff B said he/she had been helping with the PBJ reports and did a lot of the input. He/She verified the PBJ report is accurate and had confirmed it with the administrator at the time. He/She had suggested the facility borrow RNs from other sister facilities to get those hours covered. These are the hours they could not get coverage for.

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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. 42247 Based on observation, interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for two of two narcotic books reviewed. The census was 85. Review of the Facility's Controlled Substance Administration & Accountability policy, dated 9/1/21, showed: -Policy: it is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure; -Policy explanation and compliance guidelines: -Inventory Verification: for areas without automated dispensing systems, two licensed nurses or per state regulations account for all controlled substances and access keys at the end of each shift. Review of the facility's Controlled Substance Shift Change Count -Check Sheet, for the dates of 7/1/24 through 7/29/24, showed: -Station: 300; -Number of packages: -73 out of 87 opportunities were blank; -Nurse's initials on: 29 of 87 opportunities were blank; -Nurses initials off: 32 of 87 opportunities were blank; -Station: 100/700; -Number of packages: 23 out of 87 opportunities were blank; -Nurse's initials on: 19 of 87 opportunities were blank; -Nurses initials off: 25 of 87 opportunities were blank. During an interview on 7/30/24 at 7:30 A.M. and at 9:00 A.M., the Director of Nursing said the oncoming nurse should count controlled substances with the off going nurse. Both nurses should document on the controlled substance count sheet. She would expect the controlled substance change count to be completed without blanks on it. Some of the nurses work eight-hour shifts and some of the nurses work 12-hour sheets. The form is set up for eight-hour shifts and this is confusing for some of the nurses. She would expect for staff to follow the facility's policy and procedures.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 42247 Based on observation, interview and record review, the facility failed to ensure a medication rate less than 5%. Out of 27 opportunities for errors, four errors occurred resulting in a 14.81% medication error rate (Residents #18, #72 and #50). The sample was 18. The census was 85. Review of the facility's Medication Administration Policy, dated 9/1/21, showed: -Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection; -Policy explanation and compliance guidelines; -Review Medication Administration Record (MAR) to identify medication to be administered; -Compare medication source (bubble pack, vial, etc.) with MAR to verify name, medication, form, dose, route, and time; -Administer medication as ordered in accordance with manufacturers specifications; -Crush medications as ordered. Do not crush medications with do not crush instructions; -Do not crush medications: enteric coated. Review of the manufacturer's instructions for use for insulin lispro (Humalog, short acting insulin) pen, showed: -Select a new needle. Push the capped needle straight onto the pen and twist the needle until it is tight; -Pull off the outer and inner needle shield; -Prime before each injection: Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensure that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin; -To prime your pen, turn the dose knob to select 2 units; -Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top; (continued on next page)

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	265586	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Place Health and Rehabilitation	2600 Redman Road Saint Louis, MO 63136

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Continue holding your pen with needle pointing up. Push the does knob until it stops and 0 is seen in the dose window. Hold the does knob in and count to 5 slowly. If you do not see insulin, repeat priming, no more than 4 times. If you still do not see insulin, change the needle and repeat. 1. Review of Resident #18's medical record, showed: -Diagnoses included diabetes; -An order dated 7/2/24, for Humalog (insulin lispro) 4 units subcutaneously (under the skin) three times a day. Scheduled administration time 8:00 A.M., 12:00 P.M., and 5:00 P.M.; -An order dated 7/2/24, for Humalog insulin per sliding scale. Administer 4 units for a blood sugar level between 251 and 300. Observation on 7/30/24 at 11:33 A.M., showed Licensed Practical Nurse (LPN) F checked the resident's blood sugar level with a result of 254. He/She obtained the resident's insulin lispro pen, applied the needle to the end, and set the insulin to administer 8 units of insulin. He/She did not prime the insulin pen. LPN F entered the resident's room and administered the insulin into the resident's right upper arm. During an interview on 7/30/24 at 1:06 P.M., the Director of Nursing (DON) said insulin pens should be primed prior to administration. 2. Review of Resident #72's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/16/24, showed: -Should brief interview for mental status be conducted? No; -Cognitive skills for daily decision making severely impaired never/rarely made decisions; -Diagnoses included heart failure and high blood pressure. Review of the order summary, dated 6/30/24, showed: -An order for ascorbic acid (vitamin C) 500 milligrams (mg) take one by mouth twice daily for wound healing; -An order for aspirin 81 milligrams (mg) (chewable) via gastrostomy tube (g-tube, a tube surgically inserted into the stomach to give direct access for supplemental feeding, hydration, or medicine) one time daily for acute heart attack. Observation on 7/30/24 at 7:30 A.M., showed LPN N poured one tablet of Vitamin C 250 mg into a medication cup and crushed the medication. Then he/she poured one tablet of enteric coated (EC) aspirin 81 mg into another medication cup and crushed it. After the medications were crushed, LPN N administered the medications via the g-tube. 3. Review of Resident #50's annual MDS, dated [DATE], showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitive intact; -Diagnoses included diabetes and high blood pressure. Review of the Fluorometholone ophthalmic suspension (used to help reduce swelling in the eye) manufacturer's guidelines, showed: -Tilt head back, look upward, and pull the lower eyelid to make a pouch; -Hold the dropper directly over the eye and place 1 drop into the pouch; -Look downward and gently close eyes for 1 to 2 minutes; -Place one finger at the corner of the eye (near the nose) and apply gentle pressure. Review of the physician order summary sheet, dated 6/30/24, showed: -An order for Fluorometholone ophthalmic suspension, instill 1 drop in both eyes two times a day for eyes. Observation on 7/30/24 at 8:05 A.M., showed Certified Medication Technician (CMT) M administered one Fluorometholone eye drop into each eye and handed the resident a tissue for the resident to pat his/her eye after the eye drop was administered. CMT M did not place one finger at the corner of the eye near the nose and apply gentle pressure. 4. During an interview on 8/2/24 at 7:55 A.M., LPN G said EC medications should not be crushed and when staff administers an eye drop, they should instill one eye drop at a time and the eye drop should sit in the resident's eye for 1 to 2 minutes. Staff should have a Kleenex ready in case there is any drainage. 5. During an interview on 8/2/24 at 9:00 A.M., the DON said she expected staff to follow acceptable nursing practices and follow the manufacturer's recommendations for medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42247 Based on interview and record review, the facility failed to keep one resident (Resident #92) with a seizure disorder free from a significant medication error, when the facility failed to obtain Vimpat (medication used to prevent seizures) from the pharmacy timely, resulting in the medication not being administered for four and half days. The sample was 18. The census was 85. Review of the facility's Unavailable Medication Policy, dated 9/1/21, showed: -The facility maintains a contract with a pharmacy provider to supply the facility with routine, as needed (PRN), and emergency medications; -Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: -Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medications. -Notify physician of inability to obtain medications upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold; -If a resident misses a scheduled dose of the medication, staff shall notify physician/family and monitor the resident for adverse reactions to omission of the medication. Review of Resident #92's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 6/26/24, showed: -Cognitively intact; -Diagnoses included: seizure disorder or epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). Review of the resident's care plan in use at time of the survey, showed: -Problem: Resident has a seizure disorder; -Goal: will be free from injury from seizure activity through the review date; -Intervention: give medications as ordered. Review of the resident's order summary sheet dated 7/29/24, showed an order for Vimpat tablet 200 milligrams (mg), give 200 mg two times a day for seizures. Review of the resident's Medication Administration Record (MAR), dated 6/21/24 through 6/25/24, showed an order for Vimpat tablet 200 mg two times a day for seizure: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medication not documented as administered for the 5:00 P.M. administration on 6/21 through 6/25/24; -The medication not documented as administered for the 9:00 A.M. administration on 6/22 through 6/25/24. Review of the resident's progress notes dated 6/21/24 through 6/25/24, showed: -On 6/23/24 at 11:41 A.M., pharmacy was contacted regarding Vimpat medication. Representative verbalized they were waiting on a new script; it was requested 6/21 and a new request will be sent to the medical doctor (MD); -On 6/23/24 at 11:43 A.M., MD's office was contacted. A representative verbalized I will see if the on-call physician can get it signed. I don't know. I'll let the nurses know also. The representative was also informed of missing doses at this time. Nurse will continue to monitor request today; -On 6/24/24 at 11:32 A.M., received a fax from the pharmacy regarding the residents Vimpat requesting a signed script. The nurse faxed information over to MD office; -There was no other documentation showing the MD was made aware the resident did not receive his/her medication and/or if the MD gave orders for an alternate treatment or monitoring while the pharmacy was waiting for a new script and the facility was waiting for the medication to be delivered. During an interview on 7/31/24 at 7:35 A.M., The Director of Nursing (DON) said if a medication was not available she would expect for staff to call the pharmacy and check to see what is going on with the medication/when the medication would be at the facility and notify the MD and check to see if something else can be given or if the medication should be placed on hold until it was available. The DON would expect staff to notify the MD for each dose of medication that was missed. During an interview on 7/31/24 at 7:45 A.M., Licensed Practical Nurse (LPN) K said Certified Medication Technicians (CMTs) would report to him/her if a medication was not available and he/she would call the pharmacy, to see what was going on with the medication. If a medication needed a script, he/she would follow up with the MD. LPN K said the facility did try to contact the pharmacy and the MD to obtain the residents script for his/her Vimpat. He/She did not recall how long the resident was out of his/her medication. During an interview on 7/31/24 at 7:55 A.M., LPN J said if a medication was not available, he/she would call the pharmacy and notify the MD. The MD should be notified for each dose of medication missed and it should be documented in the progress notes. If a script was needed, staff should call the MD's office and let them know we are waiting on a script. During an interview on 7/31/24 at 8:12 A.M., CMT I said if a medication was not available, he/she would check to see if the medication was available in the overstock and call the pharmacy. Medications are reordered through the computer system. Seizure medications are important because if the resident did not get their medication they are at risk for seizures. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 8:43 A.M., Registered Nurse (RN) H said if a medication was not available, he/she would tell the pharmacy we are out of the medication, and they would rush it out. Plus, he/she would check in the computer system. Seizure medication would be considered a high importance medication. If he/she was not getting a timely response from the pharmacy, he/she would call the pharmacy and call the MD and update the MD of the situation. During an interview on 7/31/24 at 8:50 A.M., the Pharmacist said medications can be reordered by pulling the sticker off the medication label and faxing it to the pharmacy or by electronically ordering it. Medications ordered by noon will be delivered the same day. Medications ordered after noon will be delivered the next day unless staff notified the pharmacy they needed the medication the same day. If a medication needed a script, the pharmacy would reach out to the MD to obtain the script. Nurses are educated to reorder medications five days prior to running out of the medication. Vimpat required a script. The facility contacted the pharmacy on 6/21/24 at 6:21 P.M. that they needed the medication. There were no refills on the script. The MD's office was faxed on 6/21 and 6/23 to try to obtain a new script. The pharmacy obtained the script on 6/24 and the medication was sent out on 6/24/24. During an interview on 8/2/24 at 9:00 A.M., the DON said she would expect staff to refill the medication when it is the blue (color on the medication card to indicate low quantity). Both the CMTs and nurses can reorder the medication. She would expect staff to follow the facility's policy and procedures. MO00239482

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional standards and facility policy in three of three medication carts reviewed. The census was 85. Review of the facility's Medication Storage Policy, dated [DATE], showed it is the policy of this facility to ensure all medication housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of the facility's Medication Administration policy, dated [DATE], showed identify expiration date. If expired, notify nurse manager. 1. Observation and interview on [DATE] at 7:15 A.M., of the ,d+[DATE] nurse medication cart, showed in the top drawer, one out of three Aspart insulin (short acting insulin) pens opened and undated. The Director of Nursing (DON) said insulin should be dated when opened. She did not know when the insulin was opened. 2. Observation and interview on [DATE] at 7:20 A.M., of the ,d+[DATE] Certified Medication Technician (CMT) medication cart, showed: -In the top drawer there were 2 plastic medication cups with pre-popped medications in them. One cup had six pills in it and the other cup had four pills in it. The DON said she did not know who the medications belonged to, and staff should pop the medications when they are given; -Seven out of 16 eye drops opened and undated; -One bottle of geritussin (cough syrup) open and undated and one bottle of Levetiracetam solution (used to treat seizures) open and undated; -One bottle of allergy relief tablets with an expiration date of ,d+[DATE]; -One bottle of sodium bicarb (baking soda) tablets with an expiration date of ,d+[DATE]; -One bottle of multivitamin with an expiration date of ,d+[DATE]. 3. Observation and interview on [DATE] at 7:30 A.M., of the 300-nurse medication cart, showed: -In the top drawer, one out of thirteen insulin pens opened and undated; -One bottle of lactulose (used to treat constipation) open and undated; -One bottle of senna plus (stool softener plus laxative) with an expiration date ,d+[DATE]; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Five out of seven eye drops opened and undated. 4. During an interview on [DATE] at 7:20 A.M., the DON said both CMTs and nurses should check meds for expiration dates and remove from the cart if they are expired. Eye drops should be dated when opened and they are good for 30 to 45 days after opening. Liquid medications should be dated when opened. On [DATE] at 9:00 A.M., the DON said she would expect medications to be stored according to standards of practice and she would expect staff to follow the facility's policy and procedures.

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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. 35394 Based on observation and interview, the facility failed to maintain an effective pest control program to control the presence of flies in the kitchen. The facility census was 85. Observation of the kitchen on 7/29/24 at 10:30 A.M., showed the backdoor to the outside left opened. There were several flies throughout the food prep areas of the kitchen, outside of the walk-in cooler, and inside the dry food storage room. There were flies outside of the walk-in cool. Observation of the kitchen on 7/30/24 at 6:27 A.M. and 7:05 A.M., showed multiple flies throughout the food prep areas of the kitchen. There was a swarm of flies outside of the walk-in cooler. The backdoor to the outside stood opened. Observation of the kitchen on 8/1/24 at 7:30 A.M. and 12:25 P.M., showed multiple flies throughout the food prep area of the kitchen. The backdoor to outside remained opened. During an interview on 8/2/24 at 9:07 A.M., the administrator said she would expect for the kitchen to be free of flies and for the back door to be closed.