STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265598	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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. 38016 Based on interview and record review, the facility failed to ensure one (Residents #5), in a review of 15 sampled residents, were treated with dignity and respect. The facility census was 31. Review of the facility's policy, Resident Rights, dated 07/2023, showed the following: -Employees shall treat all residents with kindness, respect, and dignity; -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. Exercise his or her rights; b. Be informed about what rights and responsibilities he or she has; f. Voice grievances and have the facility respond to those grievances; l. Retain and use personal possessions to the maximum extent that space and safety permit; -Residents are entitled to exercise their rights and privileges to the fullest extent possible; -Our facility will make every effort to assist each resident in exercising his/her rights; -To assure that the resident is always treated with respect, kindness, arid dignity; -Orientation and in-service training programs are conducted periodically to assist our employees in understanding our residents' rights. 1. Review of Resident #5's significant change in status Minimum Data Set (MDS) assessment, a federally mandated assessment, dated 2/6/24, showed the following: -Moderate cognitive impairment; -No signs of delirium, hallucinations, delusions, or behaviors. (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	Review of a grievance form, dated 2/19/24, showed a staff member reported to a nurse manager that he/she overheard Nurse Assistant (NA) F being impatient and rude to Resident #5 during a toileting transfer. NA F told the resident to do it yourself and you're making it harder on yourself and seemed to rush. Staff documented on the form education was completed with NA F on 2/22/24. The follow up on the grievance showed the Assistant Director of Nursing (ADON) spoke with NA F about being more patient, slowing down, and explaining what he/she is doing before doing it. Also instructed NA F to bring two staff members in while doing cares on the resident. Review of a grievance form, dated 3/4/24, showed the resident said NA F was not being nice to him/her. NA F doesn't say nice things to her and would not lay him/her down when requested. He/She feels NA F does not like him/her and the resident does not want NA F in his/her room. The follow up on the grievance showed the Social Service Director asked NA F not to go into the resident's room and if he/she has to, bring another staff member with him/her. During an interview on 4/18/24, at 10:35 A.M., the resident said the following: -NA F was not always nice to him/her; -NA F tells him/her to do it yourself, and was rude about helping him/her all the time; -He/She thought the staff were supposed to be there to help the residents; -It makes him/her feel bad, like a burden or not good enough; -The resident teared up and tears fell down his/her cheeks. During an interview on 5/6/24, at 4:15 P.M., NA F said the following: -The resident was upset with him/her because sometimes he/she will want to lay down 10 minutes before a meal and he/she takes the resident to the dining room instead; -The resident will pull the emergency light in his/her bathroom because staff do not come right away when we are working with other residents, and he/she has asked the resident multiple times not to use the emergency light unless it is an emergency; -The resident does have to sit on that hard toilet longer than he/she wants, so he/she probably is upset, but staff do the best they can; -He/She has had multiple heart to hearts with the resident trying to explain he/she is not the only resident and it doesn't seem to help. During an interview on 4/24/24, at 1:05 P.M., the Director of Nursing (DON) said residents should be spoken to and treated respectfully, like they (staff) are a guest in the residents' home. She was aware of complaints against NA F on 2/19/24 and 3/4/24. 42592

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to create an environment respectful of the rights of each resident to make choices about significant aspects of their lives for four residents (Residents #15, #27, #30 and #36), in a review of 15 sampled residents, who all had diagnosis of dementia, were cognitively impaired, and dependent on staff for assistance with activities of daily living. Staff woke and dressed the residents early in the morning without consideration of the resident's preferences for waking and for staff convenience. The facility census was 31. Review of the facility policy, Quality of Life, dated June 2023, showed the following: -The community environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being; -Residents whom are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming and personal and oral hygiene; -Residents are provided with appropriate care and services including: a. Hygiene; b. Mobility; c. Elimination, and d. Dining, including meals and snacks, e. Communication. Review of the facility policy, Resident Rights, dated July 2023, showed the following: -Employees shall treat all residents with kindness, respect, and dignity. -Our facility will make every effort, to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. 1. Review of Resident #15's annual Minimum Data Set (MDS), a federally mandated assesment completed by staff, dated 10/18/23, showed the following: -Cognition not assessed, cannot do interview because resident is rarely understood; -Diagnosis include hemiplegia (paralysis one side of body) affecting right dominant side; cerebral vascular accident (stroke) Parkinson's (disorder of the central nervous system that affects movement, often including tremors), back pain related to cervical disc issue; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff with hygiene, transfers, toilet use, and bathing. Review of the resident's care plan, dated 10/18/23, showed the resident has a history of cognitive impairment. The resident can make simple needs known. The resident is dependent on staff for toileting, transfers, hygiene, and requires partial to moderate assistance with dressing. The care plan did not address the resident's preference on when to get up in the mornings. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No behaviors; -Presence of pain left blank. Observation on 4/17/24, at 5:30 A.M., showed the following: -Resident in his/her bed with eyes closed; -Nurse Assistant (NA) K and NA L entered the resident's room and turned the light on; -NA L woke the resident; -The resident said it doesn't feel like its time; -NA L told NA K the resident said he/she would get up but it doesn't feel like the right time; -The NA's got the resident dressed and used the mechanical lift to get him/her out of bed; -The NA's did not give the resident a choice about getting up; -Staff propelled the resident out to the dining room (breakfast was not to be served until 7:30 A.M.). 2. Review of Resident #36's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of dementia; -Usually understood and usually understands. Review of the resident's care plan, dated 4/26/23, showed the following: -The resident's memory isn't good; -Offer simple choices; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Explain what is happing to the resident. The care plan did not address the resident's preference on when to get up in the mornings. Review of the residents quarterly MDS, dated [DATE], showed the following: -Supervision/cues from staff for upper body dressing, toilet transfer, ambulate 51-150 feet; -Partial/moderate assistance from staff with toileting hygiene, lower body dressing and footwear; -Substantial/maximal assistance from staff with shower/bathe. Observation on 4/17/24, at 6:00 A.M., showed the following: -Resident in bed with his/her eyes closed; -NA L went into the resident's room, turned the light on and asked him/her if he/she is ready to get up; -The resident said no, but I guess I will; -The NA assisted the resident to the bathroom and to get dressed; -The resident said I want to lay back down; -The NA told the resident once he/she was dressed and ready for the day he/she could lay down for a while; -After the resident was dressed in clothes and shoes, staff assisted the resident back to bed. During an interview on 4/17/24, at 6:04 A.M., NA L said the resident doesn't like to get out of bed. The resident can be feisty when you try to get him/her up so you have to watch out. 3. Review of Resident #30's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of Alzheimers; -No behaviors or rejection of care; -Dependent with toileting, transfers, hygiene, and shower/bathe; -Requires substantial/maximal dressing, footwear, and bed mobility; Review of the resident's care plan, dated 12/14/23, showed the following: -The resident once was very sociable, now quiet and will give short answers to questions; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Respect the resident's wishes; -Requires help with dressing, grooming, toileting, and transfers. The care plan did not address the resident's preference on when to get up in the mornings. Review of the resident's quarterly MDS, dated [DATE], showed the resident is dependent with toilet hygiene, shower/bathe, dressing, footwear, personal hygiene, sit to lying, lying to sitting on side of bed, and transfers. Observation on 4/17/24, at 6:15 A.M., showed the following: -The resident in his/her bed with eyes closed; -NA K and NA L entered the resident's room, turned the light on and said it's time to get up; -The resident replied no; -NA K and NA L dressed the resident anyway; -NA K and NA L transferred the resident using the mechanical lift; -After cares were completed and the resident dressed for the day, staff took the resident to the dining room (breakfast was not to be served until 7:30 A.M.). 4. Review of Resident #27's face sheet showed the resident's had a durable power of attorney. Review of the resident's care plan, dated 10/18/23, showed the resident required partial/moderate to dependent assistance with dressing. The resident had limited physical mobility related to Alzheimer's disease and cognitive impairment. The care plan did not address the resident's preference on when to get up in the mornings. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent with bathing, transfers and personal hygiene. 5. Review of a resident roster showed Resident #15, #27, #30 and #36 all resided on Cardinal Lane. During an interview on 4/17/24, at 5:44 A.M., NA L said the following: -There was no list of residents to get up or a list of what time residents want to get up; -On night shift, the NA/certified nurse aides (CNA's) are expected to get up all the residents on this hall (referring to Cardinal Lane); -The night shift was not allowed to leave until the residents were are all up; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The night shift was supposed to end at 6:00 A.M.; -Some resident's fight staff, especially Resident #27 and Resident #36; -Resident #36 will usually lay back down after they get him/her up; -Resident #15 and Resident #30 do not like to get up, but they will, they just complain about it; -He/She tried to get Resident #27 up this morning but he/she tried to hit him/her (NA L) so he/she told the charge nurse that day shift would have to try to get him/her up later. During an interview on 4/17/24, at 6:15 A.M., Registered Nurse (RN) T said the following: -The aides on night shift get the residents up on Cardinal hall; -They are expected to get them all up unless there is an issue, otherwise day shift will not have time to get everyone out for breakfast. During an interview on 4/17/24, at 1:30 P.M., the Director of Nursing said she is not sure if there is a get up list or how the aides know who to get up in the morning. If a resident didn't want to get up, staff should try later. During an interview on 4/17/24, at 3:09 P.M., the Administrator said he/she did not know the night shift aides were supposed to get up everyone on Cardinal hall before they leave. If a resident does not want to get up, he/she would expect staff to try later.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42592 Based on interview and record review, the facility failed to notify the physician and/or responsible party when one resident (Resident #11), in a review of 15 sampled residents, had a fall with minor injury. The facility census was 31. During an email communication on 04/30/24 at 2:09 P.M., the administrator said the facility did not have a specific policy on reporting resident condition changes or falls. 1. Review of Resident #11's summary sheet showed the following: -The resident has a responsible party to help with decision-making; -Diagnoses included dementia without behavioral disturbance. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument, dated 01/12/24, showed the following: -Severe cognitive impairment; -Fall with major injury. Review of the resident's care plan, revised 01/23/24, showed the following: -Focus area of cognitive loss/dementia with an intervention to cue, reorient and supervise as needed; -Focus area of at risk for falls related to impaired mobility and dementia. Review of the resident's nursing progress notes, dated 03/31/24, showed the resident had an unwitnessed fall and received a small laceration to his/her right upper cheek from his/her glasses hitting his/her face when he/she fell . There was no documentation staff notified the resident's physician or next of kin/responsible party regarding the unwitnessed fall with injury. During an interview on 04/15/24, at 3:27 P.M., the resident's responsible party said the following: -The facility did not call him/her when the resident fell out of his/her wheelchair and received an injury to his/her face; -Staff told the responsible party he/she did not receive a call about the fall because someone new was working and did not know to call him/her; -There was always new staff and there was a severe lack of communication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24, at 3:57 P.M., Registered Nurse (RN) T said the following: -He/She was on duty the night the resident had an unwitnessed fall with minor injury; -He/She was also sending a critical resident to the hospital at the same time as the resident's fall; -Family and physician should be notified of a fall with injury, but at 4:00 A.M., if the injury was not major sometimes he/she would call at the end of the shift or have day shift call; -He/She thought the day shift would call all necessary parties to inform them of the fall; -He/She did not recall asking the day shift nurse to notify the necessary parties. During an interview on 04/18/24, at 7:30 P.M., the Director of Nursing said she expected staff to notify family and physician with any condition change or fall with injury. During an interview on 04/18/24, at 12:35 P.M., the Medical Director said he would expect staff to notify the resident's physician when a resident fell .

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to give appropriate Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) (CMS-10055) and the CMS Notice of Medicare Non-Coverage (NOMNC) (CMS-10123) in writing to three residents (Residents #1, #91, and #33) reviewed, when the facility initiated discharge from Medicare Part A Services when benefit days were not exhausted. The facility census was 31. During an interview on 4/18/24 at 1:15 P.M., the Administrator said the facility did not have a policy in regards to ABN and NOMNC notices. The facility followed the regulatory guidelines related to these areas. 1. Review of Resident #1's face sheet showed the resident had a durable power of attorney (DPOA) for health care. Review of the resident's discharge Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 2/7/24, showed the resident was transferred to the hospital. Review of the resident's entry MDS, dated [DATE], showed the resident began a Medicare Part A stay. Review of the resident's NOMNC, dated 3/29/24, showed the resident's Part A services would end 4/2/24. The notice showed Call your QIO (Quality Improvement Organization) at: [insert QIO name and toll-free number of QIO] to appeal. The staff documented on the end of the NOMNC: Resident is blind but acknowledges NOMNC, and representative informed via phone call and is dated 3/29/24. (Review showed no documentation staff mailed a copy of the notice to the resident's DPOA.) The facility did not provide a written NOMNC or include the name and phone number to appeal the discharge from Medicare part A services to the resident/resident's representative. The resident had days remaining and continued to reside in the facility. The facility did not complete an ABN for the resident or provide the resident/resident's representative with a written ABN. 2. Review of Resident #33's face sheet showed the resident had a durable power of attorney for health care. Review of the resident's discharge MDS, dated [DATE], showed the resident was transferred to the hospital. Review of the resident's entry MDS, dated [DATE], showed the resident began a Medicare part A stay. Review of the resident's NOMNC, dated 10/9/23, showed the resident's Part A services will end 10/12/23. The notice did not include how to contact the QIO. The staff documented on the NOMNC: Informed family over the phone. (Review showed no documentation staff mailed a copy of the notice to the resident's DPOA.) (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility did not provide a written NOMNC or include the name and phone number to appeal the discharge from Medicare part A services to the resident/resident's representative. The resident had days remaining and continued to reside in the facility. The facility did not complete an ABN for the resident or provide the resident/resident's representative with a written ABN. 3. Review of Resident #91's face sheet showed the resident made his/her own decisions. Review of the resident's entry MDS, dated [DATE], showed the resident began a Medicare part A stay. Review of the resident's NOMNC, dated 12/18/23, showed the resident's Part A services will end 12/21/23. The notice did not include the name or phone number of the QIO or how to contact the QIO. 4. During an interview on 4/16/24, at 02:40 P.M., the Administrator said the following: -She was responsible to give the resident or resident representatives the ABN and/or NOMNC; -She didn't know about how the notices were to be given until the first of the year; -She didn't realize the QIO contact information was missing from the NOMNC; -She did not know the ABN and the NOMNC has to be given to residents who will remain in the facility and have Medicare part A days remaining: -She did not know a written notice was to be given to the resident or resident representative.

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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** 38016 Based on observation and interview, the facility failed to provide a clean, comfortable environment by failing to ensure the shower room and ceiling vents were clean and in good repair. The facility census was 31. 1. Observation on 4/15/24 at 1:10 P.M. and on 4/17/24 at 7:45 A.M., in the shower room on Cardinal hall, showed black marks on the floor near the shower stall. The shower basin had a large crack between the wall and the floor, the seam in the corner appeared black, and the tiles above the basin showed the grout was black for three of the tiles. The floor in the shower basin had brown stains by the drain. During an interview on 4/24/24 at 1:05 P.M., the Director of Nursing (DON) showed the following: -Staff were to notify maintenance if repairs were needed. -Nursing was to clean the shower room if they or the resident left a mess in the shower room. -Staff could contact housekeeping to provide extra cleaning. 2. Observations on 4/15/24 between 9:18 A.M. and 3:23 P.M., showed the following: -In the west hall shower room, the 8-inch by 8-inch ceiling vent, located by the door, had a heavy accumulation of lint and debris. The 6-inch by 6-inch ceiling vent with attached light had a moderate accumulation of lint and debris; -In occupied resident room [ROOM NUMBER], the bathroom ceiling vent had a moderate accumulation of dust and debris; -In occupied resident room [ROOM NUMBER], the bathroom ceiling vent had a moderate accumulation of dust and debris; -In occupied resident room [ROOM NUMBER], the bathroom ceiling vent had a moderate accumulation of dust and debris; -In occupied resident room [ROOM NUMBER], the bathroom ceiling vent had a moderate accumulation of dust and debris. During an interview on 4/15/24 at 9:18 A.M. and on 4/16/24 at 3:15 P.M., the maintenance director said maintenance staff was responsible for cleaning the ceiling vents. He cleaned the vents about every 45 days or when staff or residents told him they were dirty. He had overlooked cleaning the ceiling vents in the west hall shower room. 42592

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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. 38016 Based on interview and record review, the facility failed to complete required pre-employment screenings for five of eight sampled employees hired since the previous survey. The facility failed to request a criminal background check for four employees, complete an Employee Disqualification List (EDL) check for four employees, and complete a Nurse Aide (NA) registry check for two employees, prior to hire. The facility census was 31. 1. Review of Activity Aide N's employee file showed the following: -Date of hire 01/03/24; -Criminal background check requested on 03/09/24 (66 days after hire date); -EDL check completed on 02/08/24 (36 days after hire date). 2. Review of the Director of Nursing's (DON) employee file showed the following: -Date of hire 02/12/24; -Criminal background check requested on 03/08/24 (25 days after hire date); -EDL check completed on 03/08/24 (25 days after hire date). 3. Review of Speech Therapist O's employee file showed the following: -Date of hire 12/17/23; -No criminal background check request on file; -No EDL check on file; -NA registry check completed, but no date provided for when it was completed. 4. Review of the Administrator's employee file showed the following: -Date of hire 08/01/23; -Criminal background check completed on 08/03/23 (two days after hire date); -Criminal background check received on 08/04/23 (three days after hire date); -EDL check completed on 08/03/23 (two days after hire date); -NA registry check completed on 08/03/23 (two days after hire date). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Licensed Practical Nurse (LPN) P's employee file showed the following: -Date of hire 11/10/22; -Criminal background check requested on 11/07/22; -No record of criminal background check received. 6. During interviews on 04/16/24 at 4:24 P.M. and 04/18/24 at 1:15 P.M., the Administrator said the following: -There was no corporate policy regarding completing criminal background checks, EDL checks, or NA registry checks; -The corporation follows the state guidelines related to each area; -The employee's hire date was the same as the start date; -She was responsible for completing the criminal background checks, EDL, and NA registry checks; -The criminal background check, EDL, and NA registry checks should be completed at least two days prior to the employees' start date.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42592 Based on interview and record review, the facility failed to report a resident-to-resident abuse allegation involving two residents (Resident #11 and #19), to the state agency (SA) within two hours of the incident when Resident #19 hit Resident #11 with a fly swatter. The facility census was 31. Review of the facility's undated policy, Resident-to-Resident Altercations, showed the following: -Notify family, the attending physician, the Administrator and/or the registered nurse on-call, in the absence of the Administrator, of incident; -The Administrator and/or the on-call registered nurse shall continue the investigation; -This designated staff member will hotline the incident to the state agency within 24 hours, unless there is a serious bodily injury, then the hotline is to be made within two hours of the altercation. Review of the facility's undated policy, Reporting of Abuse Allegations, showed the following: -Should a suspected violation or a reasonable suspicion or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse), be reported, the facility Administrator, or his/her designee in the absence, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility; -The initial report, due at either two hours or 24 hours, should include sufficient information to describe the alleged violation and indicate how residents are being protected. Provide as much information as possible, to the best of what is known at the time; -Verbal/written notices to agencies will be made per state guidelines. 1. Review of Resident #19's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 2/8/24, showed the following: -The resident had moderately impaired cognition; -No behaviors. Review of the resident's nurse note, dated 4/13/24, showed the resident hit another resident (Resident #11) on the hand for getting too close to his/her table and yelled at the other resident to get away. During an interview on 4/16/24 at 8:48 A.M., Licensed Practical Nurse (LPN) C said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not witness the resident-to-resident altercation: -The staff reported Resident #11 propelled himself/herself via wheelchair too close to Resident #19's table; -Resident #19 hit Resident #11 on the hand with a fly swatter; -The staff separated both residents and LPN C assessed both residents finding no injuries on either resident; -LPN C sent a text message on his/her personal phone to the Nurse Manager and Administrator notifying them of the incident, but neither one responded. During an interview on 4/18/24 at 7:55 P.M., Certified Medication Technician (CMT) S said the following: -Resident #11 took some items out of the basket on Resident #19's table; -Resident #19 yelled at Resident #11 to stop, hit the table a couple times with the fly swatter, then hit him/her on the hand. During an interview on 4/18/24 at 7:30 P.M., the Director of Nursing said the following: -A resident-to-resident altercation should be reported to state agency within two hours of the incident; -She was not notified of the resident-to-resident altercation on 4/13/24; -The charge nurse during the incident was an as needed (PRN) nurse, who notified the Administrator by the messaging application but she expected to be notified by a phone call. During an interview on 4/18/24 at 8:00 P.M., the administrator said the following: -The staff did not notify her when the incident occurred; -LPN A mentioned it in conversation and then staff reported it to her; -No report was sent to the state agency because LPN C did not call anyone the day the incident happened and she did not become aware of the incident until two days later. 46506

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to complete a significant change status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment, required to be completed by facility staff, for two residents (Residents #30 and #36), in a review of 15 sampled residents. This assessment should have been completed within 14 days after the facility determined, or should have determined, there had been a significant change (major decline or improvement in the resident's status) in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 31. Review of the Long Term Care Facility RAI User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting; -Impacts more than one area of the resident's health status; -Requires interdisciplinary review and/or revision the care plan. -Significant Change in Status Assessment (SCSA) was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of Activity of daily living (ADL) decline or improvement). -An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. 1. Review of Resident #30's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 12/14/23, showed the following: -Requires supervision from staff with eating and oral hygiene; -Requires substantial/maximal assistance from staff for dressing, footwear, bed mobility, and transfers; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requires partial/moderate assistance from staff with personal hygiene. Review of the resident's Physician Orders, dated 1/1/24, showed an order Buspar (antianxiety medication) 7. 5 milligrams. Review of the resident's Physician Orders, dated 2/12/24, showed an order for mechanical soft diet. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Requires partial/moderate assistance from staff with eating and oral hygiene; -Dependent on staff with dressing, putting on and taking off footwear, personal hygiene, sit to lying, lying to sitting on side of bed, and transfers; -New mechanically altered diet; -New antianxiety medication. Observation on 4/16/24, at 12:25 P.M., showed staff fed the resident his/her lunch. The resident did not make any attempt to feed himself/herself. Observation on 4/17/24, at 6:15 A.M., showed the following: -The resident lay in his/her bed; -Nurse Aide (NA) K and NA L rolled the resident back in forth in bed to provide perineal care, dress the resident, and place the sling for the mechanical lift; -The staff transferred the resident to his/her wheelchair with a mechanical lift. The resident did not assist with the transfer. The resident's medical record did not contain evidence that staff completed a SCSA after the resident had a decline in multiple ADLs, started on new antianxiety medication and a new mechanically altered diet. 2. Review of Resident #36's admission MDS, dated [DATE], showed the following: -Intrudes on others privacy; -Requires supervision for eating, toileting hygiene, and dressing -Requires partial/moderate assistance from staff to bathe, bed mobility, and ambulating up to 150 feet; -Requires maximum assistance from staff for locomotion if in a wheelchair. -Weight 114 pounds (lbs). (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Independent with eating, bed mobility, and ambulating 50 feet; -Supervision/cues from staff for ambulating 51-150 feet; -Partial/moderate assistance from staff with toileting hygiene and lower body dressing; -Substantial/maximal assistance from staff with a shower/bathe; -Significant weight gain 127 lbs., not on a weight gain plan. The resident's medical record did not include a SCSA MDS after the resident had improvements with eating, bed mobility, or ambulation; had a decline in toilet hygiene, lower body dressing, and shower/bathing; and had a new significant weight gain. 3. During an interview on 4/15/24, at 11:55 A.M., Minimum Data Set Coordinator (MDSC) 1 said she was the liaison to MDSC 2 who completes the residents' MDS assessments offsite. MDSC 1 completes all of the interviews and corresponds with MDSC 2 via email. MDSC 1 does not review MDSC 2's assessments because she has limited knowledge and is not trained. She has not had formal training regarding MDS assessments. During an interview on 4/16/24 at 11:39 A.M., MDSC 2 said MDSC 1 does all of the required interviews with the residents and the cognitive section. MDSC 2 took over in December 2023, prior to that another third party company was doing the facility's MDS assessments. The facility was to notify him/her if there is a significant change since she works remote from the facility. During an interview on 4/18/24, at 7:30 P.M., the Director of Nursing said she expects the MDS to be coded according to the RAI manual. 46506

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for one sampled residents (Resident #15), in a review of 15 sampled residents, and for two closed records (Residents #6 and #17). The facility census was 31. Review of the Resident Assessment Instrument (RAI) Manual, dated [DATE], showed the following: -Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. -The RAI process has multiple regulatory requirements. Federal regulations require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts; -It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 1. Item B0100: Definition of comatose (coma) A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; they do not open their eyes, do not speak and do not move their extremities on command or in response to noxious stimuli (e.g., pain). Residents who are in a coma or persistent vegetative state are at risk for the complications of immobility, including skin breakdown and joint contractures. -Steps for Assessment 1. Review the medical record to determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. -Coding Instructions--Code 0, no: if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. -Code 1, yes: if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. 2. Item O0110K1, Hospice care Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	1. Review of Resident #6's admission MDS, dated [DATE], showed the following: -Comatose; -Diagnosis: Coronary artery disease, heart failure, high blood pressure, peripheral vascular disease, diabetes mellitus (inability to control blood glucose), schizophrenia. -Independent with eating, bed mobility transfers, and walks 10 feet; -Supervision/cues with all hygiene, dressing and footwear; -Partial/moderate staff assistance for shower/bathe; -Always continent; -The resident interview sections were not completed and were skipped when comatose was coded. Review of the resident's medical record did not contain a diagnosis for comatose. Review of the resident's care plan, dated [DATE], showed cognition was not addressed. The care plan said the resident requested bed rails because he/she was used to a bigger bed at home, the resident was a fall risk and able to feed himself/herself. Review of the resident's medical record showed the resident was at the facility for 12 days and discharged to his/her home. 2. Review of Resident #17's medical record showed the resident began hospice services [DATE]. Review of the resident's significant change in condition MDS, dated [DATE], showed the resident's life expectancy was six months or less. (Staff did not document the resident received hospice services in the last 14 days while a resident.) Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident did not have a life expectancy of six months or less; -The resident had not received hospice services in the last 14 days while a resident. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident did not have a life expectancy of six months or less; -The resident had not received hospice services in the last 14 days while a resident. Review of the resident's nurses notes, dated [DATE], showed the resident expired and hospice was notified. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on [DATE], at 11:20 A.M., the Social Services Director (SSD) said the resident was on hospice when he/she expired. The resident started on hospice [DATE] and remained on hospice services until he/she expired. 3. Review of Resident #15's Dysphagia (difficulty swallowing) Directive, dated [DATE], showed the following: -I understand the possible effects or risks of dysphagia, malnutrition, aspiration (when something you swallow enters the airway or lungs), dehydration which can lead to serious or fatal medical complications; -I understand the safe swallowing strategies and the use of appropriate food and liquid consistencies; -I understand that my diet will be advanced at my request against the advice of the physician; -With informed consent, as explained above, and in respect to my/my family member's quality of life and choice, I choose to continue with food/liquid by mouth; -Mechanical soft food and thin hot liquids; -If giving medications becomes a problem with thickened water, use thin liquids. Review of the resident's care plan, dated [DATE], showed the following: -The resident is at risk for impaired nutritional status related to Parkinson's disease, hemiplegia and cognitive impairment; -Monitor for chewing and swallowing difficulties; -May have hot thin liquids per dysphagia directive signed [DATE]. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognition not assessed, cannot do interview because resident is rarely understood; -Diagnosis include hemiplegia (paralysis one side of body) affecting right dominant side, cerebral vascular accident (stroke), Parkinson's disease and seizures; -Long and short-term memory problems; -Moderate impaired vision; -Slurs or mumbles words; -Usually understands, may miss intent of conversation; -Range of motion (ROM) impairment one upper extremity; (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-Requires supervision with eating; -Edentulous (no teeth or dentures). Review of the resident's quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment. The swallowing disorder section K on the MDS was not completed. Review of the resident's quarterly MDS, dated [DATE], showed the swallowing disorder section K on the MDS was not completed. 4. During an interview on [DATE], at 11:55 A.M., Minimum Data Set Coordinator (MDSC) 1 said he/she was the liaison to MDSC 2 who completed the residents' MDS assessments offsite. He/She completed all of the interviews and corresponds with MDSC 2 via email. He/She did not review MDSC 2's assessments because he/she had limited knowledge and was not trained. He/She had no formal training for MDS assessments. During an interview on [DATE] at 11:39 A.M., MDSC 2 said MDSC 1 completed all of the required interviews with the residents and the BIM (cognitive section). MDSC 2 took over in [DATE], prior to that, a third party company was doing the resident MDS assessments. She counts on the facility staff to complete their sections of the MDS accurately. During an interview on [DATE], at 7:30 P.M., the Director of Nursing said she expects the MDS to be coded according to the RAI manual.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592 Based on interview and record review, the facility failed to ensure two residents (Resident #13 and #23), in a review of 15 sampled residents, had a preadmission screening for individuals with a mental disorder and individuals with an intellectual disability (Pre-Admission Screening and Resident Review -PASRR) completed prior to admission. The facility census was 31. During interview on 04/18/24, at 1:15 P.M., the administrator said the facility did not have a specific policy for PASRR screenings but followed the state guidelines related to PASRR requirements. 1. Review of Resident #13's undated summary sheet showed the following: -admitted [DATE]; -Diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of the resident's quarterly Minimum Data Set (MDS, a federally required assessment instrument required to be completed by facility staff), dated 3/16/24, showed the following: -Cognitively intact; -PASRR - left blank; -Level II PASRR left blank; -Diagnosis of schizophrenia. Review of the resident's medical record showed no documentation a Level I or Level II PASRR was completed. 2. Review of Resident #23's undated summary sheet showed the following: -The resident's spouse was his/her responsible party for decision making; -Diagnoses included dementia with behavioral disturbance (a group of thinking and social symptoms that interferes with daily functioning with presence of behaviors such as physical aggression, agitation, or depression), depression (a mental health disorder that involves a depressed mood or loss of pleasure or interest in activities for a long period of time) and post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PASRR left blank; -Level II PASRR left blank; -Diagnoses include dementia, depression and PTSD. Review of the resident's medical record showed no documentation a Level I or Level II PASRR was completed. 3. During an interview on 04/17/24, at 08:46 P.M., the administrator said the following: -She received an email from the state agency on 04/19/24, at 4:37 P.M., that showed no Level I PASRR screening was found for Resident #23; -She was aware that all residents needed to have at a minimum a Level I PASRR screening prior to admission; -She would be responsible to ensure all residents had the Level I PASRR prior to admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan, specific to the resident, for four residents (Resident #2, #12, #15 and #16), in a review of 15 residents and one additional resident (Resident #37). The facility was 31. A request for a facility policy for comprehensive care plans and revisions of care plans was requested and none provided. 1. Review of Resident #2's summary page, undated, showed the following: -The resident was admitted on [DATE]; -He/She was his/her own responsible party; -Diagnoses included high blood pressure, heart failure, peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes obstructed airflow from the lungs), and asthma (disease in which the airways clog and narrow, making it hard to breathe), erythema intertrigo (common inflammatory skin condition that is caused by skin-to-skin rubbing that is intensified by heat and moisture), pyogenic arthritis (infection in the joint fluid and joint tissues), convulsions, morbid (severe) obesity (overweight), Parkinson's disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), Alzheimer's disease (type of dementia that affects memory, thinking and behavior), obstructive sleep apnea (occurs when the throat muscles relax and block the airway), cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking, muscle tone, and coordination), and edema (swelling caused by too much fluid trapped in the body's tissues). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/1/24, showed the following: -The resident was cognitively intact; -He/She was dependent on staff for upper body dressing, and lower body dressing; -He/She had scheduled pain medication for pain; -He/She received a diuretic, opioid, and hypoglycemic medications. Review of the resident's nurse's note, dated 3/14/24, showed the resident used a bed pan, oxygen at two liters/minute via nasal cannula, and had a large bed. Review of the resident's care plan, started on 3/20/24, showed the following: -The resident had limited physical mobility; (continued on next page)

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	265598	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had a pressure ulcer or potential for pressure ulcer development related to immobility; -Weekly head to toe skin assessment; -Turn and reposition every two hours; -The care plan did not include the resident had a bariatric bed, used a bed pan, had supplemental oxygen therapy, experienced pain, pressure ulcer prevention devices, skin wounds, had Alzheimer's disease, type II diabetes mellitus (long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), or Parkinson's disease. Review of the care plan, last updated on 4/1/24, showed the following: -The resident had a skin infection; -He/She would show improvement with signs and symptoms within 48 hours of starting antibiotic; -Ensure adequate nutrition to support immune function and promote tissue repair and wound healing; -Conduct a thorough assessment of the affected skin area, noting characteristics such as redness, warmth, swelling, pain, and presence of drainage or pus; -The care plan did not include the resident had a bariatric bed, used a bed pan, had supplemental oxygen therapy, experienced pain, pressure ulcer prevention devices, skin wounds, had Alzheimer's disease, type II diabetes mellitus (long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), or Parkinson's disease. Review of the resident's nurse's note, dated 4/8/24, showed the resident requested pain medication for right shoulder pain rated at 7/10. Review of the resident's nurse's note, dated 4/9/24, showed the following: -The resident had an episode of not responding when spoken to that lasted for a few seconds; -The resident's oxygen saturation was 84% on room air (normal range 92-100%); -The nurse put oxygen at three liters per minute per nasal cannula; -The staff put the resident in bed with head of bed elevated. Review of the resident's nurse note, dated 4/11/24, showed the following: -The resident continued with wounds to buttocks/gluteal, self-inflicted wound from the resident scratching, healing stage varies based on the resident's behavior; -He/She was on weekly weight monitoring; -He/She had a wheelchair cushion in place and a low air loss mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's weekly skin note, dated 4/12/24, showed the following: -Right gluteal fold noted with 4.0 centimeters (cm) x 10 cm open area, red excoriated skin with maceration noted throughout; -Left gluteal fold measuring 7 cm x 10 cm, red excoriated skin; -Both buttocks were bright red and missing top layer of skin; -Areas were self-inflicted from the resident scratching at self; -Triple butt cream applied to areas. Observation in the resident's room on 4/15/24 at 9:55 A.M., showed the following: -The resident laid in a bariatric bed; -He/She had dark areas surrounded by redness on the left lower leg; -He/She had an oxygen concentrator with oxygen cannula/tubing. Review of the resident's physician orders, dated April 2024, showed the following: -Brivaracetam (anticonvulsant) 150 mg give one tablet orally twice a day (started on 3/13/24); -Clonazepam (benzodiazepine) 0.5 mg give one tablet orally twice a day (started on 3/13/24); -Depakote DR (anticonvulsant) 250 mg give two tablets orally three times a day (started on 3/13/24); -Donepezil HCL (treat dementia related to Alzheimer's disease) 5 mg give two tablets orally at bedtime (3/13/24); -Gabapentin (anticonvulsant) 300 mg give one capsule twice a day (started on 3/13/24); -Mirapex ER (antiparkinsonism agents) 0.75 mg give one tablet orally twice a day (started on 3/13/24); -Spironolactone (potassium-sparing diuretic) 50 mg give one tablet orally daily (started on 3/13/24); -Symbicort inhalation aerosol (bronchodilator) 80-4.5 micrograms/actuation inhale two puffs twice a day (started on 3/13/24); -Tramadol (opioid) 50 mg give one tablet orally every six hours as needed for pain (started on 3/13/24); -Tramadol 50 mg give half a tablet orally twice a day (started on 3/13/24); (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tylenol #3 (opioid) give one tablet orally every six hours as needed for pain (started on 4/10/24); -CPAP on at bedtimes with current settings as needed per resident's request (started on 3/13/24); -May have oxygen at 3 liters per minute per nasal cannula to keep oxygen saturation above 92% (started on 3/13/24); -Voltaren gel (nonsteroidal anti-inflammatory) 1% apply to bilateral shoulders topically three times a day (started on 3/13/24). Review of the resident's medical record, showed the care plan did not include the resident had a bariatric bed, used a bed pan, had supplemental oxygen therapy, experienced pain, air mattress on the bed, skin wounds, had Alzheimer's disease, type II diabetes mellitus (long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), or Parkinson's disease. 2. Review of Resident #12's care plan, dated 10/04/23, showed the following: -The resident was at risk for psychosocial impairment due to disease process; -The resident was at risk for mood problem related to disease process; -No focus area related to activities. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Able to understand and be understood by others; -Activity preferences that were important to the resident: snacks between meals, choose his/her own bedtime, have family/friends involved in decisions about care, having books/newspapers/magazines to read, be around animals such as pets, keeping up with the news and going outside when weather permits; -Activity preferences that are somewhat important to the resident: choose what to wear, choose between a tub bath/shower/bed bath, and listening to music; -Activity preferences were answered by the resident; -Review of the Care Area Assessment (CAA's) of the MDS showed activities triggered as an area and should be addressed on the care plan. Review of an additional care plan provided by the facility, dated 04/03/24, showed no focus area related to activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/24, at 10:39 A.M., showed the resident lay awake in his/her bed watching television. During an interview on 04/15/24 at 10:39 A.M., the resident said he/she did not participate in activities by his/her choice and spent the majority of his/her time in his/her room. 3. Review of Resident #16's summary page, undated, showed the following: -The resident was admitted on [DATE]; -High risk for falls: -He/She was his/her own responsible party; -Diagnoses included alcohol abuse, nicotine dependence, and atherosclerotic heart disease (common condition that develops when a sticky substance called plaque builds up inside your arteries). Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She had a history of falls one month and two to six months prior to admission; -He/She received anticoagulant and antibiotic medications. Review of the resident's nurse's note, dated 3/29/24, showed the resident recently stopped drinking alcohol, no signs or symptoms of delirium tremens (severe, life-threatening form of alcohol withdrawal). Review of the resident's nurse's note, dated 3/30/24, showed the following: -The resident's lung sounds were diminished with occasional rubs; -He/She received an antibiotic for pneumonia; -He/She received Eliquis (anticoagulant) for deep vein thrombosis (occurs when a blood clot forms in one or more of the deep veins in the body, usually in the legs) ; -He/She smoked and had a history of alcohol use. Review of the resident's nurse's note, dated 4/5/24, showed the nurse practitioner ordered Ativan (anti anxiety medication) 1 milligram (mg) orally daily for five days related to alcohol withdraw. Review of the resident's nurse's note, dated 4/8/24, showed the following: -The staff found the resident on his/her knees between the recliner and bed in his/her room; -He/She wore grippy socks and had just toileted; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She said there was a slick spot on the floor in front of the bed that caused him/her to slip and fall forward to his/her knees, the resident was able to catch himself/herself with the recliner and edge of bed. Review of the resident's fall huddle interdisciplinary team note, dated 4/8/24, showed the intervention was to make sure the floors were cleaned daily, updated housekeeping. Review of the resident's baseline care plan, last updated 4/10/24, showed the following: -The resident had nutritional problem related to alcohol abuse, high blood pressure, atherosclerotic heart disease, chronic obstructive pulmonary disease, and gastroesophageal reflux disease; under normal body mass index; on high protein diet-supplement received; -The care plan did not include the resident's fall of 4/8/24 with intervention, he/she was prescribed an antibiotic twice for pneumonia, he/she smoked, or to monitor for bleeding related to anticoagulant use. Review of the resident's physician orders, undated, showed the following: -Doxycycline hyclate (antibiotic) 100 mg give one tablet orally twice a day for ten days for pneumonia (started on 4/15/24); -Eliquis (anticoagulant) 5 mg give one tablet orally twice a day for atherosclerotic heart disease (started on 4/5/24); During an interview on 4/16/24 at 8:59 A.M., the resident said the following: -He/She could go smoke when he/she wanted; -He/She could take himself/herself out, light his/her own cigarette, and come back without assistance. Review of the resident's medical record, showed the comprehensive care plan did not include the following: -The resident was high risk for falls, assessed on 3/29/24; -He/She had a fall on 4/8/24 with intervention; -He/She was prescribed an antibiotic twice for pneumonia; -He/She smoked cigarettes in the designated resident smoking area; -The staff need to monitor the resident for bleeding related to anticoagulant medication. 4. Review of Resident #15's annual MDS, dated [DATE], showed the following: -Cognition not assessed, cannot do interview because resident was rarely understood; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included hemiplegia (paralysis one side of body) affecting right dominant side, CVA (stroke), back pain, cervical disc degeneration (degeneration of the spine in the neck region), -Long and short term memory was a problem; -Slurs or mumbles words; -Usually understands, may miss intent of conversation; -Behaviors not directed towards others daily; -Rejection of care one to three days out of the last seven days; -No scheduled, PRN (as needed) pain medication, or non homological interventions for pain; -Had the following indicators of pain or possible pain in the last five days: non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movements; -Limited range of motion in one upper extremity; -Dependent on staff with hygiene, transfers, toilet use, bathing; -Substantial/maximum assistance rolling left and right; -Two or more non-injury falls since last assessment -On Section V the resident triggered for pain and staff marked they would proceed to care plan for pain. Review of the resident's care plan, dated 10/18/23, showed it did not include pain or any interventions to address pain control. Review of the resident's quarterly MDS, dated [DATE], showed staff did not answer the pain section of the MDS. Observation on 4/17/23, at 5:30 A.M., showed the following: -The resident lay in his/her bed; -Nurse Assistant (NA) L and NA K rolled the resident from side to side in bed to perform perineal care and dress the resident; -The resident's right arm was contractured and the resident kept his/her elbow bent and his/her hand clenched; -The resident's legs were stiff and when the NA's moved the resident's legs he/she would grimace in pain and moan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed staff did not answer the pain section of the MDS. Staff identified the resident had a diagnosis of pain and signs of pain. Pain was not addressed in the resident's plan of care. 5. Review of Resident #37's admission MDS, dated [DATE], showed the following: -Severely impaired cognition; -Bilateral lower extremity limitations; -Wheelchair was used for mobility; -Dependent on staff for sitting to lying position change, lying to sitting on the side of the bed position changes and chair/bed-to-chair transfers. Review of the resident's care plan, dated 01/15/24, showed the following: -Falls: the resident was at risk for falls due to cognitive impairment; -Staff would anticipate and meet resident needs; -No indication on the care plan of lower extremity limitation, mobility status, transfer status or assistance needed for transfers. Review of a second care plan for the resident and provided by the facility dated 04/17/24, showed the resident was at risk for falls with no identification of why the resident was at risk, and with no goals or interventions noted. Observation on 04/17/24, at 7:23 A.M., showed the following: -The resident lay awake and dressed in bed; -Certified Nursing Assistant (CNA) E and NA) G assisted the resident to a sitting position with manual assistance and the use of a gait belt; -CNA E and NA G assisted the resident to a standing position with manual assistance and the use a a gait belt and the resident's walker; -CNA E and NA G assisted the resident to pivot transfer to his/her wheelchair; -NA G pushed the resident to the dining room for breakfast. During an interview on 04/17/24, at 7:35 A.M., CNA E said the resident could not transfer himself/herself and required staff assistance for the transfer and to be pushed to and from any place he/she needed to go. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/24, at 11:55 A.M., MDS Coordinator (MDSC) 1 said she was the liaison to MDSC 2 who completed the residents' MDS assessments offsite. MDSC 1 completed all of the interviews and corresponded with MDSC 2 via email. MDSC 1 did not review MDSC 2's assessments because she had limited knowledge and was not trained. MDSC 1 also completed all of the residents' care plans except the Infection Preventionist/Assistant Director of Nursing completed the wound information and if they have any infection, activities completed the activity care plan and dietary completed the nutrition care plan. She had not had formal training for MDS assessments and care plans. During an interview on 4/16/24 at 11:39 A.M., MDSC 2 said MDSC 1 completed all of the required interviews with the residents, and the BIM (cognitive section). Therapy does all of section GG. MDSC 2 took over in December 2023, prior to that another 3rd party company completed the facility's MDS assessments. During an interview on 04/18/24, at 7:30 P.M., the Director of Nursing (DON) said she would expect care plans to be up-to-date and complete. 42592 46506 50675

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on observation, interview, and record review, the facility failed to update interventions in the resident's care plan to reflect current safety and care needs for three residents (Resident #1, #16, and #19), in a review of 15 sampled residents. The facility census was 31. Review of the facility's Care Plan Revision Upon Status Change policy, undated, showed the following: -The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change; -Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) Coordinator, the physician, and the resident representative, if applicable; b. The care plan will be updated with the new or modified interventions; c. Staff involved in the care of the resident will report resident response to new or modified interventions; d. Care plans will be modified as needed by the MDS Coordinator or other designated staff member; e. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 1. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She experienced inattention, disorganized thinking, and altered level of consciousness; -He/She had verbal and other behavioral symptoms not directed toward others; -He/She wandered; -He/She was independent with eating; -He/She needed setup assistance for toileting hygiene; -He/She needed supervision with personal hygiene. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician orders, dated January 2024, showed the following: -Metformin HCL (antidiabetic agent) 500 milligrams (mg) give one tablet orally twice a day related to pancreatic cancer; -Vemlidy (antiviral medication) 25 mg give one tablet orally daily related to viral hepatitis B. Review of the resident's care plan, updated 1/2/24, showed the following: -The resident continued to have falls when going to the restroom and then trying to find the bed again, after toileting; -Bells on the restroom door, room door, bed, and call light; -The staff educated the resident to bells and that the bells help him/her to find where he/she is in the room. Review of the resident's nurse note, dated 1/6/24 at 5:52 A.M., showed the following: -The staff found the resident on the floor between his/her bed and the restroom door; -The resident had an abrasion on his/her back; -The resident said he/she was trying to go to the restroom and fell back; -The staff put non-slip socks on the resident's feet and administered Tylenol (pain reliever) for headache. Review of the resident's care plan, dated 1/6/24, showed the resident continued to have falls in his/her room after toileting. No new interventions were added to the care plan to address the resident's fall on 1/6/24. Review of the resident's nurse note, dated 1/26/24, showed the following: -The staff provided all meals on a red plate with an inside edge to prevent food spillage and increase intake; -The staff encouraged the resident to try all foods on the plate and if he/she did not like a food, the staff would offer the resident an alternative; -Continue to monitor weight weekly. Review of the resident's care plan, last updated 1/26/24, showed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident walked without aids, however when out of his/her room, the resident did better when someone held his/her hand, guiding the resident where to go; -The care plan did not include the resident was prescribed an antiviral medication for viral hepatitis B infection or a hypoglycemic; -The care plan did not include the resident required setup assistance with toileting hygiene. Review of the resident's weekly Medicare meeting note, dated 1/30/24, showed the following: -The resident received physical therapy and occupational therapy services three times a week; -Occupational therapy goals were self-feeding, toileting, and bed mobility with tactile/auditory cues for locating bathroom/bed/toilet; -Physical therapy goals were to improve the resident's bilateral lower extremity strength and activity tolerance to improve gait and balance to decrease risk of fall. Review of the resident's physician orders, dated February 2024, showed consistent carbohydrate, finger food diet. Review of the resident's nurse's note, dated 2/2/24, showed the resident had five episodes of hollering out and wandering. Review of the resident's nurse note, dated 2/5/24 at 4:07 P.M., showed the following: -The staff found the resident on the floor in his/her bathroom; -The resident sustained an injury above the left eyebrow that was 5 centimeters (cm) long; -The nurse practitioner applied ten sutures to the injury. Review of the resident's nurse's note, dated 2/7/24, showed the nurse received an order to transport the resident to a psychiatric unit for further evaluation due to increased behaviors. Review of the resident's psychiatric hospital safety plan, dated 2/21/24, showed the following: -When to seek help: 1. Sudden loud noises; 2. Interrupting the resident during a conversation; 3. Yelling and cursing. -Coping strategies: 1. Talking about trivia; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Talking about the resident's military service; 3. Music from the 70's. -Making the resident's environment safe; 1. Take medications as prescribed; 2. Approach and communicate appropriately due to the resident being blind and deaf. Review of the resident's summary page, undated, showed the following: -The resident was readmitted on [DATE]; -He/She had a medical power of attorney; -Diagnoses: viral hepatitis B (viral infection that attacks the liver and can cause both acute and chronic disease), malignant neoplasm (cancer) of head of pancreas, legal blindness, left ear hearing loss, major depressive disorder (common and serious medical illness that negatively affects how you feel, the way you think and how you act), and traumatic hemorrhage of cerebrum (bleeding on a section of the brain caused by trauma). Review of the resident's nurse note, dated 2/21/24 at 7:25 P.M., showed the staff found the resident on the floor between the bed and the air conditioner. Review of the resident's interdisciplinary fall huddle note, dated 2/23/24, showed the following: -Bells are in place; -The staff toileted the resident every two hours and had the resident dressed and out for meals; -The administration educated the staff that the resident needed to be first in the dining room and last out to be monitored more closely. Review of the resident's care plan, updated 2/23/24, showed the following: -The resident was at risk for falls; -The staff anticipated and met the resident's needs; -The staff maintained a clear pathway, free of obstacles; -The staff avoided rearranging furniture; -The care plan did not include staff were to toilet the resident every two hours, staff were to dress the resident and take him/her to the dining room first and take him/her out of the dining room last in order to monitor him/her more closely; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The fall from 2/5/24 had not been addressed on the care plan. Review of the resident's care plan, updated on 3/5/24, showed the following: -Maintain a clear pathway, free of obstacles; -Avoid rearranging furniture; -The fall from 2/21/24 and the recommendations from the resident's psychiatric stay had not been addressed on the care plan. Review of the resident's annual MDS, dated [DATE], showed the following: -The resident had severely impaired cognition; -He/She had verbal and other behavioral symptoms not directed towards others one to three days of the assessment; -He/She rejected care one to three days in the assessment; -He/She wandered one to three days in the assessment that intrudes on others; -He/She required setup assistance with eating; -He/She required supervision with toileting hygiene; -He/She required moderate assistance with personal hygiene. Review of the resident's care plan, last updated 3/11/24, showed the following: -At risk for impaired cognitive function/dementia or impaired thought process related to disease process; -Bells to identify call light, restroom door, and door out into hallway; -Administer medications as ordered, monitor/document for side effects and effectiveness; -Because of traumatic brain injury, it was hard for the resident to process information; -The care plan did not include the resident's coping strategies of talking about trivia, talking about military service, or music from the 70's; -The care plan was not updated to show a change in the MDS to include wandering, required supervision with toileting hygiene, or moderate assistance with personal hygiene. -The care plan did not include consistent carbohydrate finger food with regular consistency from the physician orders; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan did not include falls on 2/21/24, 2/5/24, or 1/31/24. Review of the resident's nurse note, dated 3/21/24 at 3:57 A.M., showed the staff found the resident on the floor next to his/her bed with the emergency call light ripped from the wall and in the resident's hand. Review of the resident's nurse note, dated 3/21/24, showed the following: -A resident across the hall screamed and the facility staff found the resident naked and wandering in the other resident's room; -The resident said, I am going to the kitchen to get some chocolate. Review of the resident's nurse fall charting, dated 3/30/24, 1:19 P.M., showed the staff witnessed the resident lose balance and slide into another resident, then slid to the floor. Review of the resident's nurse note, dated 4/1/24, showed the following: -The resident was unsteady on his/her feet; -He/She had a wheelchair that he/she got around in the facility. Review of the resident's care plan, last updated 3/11/24, showed no documentation to include the resident occasionally used a wheelchair to go from his/her room to the dining room for meals, the facility implemented a toileting schedule for the resident, or the staff were supposed to check on the resident at a minimum of every two hours if not every hour. Review of the resident's weekly Medicare note, dated 4/2/24, showed Occupational Therapy recommended a bed/chair alarm for safety and a functional maintenance program for nursing. staff to continue. Review of the resident's fall huddle interdisciplinary team note, dated 4/8/24, showed the staff was re-educated on the importance of the toileting schedule and to check on the resident at a minimum of every two hours if not every hour. Review of the resident's care plan meeting note, dated 4/8/24, showed the following: -The resident had a functional maintenance program in place; -An easy touch call light was purchased for the resident making it easier to summon help and the therapy staff reported the resident was educated in the use and seemed to understand the concept; -The falls from 3/21/24 and 3/30/24 had not been addressed on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurse note, dated 4/13/24 at 5:20 AM., showed the following: -The resident fell on [DATE]; -The resident's gait was very unsteady; -He/She did not stay in bed and continued to wander around and continued to be a major fall risk; -The staff put the resident in his/her wheelchair and brought the resident up to the dining room to be watched. Review of the resident's fall nurse note, dated 4/13/24 at 2:00 P.M., showed the following: -The staff found the resident on the floor; -The nurse administered Tylenol (non-steroidal anti-inflammatory) for possible pain due to agitation from the resident; -The staff changed the resident's brief due to being damp and a night gown was put on the resident. Observation in the dining room on 4/15/24 at 11:52 A.M., showed Licensed Practical Nurse (LPN) A fed the resident, told him/her what was on the spoon before putting it up to his mouth, and the food was on a red plate. Observation in the dining room on 4/16/24 at 6:00 A.M., showed Nurse Aid (NA) K walked with the resident with him/her holding onto NA K's arm, then Certified Nurse Aid (CNA) E brought a wheelchair up behind the resident, the resident was instructed to sit down, then CNA E took the resident to the dining room table via wheelchair. During an interview on 4/16/24 at 9:10 A.M., Certified Medication Technician (CMT) D said the following: -Some days the staff took the resident to the dining room via wheelchair and some days the staff walked with the resident to the dining room with the resident holding onto the staff member's arm. Observation in the dining room on 4/17/24 at 6:55 A.M., showed the following: -LPN A cued the resident to eat and used a spoon to feed the resident; -LPN A took the resident to his/her room via wheelchair. During an interview on 4/17/24 at 6:55 A.M., LPN A said, the resident did not stay seated in the wheelchair and was too unsteady to be left alone. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #19's summary page, undated, showed the following: -The resident was admitted on [DATE]; -He/She had a durable power of attorney; -Diagnoses included high blood pressure and chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways and difficulty or discomfort in breathing). Review of the resident's nurse's note, dated 3/3/23, showed the resident fell from transferring self from wheelchair to bed without locking the breaks on his/her wheelchair. Review of the resident's nurse's note, dated 3/6/23, showed the following: -The resident used a light for assist with transfers to use the bathroom; -He/She attempted to transfer from wheelchair to the toilet without locking brakes; -The staff reminded the resident to lock wheelchair brakes; -The resident voiced concern of the wheelchair no longer being left by his/her bed and had to use the call light for assist with transfers. Review of the resident's nurse's note, dated 8/3/23, showed the following: -A staff member found the resident on the floor by his/her bed; -The resident said, she did not know how he/she fell , and the wheelchair just moved out from underneath him/her; -He/She only locked the wheelchair brakes prior to transferring; -He/She took himself/herself to the bathroom, only locked one brake on the wheelchair, so the staff member reminded the resident to lock both brakes prior to transferring Review of the resident's annual MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She required supervision with oral hygiene, toileting hygiene, upper body dressing, sitting to lying in bed, lying to sitting on bed, sitting to standing in bed, and toilet transfer; -He/She required setup with rolling left and right in bed; -He/She required moderate assistance to put on/take off footwear and propel self in wheelchair 50 feet with two turns. Review of the resident's care plan, last updated 12/6/23, showed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was able to toilet self; -He/She was independent with upper body dressing; -He/She told the staff when he/she needed assistance with toileting; -He/She did not have any recent falls; -The care plan did not include the resident required supervision with oral hygiene, toileting hygiene, upper body dressing, sitting to lying in bed, lying to sitting on bed, sitting to standing in bed, toilet transfer; -The care plan did not include the resident required setup assistance with rolling left and right in bed or required moderate assistance to propel self in wheelchair 50 feet with two turns; -The care plan did not include the resident's fall risk or the falls of 3/3/23 or 8/3/23, or keep the wheelchair away from the resident's bed while he/she was in bed. Review of the resident's nurse's note, dated 1/24/24, showed the resident had a fall on 1/18/24 and the resident's roommate picked him/her up and helped the resident get back into the wheelchair. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She was independent with oral hygiene, toileting hygiene, personal hygiene, sitting to lying in bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and propelling self in wheelchair; -He/She required supervision with upper body dressing, lower body dressing, put on/take off footwear, and rolling left and right in bed; -He/She received occupational and physical therapy. Review of the resident's nurse note, dated 3/31/24, showed the following: -Staff found the resident sitting on the floor between the bed and window; -The resident said, I was trying to get some candy. Review of the resident's care plan meeting note, dated 4/4/24, showed the following: -Staff used a dry erase board to communicate with the resident due to hearing loss; -Social Services had concerns with the resident's behavior towards others; -The family member explained to the resident that he/she was not to curse at others and try to work on his/her tone of voice. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurse note, dated 4/4/24, showed the resident yelled at another resident over the window blinds being raised and staff talked with the resident about the incident. Review of the resident's care plan, last updated 4/15/24, showed the following: -The resident was able to toilet himself/herself; -He/She was independent with upper body dressing; -He/She told the staff when he/she needed assistance with toileting; -He/She did not have any recent falls; -The care plan did not include supervision with upper body dressing, lower body dressing, put on/take off footwear, rolling left and right in bed, or occupational and physical therapy; -The care plan did not include resident falls on 1/18/24 or 3/31/24, use of a dry erase board to communicate with the resident due to hearing loss or increase of verbal behaviors. 3. Review of Resident #16's summary page, undated, showed the following: -The resident was admitted on [DATE]; -Diagnoses included alcohol abuse, high blood pressure, atherosclerotic heart disease (type of thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), chronic obstructive pulmonary disease, and dorsalgia (back pain); -Doxycycline (antibiotic) 100 milligrams give one tablet orally twice a day for 10 days related to pneumonia (started 4/15/24). Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She fell within the last month and within the last two to six months prior to admission. Review of the resident's nurse notes, dated 3/30/24, showed the following: -The resident was admitted status post hospitalization for pneumonia; -He/She continued on an antibiotic for pneumonia. Review of the resident's nurse's note, dated 4/5/24, showed the nurse received a new order for Ativan (anti anxiety medication) 1 mg orally daily for five days related to alcohol withdrawal. Review of the resident's fall nursing note, dated 4/8/24, showed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A staff member found the resident on his/her knees between the recliner and the resident's bed, grippy socks on, and the resident had just toileted; -The resident said there was a slick spot on the floor in front of the bed that caused him/her to slip and fall forward onto his/her knees, and the resident caught himself/herself with the recliner and edge of bed. Review of the resident's fall huddle, dated 4/8/24, showed the staff were to make sure the floors were cleaned daily, updated housekeeping, and resident was already wearing grippy socks. Review of the resident's care plan, last updated on 4/10/24, showed the care plan did not include the resident's fall on 4/8/24 with interventions, alcohol withdrawal monitoring with signs and symptoms, or treatment for pneumonia. During an interview on 4/18/24 at 11:25 A.M., LPN A said the following: -The MDS Coordinator #1/Medical Records (MDSC 1/MR) and the Assistant Director of Nursing/Infection Preventionist (ADON/IP) staff members were responsible for updating all resident care plans; -Falls, change in diet, change in ADL performance, bedrails, high-low bed implementation were items that needed to be updated on the care plan; -If there were psychiatric recommendations, then LPN A provided a copy to MDSC 1/MR; -Interventions to prevent falls for Resident #1 included a flat call light that was easier for the resident to find and use, tuck bed sheets under the foot of the bed to prevent falls from tripping hazard, non-skid socks, toilet the resident every two hours, and the staff encouraged the resident to eat in the dining room because he/she triggered for weight loss and staff could encourage the resident to eat; -Interventions the staff used when the resident had negative behaviors included the staff took the resident back to his/her room, encouraged the resident to listen to staff, and allow him/her to lay in bed; -The administrative staff decided to install automatic locking breaks on Resident #19's wheelchair that locked when the resident stood up; -He/She gave changes and/or updates to the MDSC 1/MR and didn't know why the care plan was not updated. During an interview on 4/15/24, at 11:55 A.M., Minimum Data Set Coordinator (MDSC) 1 said she completed all of the care plans except the Infection Preventionist/Assistant Director of Nursing completed the wound information and if the resident had any infection. Activity staff completed the activity care plan and dietary staff completed the nutrition care plan. She had not had formal training for care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/18/24 at 7:30 P.M., the Director of Nursing said the expectation was she would update care plans with each fall, and she would implement new interventions every time a fall occurred after discussion during the IDT meeting.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on interview and record review, the facility failed to provide one resident (Resident #39), who was discharged to his/her home, with a discharge summary that contained a recapitulation of the resident's nursing home stay. The facility census was 31. Review of an email correspondence from the administrator, dated 4/16/24, showed the facility did not have a policy regarding discharge recapitulation. 1. Review of Resident #39's summary page, undated, showed the following: -The resident was admitted on [DATE]; -The resident was his/her own responsible party. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/18/24, showed the following: -The resident was cognitively intact; -He/She had limited functional range of motion in bilateral lower extremities; -He/She used a wheelchair independently; -He/She required setup assistance with eating, oral hygiene, personal hygiene, and sitting to lying in bed; -He/She required supervision with rolling left and right in bed, lying to sitting on the side of the bed, and chair/bed-to-chair transfer; -He/She required moderate assistance with bathing and upper body dressing; -He/She required maximal assistance with lower body dressing; -He/She had an indwelling urinary catheter and occasional incontinence of bowel; -Diagnoses included sepsis (serious condition in which the body responds improperly to an infection), high blood pressure, obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), nicotine dependence, polyneuropathy (multiple peripheral nerves become damaged), Stage 4 sacral region pressure ulcer, and right below knee amputation. Review of the resident's care plan, last updated 3/20/24, showed the following: (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had activities of daily living (ADL) self-care performance deficit related to limited mobility; -He/She required assistance of staff with transfers and used a slide board; -He/She was dependent on staff to provide a bath as necessary; -Therapy (Occupational and Physical) evaluation and treatment per physician orders; -He/She was independent with eating; -He/She had an indwelling urinary catheter related to neurogenic bladder (lack bladder control due to a brain, spinal cord or nerve problem); -He/She had potential for a psychosocial well-being problem related to illness/disease process; -The staff increased communication between resident/family/caregivers about care and living environment, explained all procedures and treatments, medications, results of labs/tests, conditions, all changes, rules, options; -The resident had a nutritional problem or potential nutritional problem related to anorexia; -He/She had a pressure ulcer on his/her coccyx related to immobility. Review of the resident's Director of Nursing (DON) care note, dated 3/29/24, showed the following: -The DON faxed the resident's face sheet and wound orders to two different home health companies; -Both companies denied the resident for services due to compliance and refusal of care. Review of the resident's nurse's note, dated 4/1/24, showed the following: -The resident was discharged to home; -The Social Services Director and transporter took the resident to his/her home with the resident's belongings; -The Social Services Director notified the resident of upcoming appointments. Review of the resident's discharge instructions showed he/she was discharged to home on 4/1/24 . Review of the resident's medical record showed no documentation of a recapitulation summary. During an interview on 4/24/24 at 1:05 P.M., the Director of Nursing said the following: -A recapitulation summary on discharged residents should be completed with all departments addressing the resident's stay in the facility; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The charge nurse was to complete the discharge instructions showing medications to take at home, upcoming appointments, and home services, and would review with the resident/representative.

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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** 38016 Based on observation, interview and record review, the facility failed to provide four residents (Resident #15, #25, #27 and #30), of eight sampled residents, with the assistance of activities of daily living (ADL) care that the residents required. Resident #15 and #30 were not provided appropriate perineal care, Resident #27 and #30 were not offered bathing as scheduled and Resident #25 was not provided with feeding assistance when needed. The facility census was 31. Review of the facility policy, Quality of Life, dated June 2023, showed the following: -The community environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being; -Residents whom are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene; -Residents are provided with appropriate care and services including: a. Hygiene; b. Mobility; c. Elimination; d. Dining, including meals and snacks, e. Communication; -The resident or representative refuse care and treatment to restore or maintain functional abilities after efforts are given to educate about such or offer alternatives; -If a resident or representative refuses care and treatment which may contribute to a decline, then complete the following: a. Inform and/or educate the resident or responsible party of the benefits and risks of not accepting such interventions; b. Document such in the record, including the interventions identified in the care plan and in place to minimize functional loss that were refused; c. Document substitute interventions that were tried with consent or refused, and; d. Attempt to find the underlying cause of the refusal if related to depression, behavioral or dementia care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Utilize ADL reports, paper or electronic to assess ADL decline over time. Update care plan appropriately and interventions as needed. 1. Review of Resident #15's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 10/18/23, showed the following: -Cognition not assessed, cannot do interview because resident is rarely understood; -Diagnosis include hemiplegia (paralysis one side of body) affecting right dominant side; cerebral vascular accident (stroke), parkinson's, back pain related to cervical disc issue; -Always incontinent; -Range of motion (ROM) impairment of one upper extremity; -Dependent on staff with hygiene, toilet use, and bathing; Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No behaviors. Observation on 4/17/24, at 5:30 A.M., showed the following: -The resident lay in bed; -Nurse Assistant (NA) K and NA L entered the resident's room; -The resident's right hand was contracted, the resident did not fully extend his/her legs and they were bent at the knee and hip; -The resident's pad on the bed was wet from incontinence of urine; -NA K provided peri-care and cleaned the area between the resident's leg and groin with a disposable cloth but did not cleanse the resident's genital area. During an interview on 4/17/24 at 6:05 A.M. NA K said staff are expected to cleanse every area where urine or feces touches the resident's skin when providing perineal care. 2. Review of Resident #27's face sheet showed the resident's family member was the resident's durable power of attorney. Review of the resident's care plan, dated 10/18/23, showed the resident refused bathing. The plan did not list any interventions staff was to try/do in the event the resident refused. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -Dependent with bathing and personal hygiene; -Occasionally incontinent. Review of the facility's bath schedule showed the resident's bath days were Mondays and Thursdays on the day shift (twice a week). Review of the resident's bath record, in the resident's electronic medical record (EMR), dated 2/1/24-2/29/24, showed the resident had a bath on 2/1/24. Review of the resident's daily bath sheets, (paper sheets) dated 2/1/24-2/29/24, showed the following: -No documentation the resident received, was offered or refused a bath on 2/5/24; -No documentation the resident received, was offered or refused a bath on 2/8/24; -No documentation the resident received, was offered or refused a bath on 2/12/24; -On 2/15/24, staff documented the resident refused a bath; -On 2/19/24, the resident received a bath (18 days since last documented bath); -On 2/22/24, staff documented the resident refused a bath; -On 2/26/24, staff documented the resident refused a bath; -No documentation the resident received, was offered or refused a bath on 2/29/24. The resident received one bath out of eight scheduled baths in February. Review of the resident's bath record in the resident's EMR, dated 3/1/24-3/31/24, showed staff did not document any baths for the resident. Staff documented the bathing activity did not occur. Review of the resident's daily bath sheets, dated 3/1/24-3/31/24, showed the following: -On 3/4/24, staff documented the resident refused a bath; -On 3/5/24, the resident received a bath (15 days since last documented bath); -On 3/7/24, staff documented the resident refused a bath; -On 3/11/24, the resident received a bath (six days since last documented bath); -No documentation the resident received, was offered or refused a bath on 3/14/24; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation the resident received, was offered or refused a bath on 3/18/24; -On 3/21/24, staff documented the resident refused a bath; -On 3/25/24, staff documented the resident refused a bath; -No documentation the resident received, was offered or refused a bath on 3/28/24. The resident received two baths out of eight scheduled baths in March. Review of the resident's bath record in the resident's EMR, dated 4/1/24-4/18/24, showed staff did not document any baths for the resident. Staff documented the bathing activity did not occur. Review of the resident's daily bath sheets, dated 4/1/24-4/18/24, showed the following: -No documentation the resident received, was offered or refused a bath on 4/1/24; -On 4/4/24, the resident received a bath (24 days since his/her last documented bath on 3/11/24); -On 4/7/24 and 4/8/24, the resident received a bath; -No documentation the resident received, was offered or refused a bath on 4/11/24; -No documentation the resident received, was offered or refused a bath on 4/15/24; -On 4/17/24, staff documented the resident refused a bath. The resident received three baths out of five scheduled baths thus far (up to the 17th) in April. Observation on 4/15/24 at 12:45 P.M., showed the resident at the dining room table with an unkempt appearance. The resident's fingernails were long with brown debris under his/her fingernails. The resident had a urine smell and dry flaky skin. During an interview on 4/15/24 at 3:37 P.M., the resident's family member said the following: -He/She has come to the facility several times and found the resident saturated in urine or with dried feces on him/her; -Often he/she finds the resident with feces under his/her fingernails; -He/She does not want the resident to lay in urine for extended periods; -The resident has gone weeks without a shower. Staff say the resident refuses, but he/she feels staff ask the resident in a way to get a no answer because they don't have time to give the resident a shower; -In March, the resident went over two weeks without any kind of bath. (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 4/16/24 at 10:16 A.M., showed the resident in his/her bed with an unkempt appearance. The resident's fingernails were long with brown debris under his/her fingernails. The resident had a urine smell and dry flaky skin. Review of the resident's medical record showed no documentaion in the record, including the interventions staff was to do in the event of refusals, no documentation of substitute interventions that were tried with consent or refusal, and no documentation to show staff attempted to find the underlying cause of the refusals. 2. Review of Resident #30's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of Alzheimer's disease; -No behaviors or rejection of care; -Dependent with toileting hygiene and shower/bathe; -Requires substantial/maximal assistance with dressing and bed mobility; -Requires partial/moderate assistance with personal hygiene; -Always to frequent incontinent of bowel and bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnoses included urinary tract infection in the last 30 days. -Dependent on staff for toilet hygiene, shower/bathe, dressing, personal hygiene, sit to lying, lying to sitting on side of bed and transfers. Review of the facility's bath schedule showed the resident's bath days were Sundays and Thursdays on the evening shift (twice a week). Review of the resident's bath record in the resident's EMR, dated 3/1/24-3/31/24, showed the following: -Resident received a bath on 3/3/24; -No documentation the resident received, was offered or refused bathing on 3/7/24; -Resident received a bath on 3/10/24 (seven days later); -No documentation the resident received, was offered or refused bathing on 3/14/24; -No documentation the resident received, was offered or refused bathing on 3/17/24; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation the resident received, was offered or refused bathing on 3/21/24; -No documentation the resident received, was offered or refused bathing on 3/24/24; -Resident received a bath on 3/28/24 (18 days later); -Resident received a bath on 3/31/24. Review of the resident's daily bath sheets, dated 3/1/24-3/31/24, showed no documentation the resident received or refused a bath from 3/1/24 through 3/31/24. The resident received four baths out of nine scheduled baths in March. Review of the resident's bath record in the resident's EMR, dated 4/1/24-4/18/24, showed the following: -No documentation the resident received, was offered or refused bathing on 4/4/24; -No documentation the resident received, was offered or refused bathing on 4/7/24; -Resident received a bath on 4/11/24; -No documentation the resident received, was offered or refused bathing on 4/14/24; -No documentation the resident received, was offered or refused bathing on 4/18/24. Review of the resident's daily bath sheets, dated 4/1/24-4/18/24, showed on 4/7/24 the resident received a bath. The resident received two baths out of five scheduled baths thus far (up to the 18th) in April. Observation on 4/16/24 at 11:45 A.M., showed the resident in the dining room at his/her table with an unkempt appearance. The resident smelled of urine and had dry flaky skin. Observation on 4/17/24, at 6:15 A.M., showed the following: -The resident lay in his/her bed; -NA K and NA L entered the resident's room; -The resident had a strong smell of urine and his/her pad on the bed was visibly saturated with urine up past the resident's hips; -The resident had long toenails extending past the resident's toes and long fingernails; -The resident had dry flaky skin; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NA K and NA L turned the resident to his/her side and cleaned the left buttock that was against the wet pad but did not clean the right buttock; -The NAs proceeded to remove the soiled linens and dress the resident; -NA K and NA L did not perform perineal care to the resident's front perineal area; -NA K and NA L did not clean all areas of the resident's skin that was in contact with urine. Review of the resident's medical record showed no documentation in the record, including the interventions staff was to do in the event of refusals, no documentation of substitute interventions that were tried with consent or refusal, and no documentation to show staff attempted to find the underlying cause of the refusal. During an interview on 04/18/24 at 1:56 P.M., NA G said due to call-ins in the past two days, all of the residents scheduled to receive a bath did not get one. NA G and CNA E were the only two aides scheduled for the past two days due to call-ins. During an interview on 5/6/24, at 4:15 P.M., NA F said the following: -The facility often only had two aides and it was impossible to get to everyone quickly; -The facility was short staffed. During an interview on 04/18/24 at 1:50 P.M., Certified Nursing Assistant (CNA) E said the following: -Residents were scheduled to receive showers/bed baths two times a week; -If staff called in (did not come to work as scheduled), there was not enough staff to get all of the cares done and to give the residents showers/baths; -Staff call-in frequently. 4. Review of Resident #25's face sheet showed the resident had diagnoses that included unspecified protein-calorie malnutrition, dementia. Review of the resident's medical record showed his/her weight on 1/18/24 was 125 pounds (lb). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnoses of dementia; -Upper extremity impairment on both sides; -Required partial/moderate assistance with eating. (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 resident's medical record showed his/her weight on 3/1/24 was 122.5 lbs. Review of the resident's care plan, dated 3/1/24, showed the resident needed help to eat and drink. Record review of the resident's medical record showed the following: -Weight on 4/1/24 was 118.5 lbs. -The resident had a six pound weight loss in 75 days. Observation of the dining room on 04/15/24 at 12:00 P.M. showed the following: -Resident #25 sat in a wheelchair at a table with two other residents (#27 and #30); -CNA E assisted Residents #27 and #30 with their noon meal; -Resident #25's plate was untouched with no food items eaten. No one assisted Resident #25 with her meal. During an interview on 04/15/24 at 12:45 P.M., CNA E said CNA I was to assist the resident with eating, but CNA I was on his/her break. Observation on 04/15/24 at 12:45 P.M. thru 1:05 P.M., showed the resident sat in the dining room without feeding assistance. The resident had contracted hands (a condition that causes one or more fingers to bend toward the palm of the hand). The resident fed him/herself 1/3 of his/her glass of tea, 2/3 of his/her nutritional shake, and all of his/her pudding . The resident's plate including all of his/her meat, all of his/her vegetables and all of his/her macaroni, was untouched. During an interview on 04/16/24 at 09:50 A.M., the resident said he/she needed help to eat. Staff helped him/her when someone was around. If no one was around, he/she did not get help to eat. During an interview on 04/17/24 at 12:26 P.M., Hospitality Aide (HA) M, (family member of the resident), said the resident needed help eating. He/She usually fed resident. He/She was not at the lunch meal on 4/15/24. He/She expected staff to help the resident whenever he/she needed help and when he/she was not there. During an interview on 04/16/24 at 09:35 A.M., CNA I said he/she assisted the resident yesterday (4/15/24) at lunch. CNA I said the resident took one bite of everything then refused the rest of the meal (during the continuous observation by the state agency (SA) of the noon meal on 4/15/24, no observation was made of CNA I attempting to assist the resident or the resident refusing assistance). During an interview on 04/16/24 at 09:30 A.M. Licensed Practical Nurse (LPN) A said the resident needed help to eat and/or encouragement to eat. During an interview on 04/18/24, at 7:30 P.M., the Director of Nursing (DON) said the following: -She expected staff to give showers as scheduled; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She would expect nail care and shaves to be performed during a shower/bath; -If there were no call-ins, there was enough staff scheduled to provide all cares; -It would be difficult to complete showers, shaving, nail care, and provide all cares needed with just two CNAs working the floor; -The past two days, there were only two CNAs working the floor; -Showers did not get completed the past two days due to call-ins. 46506

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to consistently evaluate the root cause for falls and implement and modify interventions as necessary following falls for one resident (Resident #1), in a review of 15 sampled residents. The facility failed to use or properly use a gait belt (a canvas belt placed around the resident's waist to assist with ambulation and transfers) during transfers and/or assistance with walking for two additional residents (Residents #33 and #37). The facility census was 31. A request for a facility Fall policy was made with none provided. Review of the undated facility policy, Gait Belt Policy & Procedure showed the following: Purpose: Gait belts are used to aid in safe ambulation and transfers of resident Procedure: 2. Explain what you are going to do; 4. Lower the resident's bed to the lowest level, and lock the wheels. Assist the patient in sitting, and then moving legs so that they hang over the edge of the bed; 5. Apply the transfer belt around the resident's waist. Help the person to stand by first standing in front of the patient. Have the resident's place his/her hands on the bed and place feet on the floor. Grasp the transfer belt with an underhand grip. Place your feet alongside the resident's feet, and flex knees slightly. Assist the patient to a standing position by gently lifting and steadying the person; 6. Once resident is steady, provide a cane or walker if needed. Assist the person to walk by standing slightly behind the patient on their weaker side and holding the transfer belt using an underhanded grip; -Use the same procedure for standing from a chair as you did when helping them get up from bed. 1. Review of Resident #1's care plan, updated on 11/20/23, showed the following: -Remove extra things in the resident's room to prevent him/her from bumping into furniture; -Provide a calm environment, decreased noise; -Ensure the floor is clean and the resident wears dry, non-slip footwear; -Provide purposeful hourly rounding; -Ensure the call light is within reach when the resident is in bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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, dated 12/7/23, showed the following: -The resident had severe cognitive impairment; -He/She experience fluctuating behaviors of inattention, disorganized thinking, and altered level of consciousness; -He/She had a behavior of wandering; -He/She was independent with bed mobility and transfers; -Ambulation did not occur; -He/She was occasionally incontinent of bladder and frequently incontinent of bowel; -He/She received antipsychotic and antidepressant medications; -No falls since last review. Review of the resident's nurse note, dated 12/12/23 at 3:58 A.M., showed the following: -Staff found the resident sitting on the floor in another resident's room; -Assist the resident to the restroom after meals and stay with the resident until complete; -The resident refused the intervention and said he/she didn't need to use the restroom. Review of the resident's care plan, updated 12/12/23, showed the resident was found on the floor in another resident's room. (Review showed no documentation staff updated the care plan with the intervention identified after the fall on 12/12/23.) Review of the resident's care plan, updated 1/2/24, showed the following: -The resident continued to have falls when going to the restroom and then trying to find the bed again after toileting; -Bells on the restroom door, room door, bed and call light; -Staff educated the resident to bells and that the bells help him/her to find where he/she was in the room. Review of the resident's nurse note, dated 1/6/24 at 5:52 A.M., showed the following: -Staff found the resident on the floor between his/her bed and the restroom door; -The resident had an abrasion on his/her back; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident said he/she was trying to go to the restroom and fell back; -Staff put non-slip socks on the resident's feet and administered Tylenol (pain reliever) for headache. Review of the resident's care plan, dated 1/6/24, showed the resident continued to have falls in his/her room after toileting. (Review of the resident's medical record showed no documentation the facility re-evaluated current interventions or implemented new interventions to prevent future falls.) Review of the resident's fall note, dated 1/23/24 at 2:37 A.M., showed the staff found the resident on the floor in his/her room with blankets wrapped around the resident's feet. Review of the resident's care plan, dated 1/23/24, showed staff to make sure the bed linens were tucked under the resident's mattress. Review of the resident's nurse note, dated 2/5/24 at 4:07 P.M., showed the following: -Staff found the resident on the floor in his/her bathroom; -The resident sustained an injury above the left eyebrow that was 5 centimeters (cm) long; -The nurse practitioner applied ten sutures to the injury. Review of the resident's medical record showed no documentation staff attempted to identify the root cause of the resident's fall on 2/5/24, and no documentation staff re-evaluated or implemented new interventions to prevent future falls. Review of the resident's nurse note, dated 2/21/24 at 7:25 P.M., showed the staff found the resident on the floor between the bed and the air conditioner. Review of the resident's interdisciplinary fall huddle note, dated 2/23/24, showed the following: -Bells are in place; -The staff toileted the resident every two hours and had the resident dressed and out for meals; -The administration educated staff the resident needed to be first in the dining room and last out to be monitored more closely. Review of the resident's care plan, updated 2/23/24, showed the following: -The resident was at risk for falls; -Anticipate and meet the resident's needs; -Maintain a clear pathway, free of obstacles; -Avoid rearranging furniture; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(The care plan did not include staff were to toilet the resident every two hours, staff were to dress the resident and take him/her to the dining room first and take him/her out of the dining room last in order to monitor him/her more closely.) Review of the resident's annual MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She had a behavior of wandering that intruded on others; -He/She was independent with bed mobility and transfers; -He/She required supervision with walking; -He/She was occasionally incontinent of bladder and frequently incontinent of bowels; -He/She received antipsychotic and antidepressant medications; -No falls since last review. Review of the resident's nurse note, dated 3/21/24 at 3:57 A.M., showed staff found the resident on the floor next to his/her bed with the emergency call light ripped from the wall and in the resident's hand. Review of the resident's medical record showed no documentation staff attempted to determine the root cause of the resident's fall or evaluated current interventions or implemented new interventions after the resident fell on [DATE]. Review of the resident's nurse fall charting, dated 3/30/24 at 1:19 P.M., showed staff witnessed the resident lose balance and slide into another resident, then slide to the floor. Review of the resident's medical record showed no documentation staff attempted to determine the root cause of the resident's fall or evaluated current interventions or implemented new interventions after the resident fell on [DATE]. Review of the resident's nurse note, dated 4/1/24, showed the following: -The resident was unsteady on his/her feet; -He/She had a wheelchair that he/she got around in the facility. Review of the resident's weekly Medicare note, dated 4/2/24, showed Occupational Therapy recommended a bed/chair alarm for safety and a functional maintenance program for nursing staff to continue. Review of the resident's nurse note, dated 4/7/24 at 1:19 P.M., showed the staff found the resident on the floor near his/her room. (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 the resident's fall huddle interdisciplinary team note, dated 4/8/24, showed to re-educate staff on the importance of the toileting schedule and for staff to check on the resident at a minimum of every two hours if not every hour. Review of the resident's nurse note, dated 4/13/24 at 5:20 A.M., showed the following: -The resident fell on [DATE]; -The resident's gait was very unsteady; -He/She did not stay in bed and continued to wander around and continued to be a major fall risk; -Staff put the resident in his/her wheelchair and brought the resident up to the dining room to be watched. Review of the resident's medical record showed no documentation staff attempted to determine the root cause of the resident's fall or evaluated current interventions or implemented new interventions after the resident fell on [DATE]. Review of the resident's fall nurse note, dated 4/13/24 at 2:00 P.M., showed the following: -Staff found the resident on the floor; -The nurse administered Tylenol (non-steroidal anti-inflammatory) for possible pain due to agitation from the resident; -Staff changed the resident's brief due to being damp and a put a night gown on the resident. Review of the resident's medical record showed no documentation staff attempted to determine the root cause of the resident's fall or evaluated current interventions or implemented new interventions after the resident fell on [DATE]. Observation on 4/15/24 at 10:00 A.M., showed the resident lay in bed that was in the low position. A touch call light was located on the left side of the resident's pillow with a bell attached. The resident did not have a bed/chair alarm. Observation on 4/17/24 at 5:16 A.M., showed the following: -Licensed Practical Nurse (LPN) T told the resident to sit down several times, but the resident continued to stand up from the bed; -The resident sat on the foot of the bed on the footboard, then laid back in bed; -When Registered Nurse (RN) T left the resident's room, the resident's shoulders and head hung off the side of the bed; -The resident was in this position for 15 minutes before RN T asked Nurse Aid (NA) K to stay close to the resident; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident did not have a bed/chair alarm; -Bells were present on the resident's call light and the bathroom door. During an interview on 4/18/24 at 11:25 A.M., LPN A said the following: -The facility provided the resident with a flat call light that was easier to find and for the resident to use; -Staff tucked the bed sheets under the foot of the resident's bed to prevent him/her from falling on the floor causing a tripping hazard; -Staff were supposed to ensure the resident wore non-skid shoes; -Staff toileted the resident every two hours; -If the shift was not too busy, he/she checked with staff to ensure the interventions were being completed; -If he/she found the interventions of tucking the sheets under the foot of the resident's bed or the call light within reach were not being implemented, then he/she would address it with the staff immediately; -When a staff member did not come in for a shift, then the staff did not check on the resident as often as every two hours but as soon as possible. During an interview on 4/18/24 at 11:58 A.M., Certified Medication Technician (CMT) D said the following: -To prevent falls, the staff put non-slip socks on the resident; -Staff checked on the resident immediately when he/she yelled out. During an interview on 4/24/24 at 1:05 P.M., the Director of Nursing said the following: -The charge nurse was expected to check on the staff/residents to ensure care planned interventions were being used; -He/She did not remember why Resident #1 did not have a bed/chair alarm; -The staff were expected to check and toilet Resident #1 every two hours unless he/she was sleeping well at night. 2. Review of Resident #33's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She had functional limitations in range of motion to the bilateral lower extremities; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's ability to walk was not assessed; -He/She required moderate assistance from staff for chair/bed-to-chair transfers and bed mobility; -He/She had one fall with minor injury since last assessment. Review of the resident's care plan, last updated 3/29/24, showed the following: -The resident was at risk for falls. He/She fell on [DATE] related to deconditioning and gait/balance problems; -He/She had limited physical mobility related to weakness and recent hospitalization ; -He/She required substantial assistance with bed mobility and transfers; -Ambulation was documented as not applicable. Observation in the resident's room on 4/17/24 at 6:34 A.M., showed the following: -NA G did not put a gait belt on the resident. He/She wrapped his/her arms around the resident's chest, told the resident to stand on three, and on three NA G lifted while the resident to a standing position; -NA G walked beside the resident with his/her hand on the resident's back while the resident walked to the bathroom with a wheeled walker. NA G did not put a gait belt on the resident; -NA G assisted the resident from the toilet to the wheelchair. He/She wrapped his/her arms around the resident's chest, instructed the resident to stand up on three, then lifted up while the resident stood. NA G did not use a gait belt. During an interview on 4/17/24 at 6:34 A.M., NA G said the following: -Staff were supposed to use a gait belt when assisting a resident with a transfer or with walking; -He/She did not use a gait belt when assisting the resident with standing up or ambulating in the room; -He/She should have used a gait belt but forgot to get one. 3. Review of Resident #37's admission MDS, dated [DATE], showed the following: -Severely impaired cognition; -Bilateral lower extremities range of motion limitations; -Dependent on staff for transfer from a sitting to lying position, lying to sitting on the side of the bed, chair/bed-to-chair transfer. (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 the resident's care plan, dated 01/15/24, showed the following: -He/She is at risk for falls due to cognitive impairment; -Interventions included staff will maintain bed in lowest position, ensure call light is within reach and keep all needed items in resident's reach; -No indication of transfer status or need of staff for assistance with transfers. Observation on 4/17/24, at 7:23 A.M., showed the following: -Certified Nurse Assistant (CNA) E assisted the resident from a lying to sitting position in bed by placing his/her hand on the resident's right shoulder and on the back of the resident's neck. CNA E lifted the resident by his/her shoulder and the back of his/her neck to a sitting position; -During the change in position the resident called out Oh and had a facial grimace; -The resident complained of discomfort, but did not identify the specific area of his/her pain; -CNA E and NA G placed a gait belt around the resident's waist; -The resident was again resistant to the transfer, so NA G got the resident's walker to assist to a standing position; -CNA E lifted the resident by the gait belt and under the resident's left shoulder to a standing position; -NA G lifted the resident by the gait belt and the resident's right forearm. During an interview on 4/18/24, at 1:50 P.M., CNA E said the following: -The resident needed manual assistance with transfers; -He/She assisted the resident to a sitting on the side of the bed position and did not realize he/she lifted the resident behind the neck; -A resident should not be lifted to a sitting position by lifting behind his/her neck; -He/She assisted the resident to a standing position and did not realize he/she lifted the resident under his/her left shoulder; -He/She should not assist a resident to a standing position by lifting under his/her shoulder. During an interview on 4/18/24, at 1:56 P.M., NA G said the following: -He/She assisted the resident to a standing position by lift on the gait belt and with his/her right forearm; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She should not have listed the resident by his/her forearm as it could cause an injury. 4. During an interview on 04/18/24, at 7:30 P.M., the Director of Nursing (DON) said the following: -She expected staff to use a gait belt if a resident was unsteady with a manual transfer or during ambulation; -She expected staff to use a gait belt appropriately during a transfer; -She would not expect staff to lift a resident by the forearm or under their shoulder during a transfer as an injury could occur; -She implemented new interventions every time a fall occurred after discussion during the interdisciplinary team meeting; -She was responsible for updating the care plan with each fall. 42592 46506

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to assess residents for the use of bed rails/assist bars prior to installation, to have a system in place to obtain informed consent and educate residents and their responsible parties about the risks of bed rail use prior to use, assess residents for entrapment risk, and failed to assess for continued safe use of bed rails for six residents (Residents #2, #12, #15, #23, #30 and #31), in a review of 15 sampled residents. The facility census was 31. Review of the facility's undated policy, Restraints: Side Rail Utilization Assessment, showed staff was to complete this form as they went through the decision-making process of determining whether a side rail was appropriate for a particular resident. Review of the Food and Drug Administration (FDA) Guide of Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised April 2010, showed the following: -Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling; -Assessment by the patient's health care team will help to determine how best to keep the patient safe; -Potential risks of bed rails may include strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress, more serious injuries from falls when patients climb over rails, skin bruising, cuts, and scrapes, feeling isolated or unnecessarily restricted, and preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet; -When bed rails are used, perform an on-going assessment of the patient's physical and mental status and closely monitor high-risk patients; -Use a proper size mattress or mattress with raised foam edges to prevent patients from being trapped between the mattress and rail; -Reduce the gaps between the mattress and side rails; -A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety; -Reassess the need for using bed rails on a frequent, regular basis. 1. Review of Resident #12's summary sheet showed the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was his/her own responsible party; -Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (another term for hemiplegia) following a cerebral infarction (stroke) affecting the left side. Review of the resident's care plan, revised 04/03/24, showed the following: -The resident has limited physical mobility related to stroke with residual hemiparesis; -Required extensive assistance with bed mobility; -No indication of side rails used. Review of the resident's annual Minimum Data Set (MDS), a federally required assessment instrument required to be completed by facility staff, dated 04/05/24, showed the following: -Cognitively intact; -Substantial/maximum assist required for rolling left and right in bed; -Dependent on staff for chair/bed-to-chair transfer. Observation on 04/15/24, at 10:47 A.M., showed the resident had 1/2 side rails in the raised position on both sides of the resident's bed. Review of the resident's medical record on 4/15/24 showed no side rail assessments, no physician order for side rails, no documentation of interventions attempted prior to installation of bed rails, no bed rail entrapment assessment or informed consent from the resident for bed rail use. Observation on 04/16/24, at 11:00 A.M., showed the resident lay awake in his/her bed. The resident had 1/2 side rails in the raised position on both sides of the resident's bed. Review of the resident's April 2024 physician order sheet (POS) showed an order the resident may have bilateral 1/4 side rail for bed mobility with an order start date of 04/17/24. Observation on 04/17/24, at 7:39 A.M., showed the following: -The resident lay awake in bed watching television with bilateral upper 1/2 side rails in the raised position; -Staff entered the room to get the resident up for the day; -The resident used bilateral side rails to assist in turning from side to side. Review of the resident's bed rail assessment form, dated 04/18/24, showed the following: -Full bed rail, left and right side, is being used; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Symptoms/Functional deficits that require a rail: helps him/her roll and toilet; -Did the resident show you how they safely use the rails - yes; -How does the device benefit the resident - positioning; -The rails are secure - yes; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone); -Completed by the Director of Nursing (DON). 2. Review of the Resident #23's summary sheet showed the following: -The resident's spouse was his/her responsible party for decision making; -Diagnoses include: dementia with behavioral disturbance (a group of thinking and social symptoms that interferes with daily functioning with presence of behaviors such as physical aggression, agitation, or depression) and obesity. Review of the resident's care plan, updated 12/1/23, showed the following: -He/She has cane rails on either side of his/her bed; -He/She is at risk for falls because of medication taken daily; -Goals of no injury because of a fall and he/she wants to be as independent as possible. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Partial/Moderate assist by staff for rolling left and right in bed; -Supervision/touch assist by staff for transfers sit to lying, lying to sitting, sit to stand, chair/bed-to-chair and toilet. Observation on 04/15/24, at 10:32 A.M., showed the following: -The resident lay awake in bed watching television; -Upper 1/2 side rails were in the raised position on both sides of the resident's head of the bed; -The resident used the left side rail to change position, pull self up to a sitting position and transferred self to the wheelchair. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record on 4/15/24 showed no side rail assessments, no physician order for side rails, no documentation of interventions attempted prior to installation of bed rails, no bed rail entrapment assessment or informed consent from the resident for bed rail use. Observation on 04/16/24, at 11:15 A.M., showed the resident lay in bed asleep and had 1/2 side rails in the raised position on both sides of the resident's head of the bed. Observation on 04/17/24, at 6:46 A.M., showed the resident lay awake in bed watching television and had 1/2 side rails in the raised position on both sides of the resident's head of the bed. Review of the resident's April 2024 POS showed an order the resident may have bilateral 1/4 side rail for bed mobility with an order start date of 04/17/24. Review of the bed rail assessment form, dated 04/18/24, showed the following: -Full bed rail, left and right side, is being used; -Symptoms/Functional deficits that require a rail: helps him/her roll and get up; -Did the resident show you how they safely use the rails - yes; -How does the device benefit the resident - assist with mobility and positioning; -The rails are secure - yes; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone); -Completed by the DON. 3. Review of Resident #15's summary sheet showed family is responsible to make decisions for the resident. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognition not assessed, cannot do interview because resident is rarely understood; -Diagnosis include hemiplegia affecting right dominant side, stroke, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and seizures; -Moderate impaired vision; -Limited range of motion (ROM) in one upper extremity; -Uses wheelchair; -Dependent on staff with hygiene, transfers, toilet use, bathing; -Substantial/maximum assistance rolling left and right; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two or more non-injury falls since last assessment. Review of the resident's care plan, dated 10/18/23, showed the following: -Resident has limited physical mobility related to Parkinson's and cognitive impairment; -Dependent on staff with bed mobility and transfers, staff uses a hoyer (mechanical) lift for transfers; -The resident is incontinent; -At risk for falls; -No documentation regarding bed rail use or entrapment risk. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -One non injury fall. Observation on 4/16/24 at 10:33 A.M., showed the resident in his/her bed with a cover over his/her head. The residents bed had 1/4 rail in the raised position on the resident's right side of his/her bed. Review of the resident's medical record on 4/16/24 showed no documentation of the interventions attempted prior to installation of the bed rails, a bed rail entrapment assessment, informed consent for bed rail use or an order for bed/side rail use. Observation on 4/17/24, at 5:30 A.M., showed the following: -The resident in his/her bed with a 1/4 rail in the raised position; -Nurse Assistant (NA) K and NA L raised the resident's bed and lowered the resident's bed rail; -The NA's rolled the resident back in forth in bed to provide perineal care, dress the resident, and place the sling for the mechanical lift; -Staff transferred the resident to his/her wheelchair with a mechanical lift. -The resident did not utilize his/her bed rail. During an interview on 4/17/24, at 5:40 A.M., NA L said he/she did not know if the resident was at risk for entrapment. He/She was not sure what entrapment risk meant. Facility staff provided a resident document titled Bed Rail Assessment Form on 4/18/24, dated 4/18/24, that showed the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assist grab bar on left and right side of the bed; -To assist the resident to roll/toilet; -The resident showed how they safely use the rail for positioning; -The rails are secure; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). -Completed by the Director of Nursing. 4. Review of Resident #30's summary sheet showed family is responsible to make decisions for the resident. Review of Resident #30's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of Alzheimers (type of dementia that affects memory, thinking and behavior); -Sometimes understands; -Limited ROM both lower extremities; -Requires substantial/maximal dressing, bed mobility, transfers. The resident's care plan, dated 12/14/23, did not identify if the resident was at risk for entrapment or that the resident had bed rails. Review of the resident's quarterly MDS, dated [DATE], showed the resident was dependent on staff for toileting, personal hygiene, sit to lying, lying to sitting on side of bed, transfers, and locomotion. Observation on 4/15/24, at 10:23 A.M., showed the resident in bed. The resident's bed has half metal bed rails raised on both sides of the bed while the resident was in bed awake. Review of the resident's medical record on 4/15/24 showed no documentation of the interventions attempted prior to installation of the bed rails, a bed rail entrapment assessment, informed consent for bed rail use or a physician order for bed/side rail use. Observation on 4/17/24, at 6:15 A.M., showed the following: -The resident in his/her bed with both 1/2 metal bed rails in the raised position; -The NA K and NA L rolled the resident back in forth in bed to provide perineal care, dress the resident, and place the sling for the mechanical lift; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When the staff rolled the resident the resident grabbed the rail and pushed against being turned; -NA K said the resident was fearful when he/she rolled and pushed against the rail; -Staff transferred the resident to his/her wheelchair with a mechanical lift; -The resident did not utilize his/her bed rail to assist with care. Facility staff provided a resident document titled Bed Rail Assessment Form on 4/18/24, dated 4/18/24, that showed the following: -Full bed rail to left and right side of the bed; -To assist the resident to roll; -The resident showed how they safely use the rail for positioning; -The rails are secure; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). -Completed by the Director of Nursing. Review of the resident's medical record on 4/17/24 showed no documentation of the interventions attempted prior to installation of the bed rails, a bed rail entrapment assessment or informed consent for bed rail use. 5. Review of Resident #2's summary page, undated, showed the following: -The resident was his/her own responsible party; -He/She required a mechanical lift; -Diagnoses included morbid (severe) obesity (overweight), Parkinson's disease, Alzheimer's disease, cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking, muscle tone, and coordination), encephalopathy (any disturbance of the brain's functioning), and convulsions (condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). Review of the resident's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She required maximal assistance with rolling left and right in bed; -He/She was dependent on staff for lying to sitting on the side of the bed and chair/bed-to-chair transfer. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last updated 4/1/24, showed the following: -The resident had limited physical mobility; -He/She required a mechanical lift with two staff members for transfers; -He/She required two staff members for bed mobility; -No indication bed rails were used. Observation in the resident's room on 4/15/24 at 9:55 A.M., showed the resident lay in bed with assist bars on both sides of the bed. Review of the resident's medical record on 4/15/24 showed no documentation of the following: -A side rail assessment; -Any documentation of the interventions attempted prior to installation of the bed rails; -A bed rail entrapment assessment; -Informed consent for bed rail use; -Physician order for bedrails. Observation in the resident's room on 4/17/24 at 11:10 A.M., showed the resident lay in bed with assist bars on both sides of the bed. Review of the resident's bed rail assessment form, dated 4/18/24, showed the following: -The resident had an assist/grab bar on the left and right side of the bed; -The functional deficit was to help the resident turn/roll over-toileting; -He/She showed staff how to safely use the rails; -He/She benefited by positioning; -Completed by the Director of Nursing. 6. Review of Resident #31's care plan, last updated on 12/6/23, showed the following: -He/She required substantial assistance from staff for bed mobility; -He/She was dependent on staff and a mechanical lift for transfers. -No indication bed rails were used. (continued on next page)

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	265598	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She had a power of attorney; -He/She required moderate assistance from staff for rolling left and right in bed, sitting to lying in bed, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. Observation in the resident's room on 4/15/24 at 9:47 A.M., showed the resident lay in bed with assist bars on both sides of the bed. Review of the resident's medical record on 4/15/24 showed no documentation of the following: -A side rail assessment; -Any documentation of the interventions attempted prior to installation of the bed rails; -A bed rail entrapment assessment; -Informed consent for bed rail use; -Physician order for bedrails. Observation in the resident's room on 4/16/24 at 8:57 A.M., showed the resident lay in bed with assist bars on both sides of the bed. Observation in the resident's room on 4/18/24 at 11:10 A.M., showed the resident lay in bed with assist aides on both sides of the bed. Review of the resident's bed rail assessment, dated 4/18/24, showed the following: -The resident had an assist/grab bar on the left and right side of the bed; -The functional deficit was bed bound-helped to turn himself/herself-roll; -He/She showed staff how to safely use the rails; -He/She benefited by positioning; -Completed by the Director of Nursing. During an interview on 04/18/24, at 7:30 P.M., the DON said the following: -She would expect quarterly side rail assessments to be done on any resident using side rails; -She would expect the side rail assessments to be completed by the nurse managers; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-To her knowledge no side rail assessments had been completed prior to the annual survey beginning (4/15/24). 42592 46506

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet the needs of two residents, (Resident #12 and #27) in a review of 15 sampled residents, when the facility failed to provide regular baths or showers. The facility also failed to respond to resident call lights in a timely manner for three residents (Resident #2, #5 and #19) resulting in resident's voicing frustration/concerns over wait time. The facility census was 31. Review of the undated facility policy titled, Staffing, showed the following: -Facilities will have sufficient and competent staff to meet the needs of the residents; Policy Interpretation and Implementation: 1. Recruit and train staff according to the needs of the residents residing in the facility; 2. Facilities will identify staffing needs and educational opportunities based on the Facility Assessment; 3. Facilities will meet or exceed any state specific staffing requirements. 1. Review of the facility's Facility Assessment, dated 1/1/24-4/16/24, showed the following: Nurse Staffing Ration for Census 32-37: -Days 1:10, 1 charge nurse, 1 Certified Medication Technician (CMT), 3 Certified Nurse Assistant (CNA)/Nurse Assistant (NA); -Evenings 1:15 1 charge nurse, 1 CMT for 6 hours, 2 CNA/NA; -Nights 1:20 1 charge nurse, 2 CNA/NA. 2. Review of the daily staffing sheets for 4/1/24-4/15/24, showed staffing for the following dates: -4 /1/24, census 35, day shift: 1 Licensed Practical Nurse (LPN), 1 CMT, 1 CNA, and 1 NA; evening shift: 1 LPN, 1 CMT, 1 CNA and 1 NA; night shift: blank, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment and night shift was left blank; -4/2/24, census 35, day shift: 1 LPN, 1 CMT, 2 CNA, and 2 NA; evening shift: 1 LPN, 1 CMT, 1 CNA and 1 NA; night shift: 1 Registered Nurse (RN), 1 CNA and 1 NA; -4/3/24, census blank, day shift: 1 RN, 1 LPN, 1 CMT, and 1 CNA; evening shift: 1 LPN, 1 CMT, 2 CNA and 1 NA; night shift: 1 RN, 1 CNA and 1 NA, the facility had 2 less aides on day shift than needed according to identified staffing need in the facility assessment ; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/4/24, census 35, day shift: 1 LPN, 1 CMT, 1 CNA, and 2 NA; evening shift: 1 LPN, 1 CMT, 2 CNA and 1 NA; night shift: 1 RN, 1 CNA and 1 NA, ; -4/5/24, census 34, day shift: blank; evening shift: 1 LPN, 1 CMT, 2 CNA and 2 NA; night shift: blank; -4/6/24, census 34, day shift: 1 RN, 1 CMT, and 2 CNA; evening shift: 1 RN, 1 CMT, 1 CNA and 2 NA; night shift: 1 RN, 1 CNA and 1 NA, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment; -4/7/24, census 33, day shift: 1 LPN, 1 CMT, and 2 CNA; evening shift: 1 LPN, 1 CMT, 2 CNA and 1 NA; night shift: 1 RN, 1 CNA and 1 NA, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment ; -4/8/24, census 33, day shift: 1 LPN, 1 CMT, and 2 CNA; evening shift: 2 LPN, 1 CMT, 2 CNA and 1 NA; night shift: 1 RN, 1 CNA and 1 NA, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment; -4/9/24, census 33, day shift: 1 LPN, 1 CMT, 1 CNA, and 2 NA; evening shift: 1 LPN, 1 CMT, and 2 CNA; night shift: blank; -4/10/24, census 33, day shift: 1 LPN, 1 CMT, and 2 NA; evening shift: 1 LPN, 1 CMT, 3 CNA and 1 NA; night shift: 1 RN, and 2 NA, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment ; -4/11/24, census 31, day shift: 1 LPN, 1 CMT, 2 CNA, and 1 NA; evening shift: 2 LPN, 1 CMT, and 3 CNA; night shift: 1 RN, and 2 NA; -4/12/24, census 31, day shift: 1 LPN, 1 CMT, 1 CNA, and 1 NA; evening shift: 1 RN, 1 LPN, 1 CMT, and 2 CNA; night shift: 1 RN, 1 CNA and 1 NA; -4/13/24, census 31, day shift: 2 LPN, and 2 NA; evening shift: 1 LPN, 1 CMT, and 2 NA; night shift: blank, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment; -4/14/24, census 31, day shift: 1 LPN, 1 CMT, 1 CNA, and 1 NA; evening shift: 1 LPN, 1 CMT, and 2 CNA; night shift: 1 LPN, 1 CNA and 1 NA, the facility had 1 less aide on day shift than needed according to identified staffing need in the facility assessment . 1. Review of Resident #12's summary sheet showed the following: -The resident is his own responsible party; -Diagnoses include: diabetes mellitus (too much sugar in the bloodstream), essential hypertension (high blood pressure), chronic atria fibrillation (an irregular heart beat), heart failure (a chronic condition in which the heart does not pump blood as well as it should) and hemiplegia and hemiparesis following a cerebral infarction affecting the left side (left side weakness/paralysis after a stroke). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, revised 04/03/24, showed the following: -Activities of daily living focus - he/she has limited physical mobility related to stroke with residual hemiparesis; -Dressing: set up - uppers, substantial - lowers, dependent for footwear; -Toileting substantial assistance; -Personal hygiene: set up; -Bathing: partial/moderate assistance. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 04/05/24, showed the following: -Cognitively intact; -Bilateral lower extremity mobility limitations; -Toileting hygiene assistance was answered only with a dash; -Dependent on staff for bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene and tub/shower transfers. Review of the facility provided shower schedule showed the resident's bath schedule was on Monday and Thursday during the day shift. Review of the resident's daily bathing records from 02/15/24 through 04/18/24 showed staff did not provide or offer the resident six showers or bed baths of the 19 times one was to be given/offered. There was no documentation the resident had refused the offering of these six showers. During an interview on 04/15/24, 10:39 A.M., the resident said the following: -He/She takes a bath about every two weeks because their was not enough staff to give him/her showers or bed bath; -He/She just got out of the shower and it had been at least a week or more since his/her last one; -He/She prefers to get his/her shower or bed bath as schedule. 2. Review of Resident #27's face sheet shows the resident's family member is the residents durable power of attorney. Review of the resident's care plan, dated 10/18/23, says the resident refuses bathing. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -Wandering one to three days; -Dependent with bathing transfers and personal hygiene. Review of the facility's bath schedule the resident's bath days are Mondays and Thursdays on day shift (twice a week). Review of the resident's daily bathing records from 02/15/24 through 04/18/24 showed staff did not provide or offer the resident eight showers or bed baths of the 19 times one was to be given/offered. There was no documentation the resident had refused the offering of these eight showers. During an interview on 4/15/24, at 3:37 P.M., the resident's family member said the following: -He/She has had several conversations with the management of the facility; -The resident is often incontinent; -He/She has come in several times and the resident is saturated, or has dried feces on him/her; -Often he/she finds the resident with feces under his/her fingernails; -He/She does not want the resident to just lay for extended periods in urine; -The resident has had a couple of urinary tract infections; -The facility has had issues with keeping help; -He/She feels like the facility doesn't have enough staff; -The resident wanders and there aren't enough staff to notice him/her wandering; -Last week they found the resident down the other hall going to the bathroom, and they have found the resident in the front offices by the front door going to the bathroom; -The resident has gone weeks without a shower, they will say the resident refuses but to him/her they ask the resident in a way to get a no answer because they don't have time to give him/her a shower; -He/She knows in March the resident went over two weeks without any kind of bath. -He/She feels like if he/she doesn't stay on top of the staff they wouldn't do much for the resident at all. 3. Review of Resident #2's admission MDS, dated [DATE], showed the following: -The resident was cognitively intact; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was dependent on staff for upper and lower body dressing, personal hygiene, sit to lying in bed, lying to sitting on the side of bed, chair/bed-to-chair transfer, and locomotion via wheelchair; -He/She required maximal assistance from staff for rolling left and right in bed; -He/She was frequently incontinent of bladder and bowel. Review of the resident's care plan, last updated on 4/1/24, showed the following: -The resident had limited physical mobility; -He/She required assistance of two staff and Hoyer lift (mechanical resident lift equipment) for transfers; -He/She required assistance of two staff for bed mobility; -He/She was dependent on staff for locomotion via wheelchair; -He/She had bowel/bladder incontinence related to impaired mobility; -He/She used incontinence briefs the staff changed every two hours and as needed. During an interview on 4/15/24 at 9:55 A.M., the resident said the following: -He/She was frustrated some days because the staff were too busy to get him/her out of bed when he/she wanted to get up; -He/She was also frustrated because some days there was not enough staff, so he/she had to wait longer than he/she wanted to wait. Review of the call light log printed on 4/18/24 showed the following: -On 4/1/24, the resident activated his/her call light at 6:15 A.M. and it was answered at 6:42 A.M. (26 minutes); -On 4/1/24, the resident activated his/her call light at 8:06 P.M. and it was answered at 8:27 P.M. (20 minutes); -On 4/2/24, the resident activated his/her call light at 1:34 A.M. and it was answered at 1:56 A.M. (21 minutes); -On 4/2/24, the resident activated his/her call light at 8:17 P.M. and it was answered at 8:39 P.M. (21 minutes); -On 4/3/24, the resident activated his/her call light at 6:45 A.M. and it was answered at 7:10 A.M. (25 minutes); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/3/24, the resident activated his/her call light at 11:49 A.M. and it was answered at 12:07 P.M. (18 minutes); -On 4/4/24, the resident activated his/her call light at 5:47 A.M. and it was answered at 6:77 A.M. (30 minutes); -On 4/5/24, the resident activated his/her call light at 5:35 A.M. and it was answered at 5:52 A.M. (17 minutes); -On 4/5/24, the resident activated his/her call light at 1:06 P.M. and it was answered at 1:35 P.M. (29 minutes); -On 4/18/24, the resident activated his/her call light at 9:03 A.M. and it was answered at 9:32 A.M. (29 minutes). 4. Review of Resident #19's quarterly MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She required staff supervision with upper and lower body dressing and rolling left to right in bed. Review of the resident's care plan meeting note, dated 4/4/24, showed the resident had concerns with staff answering the call light in a timely manner. Review of the resident's care plan, last updated 4/15/24, showed the following: -The resident required minimal assistance with transfers to his/her wheelchair; -He/She required minimal assistance with lower body dressing but was independent with upper body dressing. During an interview on 4/15/24 at 10:05 A.M., the resident said the following: -Sometimes the staff take a long time to answer his/her call light; -He/She felt like it took half an hour for staff to respond. Review of the call light log printed on 4/18/24 showed the following: -On 4/1/24, the resident activated his/her call light at 6:05 A.M. and it was answered at 6:36 A.M. (30 minutes); -On 4/2/24, the resident activated his/her call light at 6:34 A.M. and it was answered at 7:07 A.M. (32 minutes); -On 4/3/24, the resident activated his/her call light at 6:10 A.M. and it was answered at 6:40 A.M. (29 minutes); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/4/24, the resident activated his/her call light at 5:28 A.M. and it was answered at 5:45 A.M. (17 minutes); -On 4/4/24, the resident activated his/her call light at 6:05 A.M. and it was answered at 6:31 A.M. (25 minutes); -On 4/11/24, the resident activated his/her call light at 5:56 A.M. and it was answered at 6:17 A.M. (20 minutes); 5. Review of Resident #5's significant change MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No signs of delirium, hallucinations, delusions, or behaviors. During an interview on 4/18/24, at 10:35 A.M., the resident said the following: -Sometimes it took forever for staff to answer his/her call light; -It made him/her feel bad, like a burden or not good enough; -Sometimes he/she is incontinent because it took too long, and he/she did not like that. Review of the call light log printed on 4/18/24 for, dates 4/1/24-4/18/24, showed the following: -On 4/1/24, the resident activated his/her call light at 8:29 P.M. and it was answered at 8:45 P.M. (15 minutes), the resident pushed his/her call light six times during that time; -On 4/2/24, the resident activated his/her call light at 8:34 A.M. and it was answered at 8:47 A.M. (13 minutes), the resident pushed his/her call light five times during that time; -On 4/3/24, the resident activated his/her call light at 7:28 A.M. and it was answered at 8:08 A.M. (40 minutes), the resident pushed his/her call light 14 times during that time; -On 4/4/24, the resident activated his/her call light at 8:18 A.M. and it was answered at 8:39 A.M. (20 minutes), the resident pushed his/her call light seven times during that time; -On 4/5/24, the resident activated his/her call light at 8:08 A.M. and it was answered at 8:33 A.M. (25 minutes), the resident pushed his/her call light nine times during that time; -On 4/5/24, the resident activated his/her call light at 9:48 A.M. and it was answered at 10:09 A.M. (20 minutes), the resident pushed his/her call light seven times during that time; -On 4/5/24, the resident activated his/her call light at 1:59 P.M. and it was answered at 2:16 P.M. (17 minutes), the resident pushed his/her call light six times during that time; -On 4/6/24, the resident activated his/her call light at 8:59 A.M. and it was answered at 9:17 A.M. (17 minutes), the resident pushed his/her call light six times during that time; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/7/24, the resident activated his/her call light at 8:44 A.M. and it was answered at 9:18 A.M. (33 minutes), the resident pushed his/her call light twelve times during that time; -On 4/7/24, the resident activated his/her call light at 10:49 A.M. and it was answered at 11:09 A.M. (20 minutes), the resident pushed his/her call light seven times during that time; -On 4/7/24, the resident activated his/her call light at 1:42 P.M. and it was answered at 2:02 P.M. (20 minutes), the resident pushed his/her call light seven times during that time; -On 4/7/24, the resident activated his/her call light at 3:51 P.M. and it was answered at 4:09 A.M. (17 minutes), the resident pushed his/her call light six times during that time; -On 4/7/24, the resident activated his/her call light at 5:25 P.M. and it was answered at 5:37 P.M. (12 minutes), the resident pushed his/her call light five times during that time; -On 4/8/24, the resident activated his/her call light at 8:18 A.M. and it was answered at 8:34 A.M. (16 minutes), the resident pushed his/her call light six times during that time; -On 4/9/24, the resident activated his/her call light at 8:25 A.M. and it was answered at 8:43 A.M. (18 minutes)the resident pushed his/her call light six times during that time; -On 4/9/24, the resident activated his/her call light at 10:00 A.M. and it was answered at 10:29 A.M. (28 minutes)the resident pushed his/her call light ten times during that time; -On 4/10/24, the resident activated his/her call light at 6:45 P.M. and it was answered at 7:02 P.M. (17 minutes), the resident pushed his/her call light six times during that time; -On 4/13/24, the resident activated his/her call light at 9:19 A.M. and it was answered at 9:36 A.M. (16 minutes), the resident pushed his/her call light six times during that time; -On 4/13/24, the resident activated his/her call light at 3:44 P.M. and it was answered at 3:57 P.M. (13 minutes), the resident pushed his/her call light five times during that time; -On 4/14/24, the resident activated his/her call light at 9:57 P.M. and it was answered at 10:11 P.M. (14 minutes), the resident pushed his/her call light six times during that time; -On 4/16/24, the resident activated his/her call light at 7:21 A.M. and it was answered at 7:36 A.M. (15 minutes), the resident pushed his/her call light five times during that time; -On 4/18/24, the resident activated his/her call light at 8:14 A.M. and it was answered at 8:29 A.M. (15 minutes), the resident pushed his/her call light six times during that time; -On 4/18/24, the resident activated his/her call light at 9:47 A.M. and it was answered at 10:06 A.M. (19 minutes), the resident pushed his/her call light seven times during that time; -On 4/18/24, the resident activated his/her call light at 10:15 A.M. and it was answered at 10:30 A.M. (14 minutes), the resident pushed his/her call light five times during that time. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/24 at 1:50 P.M., Certified Nursing Assistant (CNA) E said the following: -Residents were scheduled to receive showers/bed baths two times a week; -If staff called in (did not come to work as scheduled), there was not enough staff to get all of the cares done and to give the residents showers/baths; -Staff called in frequently. During an interview on 04/18/24 at 1:56 P.M., Nursing Assistant (NA) G said due to call-ins in the past two days, all of the residents scheduled to receive a bath did not get one. NA G and CNA E were the only two aides scheduled for the past two days due to call-ins. During an interview on 5/6/24, at 4:15 P.M., NA F said the following: -Staff are not able to answer call lights right away when we are working with other residents; -The facility often only has two aides and it was impossible to get to everyone quickly; -The facility was short staffed; -Some residents have to wait longer that they would like; -With more staff they could get to residents quicker and there would not be near as many issues. During an interview on 04/18/24, at 7:30 P.M., the Director of Nursing (DON) said the following: -She expected staff to give showers as scheduled; -If there are not call-ins, there was enough staff scheduled to provide all cares; -It would be difficult to complete showers, shaving, nail care, answer call lights and provide all cares needed with just two CNAs working the floor; -The past two days, there were only two CNAs working the floor; -Showers did not get completed the past two days due to call-ins. -Call ins occurred more than she would like; -The corporation will not let them use agency for CNA's, only licensed staff. During an interview on 4/18/24 at 11:15 A.M., the Administrator said staff are to answer call lights within three minutes. If a call light is over 10 minutes, that would be too long. Reviewing the report, there were some call light times that would not be acceptable, and a lot of them seem to be during meals. (continued on next page)

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	265598	A. Building B. Wing	04/18/2024

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO232587

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 38016 Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all residents. The facility census was 31. During an interview on 4/18/24, at 1:15 P.M., the Administrator said the facility did not have a policy for RN coverage. The facility followed the regulatory guidance. Review of the Payroll Based Journal (PBJ) report (the facility is mandated to report staffing hours to the Centers for Medicare and Medicaid Services (CMS) and those hours are reviewed and calculated into a report) dated 10/1/23-12/31/23, showed the following dates when the facility did not have any documented RN hours: -11/6/23; -11/7/23; -11/8/23; -11/12/23; -11/14/23; -11/15/23; -12/15/23; -12/18/23; -12/24/23; -12/28/23; -12/29/23; -12/31/23. Review of the facility's payroll and agency staffing, dated 2/15/24-4/15/24, showed the following: -2/17/24 no RN hours; -2/18/24 no RN hours; -2/24/24 no RN hours; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2/25/24 no RN hours; -3/3/24 no RN hours; -3/5/24 6.12 RN hours; -3/10/24 no RN hours; -3/16/24 no RN hours; -3/17/24 no RN hours; -3/18/24 no RN hours; -3/23/24 no RN hours; -3/28/24 5.73 RN hours; -3/30/24 no RN hours; -3/31/24 no RN hours; -4/5/24 RN hours started at 10:25 P.M. to 12:00 A.M. (1 hour and 35 minutes); -4/7/24 RN hours started at 10:31 P.M. to 12:00 A.M. (1 hour and 29 minutes); -4/9/24 3.73 RN hours; -4/12/24 RN hours started at 8:20 P.M. to 12:00 A.M. (3 hours and 40 minutes); -4/13/24 RN hours 12:00 A.M. to 7:21 A.M. (7 hours 21 minutes); -4/14/24 no RN hours. During an interview on 4/16/24, at 10:21 A.M., the Director of Nursing said the facility did not have full RN coverage. The facility did not have RN coverage everyday. During an interview on 4/15/24, at 1:28 P.M., the Administrator said the facility has had days with no RN coverage. MO232587

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to ensure four nurse aides (NA) (NA J, NA L NA K and NA F) completed a nurse aide training program within four months of their employment as an NA in the facility. The facility census was 31. During an interview on [DATE], at 1:15 P.M., the Administrator said the facility did not have a policy regarding certification of nurse assistants. The facility followed the regulatory guidance. 1. Review of NA J's employee files showed his/her employment as an NA started on [DATE] (approximately seven months and three weeks prior). 2. Review of NA L's employee files showed his/her employment as an NA started on [DATE] (one year prior); 3. Review of NA K's employee files showed his/her employment an an NA started on [DATE] (two years, eight months, and approximately one week prior); 4. Review of NA F's employee files showed his/her employment as an NA started on [DATE] (approximately eight months prior). 5. During an interview on [DATE], at 12:43 P.M., the ADON said the following: -She confirmed all of the NAs' start dates; -All of the NAs had been in classes but some of them had not passed successfully, so they were not certified; -She did not know the waiver expired for NA certification; -The NAs were not certified within four months. During an interview on [DATE], at 10:21 A.M., the Director of Nursing said the following: -If an NA was not certified within four months, they should be terminated; -The Assistant Director of Nursing (ADON) oversees the certification process. During an interview on [DATE], at 1:28 P.M., the Administrator said she was told there was a waiver for NA certification and the NAs did not need to be certified within four months. She did not know the waiver had expired.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38016 Based on observation, interview, and record review, the facility failed to post required nurse staffing information, which included the total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift on a daily basis. The facility census was 31. Review of the facility's staffing sheet, dated 4/5/24 showed the days shift did not include staff working or total hours worked for the Nurse (RN), Licensed Practical Nurse (LPN), Certified Medication Technician (CMT), Certified Nurse Assistant (CNA) or Nurse Assistant (NA)'s. Night shift did not include staff working, the census, or the total hours worked for RN, LPN, CMT, CNA or NA's. Review of the facility's staffing sheet, dated 4/9/24 showed the night shift did not include staff working, the census, or the total hours worked for RN, LPN, CMT, CNA or NA's. Review of the facility's staffing sheet, dated 4/12/24 showed the night shift did not include staff working, the census, or the total hours worked for RN, LPN, CMT, CNA or NA's. Review of the facility's staffing sheet, dated 4/13/24 showed the day shift did not included total hours for RN, LPN, CMT, CNA or NA's. Observation on 4/15/24, at 1:00 P.M., showed the staff posting did not include the total hours for RN, LPN, CMT, CNA or NA's for the day shift. Observation on 4/16/24, at 10:28 A.M., showed the staff posting did not include total hours for the day shift staff. Observation on 4/17/24, at 5:21 A.M., showed the staff posting was still up for 4/16/24. The day shift for 4/16/24 did not include total hours for RN, LPN, CMT, CNA or NA's. The night shift did not contain any information (blank) for the night shift starting 4/16/24 that was currently ending in 40 minutes. During an interview on 4/17/24 at 2:00 P.M., Licensed Practical Nurse (LPN) B said the charge nurse on the day shift posts the staffing sheet at the beginning of their shift and each charge nurse was expected to update it. All of the areas were to be completed. During an interview on 4/16/24 at 10:21 A.M., the Director of Nursing said the charge nurses were responsible to post the staff and adjust the staffing each shift if there were changes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to ensure gradual dose reductions (GDRs; the stepwise tapering of a medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose of medication can be discontinued) were attempted, or the physician documented the rationale for not attempting a GDR, on psychotropic medications (affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) for three residents (Resident #1, #13, and #22), in a review of 15 sampled residents. The facility census was 31. Review of the facility's Unnecessary Drugs F757 and F758 policy, dated June 2023, showed the following: -Residents will only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and will not be used for discipline or convenience of the staff; -Review the medication regimen and apply appropriate clinical indications, monitoring, and documentation. 1. Review of Resident #1 Summary Page, undated, showed the following: -The resident had a medical power of attorney (POA); -Diagnoses included major depressive disorder (common and serious medical illness that negatively affects how you feel, the way you think and how you act) and traumatic hemorrhage of cerebrum (bleeding on a section of the brain caused by trauma). Review of the resident's physician orders, dated February 2023, showed the following: -Sertraline (antidepressant) 100 mg give orally daily for depression (started on 4/29/22); -Mirtazapine (antidepressant) 30 mg give orally daily at bedtime (started on 4/29/22). Review of the resident's pharmacist recommendations, dated 11/3/23, showed no recommendation for a GDR for sertraline or mirtazapine. Review of the resident's pharmacist recommendations, dated 12/13/23, showed no recommendation for a GDR for sertraline or mirtazapine. Review of the resident's pharmacist recommendations, dated 1/11/24, showed no recommendation for a GDR for sertraline or mirtazapine. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/8/24, showed the following: -The resident had severe cognitive impairment; -He/She had verbal and other behavioral symptoms directed towards others; -He/She rejected care; -He/She received an antipsychotic and antidepressant; -No GDR or documentation a GDR was declined. Review of the resident's care plan, last updated 3/11/24, showed the following: -Psychotropic medication use related to behavior management; -Administer medications as ordered, monitor/document for side effects and effectiveness; -Educate resident and family/caregiver about risks, benefits, and the side effects of medication drugs being given; -Discuss with physician and family the ongoing need for use of medication; -The resident had a diagnosis of depression and took three antidepressants (Remeron, Zoloft, and Trazadone) and an antipsychotic (Seroquel) every day; -The pharmacist will look over my medications monthly. Review of the resident's pharmacist recommendations, dated 3/12/24, showed no recommendation for a GDR for sertraline or mirtazapine. Review of the resident's pharmacist recommendations, dated 4/9/24, showed no recommendation for a GDR for sertraline or mirtazapine. Review of the resident's physician order, dated April 2024, showed the following: -Sertraline 100 mg give one tablet orally daily for major depressive disorder (started on 2/21/24); -Mirtazapine 30 mg give one tablet orally at bedtime for major depressive disorder (started on 2/21/24). During an interview on 4/24/24 at 9:31 A.M., the consultant pharmacist said he/she did not recommend a GDR for sertraline or mirtazapine because the resident was having behaviors. 2. Review Resident #13's undated summary sheet showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly); -He/She had a guardian. Review of the resident's pharmacist review progress note, dated 03/09/23, showed the following: -Within the first year of which a resident is admitted on a psychotropic medication, a gradual dose reduction (GDR) must be attempted in two separate occasions, at least a month apart, unless clinically contraindicated; -After the first year, a GDR should be attempted annually unless clinically contraindicated; -Resident has an order for Florentine (antidepressant) 40 mg daily since 2/2/22 for depression. Consider a GDR to Florentine 20 mg daily; -Resident is also on Invega (medication used to treat schizophrenia) 117 mg every four weeks with a start date of 10/17/22. Review of the resident's psychiatry progress note, dated 10/23/23, showed continue psychiatric medications as ordered. Review of the resident's pharmacist review, dated 12/13/23, showed the following: -Resident has an order Florentine 40 mg daily since 2/2/22. Consider a GDR to Florentine 20 mg daily (as previously recommended on 3/9/23); -Resident is also on Invega (paliperidone palmitate) 117 mg every four weeks; -A handwritten note attached to the communication please send this with the resident to his/her psychiatry appointment; -There was no documentation the pharmacist recommendation had been addressed. Review of the resident's care plan, dated 12/14/23, showed the following: -He/She usually had understandable speech, but sometimes may need to repeat himself/herself because of unusual mouth movements that were a side effect of the antipsychotics that he/she took regularly; -His/Her physician said he/she had a diagnosis of catatonic schizophrenia (a rare, severe, mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitation) what would not go away; -He/She received an injection of Invega every four weeks and took Florentine daily. Review of the resident's psychiatry progress note, dated 3/11/24, showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No changes; -No indication that pharmacist review recommendations from 3/9/23 and 12/13/23 were addressed. Review of the resident's quarterly minimum data set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 3/16/24, showed the following: -Diagnosis of schizophrenia; -Daily antidepressant; -Antipsychotic received on a routine basis; -No gradual dose reduction (GDR) attempted; -GDR has not been documented by a physician as clinically contraindicated; -Drug regimen review was left blank. Review of the resident's April 2024 physician order sheet showed the following: -Invega extended-release 117 mg intramuscularly (given in the muscle) every four weeks on the third (original order dated 10/17/22); -Florentine 40 mg every day (original order dated 02/02/22). During an interview on 04/18/24, at 5:15 P.M. the social services director said she took the resident to his/her last psychiatry appointment and the pharmacy recommendation from 12/12/23 was not included in the paperwork to take to the appointment. 3. Review of Resident #22's undated summary sheet showed diagnoses included vascular dementia with agitation (a condition characterized by problems with reasoning, planning, judgment, memory or other though processes caused by brain damage from impaired blood flow to the brain that can include agitation) and major depressive disorder (a common mental health disorder that involves a depressed mood or loss of pleasure or interest in daily activities). Review of the resident's annual MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behaviors or rejection of cares; -Severity score of mild depression; -Diagnoses of dementia and depression; -Antianxiety and antidepressant received on a routine basis; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-GDR attempted section was left unanswered/blank; -Drug regimen review section was left unanswered/blank. Review of the resident's pharmacist review progress note, dated 03/12/24, showed the following: -Within the first year of which a resident was admitted on a psychotropic medication, gradual dose reduction (GDR) must be attempted in two separate occasions, at least a month apart, unless clinically contraindicated; -After the first year, a GDR should be attempted annually unless clinically contraindicated; -Resident has an order Escitalopram (antidepressant medication) 20 mg everyday since 07/31/23, consider a GDR to 10 mg every day; -Physician addressed with simply a disagree with no rationale given. Review of the resident's care plan, revised 02/05/24, showed the following: -He/She was at risk for impaired cognitive function/dementia or impaired thought process and would maintain current level of decision making ability and be able to communicate basic needs on a daily basis; -He/She took antidepressant medication and would be free from discomfort or adverse reactions related to antidepressant medication therapy. Review of the resident's April 2024 physician order sheet showed an order for escitalopram 20 mg daily at 8:00 A.M. (original order dated 07/31/23). During an interview on 4/18/24 at 7:30 P.M. and 4/24/24 at 1:05 P.M., the Director of Nursing said the following: -She expected GDRs to be addressed in a timely manner; -The MDS Coordinator #1/Medical Records staff member was responsible for ensuring psychotropic medication GDRs were addressed (communicated to the DON and then the physician) and that the medications had appropriate diagnoses. However, this was now the responsibility of the Director of Nursing. During an interview on 4/18/24 at 12:35 P.M., the Medical Director said he expected the GDRs to be addressed in a timely manner. 42592 46506

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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** 42592 Based on observation and interview, the facility failed to ensure a medication cart was secured when unattended. The facility census was 31. Review of the facility's undated policy, Medication Storage in the Facility, showed the following: -Medications and biologicals are stored, safely, securely, and properly, following manufacturer's recommendations or those of the supplier; -The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication; -Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1. Observation on 04/17/24, from 5:23 A.M. to 6:01 A.M., showed the following: -Registered Nurse (RN) T passed morning medication on the west hall; -At 5:23 A.M., RN T walked away from the medication cart with cart unlocked to provide resident care; -RN T entered a resident's room and turned his/her back on the medication cart with the resident's room door open. RN T could not visualize the cart; -The medication cart was unsecured and unattended for approximately four minutes. No residents were in the hallway while the medication cart was unsecured and unattended; -At 5:28 A.M., RN T walked away from the medication cart with the cart unlocked to provide resident care; -RN T entered another resident's room and took the resident to the bathroom. The medication cart was not in RN T's line of sight as RN T had his/her back to the cart; -The medication cart was unsecured and unattended for approximately three minutes. No residents were in the hallway while the medication care was unsecured and unattended; -At 5:32 A.M. RN T walked away from the cart to get ice for a resident and turned his/her back on the medication cart leaving the medication cart unattended and out of his/her line of sight; -The medication cart was left unsecured and unattended with the top drawer left ajar and open for approximately three minutes. A resident walked past the medication cart while it was unattended; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 5:52 A.M., RN T walked away from the medication cart down the hallway to get staff to help with another resident. RN T had his/her back to the medication cart; -The medication cart was left unsecured and unattended with the top drawer left ajar and open for approximately three minutes; -No residents were in the hallway while the medication cart was unsecured and unattended; -At 5:59 A.M., RN T walked away from a resident's room to get water for the resident. RN T left [NAME] Thyroid 180 milligrams (a medication used to treat low thyroid levels) on the counter in the resident's room, the medication cart was unlocked and the drawer was left ajar; -RN T walked down the hallway with his/her back to the medication cart and out of the resident's room, leaving the medication sitting on the counter in the resident's room out of sight and unsupervised as well as the medication cart out of sight and unsupervised; -The medication cart was left unsecured and unattended with the top drawer left ajar and open for approximately three minutes; -No residents were in the hallway while the medication cart was unsecured and unattended. During an interview on 04/17/24, at 6:14 A.M., RN T said the following: -The medication cart should always be locked and secured when unattended; -He/She felt like he/she locked the cart when he/she walked away to provide resident care; -Medications should not be left in a resident room unsupervised; -He/She does not usually leave the medication cart unattended and unlocked or medications unsupervised; -The medication cart should be locked and medications secured for resident safety. During an interview on 04/18/24, at 8:45 P.M., the Director of Nursing said she would expect the medication carts to be securely locked any time a staff member is not in direct line of sight and medication should not be left at a resident's bedside at any time.

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	265598	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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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. 38016 42592 44610 Based on observation, interview, and record review, the facility failed to provide food items at a safe and appetizing temperature. The facility census was 31. Review of the facility Food Storage Guideline and Procedure Manual, 2016 Edition, showed to keep potentially hazardous foods out of the temperature danger zone (41 degrees Fahrenheit to 135 degrees Fahrenheit). 1. During an interview on 4/17/24, at 6:22 A.M., Resident #3 said his/her food isn't hot. He/She wants his/her food to be hot. During an interview on 04/18/24, at 3:14 P.M., Resident #12 said yesterday morning when he/she went to the dining room, his/her tray was sitting on the table with a cover on it. His/Her breakfast was not warm. Breakfast today was part warm and part not. 2. Review of the Diet Spreadsheet Menu for the lunch meal on 4/15/24 showed the following: -Salisbury steak/gravy; -Cheesy noodles; -Stewed tomatoes; -Banana pudding. Review of the Salisbury steak/gravy recipe showed to maintain the temperature of the food at 135 degrees Fahrenheit or above. Review of the cheesy noodle's recipe showed to maintain the temperature of the food at 135 degrees Fahrenheit or above. Review of the stewed tomatoes recipe showed, maintain the temperature of the food at 135 degrees Fahrenheit or above. Review of the banana pudding recipe showed to maintain holding temperature of 41 degrees Fahrenheit or below. Review of the final cooking temperature log (food temperatures taken prior to the meal service) for the lunch meal on 4/15/24, showed the following: -Salisbury steak with gravy was 165 degrees Fahrenheit; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cheesy noodles were 165 degrees Fahrenheit; -Stewed tomatoes were 170 degrees Fahrenheit; -Banana pudding was 40 degrees Fahrenheit. Observation on 4/15/24 showed the following: -At 11:30 A.M., staff began preparing the hall trays from pots on the stovetop and on the griddle. Both the stovetop and the griddle were turned off; -Staff served gravy from a pot on the stovetop, served cheesy noodles from a pot on the stovetop, served Salisbury steak from a pan on the stovetop, and served stewed tomatoes from a pot on the griddle; -The banana pudding was in small individual bowls that sat on the surface of preparation table in front of the stovetop/oven and griddle; -Staff placed a small bowl of banana pudding from the preparation table onto the residents' meal trays; -At 11:37 P.M., staff began preparing the trays for residents who ate in the main dining room; -Staff continued to prepare the residents' plates from the pots and pans on the stovetop and griddle. The stovetop and griddle were turned off; -Staff continued to serve the individual bowls of banana pudding located on the preparation counter onto each resident's meal tray. Observation of the food temperatures for the test tray (last tray served to residents in the dining room) on 4/15/24 at 12:05 P.M., taken with a digital metal stem type thermometer, showed the following: -Salisbury steak with gravy was 110.6 degrees Fahrenheit; -Cheesy noodles were 108.3 degrees Fahrenheit; -Stewed tomatoes were 90.5 degrees Fahrenheit; -Banana pudding was 64.3.0 degrees Fahrenheit (The banana pudding dish had not been kept in a tray of ice prior to service). During an interview on 4/16/24 at 1:30 P.M., the dietary manager said the following: -She expected staff to serve hot foods at or above 120 degrees Fahrenheit; -She expected staff to serve cold foods at or below 41 degrees Fahrenheit; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff checked and recorded the temperature of the food just before serving the meal; -Sometimes staff will check the temperature of the items being served during the meal, but staff does not record these temperatures; -She and the cooks served each meal off of the stovetop and griddle; -The stovetop and griddle were turned off during the service because staff got hot while serving the trays; -She has not had any recent complaints from residents regarding cool/cold food. During an interview on 4/18/24 at 11:26 A.M., the registered dietician said she expected hot foods to be served hot and cold foods to be served cold. During an interview on 4/16/24 at 5:05 P.M., the administrator said she expected staff to serve hot foods hot and cold foods cold.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to ensure two residents with complicated feeding problems, (Resident #30 and #37), of eight residents sampled, were assisted with feeding by qualified staff. Hospitality Aide (HA) M (a paid feeding assistant and not a certified nurse aid) fed the residents without the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). The facility census was 31. Review of the 2003 Federal Registry Notice Requirements for Paid Feeding Assistants in Long Term Care Facilities, dated September 26, 2003 (Volume 68, Number 187), showed the following: -Dining Assistant (DA) Programs in Nursing Homes: Guidelines for Implementation Manual: -Federal and State Requirements for a Dining Assistant Program: -Nursing homes must ensure their DA Program meets the following requirements: DAs feed only residents who have no complicated feeding problems such as difficulty swallowing, recurrent lung aspirations, and tube or parenteral (IV feedings.) Review of the list of residents eligible for assistance from feeding assistants provided by the facility included Resident #30, and #37. Review of the list of resident's provided by the facility with aspiration risk/complicated feeding issues included: -Resident #30, mechanical soft diet add gravy; -Resident #37 mechanical soft diet add gravy. 1. Review of HA M's employee file on 04/17/24 showed he/she was not a certified nurse assistant and had completed feeding assistant training on 1/21/22. 2. Review of Resident #30 annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of Alzheimer's disease; -Requires supervision with eating. Review of the resident's Physician Orders, dated 2/14/24, showed the resident started on a mechanical soft diet. The resident had been on a regular diet with regular texture. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requires partial/moderate eating assistance; -New mechanically altered diet. Observation on 04/16/24 at 12:00 P.M., of the dining room, showed HA M fed Resident # 30 mechanically ground meat with a spoon. No licensed staff was in the dining room at this time. HA M was not being supervised by a registered nurse (RN) or licensed practical nurse (LPN) and was feeding a resident with a complicated feeding problem. 3. Review of Resident #37's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Independent with eating; -Mechanically altered diet; -Coughing or choking during meals or when swallowing medication. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Mechanically altered diet; -Requires supervision or touching assistance with eating; -Swallowing section was not completed. Observation on 4/17/24, at 7:52 A.M., showed the following: -The resident sat at the dining room table with his/her tray that included mechanically ground sausage, eggs and oatmeal, a cup of coffee, and water; -HA M assisted the resident with eating; -HA M gave the resident a bite of sausage with his/her spoon; No licensed staff was in the dining room at this time. HA M was not being supervised by an RN or LPN and was feeding a resident with a complicated feeding problem. During an interview on 04/17/24 at 12:26 P.M., HM A said he/she was unaware he/she was not to assist residents with complicated eating problems. During an interview on 4/18/24, at 7:30 P.M., the Director of Nursing said she was unfamiliar with a paid feeding aide. During an interview on 4/15/24 at 9:26 A.M., the Administrator said the facility has one paid feeding assistant, HA M. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46506 50675

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38016 44610 Based on observation, interview, and record review, the facility failed to ensure dietary equipment was free of an accumulation of grease, oil, dust, and debris; failed to ensure food items were sealed in the freezer and dry storage room; and failed to ensure the facility's ice machine drain contained a proper air gap. The facility census was 31. Review of the facility's dietary cleaning schedule showed, by-weekly deep clean stove/hood/grill/oven/filters. 1. Observations on 4/15/24 from 9:20 A.M. to 3:34 P.M., in the kitchen, showed the following: -In the white up-right freezer, a cardboard box contained an unsealed plastic bag of frozen biscuits; -In the dry storage room, a 5-pound unsealed plastic bag of natural cocoa powder; -Above the refrigerator unit next to the service hall kitchen door, an approximate 2-foot by 3-foot ceiling vent with a moderate buildup of dust and debris; -On east kitchen wall, a white rotary fan, located between a countertop with the microwave/mixer/blender and the three-compartment sink, had a moderate buildup of dust and debris; -A four bulb fluorescent light fixture inside the main kitchen door had a moderate buildup of dust and debris; -A four bulb fluorescent light fixture in front of the dishwasher and above the clean dish rack had a moderate buildup of dust and debris; -A four bulb fluorescent light fixture between the three-compartment sink and the food preparation table had a moderate buildup of dust and debris; -A four bulb fluorescent light fixture between the stovetop/oven/griddle and the food preparation table had a moderate buildup of dust and debris; -Four suppression nozzles and piping manifold inside the kitchen hood had a buildup of oily residue, dust and debris; -The vertical ductwork inside the kitchen hood above the stovetop/oven/griddle had an internal buildup of dust and debris. During an interview on 4/16/24 at 10:00 A.M., the dietary manager said the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Kitchen staff currently were to clean the identified areas monthly; -She expected these areas to be clean and free of oil, dust and debris; -She expected the kitchen hood suppression nozzles and piping manifold to be free of oil, dust, and debris; -She expected the vertical kitchen hood ductwork to be free of dust and debris; -She expected items in the freezers and in the dry food storage to be sealed. During an interview on 4/16/24 at 5:05 P.M., the administrator said the following: -She expected the kitchen/dietary equipment to be clean and free of oily buildup, dust, and debris; -She expected items stored in freezers and dry storage to be sealed. During an interview on 4/18/24 at 11:26 A.M., the registered dietician said the following: -She expected the kitchen/dietary equipment and area to be kept clean and free of dust, debris, and oily buildup; -She expected items in dry storage and freezers to be sealed. 2. Observation on 4/15/24 at 3:34 P.M., of the ice machine located in the kitchen, showed the following: -An approximately 1-inch plastic drain pipe exited the ice machine and ran along, down and through the kitchen floor into the basement mechanical room; -The ice machine drain pipe in mechanical room ran down and along the south wall and into the sump pump floor well, approximately 4-inches; -There was an air gap above the sump pump floor well. During an interview on 4/16/24 at 2:05 P.M., the Maintenance Director said he was unaware the end of the ice machine drain pipe was to be above the top edge of the sump pump well. During an interview on 4/18/24 at 11:26 A.M., the registered dietician said she expected the ice machine drain to have an air gap at the drain.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to use appropriate infection control procedures for hand hygiene and changing gloves, to prevent the spread of bacteria or other infectious causing contaminates, and when indicated by professional standards of practice during personal care for four residents (Resident #3, #12, #15 and #30), in a review of 15 sampled residents. The facility failed to develop and implement a Legionella Prevention Program. The facility failed to ensure respiratory equipment remained free of contaminates for one sampled resident (Resident #19). The facility census was 31. Review of the facility's undated policy, Hand Hygiene, showed the following: -All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility; -Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR); -Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; -Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom; -Use soap and water when hands are visibly dirty, hands are visibly soiled with blood or other body fluids, after caring for a resident with infectious diarrhea; -Use either soap and water or ABHR (ABHR is preferred) when coming on duty, between resident contacts (unless caring for a resident with infectious diarrhea - then hand washing with soap and water is required), before applying and after removing personal protective equipment including gloves, before and after handling clean or soiled dressings/linens/etc., before performing resident care procedures, when - during resident care - moving from a contaminated body site to a clean body site, after assistance with personal body functions like elimination/hair grooming/smoking, after sneezing/coughing/blowing or wiping nose, when in doubt. -The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves; 1. Review of Resident #30's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 3/16/24, showed the resident was dependent with toilet hygiene, dressing, personal hygiene, sit to lying, lying to sitting on side of bed and transfers. Observation on 4/17/24, at 6:15 A.M., showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The resident lay in his/her bed; -Nurse Aide (NA) K and NA L entered the resident's room, did not wash their hands, and put on gloves; -The resident had a strong smell of urine and the bed pad under the resident was saturated with urine past the resident's hips; -NA K and NA L turned the resident to his/her side; -NA K touched the resident's urine saturated pad and linen with his/her gloves and cleaned the resident's left buttock; -NA K and NA L removed the soiled linens from under the resident, and without changing their gloves, dressed the resident in clean clothing; -NA K touched the sling for the mechanical lift, the resident's clean bed linens, and the mechanical lift with soiled gloves; -NA K and NA L transferred the resident using the mechanical lift; -Wearing the same gloves he/she wore to provide perineal care, NA K brushed the resident's hair and put the resident's dentures in the resident's mouth. During an interview on 4/17/24, at 5:44 A.M., NA L said the following: -Staff were to clean their hands and put on gloves prior to providing care to residents; -Staff were to change their gloves if they touched something considered dirty before they touched clean items. 2. Review of Resident #19's quarterly MDS, dated [DATE], showed the following: -The resident had moderate cognitive impairment; -He/She received oxygen therapy. Review of the resident's physician orders, dated April 2024, showed an order for oxygen therapy at two liters per minute per nasal cannula continuously. Observation on 4/17/24 showed the following: -At 6:41 A.M., Certified Nurse Assistant (CNA) E brought the resident's concentrator to the dining room. The nasal cannula tubing dragged on the floor behind CNA E. The nasal prongs on the cannula slid across the dining room floor. CNA E picked up the nasal cannula tubing off the floor and placed it on the resident's table. (The resident wasn't in the dining room at this time.) CNA E plugged in the concentrator and left the nasal cannula tubing on the table. CNA E turned the oxygen concentrator on and left the table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 7:05 A.M., the resident put the nasal cannula that had been on the floor into his/her nose. 3. Review of Resident #12's care plan, revised 04/03/24, showed the following: -Activities of daily living focus - he/she has limited physical mobility related to stroke with residual hemiparesis; -Substantial assistance with toileting; -Extensive assistance with bed mobility. Review of the resident's annual MDS, dated [DATE], showed the following: -Dependent on staff to provide personal hygiene; -Substantial/maximum assist by staff for rolling left and right in bed; -Dependent on staff for chair/bed-to-chair transfer. Observation on 04/17/24, at 7:39 A.M., showed the following: -The resident lay in bed. A urinal sat containing urine sat on his/her bedside table; -CNA E and NA G entered the resident's room to get him/her up for the morning; -While wearing gloves, NA G took the urinal to the resident's bathroom and emptied the urinal in the toilet; -NA G returned to the resident's room, ran water in the urinal from the resident's sink, took the urinal back to the bathroom and emptied the urinal into the toilet; -NA G returned to the resident's room and placed the empty urinal on the resident's bedrail; -Without changing his/her gloves, NA G picked up the resident's clean pants from the back of the resident's wheelchair, picked up the resident's left foot and applied the pants to the resident's left leg; -CNA E performed front perineal care for the resident; -Wearing the same gloves, NA G performed front perineal care for the resident; -Without changing gloves, NA G assisted the resident to turn on his/her right side by touching the resident's left hip; -NA G then performed perineal care to the resident's buttocks. NA G ran out of peri-care wipes and went to the resident's drawers, opened the drawer with his/her gloves, got a new pack of wipes out of the drawer, closed the drawer, opened the new wipes and continued performing perineal care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Without changing gloves, NA G touched and moved the mechanical lift pad from the back of the resident's wheelchair and started to place the lift pad under the resident; -Wearing the same gloves he/she wore to provide perineal care, CNA E assisted the resident to roll on his/her left side, attached the clean incontinent brief, and pulled up the resident's pants. During an interview on 4/18/24, at 1:50 P.M., CNA E said the following: -He/She should wash his/her hands before he/she performed cares, after he/she touched dirty linen, before he/she put on clean gloves, and before he/she left a resident's room; -He/She should change his/her gloves if they were soiled and after he/she provided care. During an interview on 4/18/24, at 1:56 P.M., NA G said the following: -He/She should wash his/her hands before and after he/she provided care and sometimes during care; -He/She should change his/her gloves each time they became dirty; -He/She did not realize he/she did not change his/her gloves when providing care for the resident; -His/Her gloves were soiled after dumping the urinal. He/She should have changed his/her gloves; -His/Her gloves were soiled after providing perineal care. He/She should have changed his/her gloves prior to touching the dresser and getting new wipes; 4. Review of Resident #15's annual MDS, dated [DATE], showed the following: -Always incontinent; -Dependent on staff with hygiene, transfers, toilet use, and bathing. Observation on 4/17/24, at 5:30 A.M., showed the following: -The resident lay in his/her bed; -NA K entered the resident's room, and without washing his/her hands, put on gloves; -The bed pad under the resident was wet and smelled like urine; -NA K cleaned the resident's perineal area between the resident's leg and the groin; -Without removing his/her gloves, he/she rolled the resident to his/her side, touching the resident; -NA K cleaned the resident's buttocks and touched the urine saturated pad with his/her gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Without removing his/her gloves, NA K touched the resident's clean clothing, the sling for the mechanical lift, and the resident's clean incontinence brief. 5. Review of Resident #3's annual MDS, dated [DATE], showed the following: -Requires partial/moderate assistance from staff for toilet hygiene, going from sitting to standing, bed to chair and toilet transfers; -Dependent on staff for personal hygiene; -Frequently incontinent. Observation on 4/17/24, at 05:46 A.M., showed the following: -The resident lay in his/her bed; -The bed pad under the resident was visibly wet and smelled like urine; -NA L did not clean the resident's skin that was against the urine soaked pad and transferred the resident into his/her wheelchair; -The resident's bare buttocks sat directly on the wheelchair cushion; -NA L transferred the resident to the toilet, and assisted the resident to dress. NA L did not cleanse the resident's skin that had been against the urine soaked pad in the bed, or clean the cushion the resident sat on in the wheelchair; -NA L assisted the resident to transfer back into the wheelchair and to sit on the soiled wheelchair cushion. 6. Review of the facility's policy, Water Management Program, implemented 11/1/23, showed the following: -It is the policy to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facility's water systems; -Water management plans refer to the documents that contain all the information pertaining to the development and implementation of the facility's water management activities for reducing risk of Legionella and other opportunistic pathogens; -Control measures are things done in the building water systems to limit growth and spread of Legionella, such as heating, adding disinfectant, or cleaning; -Control Limits are the maximum value, minimum value, or range of values that are acceptable for the control measures being monitoring to reduce the risk for Legionella growth and spread; -Control points are locations in the water systems where a control measure can be applied; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Definite healthcare-associated Legionnaires' disease refers to a case of Legionnaires' disease in a resident who spent the entire 10 days prior to onset of illness in the facility; -Possible healthcare-associated Legionnaires' disease refers to a case of Legionnaires' disease in a resident who spent only part of the 10 days before symptoms began in the facility; -A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing; a. Team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role; b. The water management team has access to water treatment professionals, environmental health specialists, and state/local health officials; -The Maintenance Director maintains documentation that describes the facility's water system; -A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements: a. Premise plumbing: This includes water system components as described in the documentation of the facility's water system; b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration; c. At-risk population - This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process; -Data to be used for completing the risk assessment may include, but are not limited to: a. Water system schematic/description; b. Legionella environmental assessment; c. Resident infection control surveillance data (i.e. culture results); d. Environmental culture results; e. Rounding observation data; f. Water temperature logs; g. Water quality reports from drinking water provider (i.e. municipality, water company); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed, such as when any of the following events occur: a. Data review shows control measures are persistently outside of control limits, b. A major maintenance or water service change occurs (including replacing tanks, pumps, heat exchangers, distribution piping, or water service disruption from the supplier to the building), c. One or more cases of disease are thought to be associated with the facility's systems, or; d. Changes occur in applicable laws, regulations, standards, or guidelines; -In the event of an update to the water management program, the water management team shall: a. Update the water system schematic/description, associated control points, control limits, and any pre-determined corrective actions; b. Train those responsible for implementing and monitoring the updated program; -Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of three years; -The water management team shall report relevant information to the QAPI Committee. The facility did not provide any documentation to show the water management team conducted a risk assessment annually, and did not provide any documentation of any water management team meeting notes. During an interview on 4/16/24 at 1:05 P.M., the Infection Preventionist (IP) said she was not on a water management team and had never attended a water management team meeting . She had no knowledge of monitoring for Legionella exposure or Legionnaire's disease, and had not been educated as the policy said she would be as part of the team. She did not look at health acquired pneumonia cases screening for the Legionella antigen with sputum or urine test. During an interview on 4/16/24 at 4:34 P.M., the Maintenance Director said he monitored the water temperatures weekly to make sure the temperature was not over 120 degrees F in residents' rooms and under 165 degrees in the kitchen. He did not test the cold water. The facility did not have a water management team. He had never inspected water sources or vessels for sediment or biofilm. The facility did not check chlorine levels. He did not know what Legionella was or what to watch for. He had never reviewed ASHRAE guidelines. He didn't flush unused faucets or faucets in empty rooms. 7. During interviews on 4/17/24 at 10 :30 A.M. and 4/18/24 at 7:30 P.M., the Director of Nursing said the following: -Staff should wash their hands any time their hands were visibly soiled, after they provided cares, and when they changed their gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-S should change gloves if they were visibly soiled and any time they touch a different body part, such as when providing perineal care from front to back; -Staff should remove soiled gloves after pericare and before touching clean items; -She did not have training on Legionella and was not on the water management team. 42592 46506 50675

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 38016 Based on interview and record review, the facility failed to follow an antibiotic stewardship program as part of their infection prevention and control program that included antibiotic use protocols and a system to monitor antibiotic use. The facility census was 31. Review of the facility's undated policy, Infection Control Program - Antibiotic Stewardship F881, showed the following: -This community has established an infection prevention and control program that includes protocols to establish a system for the use and monitoring of adverse effects of antibiotics; -Residents who need an antibiotic are prescribed an antibiotic; -Antibiotic Stewardship: a set of commitments and actions designed to optimize this treatment of infections while reducing the adverse effects associated with antibiotic use; -Loeb Criteria: minimum criteria for the initiation of antibiotics; -McGeer Criteria: surveillance criteria -The basic tenants of an antibiotic stewardship program include: a. Appropriate prescribing; b. Appropriate administration; c. Management practices to reduce inappropriate use to ensure that residents receive the right antibiotic for the right indication, right dose and right duration; -Potential side effects to monitor for with use of antibiotics: a. Increased adverse drug events and drug interactions; b. Serious diarrheal infections for C. Difficile; c. Disruption of normal flora; and/or d. Colonization and/or infection with antibiotic resistant organisms; -Core elements on an antibiotic stewardship program: a. Facility leadership commitment to safe and appropriate antibiotic use; b. Appropriate staff accountable for promoting and overseeing antibiotic stewardship; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Access pharmacist and others with experience or training in antibiotic stewardship; d. Implement policies or practice to improve antibiotic use; e. Track measures of antibiotic use on the facility, one process and one outcome measure; f. Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff; g. Education of the staff and residents about antibiotic stewardship; -The program is a portion of the overall Infection Prevention and Control Program; -The Antibiotic Stewardship Program will be reviewed annually; -Measure the following indicators: a. Number of days of antibiotic use per 1000/days of care, and; b. Outcome surveillance data, ex. incidence of C difficile, MRSA and CRE in residents whom received at least one antibiotic; -Monitoring of Antibiotic Use: a. Monitoring is initiated with any order written at any time for an antibiotic; b. Use is compared to the Loeb minimum criteria for the initiation of antibiotics; feedback is provided to the practitioner if outside the norm; note signs and symptoms in the electronic health record; c. Obtaining Antibiogram from contracted laboratory as a summary of antibiotic susceptibility over past 12-24 months; d. Compile a report on antibiotic utilization (from sources such as the pharmacy and the EHR itself) and provide feedback at least quarterly to each practitioner. Include in the report: 1. Resistance data; 2. Antibiotic prescribing practices; e. Medical record reviews to identify signs and symptoms for the use of the antibiotic; f. Noted signs and symptoms and relate back to the criteria for need of a foley; g. Lab results; h. Documentation of indications; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Dosage and duration (including use of stop dates); j. Notes in the record from the practitioner if applicable. k. Comparisons to McGeer post order surveillance criteria; -Educate staff and practitioners on the principles and protocol. -Recommended Protocol: a. Prior to obtaining order for antibiotic, using information available: 1. Inform the physician of 1. Clinical signs and symptoms, and complaints, 2. Vital signs, pulse oximetry, 3. Localizing pain or appropriate Loeb (minimal use) criteria; 4. Previous recent antibiotic exposure; 5. Previous recent culture and susceptibility results; 6. Current medication; and 7. Medication allergy history. b. Order to contain: 1. Dose (including route); 2. Duration (including start date, end date and planned days of therapy); 3. Indication; and 4. Treatment site; c. Administer ordered medication, complete progress note; d. After order has been received, the Infection Control Coordinator or designee should complete the surveillance document, utilizing the McGeer criteria, noting evidence for the infection. If the antibiotic does not fit the criteria, the physician will be contacted. Review of the facility's undated policy, Antibiotic Monitoring, showed the following: -Purpose: to guide nursing staff to closely monitor all residents who are placed on antibiotic therapy for the possibility of adverse reactions; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When an antibiotic is initiated for whatever purpose, the charge nurse shall initiate antibiotic monitoring nurse's notes; -The charge nurse shall conduct a brief assessment on the resident every shift through the duration of the short-term antibiotic therapy. 1. Record review of facility antibiotic tracking system, provided by the Infection Preventionist (IP), showed the following: -Review of the last 12 months of antibiotic use showed for the months of February, March and April 2024 included only a list of residents taking the antibiotic and what the antibiotic was prescribed for; -For UTI's, no indication of culture and sensitivity or organism being treated was noted; -For wound infections, no indication of type of infection or signs and symptoms of infection was noted; -Trending and tracking of infections per wing was completed; -No tracking of post antibiotic use was completed; -No indication of antibiotic assessment tool, like McGreer's tracking; -There was no evidence of any current residents with infections included in the tracking. During an interview on 04/18/24, at 7:17 P.M., the IP said the following: -She had not been keeping up to date on antibiotic tracking because she thought she was doing too much and she thought the Director of Nursing (DON) was helping on the antibiotic tracking for antibiotic stewardship; -She was not aware that more was required other than a listing of antibiotic being used, what it was treating, and a surveillance of where infections were occurring. During an interview on 04/18/24, at 7:30 P.M., the DON said the IP did the tracking of antibiotic use for the antibiotic stewardship program. 42592 46506

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to provide the pneumococcal vaccine (a vaccine that can protect against pneumococcal disease) as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for five residents (Residents #2, #11, #22, #23 and #30), in a review of 15 sampled residents. The facility census was 31. Review of the facility's policy, Vaccination of Residents, Including Influenza, dated 06/2023, showed the following: -Residents will be offered pneumovax vaccinations per Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines, and when vaccines are made available to the community; -Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations; -Residents have the right to refuse, be free of interference, coercion, discrimination, and reprisal for the community staff for refusing to take any vaccines; -Certain vaccines (e.g., influenza, pneumococcal vaccines, COVID-19) may be administered per the physician-approved facility protocol (standing orders). Review of the CDC Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 9/22/23, showed the following: -Adults 19 through [AGE] years old with any of these conditions or risk factors: 1. Alcoholism or cigarette smoking; 2. Cerebrospinal fluid leak; 3. Chronic heart disease, including congestive heart failure and cardiomyopathies, excluding hypertension; 4. Chronic liver disease; 5. Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma; 6. Cochlear implant; 7. Diabetes mellitus 8. Decreased immune function from disease or drugs (i.e., immunocompromising conditions); 9. Immunocompromising conditions include: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Chronic renal failure or nephrotic syndrome; b. Congenital or acquired asplenia, or splenic dysfunction; c. Congenital or acquired immunodeficiency; d. Diseases or conditions treated with immunosuppressive drugs or radiation therapy; e. HIV infection; f. Sickle cell disease or other hemoglobinopathies; -Adults 19 through [AGE] years old who never received any Pneumococcal Vaccine, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (8 weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; -Adults 19 through [AGE] years old who only Received PPSV23, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination; 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete. -Adults 19 through [AGE] years old who only received PCV13, who have a risk condition (see above) other than an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13 for those with a cochlear implant or cerebrospinal fluid leak. The PPSV23 dose should be given at least 1 year after PCV13 for any of the other chronic health conditions. When PPSV23 is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included type II diabetes mellitus (long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), heart failure (lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), chronic obstructive pulmonary disease (group of diseases that cause airflow blockage and breathing-related problems), and asthma (airways narrow and swell and may produce extra mucus); -Physician's order for pneumococcal and influenza vaccines per facility policy and if not contraindicated start on 3/13/24. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/17/24, showed the following: -The resident was cognitively intact; -The resident's pneumococcal vaccine was up to date. Review of an undated facility provided immunization record showed the following: -The resident was less than [AGE] years old; -PPV23 administered on 10/6/09. (The resident was not up-to-date per CDC recommendations.) During an interview on 4/18/23 at 6:30 P.M., the resident said that if he/she was due to have a pneumococcal vaccination, he/she would want to receive it. 2. Review of Resident #11's summary sheet showed the following: -The resident had a responsible party to help with decision making; -Diagnoses included congestive heart failure; -Physician order for pneumococcal vaccine per facility policy and if not contraindicated with an order start date of 01/08/24. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Pneumococcal vaccination status was left blank. Review of the undated facility provided immunization record showed the following: -The resident greater than [AGE] years of age; -PPV (no indication of what type of PPV was administered) administered on 9/28/15; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-PCV (no indication of what type of PCV was administered) administered on 11/28/17; (The resident was not up-to-date per CDC recommendations.) During an interview on 04/18/24, at 6:40 P.M., the resident's responsible party said he/she would like the resident to be up-to-date on all vaccinations including the pneumococcal vaccination. 3. Review of Resident #22's summary sheet showed the following: -The resident had a guardian; -Diagnoses included diabetes mellitus, atherosclerotic heart disease (damage or disease in the heart's major blood vessels) and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should); -Physician order for immunizations per facility standing orders with a start date of 07/31/23. Review of the resident's annual MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Pneumococcal vaccination status was left blank. Review of an undated facility provided immunization record showed the following: -The resident was greater than [AGE] years of age; -PCV 13 administered on 04/20/16; -Pneumovax administered on 06/14/17; (The resident was not up-to-date per the CDC's recommendations.) During an interview on 04/18/24, at 7:45 P.M., the resident said if he/she was due for an pneumococcal vaccination, he/she would take it and would like to be up-to-date. During an interview on 04/30/24, at 2:20 P.M., the resident's responsible party said he/she wanted the resident to be up-to-date on all vaccinations. 4. Review of the Resident #23's summary sheet showed the following: -The resident's family member was his/her responsible party for decision making; -Diagnoses include malignant neoplasm of the bladder (bladder cancer) and congestive heart failure; -A physician standing order for pneumococcal vaccines per facility policy and if not contraindicated with a start date of 11/14/23. (continued on next page)

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	265598	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brunswick Nursing & Rehab	721 West Harrison St Brunswick, MO 65236

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Up-to-date on pneumococcal vaccines. Review of an undated facility provided immunization record showed the following: -The resident was greater than [AGE] years of age; -Vaccine administered 08/14/14 (no indication of what type of vaccine was administered); -PCV 13 administered on 09/03/15; (The resident was not up-to-date per CDC recommendations.) During an interview on 04/18/24, at 3:30 P.M., the resident's responsible party said he/she wanted the resident to be up-to-date on pneumococcal vaccinations. 5. Review of the Resident #30's summary sheet showed the following: -The resident's family member was his/her responsible party for decision making; -Diagnoses included heart failure. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Pneumococcal not up to date. Review of an undated facility provided immunization record showed the following: -The resident was greater than [AGE] years of age; -PPSV23 administered on 07/27/16; -PCV13 administered on 06/17/15; (The resident was not up-to-date per CDC recommendations.) The resident's medical record did not include a consent or decline for the pneumococcal vaccination. 6. During an interview on 04/18/24, at 7:17 P.M., the infection preventionist (IP) said the following: -She followed the CDC guidelines for pneumococcal vaccinations; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She typed in the resident's vaccines into the CDC pneumovax application to determine what was needed; -She would not be surprised to know some of the residents were behind on their pneumococcal vaccinations; -She was responsible for ensuring the residents were up-to-date on all vaccinations; -She needed to do a full review of all residents' vaccinations; -She had not had time to do a full review due to many other responsibilities. During an interview on 04/18/24 at 12:35 P.M., the facility's Medical Director the following: -He expected the facility to follow the CDC guidelines for pneumococcal vaccinations; -He expected the residents' vaccines to be up-to-date and to be administered if the resident/resident responsible party wanted the vaccine; -He expected the facility to provide education to the resident/resident responsible party if a resident refused any vaccination. 42592

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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** 38016 Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattresses, and bed rails as part of regular maintenance program to identify areas of possible entrapment for six residents (Resident #2, #12, #15, #23, #30, and #31), in a review of 15 sampled resident who used bed rails/assist bars. The facility census was 31. Review of the facility's Potential Zone of Entrapment, undated, showed the following: -The guidance described seven zones in the hospital bed system where there is a potential for patient entrapment; -Zone 1 is any open space within the perimeter of the rail; -Zone 2 is the gap under the rail between a mattress compressed by the weight of a patient ' s head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support; a. Factors to consider are the mattress compressibility which may change over time due to wear, the lateral shift of the mattress or rail, and any degree of play from loosened rails or rail supports. -Zone 3 is the space between the inside surface of the rail and the mattress compressed by weight of a patient's head; -Zone 4 is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail; -Although seven potential zones of entrapment have been identified, Federal Drug Administration (FDA) is recommending dimensional limits for zones 1-4 because these zones were most frequently reported as having entrapments; -Zone 5 occurs when panel length head and foot side rails (split rails) are used on the same side of the bed; a. The space between the split rails may present a risk of either neck entrapment or chest entrapment between the rails if a patient attempts to, or accidentally, exits the bed at this location; b. Any V-shaped opening between the rails may present a risk of entrapment due to wedging; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Zone 6 is the space between the end of the rail and the side edge of the headboard or footboard; -Zone 7 is the space between the inside surface of the headboard or footboard and the end of the mattress. Review of the facility's Restraints: Bed Rail Safety Check policy, showed the following: -Regularly inspect each of these seven areas on each bed with restraints; -Take into consideration the following: a. The bars within the bed rails should be closely spaced to prevent a resident's head from passing through the openings and becoming entrapped; b. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. c. Mattresses may slumping over time or after cleaning causing space between the rails and the mattress; d. Check for compression of the mattress's outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail; e. Ensure that the mattress is appropriately sized for the bed frame. Not all beds and mattresses are interchangeable; f. The space between the bed rails and the mattress and the headboard and the mattress should be filled by the mattress or by an added firm inlay. This creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails; g. Latches securing bed rails should be stable so that the bed rails will not fall when shaken; h. Older bed rails with tapered or winged ends should not be used for residents at risk of entrapment; i. Maintenance and monitoring of the bed, mattress, and accessories (such resident/caregiver assist items). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/17/24, showed the following: -The resident was cognitively intact; -He/She required maximal assistance with rolling left and right in bed; -He/She was dependent on staff for sitting to lying in bed, lying to sitting on the side of the bed, and chair/bed-to-chair transfer. Review of the resident's care plan, last updated on 4/1/24, showed the following: -The resident had limited physical mobility; -He/She required a mechanical lift with two staff members for transfers; -He/She required two staff members for bed mobility. Observation in the resident's room on 4/15/24 at 9:55 A.M., showed the resident lay in a bariatric bed with an assist bar on the left side of the bed. Observation in the resident's room on 4/17/24 at 11:10 A.M., showed the resident lay in a bariatric bed with an assist bar on the left side of the bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress, or assist bars to identify areas of possible entrapment. 2. Review of Resident #31's care plan, last updated 1/4/24, showed the following: -The resident had impaired activities of daily living (ADL) functioning; -He/She needed substantial assistance with bed mobility; -He/She was dependent on staff and a mechanical lift for transfers. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was independent with daily decisions; -He/She required maximal assistance with rolling left and right in bed. (transfer ability was not completed) Observation in the resident's room on 4/15/24 at 9:47 A.M., showed the resident in bed with assist bars on bilateral sides of the bed. Observation in the resident's room on 04/16/24 at 08:57 A.M., showed the resident in bed with assist bars on bilateral sides of the bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the resident's room on 4/18/24 at 11:10 A.M., showed the resident in bed with assist bars on bilateral sides of the bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress, or assist bars to identify areas of possible entrapment. 3. Review of Resident #12's undated summary sheet showed the following: -The resident was his/her own responsible party; -Diagnoses included hemiplegia and hemiparesis following a stroke affecting the left side (left side weakness/paralysis after a stroke); -Physician order for bilateral 1/2 side rail for bed mobility, with an order start date of 04/17/24. Review of the resident's care plan, revised 04/03/24, showed the following: -Activities of daily living focus - he/she has limited physical mobility related to stroke with residual hemiparesis; -Bed mobility extensive assistance; -No indication of side rails being used. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Substantial/maximum assist by staff for rolling left and right in bed; -No use of bed rails. Review of the resident's medical record showed no entrapment zone assessment or entrapment zone measurement or physician order for side rails prior to the first day of the annual survey (4/15/24). Observation on 04/15/24, at 10:47 A.M., showed the resident sat up in his/her wheelchair with bilateral 1/2 side rails in the raised position. Observation on 04/16/24, at 11:00 A.M., showed the resident lay awake in his/her bed with bilateral upper 1/2 side rails in the raised position. Observation on 04/17/24, at 7:39 A.M., showed the following: -The resident lay awake in bed watching television with bilateral upper 1/2 side rails in the raised position; -Staff entered the room to get the resident up for the day; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident used bilateral side rails to assist in turning from side to side. Review of the bed rail assessment form, dated 04/18/24, showed the following: -Full bed rail, left and right side, are being used; -Symptoms/Functional deficits that require a rail: helps him/her roll and toilet; -Did the resident show you how they safely use the rails - yes; -How does the device benefit the resident - positioning; -The rails are secure - yes; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). 4. Review of Resident #23's care plan, updated 12/1/23, showed the following: -He/She has cane rails on either side of his/her bed; -He/She was at risk for falls because of medication taken daily; -Goals of no injury because of a fall and he/she wants to be as independent as possible. Review of the resident's quarterly MDS dated [DATE], showed the following: -Severe cognitive impairment; -Partial/Moderate assist by staff for rolling left and right in bed; -Supervision/touch assist by staff for transfers sit to lying, lying to sitting, sit to stand, chair/bed-to-chair and toilet; -No use of bed rails. Review of the resident's medical record showed no zone assessment, entrapment zone measurement or physician order for side rails prior to 4/15/24 (first day of the survey). Review of the resident's undated summary sheet showed the following: -The resident's spouse is his/her responsible party for decision making; -Diagnoses include dementia with behavioral disturbance (a group of thinking and social symptoms that interferes with daily functioning with presence of behaviors such as physical aggression, agitation, or depression) and obesity; -Physician order for bilateral 1/4 side rail for bed mobility with an order start date of 04/17/24. (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 04/15/24, at 10:32 A.M., showed the following: -The resident lay in bed awake watching television; -Bilateral upper 1/2 side rails in the raised position; -The resident used the left side rail to change position, rise from a lying to a sitting position and transferred to his/her wheelchair. Observation on 04/16/24, at 11:15 A.M., showed the resident in bed asleep with bilateral upper 1/2 side rails in the raised position. Observation on 04/17/24, at 6:46 A.M., showed the resident lay awake in bed watching television with bilateral upper 1/2 side rails in the raised position. Review of the resident's bed rail assessment form, dated 04/18/24, showed the following: -Full bed rail, left and right side, being used; -Symptoms/Functional deficits that require a rail: helps him/her roll and get up; -Did the resident show you how they safely use the rails - yes; -How does the device benefit the resident - assist with mobility and positioning; -The rails are secure - yes; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). 5. Review of Resident #15's annual MDS, dated [DATE], showed the following: -Cognition not assessed, cannot do interview because resident is rarely understood; -Diagnosis include hemiplegia (paralysis one side of body) affecting right dominant side, stroke), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and seizures; -Memory long and short term is a problem; -Dependent on staff with hygiene, transfers, toilet use, bathing; -Substantial/maximum assistance rolling left and right; -Two or more non-injury falls since last assessment. Review of the resident's care plan, dated 10/18/23, showed the following: Resident has limited physical mobility related to Parkinson's and cognitive impairment; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff with bed mobility and transfers, used a mechanical lift for transfers; -At risk for falls. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -One non injury fall. Review of the resident's medical record showed no documentation staff completed an inspection of the resident's bed frame, mattress, and assist rails to identify areas of possible entrapment prior to 4/15/24. Observation on 4/16/24 at 10:33 A.M., showed the resident in his/her bed with a cover over his/her head. The resident's bed had 1/4 rail in the raised position on the resident's right side of his/her bed. Observation on 4/17/24, at 5:30 A.M., showed the resident in his/her bed with a 1/4 rail in the raised position. Facility staff provided a resident document titled Bed Rail Assessment Form on 4/18/24, dated 4/18/24, that showed the following: -The rails are secure; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). -Completed by the Director of Nursing. 6. Review of Resident #30's annual MDS dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis of Alzheimers; -Sometimes understands; -Limited range of motion both lower extremities. Review of the resident's quarterly MDS, dated [DATE], showed the resident was dependent on staff for toileting, personal hygiene, sit to lying, lying to sitting on side of bed, transfers, and locomotion. Review of the resident's medical record showed no documentation staff completed an inspection of the resident's bed frame, mattress, and assist rails to identify areas of possible entrapment prior to 4/15/24. (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 4/15/24, at 10:23 A.M., showed the resident in bed with his/her eyes open. The resident's bed had half metal bed rails raised on both sides of the bed while resident in bed awake. Observation on 4/17/24, at 6:15 A.M., showed the following: -The resident in his/her bed with both 1/2 metal bed rails in the raised position; -Nurse Aide (NA) K and NA L rolled the resident back and forth in bed to provide perineal care, dressed the resident, and placed a under the resident sling for the mechanical lift; -When the staff rolled the resident the resident grabbed the side rail and pushed against staff turning him/her; -NA K said the resident was fearful of rolling so he/she pushed against them with the rail; -The staff transferred the resident to his/her wheelchair with a mechanical lift; -The resident did not utilized his/her bed rail to assist with care. Facility staff provided a resident document titled Bed Rail Assessment Form on 4/18/24, dated 4/18/24, that showed the following: -The rails are secure; -Critical entrapment zones 1-4: pass (no specific measurements listed on each zone). -Completed by the Director of Nursing. 7. During an interview on 4/18/24 at 7:30 P.M., the Director of Nursing said the following: -She was not aware of any other form other than the ones the facility completed that indicated the entrapment zones on 4/17/24, after the survey began; -To her knowledge no entrapment zone assessments or measurements had been completed prior to the annual survey. 42592 46506