STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265607	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42795 Based on observation, interview and record review, the facility failed to follow acceptable nursing practice when the facility's staff left medication in one resident's room who did not have a physician order for self-administration or medications to be left at the bedside (Resident #46). The sample was 24. The census was 120. Review of the facility's Medication Administration policy, undated, showed: -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care; -Procedure: Never leave medications unattended. Review of the facility's Self-Administration of Medication policy, undated, showed: -Policy: It is the policy of this facility to provide resident centered care that safeguards the resident's right for self-administration of their own medication that supports resident dignity and self-determination; -Procedure: Determine if the resident desires to self-administer their own medication; A resident may not self-administer medication until the assessment is completed by the interdisciplinary team (IDT) and determine to be safe to do so; A physician order is required for residents to self-administer medication. Review of Resident #46's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 5/18/24, showed: -Cognitively intact; -Vision moderately impaired; -Staff setup and assist the resident with eating, bathing, oral hygiene and toilet hygiene; -Diagnoses included heart failure, kidney failure, high blood pressure, anemia (low iron in the blood) and diabetes. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, showed it did not address the resident's medications could be left at bedside or that the resident could self-administer his/her medications. Review of the resident's medical record, showed no self-medication assessment. Review of the resident's physician order sheets (POS), dated August, 2024, showed no order for the resident's medications to be left at bedside or for the resident to self-administer medications. Review of the resident's Medication Administration Record (MAR), dated August, 2024, showed: -An order, with a start date 6/14/24, amlodipine (medication used to treat high blood pressure) 5 milligrams (mg), dose scheduled for A.M.; -An order, with a start date 6/14/24, azathioprine (medication used to treat arthritis) 50 mg, dose scheduled for A.M.; -An order, with a start date 6/15/24, furosemide (removes excess water weight) 80 mg give Tuesday, Thursday and Saturday, dose scheduled for A.M.; -An order, with a start date 6/14/24, prednisone (steroid) 20 mg, give two tablets, dose scheduled in A.M.; -An order, with a start date 6/14/24, carvedilol 6.25 mg (medication used to treat high blood pressure), give one tablet twice a day, scheduled doses A.M. and P.M.; -An order, with a start date 6/14/24, Cholestyramine light oral packet (medication used to treat high cholesterol) 4 gm, give twice a day, scheduled doses A.M. and P.M.; -An order, with a start date 6/14/24, sevelamer carbonate (medication used to treat kidney failure) 2.4 gm, give one packet three times a day, scheduled doses 9:00 A.M., 1:00 P.M., and 5:00 P.M.; -An order, with a start date 6/14/24, docusate sodium (medication used to treat constipation) 100 mg, give twice a day, scheduled doses, 9:00 A.M. and 5:00 P.M.; -On 8/8/24, A.M. doses of amlodipine, azathioprine, furosemide, prednisone, carvedilol, Cholestyramine light, sevelamer carbonate, and docusate sodium were documented as administered. During observation and interview on 8/8/24 at 10:57 A.M., the resident sat in his/her wheelchair and his/her bedside table was approximately three feet from where the resident was seated. On the bedside table, sat a medicine cup filled with multiple pills. The resident also had a clear plastic water cup filled with cloudy liquid. The resident said the medications were his/her morning dose of pills, and the cloudy fluid was for his/her kidneys. The resident wasn't sure the names of the medications he/she was on but knew he/she was on a steroid and a water pill. The resident said staff leave his/her medications at bedside for him/her to take at his/her convenience all the time. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said there should be a physician order that states the resident's medication can be left at the bedside or the resident can self-administer. There is an assessment that is completed to ensure the resident can take their medication on their own. Staff are to watch the resident take medications and not leave them unattended at the bedside if there is no physician order. During an interview on 8/13/24 at 12:45 P.M., Certified Medication Technician (CMT) J said there are no residents who self-administer medications. Once the medication is given to the resident, the staff member giving the pills should wait and make sure the resident swallows the medication. Medications of any kind are not to be left at the bedside. During an interview on 8/14/24 at 10:50 A.M., the Director of Nursing (DON) said there are no residents in the building who can self-administer their medications. An assessment that the resident can safely take their medication on their own is expected to be completed and placed in the medical record. Physician orders for medications to be left at bedside, or the resident can self-administer is expected to be obtained by the nursing staff. Medications are not to be left at the bedside if there is no physician order. Staff are expected to watch the resident take all their medications.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 40290 Based on interview and record review, the facility failed to maintain documentation of a system that assures complete accounting of resident personal funds, and the facility failed to ensure access to resident personal funds was transferred to the facility's new management company upon a change in ownership. This deficient practice affected all 61 residents whose funds were handled by the facility. The census was 120. During an interview on 8/12/24 at 7:15 A.M., the Business Office Manager (BOM) said she reconciles funds in the resident trust account monthly. She does not have records of her monthly reconciliations for the past 12 months due to a recent change in the facility's ownership. The facility changed ownership on 7/30/24 and now the facility no longer has access to the electronic accounting system used to manage funds. The previous ownership has not been responding or cooperating with the new ownership to get this resolved. The facility no longer has access to the resident trust account where resident personal funds are held. She cannot review or access the resident trust bank statements. She pulled the last withdrawal record from July 2024 to determine approximately how much money each resident receives each month for personal allowance. Since she no longer has access to the resident trust account, she has been guessing how much to give each resident when they make requests for personal funds. She does not have access to authorizations to hold funds, signed by residents prior to the change in ownership. She has not had residents sign new authorizations to hold funds under the new ownership because she does not have access to the funds accounting system from which she can print these documents. During an interview on 8/12/24 at 11:55 A.M., the BOM said she requires access to the resident trust accounting system and bank statements in order to reconcile funds on a monthly basis. She needs to be able to review resident account balances to ensure residents do not exceed their spenddown limits. She needs access to the resident trust account in order to know each resident's current balance for fund requests. During an interview on 8/12/24 at 11:59 A.M., the Administrator said the facility does not have access to the resident trust account or the fund accounting system due to the facility's change in ownership. The new ownership is working on getting this information. She is not sure about a timeline for getting this resolved. The BOM requires access to the resident trust account and fund accounting system in order to reconcile funds on a monthly basis. She expected the BOM to have access to the resident trust account to ensure spenddown limits are not reached. She expected the BOM to have access to the resident trust account for resident cash withdrawal request. Residents are provided with cash withdrawals upon request. Any accounting error that occurs prior to the facility regaining access to the resident trust account will be covered by the facility and will not negatively impact the residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 44948 Based on observation, interview and record review, the facility failed to maintain a homelike environment for residents at the facility, including walls in resident common areas, food and debris left in resident rooms, resident room doors not closing to the hallway, and resident hall bathrooms not kept clean and orderly. The sample was 24. The census was 120. 1. Review of Resident #85's quarterly Minimum Data Set (MDS, a federally mandated instrument completed by facility staff), dated 5/10/24, showed: -Cognitively intact; -History of burn wound to the upper and lower back. Observation on 8/8/24 at 11:28 A.M. and on 8/12/24 at 11:37 A.M., , showed the resident's room with an approximate 4 inch wide by 9 inch long strip of the drywall behind the bed damaged with drywall debris on the floor. The resident's bathroom showed a large amount of clear liquid draining from the bottom of the toilet bowl near the floor flange and into the adjoining shower stall. The resident said these issues have been present for months. The resident said he/she reported this to nursing staff. 2. Review of Resident #121's admission MDS, dated [DATE], showed: -Cognitive impairment; -Wheelchair use for locomotion. Observation on 8/8/24 at 11:44 A.M. and on 8/12/24 at 11:44 A.M., of the resident's bathroom, showed a large amount of clear liquid draining from the bottom of the toilet bowl near the floor flange. The resident said this had been going on for some time and had reported this to nursing staff to pass onto maintenance. 3. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Cognitive impairment; -Colostomy status. Observation on 8/9/24 at 10:21 A.M., 8/12/24 at 9:06 A.M. and on 8/12/24 at 11:51 A.M., showed the resident's room, along the floor of the room, food and trash debris. An unidentified, sticky substance coated the floor, causing one's feet to stick to the floor when walking. 4. Review of Resident #25's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Use of wheelchair. Observation on 8/8/24 at 11:53 A.M., showed the resident's room, a three-foot area along the bottom wall next to the bathroom with holes and gouges in the wall. A circular hole, approximately three inches in diameter, surrounded by smashed areas of dry wall next to the window, approximately four feet from the ceiling. The door to the resident's room would not close, leaving approximately three feet between the edge of the door and the door frame. During an interview, the resident said the walls in his/her room are crumbling and his/her door will not close. It gets loud at night and it would be helpful for sleep if he/she could close his/her door all the way. He/She has talked to Maintenance and other staff about his/her door not closing, but everyone says nothing can be done about it. 5. Observation on 8/8/24 at 12:27 P.M. of the feeding assistance room near the back of the dining room, with staff providing assistance to dependent residents. Along the bottom of the wall near the Western side of the room, an approximate 20 feet long strip of baseboard was missing or stripped from the wall. Observation on 8/9/24 at 7:49 A.M. of the main dining room, showed seven tables still with food and other debris from previous meals left on the tabletops as residents entered the dining room for the breakfast meal. Along the bottom of the wall near the Western side of the feeding assistance room, an approximate 20 feet long strip of baseboard was missing or stripped from the wall. Observation on 8/12/24 at 10:25 A.M. of the main dining room, showed a feeding assistance room near the back of the dining room with staff providing assistance to dependent residents. Along the bottom of the wall near the western side of the room, an approximately 20 feet long strip of baseboard was missing or stripped from the wall. 6. Observation on 8/8/24 at 2:53 P.M., of a shower room on the hall near room [ROOM NUMBER], showed no handle at the door latching mechanism and the door left ajar. The bathroom toilet appeared clogged with feces and numerous sheets of toilet paper. A soiled washcloth and trash were on the floor to the right of the door, and a Hoyer lift (mechanical lift) was in the shower stall, blocking entry. Observation on 8/12/24 at 9:07 A.M. of a shower room on the hall near room [ROOM NUMBER], showed no handle at the door latching mechanism and the door left ajar A soiled washcloth and trash were on the floor to the right of the door, and a Hoyer lift was in the shower stall, blocking entry. Multiple pairs of soiled briefs were out of the trash can near the sink. During an interview on 8/13/24 at 11:25 A.M., Housekeeping Staff I said hall bathrooms and resident rooms are cleaned daily by housekeeping staff. There is no set schedule, but the three housekeeping staff on each shift will communicate which halls are the responsibility of which staff member. Staff are instructed to clean surfaces, floors, and empty refuse cans for each resident room and hall bathroom they clean, and are expected to clean a resident's floors if they were to walk by and notice food items or debris on the floor. Housekeeping Staff I was aware of the baseboards missing or damaged in the feeding assistance dining room, but did not know how long this has been an issue. Housekeeping Staff I said Maintenance would be responsible for this but he/she had not reported it to maintenance staff, assuming someone else had already reported it. Housekeeping staff do clean dining room tables at the facility, but that responsibility falls on the dietary department. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/24 at 9:41 A.M., the Maintenance Director said the baseboards in the feeding assistance room have been damaged and were peeled off about two weeks ago after a period of heavy rain. The facility is currently waiting to replace them as the new ownership wants to remodel the walls and baseboards in that room. The Maintenance Director was aware of the leaking toilet in room [ROOM NUMBER] and was working on it today, but was unaware of issues with room [ROOM NUMBER]'s walls and leaking toilet. Nursing staff are expected to relay these concerns to maintenance through the facility's online reporting system, but the system has been down since new ownership took over. The Maintenance Director was unaware of room [ROOM NUMBER]'s door not closing properly and expected maintenance staff to correct that as soon as reported by nursing staff. The Maintenance Director was made aware of the hall bathroom near room [ROOM NUMBER] missing a handle and locking mechanism. During an interview on 8/14/24 at 12:17 P.M., the Administrator said she expected housekeeping staff to clean resident rooms and hall bathrooms daily and as needed if a staff member were to see food items or trash on the floor of a resident room. The Administrator expected all common areas to be clean and in a homelike condition, and expected all plumbing in resident rooms to be kept in working order or reported to maintenance staff. MO00239681

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 40290 Based on interview and record review, the facility failed to notify a representative of the State Long-Term Care (LTC) Ombudsman of resident transfers and discharges. The census was 120. During an interview on 8/7/24 at 12:26 P.M., the Ombudsman said he/she had not received a monthly transfer report from the facility since April 2024. During an interview on 8/14/24 at 6:57 A.M., the Social Services Director (SSD) said she is responsible for notifying the Ombudsman of resident transfers on a monthly basis. By the 5th of each month, she emails the Ombudsman with a list of all residents discharged from the facility the month before. When asked to provide documentation of Ombudsman notification since April 2024, the SSD said she did not have access to her old email due to the facility's recent change in ownership. During an interview on 8/14/24 at 1:22 P.M., the Administrator said the SSD is responsible for notifying the Ombudsman of resident transfers and discharges. The SSD is expected to notify the Ombudsman during the first week of the month. The Administrator was not aware the Ombudsman's office had not received notification from the facility since April 2024. Emails may not have been going through due to an issue the facility has been having with their emails getting full. When emails were full, the email became jammed and emails were not sent out. When this happened, the employee would not be notified of their email being full, so they did not know their emails were not going though. The facility has a new email system due to the facility's recent change in ownership.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) care needs were met for residents #107, #38, and #88. The sample was 24. The census was 120. Review of the facility's routine resident care policy, undated, showed: -Policy: It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility; -Procedure: Routine care by a nursing assistant includes but is not limited to the following: Assisting or provides for personal care, bathing, dressing, eating and hydration, and toileting. 1. Review of Resident #107's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/16/24 showed the following: -Diagnoses included gastrostomy (feeding tube), muscle weakness, and morbid obesity; -Severe cognitive impairment. Review of the resident's care plan, dated 6/7/24, showed: -Focus: Resident has ADL self care performance deficit; -Goal: Resident will maintain current level of function; -Interventions: Resident requires total assistance and is totally dependent with personal hygiene and shower care. Review on 8/9/24 of the facility's shower sheet binder, showed -The resident's last received shower/bed bath was on 8/1/24; -The resident was scheduled to receive a shower/bed bath on Mondays and Thursdays. Observation on 8/8/24 at 1:25 P.M., showed the resident lay in bed asleep. The resident's hair was oily. The resident had dried, white matter on his/her skin surrounding his/her mouth. Observation on 8/9/24 at 7:07 A.M., showed the resident lying in bed awake. The resident's hair was oily. The resident had dried, white matter on his/her skin surrounding his/her mouth. Observation on 8/12/24 at 5:22 A.M., showed the resident lay in bed asleep. The resident's hair was oily. The resident had dried, white matter on his/her skin surrounding his/her mouth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 12:21 P.M., Licensed Practical Nurse (LPN) A said nursing staff are to document if they do not give a resident a shower or bed bath on their assigned day. If a resident had oily hair or dirty skin, staff should give the resident a shower. 2. Review of Resident #38's quarterly MDS, dated [DATE], showed the following: -Diagnoses included acute kidney failure, diabetes, and Behcet's disease (inflammatory disorder that affects the body's blood vessels); -Severe cognitive impairment. Review of the resident's care plan, dated 7/23/24, showed: -Focus: Resident has an ADL self-care performance deficit; -Goal: Resident will maintain current level of function; -Intervention: Resident requires total assistance and is totally dependent with personal hygiene and shower care. Observation on 8/8/24 at 11:34 A.M., showed the resident had long nails with dark matter underneath. Observation on 8/9/24 at 7:04 A.M., showed the resident asleep in bed. The resident had long nails with dark matter underneath. Observation on 8/12/24 at 7:44 A.M., showed the resident had long nails with dark matter underneath. During an interview on 8/13/24 at 12:21 P.M., LPN A said activities staff and Certified Nursing Assistants (CNAs) were responsible for trimming residents' nails. The nurse or podiatrist was responsible for trimming nails for diabetic residents. Staff should be cleaning under the residents' nails. 3. Review of Resident #88's quarterly MDS, dated [DATE], showed the following: -Diagnoses included muscle weakness, diabetes, and aphasia (disorder that affects the ability to communicate); -Cognition not assessed. Review of the resident's care plan, dated 7/23/24, showed: -Focus: Resident has an ADL self-care performance deficit and requires assistance with ADL care; -Goal: Resident will demonstrate increased independence with ADL completion; -Intervention: Resident requires set up/clean up assistance from staff for personal hygiene needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 1:51 P.M., when asked, the resident said No he/she was not comfortable with the length of his/her beard and Yes he/she wanted it trimmed. The resident's beard was approximately half an inch long. Observation and interview on 8/12/24 at 11:53 A.M., showed the resident in the dining room. The resident's beard was approximately half an inch long. The resident said his/her beard had not been trimmed. During an interview on 8/13/24 at 12:21 P.M., LPN A said nursing staff are expected to ask residents if they would like their facial hair trimmed or shaved. 4. During an interview on 8/14/24 at 11:26 A.M., the Director of Nursing (DON) said she would expect for nursing staff to be assisting residents with all of their ADL care needs. 5. During an interview on 8/14/24 at 12:37 P.M., the Administrator said she would expect for residents' ADL needs to be met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards by not obtaining orders for breast radiation therapy (a cancer treatment that uses high energy radiation to kill cancer cells), assessing the resident after his/her daily breast radiation treatments, and assessing the resident's skin condition after breast cancer surgery for one resident (Resident #83). Staff failed to provide follow physician orders and complete wound treatments on one resident (Resident #75) with chronic vascular wounds. Staff failed to routinely turn and reposition one resident dependent on staff for assistance with bed mobility, who was at increased risk of altered skin integrity (Resident #175). In addition, staff failed to ensure one resident receiving continuous oxygen therapy had physician orders for oxygen use and maintenance care (Resident #111). The sample was 24. The census was 120. Review of the facility's Skin Care and Wound Management, undated, showed: -Policy: -The facility staff strives to prevent resident skin impairment and to promote the healing of existing wounds; -Skin care and wound management program includes, but is not limited to: -Analysis of facility pressure ulcer data for quality improvement opportunities; -Application of treatment protocols based on clinical best practice standards for promoting wound healing; -Daily monitoring of existing wounds; -Identification of residents at risk for development of pressure ulcers; -Implementation of prevention strategies to decrease the potential for developing pressure ulcers. -Treatment: -Select and complete the appropriate form, pressure ulcer documentation and or skin impairment documentation; -Review and select the appropriated treatment for the identified skin impairment; -Obtain a physician's order; -Communicate interventions to the caregiving team; (continued on next page)

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	265607	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document treatment on the Treatment Administration Record (TAR); -Monitor and document progress notes; -Evaluate effectiveness of interventions during the clinical meeting; -Modify goals and interventions as indicated; -Communicate changes to the caregiving team. Review of the facility's Physician Order policy, undated, showed: -Policy: -It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents; The safety of residents, staff and visitors is of primary importance; The purpose of this policy is to provide guidance for licensed nurses and licensed therapists to accurately document physician and provider orders as determined by the licensee's scope of practice; For the purpose of this policy and other policies at this facility, the term physician or provider also includes all approved providers that have the authority to write medical orders; -Procedure: -Execution of order and notifications; -The Medication Administration Record (MAR) and TAR should automatically be updated with the new orders is a scheduled has been assigned. Review of the facility's Routine Resident Care policy, undated, showed: -Definition: Routine resident care is that is not necessarily medically or clinical based but necessary for quality of life promoting dignity and independence, as appropriate; -Policy: It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social and spiritual needs and honor resident lifestyle preferences while in the care of this facility; -Procedure: Licensed staff will include the following services based upon their scope of practice, but not limited to: -Provide a nursing assessment, nursing diagnosis, care planning, implementation and evaluation; -Provide access to resident care policies for any staff providing care; -Delegate care to the appropriate staff is a safe ant therapeutically sound method; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessment, implementation and evaluation for personal needs including emotional, social and spiritual needs; -Provide urine daily care by a certified nursing assistant (CNA) with a specialized training in rehabilitation and restorative care under the supervision of a licensed nurse including but not limited to: -Maintaining proper body position and alignment for all residents; -Encouraging maximum function for each resident; -Implementing and maintaining program for skin care. 1. Review of Resident #83's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/1/24, showed: -Cognitively intact; -Diagnoses included cancer, peripheral vascular disease (PVD, a condition that affects the blood flow to the lower extremities), renal failure, high blood pressure and diabetes. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is at risk for impaired immunity related to new diagnosed left breast cancer; The resident had a left breast lumpectomy and lymph node biopsy on 6/10/24; The resident started breast radiation therapy on 7/22/24; -Interventions: Monitor and document report to physician signs and symptoms of infection, fever, redness, drainage or swelling to wounds; Ensure adequate rest and fluid intake; Monitor changes in behavior. Review of the resident's Physician Order Sheets (POS), dated August, 2024, showed: -An order dated, 6/1/24, weekly skin assessment to be completed; Documentation to be completed in weekly skin assessment. Review of the record, showed no skin assessments were available for review. No further orders related to the resident's recent breast surgery or radiation treatments were noted. Review of the resident's progress notes, showed: -On 6/10/24 at 6:30 P.M., the resident returned from outpatient procedure, no new orders; -On 6/18/24 at 1:01 P.M., the resident is alert and oriented to person, place and time. He/She can make his/her needs known and requires some assistance with activities of daily living (ADLs). The resident had lumps removed from both his/her breasts and will now start chemotherapy (a cancer treatment that is given in the vein). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/8/24 at 12:15 PM., transportation arrived to take the resident to chemotherapy, the resident refused. The resident said he/she did not feel up to going and will go tomorrow. The resident was educated on the importance of receiving routine treatments. Review of the resident's progress notes, showed the notes did not address the resident having recent breast surgery and daily radiation appointments. During observation and interview on 8/8/24 at 1:00 P.M., the resident said he/she goes to daily radiation treatments during the week for his/her recent diagnosis of breast cancer. He/She is not receiving chemotherapy. The resident lifted his/her shirt and exposed his/her left breast. Three areas of the resident's left breast showed black markers with a clear film. The resident said that was his/her radiation markers. The resident said the facility staff have never looked at his/her breast after his/her surgery or radiation treatments. The resident said he/she gets tired after the treatments and generally sleeps afterwards. During an interview on 8/13/24 at 9:25 A.M., Certified Nursing Assistant (CNA) H said he/she was aware the resident went out of the building daily for some type of cancer treatment. He/She thought it was for chemotherapy. CNA H said the resident is zonked out when he/she returns from his/her treatments. The resident requires some assistance with his/her showers and CNA H had not observed the resident's breast. During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said there should be a note in the progress notes daily related to the resident's radiation treatments and how he/she was tolerating the treatments. If a resident has a surgical procedure or radiation treatments, the resident's skin should be assessed for signs and symptoms of infection and integrity of the skin. There should be orders for radiation therapy in the resident's medical record. During an interview on 8/14/24 at 10:50 A.M., the Director of Nursing (DON) said she expected staff to document daily on how the resident tolerated radiation treatments in the progress notes. She also expected the nurses to check the resident's skin after a surgical procedure and document in the progress notes and in the skin assessment tab. The skin assessments are to be completed weekly or when new skin issues develop. She expected there to be orders for radiation such as when and where the appointment was, and contact information. 2. Review of Resident #75's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses include heart failure, kidney failure, wound infection other than foot and PVD; -One venous or vascular wound. Review of the resident care plan, in use at the time of survey, showed: -Focus: The resident has impaired skin integrity related to vascular disease and is at risk related to impaired mobility and incontinence; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Administer treatments as ordered by the medical provider; Complete weekly skin checks; Evaluate existing wound daily for changes (redness, swelling, drainage, pain, foul odor). Review of the facility's weekly wound log, dated, 8/9/24, showed: -Location: Left lower leg; -Measurements: Length (L) 4.5. centimeters (cm), Width (W) 5.6 cm, Depth (D) 1.2 cm; -Wound type: Venous; -Location: Right calf; -Measurements: Length 1.8 cm, Width 1.4, Depth 0.0 cm; -Wound type: Venous. Review of the resident's TAR, dated August, 2024, showed: -An order, start date, 8/10/24, cleanse left lower leg with wound cleaner, cut Xeroform (a non-adherent specialized dressing) to fit inside wound bed and wrap with Kerlix (a mesh-like wrap dressing), every other day (QOD) and as needed (PRN); -An order, start date 8/10/24, cleanse right lower leg wound with hypochlorous (wound cleaner), cut Xeroform to fit inside wound bed and wrap with Kerlix QOD and PRN. -On 8/10/24, the resident's left lower leg treatment and right lower leg wound treatment were documented as completed. During observation and interview on 8/12/24 at 10:40 A.M., the resident lay in his/her bed. Wound Nurse G removed the resident's left leg wound dressing and the dressing was not dated. The resident's left leg wound was approximately 5.0 cm wide and 5.0 cm length with minimal depth. The dressing had a moderate amount of thin reddish fluid on it and no odor was present. The wound bed was beefy red. Wound Nurse G cleansed the resident's left leg wound and reapplied a new dressing. Wound Nurse G then removed the resident's right lower leg dressing, and the dressing was dated 8/8/24. The resident's right lower leg wound was approximately 2.0 cm wide x 2.0 cm length with minimal depth. The dressing had thin reddish fluid on it and no odor was present. The wound bed was pink. Wound Nurse G cleansed the resident's right leg wound and reapplied a new dressing. Wound Nurse G said both of the resident's leg wounds were chronic (long term) and the wounds looked the same with no improvement. The resident's leg dressings are to be changed every other day. The Wound Nurse works Monday through Friday, and on the weekends the nurses are responsible for the resident dressing changes. All nurses who work in the facility know the resident's dressings need to be changed when the Wound Nurse is not available. If they are unable to complete the treatment, they are expected to inform the next shift and/or notify the on-call nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/23 at 8:24 A.M., Licensed Practical Nurse (LPN) D said treatments are completed Monday through Friday by the Wound Nurse and on the weekends the Charge Nurse on the hall is responsible to do the resident's wound treatments. If the Wound Nurse is unable to complete the treatment, then the nurse should inform the next shift. The treatment should not be documented as completed when it was not completed. During an interview on 8/14/24 at 10:50 A.M., the Director of Nursing (DON) said the staff is expected to follow physician orders and complete dressing changes as ordered. If a treatment cannot be completed, she expected staff to let the following shift know so that they could complete the treatment. Documentation of the treatments are expected to be accurate. During an interview on 8/14/24 at 12:19 P.M., the Administrator said she expected staff to follow physician orders and complete treatment documentation accurately. 3. Review of Resident #175's medical record, showed: -admitted [DATE]; -Diagnoses included motor-vehicle accident, stroke, unspecified multiple injuries sequela (aftereffect of a disease, condition, or injury) and depression. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has a recent history of mandible (jawbone) fracture and spinal fracture as a result of a motor vehicle accident; -Interventions included: Provide assistance as needed with ADLs; -Focus: ADL self-care performance deficit; -Interventions included: Lying to sitting on side of bed - totally dependent of two or more (helpers do all the effort, resident does none of the effort). Roll left and right - totally dependent of one (helper does all the effort); -Focus: Resident has impaired skin integrity or is at risk for altered skin integrity; -Interventions included: Educate resident/resident representative on need for turning and repositioning. Encourage resident to turn and reposition or assist as needed as resident allows. Ensure residents are turned and repositioned. Observations on 8/8/24 at 11:47 A.M., 1:41 P.M. and 5:12 P.M., showed the resident on his/her right side in bed. The head of the bed was elevated and the resident's right shoulder pressed into the head of the bed and his/her legs bent at the knees, which were positioned near his/her chest. The resident was nonverbal. Observations on 8/9/24 at 6:46 A.M., 8:58 A.M., 9:32 A.M., 10:28 A.M., 12:02 P.M. and 1:31 P.M., showed the resident on his/her right side in bed, tilted slightly so partially on the right portion of his/her back. The resident's legs were bent at the knees, which were positioned near his/her chest. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 8/12/24 at 5:19 A.M., 6:19 A.M., 8:22 A.M., 11:44 A.M., and 1:25 P.M., showed the resident on his/her back in bed. His/her legs were slightly bent at the knee and tilted toward the left side of the bed. Observations on 8/13/24 at 7:02 A.M., 9:02 A.M. and 11:10 A.M., showed the resident on his/her back in bed. During an interview on 8/14/24 at 7:31 A.M., CNA B said the resident is nonverbal, bed bound, and requires total care. He/She is especially high risk for skin breakdown. Residents need to be turned and repositioned at least every two hours to help prevent skin breakdown. All nursing staff are responsible for turning and repositioning residents. During an interview on 8/14/24 at 8:04 A.M., CNA C said residents who are total care and bedbound are especially high risk for developing pressure ulcers. Residents need to be turned and repositioned every two hours to keep the pressure off of them. CNAs are responsible for turning and repositioning residents. During an interview on 8/13/24 at 11:58 A.M., LPN A said residents should be turned and repositioned very two hours. CNAs are responsible for turning and repositioning. Turning and repositioning is important for wound prevention and is especially important for residents who are bed bound. During an interview on 8/14/24 at 8:24 A.M., LPN D said CNAs and nursing staff are responsible for ensuring residents are turned and repositioned every two hours. Residents should be turned and repositioned to reduce pressure, especially if a resident is at high risk for developing wounds. During an interview on 8/14/24 at 10:49 A.M., the DON said the resident is nonverbal and requires total care from staff. He/She high risk for skin breakdown. The DON expected staff to turn and reposition the resident every two hours to prevent skin breakdown. When turning and repositioning, staff should make sure they fully move the resident to a new position. The resident is very contracted, so staff could place pillows underneath him/her to ensure pressure is offloaded. During an interview on 8/14/24 at 12:17 P.M., the Administrator said the resident is at higher risk for skin breakdown due to his/her medical condition. She expected residents to be turned and repositioned every two hours. This is important to offload pressure and prevent skin breakdown. 4. Review of Resident #111's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease) and congestive heart failure (CHF); -Shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat; -Oxygen therapy received while a resident. Review of the resident's care plan, in use at the time of survey, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Resident has oxygen therapy at 2 liters (L) via nasal cannula (NC), continuous, related to CHF, ineffective gas exchange, and hypoxia (low levels of oxygen in body tissues); -Goal: Resident will have no signs/symptoms of poor oxygen absorption through the next review date; -Interventions included: 3L by NC route for hypoxia, CHF, and COPD diagnoses. Review of the resident's POS, dated July 2024, showed: -An order, dated 3/5/24, for oxygen at 2 L via NC, continuous, every shift for shortness of breath, discontinued 7/24/24; -An order, dated 3/10/24, to clean oxygen tubing and humidifier every seven days and PRN every night shift, every Sunday, for oxygen maintenance, discontinued 7/24/24; -An order, dated 3/10/24, to clean oxygen concentrator filter every seven days and PRN every night shift, every Sunday, for oxygen, discontinued 7/24/24. Review of the resident's medical record, showed: -discharged to hospital on 7/24/24; -readmitted to facility on 7/27/24; -discharged to hospital on 7/29/24; -readmitted to facility on 8/5/24. Review of the resident's POS, reviewed on 8/8/24, showed no orders for oxygen use or oxygen maintenance. Observation on 8/8/24 at 12:09 P.M., showed the resident on his/her back in bed. The resident's oxygen concentrator was on and running at 3L, connected to a NC on the resident's face, with one prong of the NC inside the resident's right nostril, and the other prong outside of his/her nose. During an interview, the resident said he/she just got back from the hospital recently for a heart procedure. He/She uses oxygen at all times. Observations on 8/9/24 at 9:01 A.M., 10:31 A.M., and 12:02 P.M., and on 8/12/24 at 8:26 A.M. and 11:43 A. M., showed the resident in bed with oxygen on at 3L via NC. During an interview on 8/14/24 at 8:04 A.M., CNA C said the resident receives continuous oxygen. The resident should have physician orders for oxygen use. During an interview on 8/13/24 at 11:58 A.M., LPN A said physician orders are required for residents receiving oxygen. Physician orders should specify whether their oxygen is continuous or PRN, and the liter flow. There should be physician orders to clean oxygen tubing. Nurses are responsible for ensuring oxygen orders are obtained and entered onto the POS. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 8:24 A.M., LPN D said the resident receives continuous oxygen. Physician orders are required for oxygen use, and should include orders for flow rate and cleaning oxygen tubing. Nurses are responsible for ensuring physician orders are obtained. When a resident went out to the hospital and returned to the facility, nurses are responsible for ensuring orders are obtained and entered into the medical record. During an interview on 8/14/24 at 10:49 A.M., the DON said the resident receives continuous oxygen. He/She should have physician orders for oxygen use, including the flow rate, and to change the tubing weekly. The resident used to have orders for oxygen, but recently went out to the hospital. The facility recently had a change in ownership. It may be that the recent change in ownership or the resident's recent hospitalization resulted in the missed oxygen orders. When a resident went out to the hospital and returned to the facility, the nurse is responsible for entering physician orders in the resident's electronic medical record (EMR). During an interview on 8/14/24 at 12:17 P.M., the Administrator said she expected residents receiving oxygen therapy to have physician orders in the EMR for oxygen flow rate, cleaning, and maintenance. If a resident went out to the hospital and returned to the facility, she expected the admitting nurse to ensure orders are accurately re-entered in the EMR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42795 Based on observation, interview and record review, the facility failed to ensure one resident with a pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) received necessary treatments and services to promote healing (Resident #75). The sample size was 24. The census was 120. Review of the facility's Skin Care and Wound Management, undated, showed: -Policy: -The facility staff strives to prevent resident skin impairment and to promote the healing of existing wounds; -Skin care and wound management program includes, but is not limited to: -Analysis of facility pressure ulcer data for quality improvement opportunities; -Application of treatment protocols based on clinical best practice standards for promoting wound healing; -Daily monitoring of existing wounds; -Identification of residents at risk for development of pressure ulcers; -Implementation of prevention strategies to decrease the potential for developing pressure ulcers. Treatment: -Select and complete the appropriate form, pressure ulcer documentation and or skin impairment documentation; -Review and select the appropriated treatment for the identified skin impairment; -Obtain a physician's order; -Communicate interventions to the caregiving team; -Document treatment of the Treatment Administration Record (TAR); -Monitor and document progress notes; -Evaluate effectiveness of interventions during the clinical meeting; -Modify goals and interventions as indicated; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Communicate changes to the caregiving team. Review of the facility's Physician Order policy, undated, showed: -Policy: -It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents; The safety of residents, staff and visitors is of primary importance; The purpose of the this policy is to provide guidance for licensed nurses and licensed therapists to accurately document physician and provider orders as determined by the licensee's scope of practice; For the purpose of this policy and other policies at this facility, the term physician or provider also includes all approved providers that have the authority to write medical orders; -Procedure: -Execution of order and notifications; -The Medication Administration Record (MAR) and Treatment Administration Record (TAR) should automatically be updated with the new orders is a scheduled has been assigned. Review of Resident #75's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/9/24, showed: -Moderately impaired cognition; -Diagnoses included heart failure, kidney failure, wound infection other than foot and peripheral vascular disease (PVD, a condition in which the blood flow is restricted to the lower extremities); -The resident has one or more unhealed Stage One (red or painful area of the skin) or higher pressure ulcer; -The resident has one Stage Three pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Review of Resident #75's care plan, in use at the time of survey, showed: -Focus: The resident has impaired skin integrity related to vascular disease and is at risk related to impaired mobility and incontinence; -Interventions: Administer treatments as ordered by the medical provider; Complete weekly skin checks; Evaluate existing wound daily for changes (redness, swelling, drainage, pain, foul odor). Review of the resident's wound company progress notes, dated, 8/1/24, showed: -Location: Coccyx (tailbone); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Size: Length (L) 3.2 centimeters (cm); Width (W) 2.0 cm, Depth (D) 0.3 cm. -Pressure Wound: Stage Three; -Exudate (fluid that leaves the blood vessels into nearby tissues): Moderate; -Eschar (dead tissue): 0%; -Slough (non-viable yellow or tan tissue): 10%; -Granulation (red or pink new tissue growth): 80% -Progress: Remained the same. Review of the resident's TAR, dated August, 2024, showed: -An order, dated 7/24/24, cleanse coccyx with hypochlorous, apply Santyl nickel thickness to wound bed and cut calcium alginate to fit inside wound bed and cover with superabsorbent dressing, daily and PRN; -On 8/10 and 8/11/24, the treatment was documented as completed. During observation and interview on 8/12/24 at 10:40 A.M., the resident lay on his/her back and Wound Nurse G repositioned the resident to his/her left side and removed the dressing to the resident's coccyx. The coccyx dressing was dated 8/9/24. The resident's coccyx wound was approximately 3 cm wide x 3 cm length, with minimal depth. The dressing had a moderate amount of yellowish drainage. No odor was noted. The resident's coccyx wound had small patches of slough in the wound bed and pink tissue noted. Wound Nurse G cleansed the resident's coccyx wound and reapplied a new dressing. Wound Nurse G said the resident's coccyx dressing should be changed daily. The Wound Nurse works Monday through Friday. On the weekends, the nurses are responsible for the resident dressing changes. Wound Nurse G said he/she thought the resident's wound looked the same with no improvement. All nurses who work in the facility know the residents' dressings need to be changed when the Wound Nurse is not available. If they are unable to complete the treatment, they are expected to inform the next shift and/or notify the on-call nurse. During an interview on 8/14/23 at 8:24 A.M., Licensed Practical Nurse (LPN) D said treatments are completed Monday through Friday by the Wound Nurse, and on the weekends the Charge Nurse on the hall is responsible to do the resident's wound treatments. If the Wound Nurse is unable to complete the treatment, then the nurse should inform the next shift. The treatment should not be documented as completed when it was not completed. During an interview on 8/14/24 at 10:50 A.M., the Director of Nursing (DON) said staff is expected to follow physician orders and complete dressing changes as ordered. If a treatment cannot be completed, she expected staff to let the following shift know so that they could complete the treatment. Documentation of the treatments are expected to be accurate. During an interview on 8/14/24 at 12:19 P.M., the Administrator said she expected staff to follow physician orders and complete treatment documentation accurately. (continued on next page)

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	265607	A. Building B. Wing	08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00234118

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 42795 Based on observation, interview and record review, the facility failed to ensure one resident with limited mobility received appropriate services, equipment and assistance to maintain mobility (Resident #40). The sample was 24. The census was 120. Review of the facility's Routine Resident Care policy, undated, showed: -Definition: Routine resident care: care that is not necessarily medically or clinical based but necessary for quality of life promoting dignity and independence, as appropriate; -Policy: It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social and spiritual needs and honor resident lifestyle preferences while in the care of this facility; -Procedure: Licensed staff will include the following services based upon their scope of practice, but not limited to: -Provide a nursing assessment, nursing diagnosis, care planning, implementation and evaluation; -Provide access to resident care policies for any staff providing care; -Delegate care to the appropriate staff is a safe ant therapeutically sound method; -Assessment, implementation and evaluation for personal needs including emotional, social and spiritual needs; -Provide urine daily care by a Certified Nursing Assistant (CNA) with a specialized training in rehabilitation and restorative care under the supervision of a licensed nurse including but not limited to: -Maintaining proper body position and alignment for all residents; -Encouraging maximum function for each resident; -Implementing and maintaining program for skin care; -Assisting in techniques of ambulation and in providing exercises as directed by the Physical Therapist (PT), Speech Therapist (ST), or Occupational Therapist (OT) between visits; -Assisting with special devices; -Providing therapeutic interventions for cognitively impaired residents. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 7/15/24, showed: -Cognition not assessed; -Functional limitations in range of motion (ROM) in both upper and lower extremities. Review of the resident's face sheet, undated, showed diagnoses included anoxic (lack of oxygen) brain injury, quadriplegia (paralysis of arms and legs), muscle spasms and muscle contractures. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has a right wrist hand splint; -Interventions: Right hand and wrist splint to donn (place on) and doff (remove) on evening shift, check skin integrity prior and post application, report any abnormal findings. Review of the resident's OT notes, dated 2/7/24, showed splint recommended for right upper extremity. Review of the resident's Treatment Administration Record (TAR) dated August, 2024, showed: -An order, dated 2/13/24, right hand and wrist splint to donn on day shift and doff on evening shift, check skin integrity prior and post application, every day, and evening shift, Monday, Tuesday, Wednesday, Thursday and Friday. -On 8/8 and 8/9/24. showed the treatment was completed; -On 8/12/24, treatment documentation was blank. Observation on 8/8/24 at 1:25 P.M., 8/9/24 at 7:40 A.M. and 8/12/24 at 9:34 A.M. and 11:58 A.M., showed the resident lay in his/her bed. The resident did not have his/her right-hand wrist splint on. Both of the resident's hands were loosely clenched. During an interview on 8/12/24 at 9:34 A.M., CNA H said the resident used to have splints on both hands that his/her family brought in. He/She has not seen the resident's splint for a several weeks. The Restorative Aide (RA) is responsible for placing the splints on the residents but is pulled to the floor. Any nursing staff can apply splints. During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said the RA is responsible for placing the splints on the residents. The nurse should check to make sure it is applied and document in the TAR. During an interview on 8/13/24 at 12:58 P.M., RA K said she is responsible for placing the splints on the residents. He/She gets pulled in all different directions and sometimes cannot apply the splints due to lack of time. The aides and nurses can also apply the splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 10:50 A.M., the Director of Nursing (DON) said that splints are expected to be applied as per the physician order. The RA is responsible for applying the splints. If the RA is not available to place the splints, then the CNAs can apply the splints. Documentation is completed by the nurse on the TAR and is expected to be accurate. A blank box on the TAR indicates the task was not completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 44948 Based on observation, interview and record review, the facility failed to properly ensure physician orders for care of a colostomy (a surgical opening in the stomach to facilitate waste drainage from the colon) were maintained and completed as ordered. The sample was 24. The census was 120. Review of Resident #18's quarterly Minimum Data Set (MDS, a federally-mandated assessment instrument completed by facility staff), dated 5/26/24 ,showed: -Basic Interview for Mental Status (BIMS, an assessment tool used to identify a resident's cognitive status) score not completed; -Diagnoses included hypertension (high blood pressure), cardiac arrythmia (an abnormal heart rate and rhythm), colostomy status, history of cerebral infarction (stroke), and quadriplegia (loss of motor function in the upper and lower limbs). Review of the resident's current care plan, showed: -A focus of alteration in bowel elimination related to colostomy status as a result of chronic cystitis (chronic inflammation and pain in the large intestine and colon) with a goal for the resident to continue bowel movements into the colostomy during admission. Interventions included educating the resident on ostomy care, management of the ostomy site, signs and symptoms of infection and dietary restrictions. Review of the resident's Physician Orders, showed no active orders for routine or as needed colostomy care. Observation on 8/8/24 at 10:24 A.M., showed the resident resting in bed with a colostomy bag visible under the resident's gown. The resident said he/she did not get regular colostomy care, and has to ask staff repeatedly to change it when it becomes full of waste. Observation on 8/12/24 at 8:16 A.M.,. showed the resident resting in bed on his/her back. Observation of the colostomy site, showed the bag approximately 3/4 full of waste and stretched tightly by pressure from bowel gases. During the observation, the resident said he/she had not received colostomy care at all over the weekend. Observation on 8/13/24 at 7:59 A.M., showed the resident resting in bed on his/her back. Observation of the colostomy site showed the bag near full of waste and stretched tightly by pressure from bowel gases. During the observation, the resident said he/she had not received colostomy care at all on 8/12/24. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/14/24 at 7:41 A.M., showed the resident resting in bed on his/her back. Observation of the colostomy site, showed the bag empty and deflated. During the observation, the resident said he/she received colostomy care on the evening shift on 8/13/24 after requesting help due to fear the bag may burst from pressure. The resident had not received colostomy care prior to this since 8/9/24. During an interview on 8/14/24 at 8:03 A.M., Certified Nurse Aide (CNA) C said the resident required routine colostomy care and would typically tell staff when it needs to be changed. The resident is unable to change his/her own colostomy bag, and required assistance to do so. CNA C expected residents with colostomy care needs to have orders for care to direct staff to best help the resident. During an interview on 8/14/24 at 8:25 A.M., Licensed Practical Nurse (LPN) D said the resident required routine colostomy care that should be completed by nursing staff on each shift, including a check of the colostomy site, contents of the bag, and appearance of the surgical site. Physician orders should be entered and should specify how often to empty and change the colostomy bag itself. Unit managers are typically responsible to ensure orders for each resident on the hall are accurate in relation to each resident's specific medical care needs. During an interview on 8/14/24 at 10:49 A.M., the Director of Nursing (DON) said the resident required routine colostomy care, is unable to complete this care on his/her own, and she expected physician orders to be entered specifying how often care should be completed and how often to change the physical bag and other surgical site equipment. Unit managers are responsible for ensuring accuracy of orders for residents on the hall, but since the corporate changeover, the facility has had difficulty accessing and verifying physician orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record, the facility failed to ensure staff followed the facility's policies regarding tube feeding, and failed to ensure residents received tube feeding in accordance with physician orders to support adequate nutritional intake. The facility identified nine residents receiving tube feedings, five of which were sampled and problems were found with four (Residents #175, #65, #38 and #107). The sample was 24. The census was 120. Review of the facility's Enteral General Nutritional (tube feeding) policy, undated, showed: -The purpose of this policy is to provide guidance for the use of enteral feeding and hydration for residents unable to tolerate oral meals and those who have a stable (not new) enteral tube in place. Enteral feedings are provided by bolus (single/specified dose given all at once) or continuous delivery; -A physician/provider order is required to include type of feeding and its caloric value, volume, rate, duration, and mechanism of administration i.e., pump or bolus syringe, and water flushes. The licensed competent nurse will provide enteral meals, provide oversight for the pump if used, and connect and/or disconnect gastrostomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) from pump or bolus meals and supplements; -Unless otherwise indicated by the physician, the licensed nurse will be responsible for: -Change administration sets daily; -Before hanging/adding any solution, review expiration date; -Change syringes, tubing or bottles used for tube feeding daily. Label and date items; -Procedure for Enteral Tube Feeding via Electronic Pump included: -Verify the practitioner's order, including the resident's identifiers; prescribed route based on the enteral tube location; enteral feeding device; prescribed formula; administration method, volume, and rate; type, volume, and frequency of water flushes; -Label the administration set with the date and time of administration including licensed nurse initials; -Prime the enteral administration set according to manufacturer's recommendations. 1. Review of Resident #175's medical record, showed: -admitted [DATE]; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included person injured in motor-vehicle accident, stroke, unspecified multiple injuries sequela (aftereffect of a disease, condition, or injury), gastrostomy status, and depression. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident with potential for altered nutrition status/nutrition related problems due to stroke, polytrauma from motor vehicle accident, depression, and respiratory failure with hypoxia (low levels of oxygen in body tissues). Enteral pump Osmolite (high protein and high calorie tube feeding formula) 1.5 cal, 65 milliliters (ml)/hour, 20 hours/day between 2:00 P.M., and 10:00 A.M.; -Goals included: Resident to maintain weight without significant change. Resident to maintain/improve skin integrity. Resident to receive/tolerate diet as ordered; -Interventions/tasks included: Observe for signs and symptoms of aspiration/dysphagia (swallowing disorder); -Focus: Resident requires tube feeding through g-tube; -Goal: Resident will maintain adequate nutrition and hydration status through review date. Resident will remain free of complications through review date; -Interventions/tasks included: Check for placement and residuals per policy. Monitor intake of enteral tube feeding. Provide tube feeding per medical provider orders. Review of the resident's electronic Physician Order Sheet (ePOS), showed: -An order, dated 7/29/24, for enteral feed in the afternoon, closed system container is used, change feeding administration with each new bottle. Scheduled for 2:00 P.M.; -An order, dated 7/29/24, for enteral feed in the afternoon, label the formula container, syringe, and administration set with the resident's name, date, time, and initials. Scheduled for 2:00 P.M.; -An order, dated 7/29/24, for enteral feed every shift, Osmolite 1.5 cal, 65 ml/hour 20 hours/day between 2:00 P.M. and 10:00 A.M. Observations on 8/9/24 at 6:46 A.M., 8:58 A.M., 9:32 A.M., and 10:28 A.M., showed the resident on his/her right side in bed. A tube feeding pole was positioned to the right of the resident's bed with no tube feeding formula or water hung on the pole. The resident was unable to be interviewed. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR), showed staff documented the resident's orders for tube feeding as administered during day shift on 8/9/24. Observation on 8/12/24 at 8:22 A.M., showed the resident on his/her back in bed. A bag of tube feeding formula hung on the pole to the right of the resident's bed. The bag of formula was undated and unlabeled with approximately 425 milliliters of formula remaining in the bag. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/13/24 at 7:02 A.M. and 9:02 A.M., showed the resident on his/her back in bed. A bottle of Osmolite 1.5 cal hung on the pole to the right of the resident's bed. The bottle of Osmolite was dated 8/13/24 at 6:00 A.M., with no nurse initials documented. During an interview on 8/14/24 at 10:49 A.M., the Director of Nurses (DON) said the resident receives continuous tube feeding. He/She is total care and is at risk for poor nutrition. 2. Review of Resident #65's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/29/24, showed: -Diagnoses included dysphagia (difficulty swallowing) following stroke, gastrostomy status, hemiplegia and hemiparesis (loss of function and feeling in the limbs) following stroke, and unspecified speech disturbances; -Severe cognitive impairment; -Nutritional assistance provided by enteral supplement and receives more than 51% of total caloric intake via enteral feeding. Review of the resident's care plan, dated 12/23/23, showed: -A focus of requiring tube feeding for nutritional support, with a goal of maintaining adequate nutrition and hydration status through the review date. Interventions included monitoring tube feeding intake and administering tube feedings per medical provider order. Review of the resident's ePOS, showed an order entered on 12/27/23, for Glucerna (a calorie-dense liquid formula for enteral feeding) 1.5 to be run at 75 ml/hour for 20 continuous hours at a time with 4 hours of bowel rest. The order indicated the tube feeding should be started at 2:00 P.M. and should be stopped after a total volume of 1500 ml was infused to provide 2,250 calories. Observation on 8/9/24 at 10:28 A.M., showed the resident in a chair with the enteral feeding not infusing. Observation on 8/12/24 at 8:31 A.M., showed the resident in bed with the enteral feeding not infusing. The bottle of tube feeding formula was marked as hung at 2:00 P.M. on 8/11/24 with approximately 450 ml left in the container. Observation on 8/12/24 at 9:11 A.M., showed the resident in his/her chair with the enteral feeding not infusing. The bottle of tube feeding formula was marked as hung at 2:00 P.M. on 8/11/24 with approximately 450 ml left in the container. Observation on 8/12/24 at 11:18 A.M., showed the resident in his/her chair with the enteral feeding not infusing. The bottle of tube feeding formula was marked as hung at 2:00 P.M. on 8/11/24 with approximately 450 ml left in the container. Observation on 8/12/24 at 1:21 P.M., showed the resident in bed on his/her left side with the enteral feeding not infusing. The bottle of tube feeding formula was marked as hung at 2:00 P.M. on 8/11/24 with approximately 450 ml left in the container. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/12/24 at 2:32 P.M., showed the resident resting in bed with the enteral feeding not infusing to the patient. The bottle of tube feeding formula was marked as hung at 2:00 P.M. on 8/11/24 with approximately 450 ml left in the container. During the observation, the resident's roommate said he/she had not seen staff in the room hanging or adjusting the enteral feeding all day. Observation on 8/13/24 at 7:35 A.M., showed the resident in bed with the enteral feeding infusing at a rate of 65 ml per hour with approximately 300 ml left in the container. The enteral feed was marked as hung at 2:00 P.M. on 8/12/24 with orders on the bottle to run the feeding at 75 ml per hour. Observation on 8/14/24 at 7:48 A.M., showed the resident in bed with the enteral feeding infusing at a rate of 65 ml per hour and approximately 100 ml had been infused. The enteral feed was marked as hung at 6:30 A. M. on 8/14/24 with orders on the bottle to run the feeding at 75 ml per hour. 3. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Diagnoses included kidney failure, type 2 diabetes mellitus, and Behcet's disease (inflammatory disorder that affects the body's blood vessels); -Severe cognitive impairment. Review of the resident's care plan, dated 7/23/24, showed: -Focus: resident requires tube feeding; -Goal: resident will maintain adequate nutrition and hydration status though review date; -Interventions: provide tube feeding per medical provider order. Review of the resident's ePOS, showed an order, dated 4/29/24, for enteral feed every shift for formula intake, 75 ml/hour, on at 8:00 P.M. and off at 6:00 A.M Observation on 8/12/24 at 7:15 A.M., showed the resident asleep in bed. The resident's feeding tube machine was on and unattached from the resident. The bottle of formula was dated 8/9/24 and had 400 ml in the bottle. 4. Review of Resident #107's quarterly MDS, dated [DATE] showed: -Diagnoses included gastrostomy, muscle weakness and morbid obesity; -Severe cognitive impairment. Review of the resident's care plan, dated 6/7/24, showed: -Focus: resident requires tube feeding; -Goal: resident will be maintain adequate nutrition and hydration status though review date; -Interventions: monitor intake of enteral tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's ePOS, showed an order, dated 5/2/24, for enteral feed every shift for formula intake, Jevity (calorically dense tube feeding formula) 1.5 at 65 ml/hour, on at 2:00 P.M. and off at 10:00 A.M Observation on 8/8/24 at 1:24 P.M., showed the resident's feeding tube pump was on and connected to the resident. The pump was set at 75 ml/hour. Observation on 8/14/24 at 7:44 A.M., showed the resident's feeding tube pump was on and connected to the resident. The pump was set at 75 ml/hour with 143 ml already infused. 5. During an interview on 8/13/24 at 7:04 A.M., Licensed Practical Nurse (LPN) F said residents with orders for continuous tube feeding should receive their tube feeding as ordered during the timeframe documented in the orders. If a resident is supposed to receive tube feeding from 2:00 P.M. to 10:00 A.M. and the formula runs out during this timeframe, the nurse should discard the empty container and hang a new container of formula. Tube feeding containers should be labeled with the date, time, and nurse's initials. Tube feeding should be provided as ordered to ensure residents receive adequate nutrition. During an interview on 8/13/24 at 7:08 A.M., LPN E said nurses should follow physician orders for tube feeding. When they hang the formula, the nurse should document the date, time, resident information, and nurse's initials on the tube feeding bottle. They should check the machine to make sure the formula is infusing at the correct rate. If the formula runs out during the time that the tube feeding is supposed to be on, the nurse should hang another bottle of formula until it is time for the tube feeding to stop. If a resident is supposed to receive tube feeding from 2:00 P.M. to 10:00 A.M., they should receive their tube feeding continuously throughout this time frame. During an interview on 8/13/24 at 11:58 A.M., LPN A said residents receiving tube feeding should have physician orders specifying the formula, infusion rate, care, and flushes. Most residents have orders for tube feeding to be on at 2:00 P.M. and off at 10:00 A.M. to give them four hours of tummy time, to let their stomachs rest. If a resident's formula runs out during the 2:00 P.M. to 10:00 A.M. timeframe, the nurse should hang a new bag. All tube feeding bags should be labeled with the formula used and the date, time, resident name, and nurse initials. If a resident's tube feeding needs to be cut off early for a particular reason, the nurse should document the reason for this in the resident's record. During an interview on 8/14/24 at 8:24 A.M., LPN D said the facility's Registered Dietician (RD) had staff enter orders for tube feeding to be on at 2:00 P.M. and off at 10:00 A.M. This can be challenging for staff to ensure all tube feedings are hung at this time. Staff need to pre-prep their supplies before the window opens and treat hanging the bags like any other medication, ensuring the tube feeding goes on or comes off within an hour before or after their tube feeding is scheduled. He/She is not sure why there is a four hour window for the tube feeding to be off when the resident receives continuous tube feeding. When the nurse hangs the formula, they are supposed to date, time, and write the patient's initials on the container. The nurse should ensure residents receive tube feeding based on the physician orders. If the formula runs out during the specified time frame, the nurse should remove the old container and hang a new container. When a new container is hung, the nurse should reset the tube feeding machine. Nurses are expected to ensure the tube feeding is infusing at the correct rate per physician orders and to change the rate if it is found to be incorrect. It is important for residents to receive tube feeding per physician orders to promote nutritional support. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 8/14/24 at 10:49 A.M., the Director of Nurses (DON) said residents receiving tube feedings should have physician orders for the formula type, infusion rate, flushes, and monitoring. Most residents have orders for their tube feeding to be on at 2:00 P.M. and off at 10:00 A.M., but she is not sure why the orders are written that way. A resident should have formula hung at all times during the window indicated in their orders. If the formula runs out, the nurse should hang a new bag. Bags should be labeled with the date, time, resident room number and staff initials. When a new bag is hung, the tube feeding should be reset. She just found out some of the nurses do not know how to reset the volume on the machine without resetting the whole machine. She expected nurses to ensure residents are receiving tube feeding at the appropriate rate and in accordance with physician orders to ensure proper nutrition is met. If a resident is not tolerating a tube feeding and the tube feeding is stopped, she expected the nurse to document this in the resident's medical record and to notify the physician. 7. During an interview on 8/14/24 at 12:17 P.M., the Administrator said she expected staff to follow physician orders for tube feeding. She expected staff to label and date tube feeding formula in accordance with the DON's expectations. She expected staff to ensure tube feeding is on at all times in accordance with the physician orders. She expected residents to receive tube feeding in accordance with physician orders to ensure appropriate nutritional intake. 44948 46888

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure residents receiving dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) had physician orders for dialysis and/or documented assessments and monitoring related to dialysis, and ongoing documented communication with the dialysis center. The facility identified seven residents as receiving dialysis, of which four were sampled and problems were identified with all four (Residents #111, #46, #50 and #26). The sample was 24. The census was 120. Review of the facility's Hemodialysis Care and Monitoring policy, undated, showed: -General Vascular Access Device (VAD, device that allows repeated and long-term access to the blood stream) Care and Precautions: --Monitor for infection; --Thrill: Normal sensation felt at site of anastomosis (connection between two passageways) for grafts (access made using a piece of soft tube to join an artery and vein) and fistulas (access made by joining an artery); --Bruit: Normal sensation heard with stethoscope as swishing sound at anastomosis for grafts and fistulas; -Pre-Dialysis: --a. Evaluation completed within four hours of transportation to dialysis to include but not limited to: -Accurate weight; -Blood pressure, pulse, respirations and temperatures; --b. Medications administered of medications withheld prior to dialysis; --d. Send copy of nursing evaluation with resident to dialysis center; -Post-Dialysis: --Nurse to review notes from dialysis center; --Post-dialysis notes will be uploaded into electronic health record; --Nurse to complete the post-dialysis evaluation upon return from dialysis center to include but not limited to: ---Thrill absence of presence for graft or fistula VAD; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	---Bruit absence or presence for graft or fistula VAD; ---Pulse in access limb; ---Visual inspection of site for bleeding, swelling, or other abnormalities; ---Any abnormal or unusual occurrence resident reports while at dialysis center; -The policy failed to provide guidance to staff on obtaining physician orders for dialysis, including dialysis schedule, and pre and post-dialysis monitoring. 1. Review of Resident #111's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/19/24, showed: -Cognitively intact; -Rejection of care behavior not exhibited;. -Diagnoses included kidney failure; -Dialysis received while a resident. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident is currently on dialysis therapy, end stage renal disease (ESRD, kidney failure). Right clavicle (collarbone) port. 7/25/24, dialysis days have changed to Monday, Wednesday, Friday; -Goal: Resident will be free of signs/symptoms of complications from hemodialysis through review date; -Interventions/tasks included: Communicate with dialysis center regarding medications, vital signs, weights, any restrictions, diet orders, nutritional/fluid needs, lab results, and who to notify with concerns. Coordinate resident's care in collaboration with dialysis center. Evaluate port for bleeding. Evaluate resident following dialysis treatment and report abnormal findings. Hemodialysis - port, do not remove dressing applied by dialysis center. Monitor vitals. Review of the resident's electronic medical record (EMR), showed: -No physician order for dialysis or monitoring of dialysis site; -No pre or post-dialysis evaluations documented. During an interview on 8/9/24 at 9:01 A.M., the resident said he/she goes to dialysis on Monday, Wednesday, and Friday. He/She could not recall if facility staff perform pre or post-dialysis assessments. 2. Review of Resident #46's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnoses included heart failure, kidney failure and diabetes; -Dialysis received. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is currently on dialysis; -Interventions: -Administer medications per medical provider's orders; Observe for side effects and effectiveness; On dialysis days, administer medications, before or after dialysis according to medical providers orders; Report abnormal findings to the medical provider, nephrologist (kidney specialist), dialysis center, and the resident's representative; -Communicate with dialysis center regarding medications, vital signs, weights, any restrictions, diet orders, nutritional or fluid needs, lab results, and who to notify with concerns; -Coordinate resident care in collaboration with dialysis center; -Evaluate Arterial Venous (AV) fistula, for bleeding; If bleeding occurs, apply continuous direct pressure to site for at least five minutes, if unable to stop the bleeding call 9-1-1; Report abnormal findings hemorrhage (bleeding) to the access site, signs, and symptoms of infection to medical provider, nephrologist, dialysis center, and the resident's representative; -Evaluate resident following dialysis treatment; Report abnormal findings to medical provider, nephrologist, dialysis center, and the resident's representative; -Monitor vitals; Report abnormal findings to medical provider, nephrologist, dialysis center, and the resident's representative; -Obtain and monitor lab and diagnostic studies, as ordered; Report abnormal findings to the medical provider, nephrologist, dialysis center, and the resident's representative; -Obtain weight as ordered; Report abnormal fluctuations to medical provider, nephrologist, dialysis center, and resident's representative; -Provide diet as ordered; Plan meal and snacks around dialysis center schedule; -Encourage resident to follow prescribed diet including fluid restrictions if applicable. Review of the resident's electronic Physician Order Sheet (ePOS) dated August, 2024, showed an order with a revision date, 6/23/24, dialysis Monday, Wednesday and Friday. No further orders related to dialysis were noted. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 8/8/24 at 10: 57 A.M., the resident said he/she has been going to dialysis for several months, three days a week. The facility transports him/her to dialysis early in the morning and he/she gets back before lunch. The resident had a dressing to his/her left upper arm. The resident pointed to the area to his/her left upper arm and said that is where they connect him/her to dialysis machine. The resident could not recall the staff checking his/her dialysis site or dressing. He/She normally just tells the staff when he/she is not feeling well. He/She gets weighed at the dialysis center. There are days that he/she feels swollen but thinks it is the medication he/she has been receiving. 3. Review of Resident #50's quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -Diagnoses included heart failure, kidney failure, respiratory failure and diabetes; -Dialysis received. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is currently on dialysis, access site right upper chest port; -Interventions: -Administer medications per medical provider's orders; Observe for side effects and effectiveness; On dialysis days, administer medications, before or after dialysis according to medical providers orders; Report abnormal findings to the medical provider, nephrologist, dialysis center, and the resident's representative; -Communicate with dialysis center regarding medications, vital signs, weights, any restrictions, diet orders, nutritional or fluid needs, lab results, and who to notify with concerns; -Coordinate resident care in collaboration with dialysis center; -Evaluate the dialysis port site, for bleeding; If bleeding occurs, apply continuous direct pressure to site for at least five minutes, if unable to stop the bleeding call 9-1-1; Report abnormal findings hemorrhage to the access site, signs, and symptoms of infection to medical provider, nephrologist, dialysis center, and the resident's representative; -Evaluate resident following dialysis treatment; Report abnormal findings to medical provider, nephrologist, dialysis center, and the resident's representative; -Monitor vitals; Report abnormal findings to medical provider, nephrologist, dialysis center, and the resident's representative; -Obtain and monitor lab and diagnostic studies, as ordered; Report abnormal findings to the medical provider, nephrologist, dialysis center, and the resident's representative; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Obtain weight as ordered; Report abnormal fluctuations to medical provider, nephrologist, dialysis center, and resident's representative; -Provide diet as ordered; Plan meal and snacks around dialysis center schedule; -Encourage resident to follow prescribed diet including fluid restrictions if applicable. Review of the resident's ePOS, dated August, 2024, showed an order revised, 6/10/24, to check dialysis site for signs and symptoms of infection every shift. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated July, 2024 and August, 2024, showed no order to check the resident's dialysis site. No further orders related to dialysis were noted. During observation and interview on 8/8/24 at 10:15 A.M., the resident sat in his/her electric wheelchair and on his/her right upper chest, a dialysis port was present with a dressing covering it. The resident said he/she had a dialysis port to his/her right upper chest for about three months and will be getting a permanent site in his/her arm in a couple of weeks. The resident said he/she went to dialysis three days a week and leaves before 6:00 A.M. He/She wasn't sure what type of assessments the facility completed before and after dialysis. He/She sometimes gets his/her vital signs checked on dialysis days. 4. Review of Resident #26's quarterly MDS, dated [DATE], showed the following: -Diagnoses of type 2 diabetes mellitus and end stage renal disease; -Cognitively intact. Review of the resident's care plan, dated 7/23/24, showed: -Focus: resident requires hemodialysis on Tuesday, Thursday, and Saturday; -Goal: resident will have no complications relate to fluid overload through the review date; -Interventions: monitor, document, report for side effects of acute renal failure, monitor, document, report to medical director the following symptoms: edema; weight gain of over 2 pounds a day; neck vein distension; difficulty breathing (dyspnea); increased heart rate (tachycardia); elevated blood pressure, skin temperature; peripheral pulses; level of consciousness ; monitor breath sounds for crackles. Review on 8/12/24 at 9:59 A.M., of the resident's ePOS, showed no order to check bruit (an audible vascular sound associated with turbulent blood flow) and thrill (a palpable vibration on the skin over the area of turbulent blood flow). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said residents receiving dialysis should have physician orders for dialysis that reflect the residents' dialysis dates. They should also have orders to check the resident's dialysis site for bruit and thrill, and signs/symptoms of infection at the dialysis site. Before a resident goes to dialysis, the nurse should obtain the residents' weights and full vital signs. They should document their findings on a form that goes out with the resident to the dialysis center. The dialysis center fills out their portion on the form and sends it back to the facility with the resident. If the resident returns to the facility without their dialysis form, the nurse should call the dialysis center and document the communication as a progress note in the resident's EMR. The facility nurse should complete a post-dialysis assessment and document it under Assessments in the EMR. During an interview on 8/14/24 at 8:24 A.M., LPN D said residents receiving dialysis should have physician orders for dialysis including dialysis days and chair time, dialysis location, and transportation to and from dialysis. The resident should have physician orders to monitor bruit and thrill and monitoring the port site, including monitoring for bleeding and signs/symptoms of infection. The facility changed ownership two weeks ago. Prior to the change in ownership, nurses were completing pre-dialysis assessments on a form printed from the EMR. They sent the form with the resident to the dialysis center. The dialysis center filled out their portion of the assessment and sent it back to the facility with the resident. The facility nurse would review the form and then complete a post-dialysis assessment. Facility pre and post dialysis assessments included assessment of vital signs, new orders, medications, and other pertinent information. If a resident returned to the facility from dialysis without the assessment form, the nurse was supposed to contact the dialysis center and enter it as a progress note in the EMR. Since the change in ownership, the facility is transitioning to another dialysis communication sheet. 6. During an interview on 8/14/24 at 10:49 A.M., the Director of Nurses (DON) said residents should have physician orders for dialysis to include days, times, and location of dialysis. They should have physician orders to monitor the graph or fistula sign for bleeding, infection, and redness. Before the recent change in ownership, the nurse completed pre-dialysis assessments on a form that was printed out from the EMR. This form went with the resident to the dialysis center and the dialysis center staff filled out their part of the assessment on the form. The form was returned to the facility and reviewed by the facility nurse during their post-dialysis assessment. Any assessment completed before the change in ownership is no longer accessible. The EMR has changed due to the change in ownership, and now the facility only has one dialysis assessment tool labeled as Pre-Dialysis, which is confusing to staff because they don't know this form also includes the post-dialysis assessment. The facility is working on developing a new system for pre and post-dialysis assessments and communication due to the change in ownership. 7. During an interview on 8/14/24 at 12:17 P.M., the Administrator said she expected residents receiving dialysis to have physician orders for dialysis that include date, time, and location of dialysis, as well as monitoring dialysis sites. She expected nursing staff to have a system for completing pre and post dialysis assessments, and a system for communicating with the dialysis center. She expected this information to be maintained in the resident's EMR. 42795 46888

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 46888 Based on observation, interview and record review, the facility failed to ensure residents were assessed for the use of side rails, failed to obtain consents for use of side rails, failed to obtain therapy/nursing assessments and/or failed to obtain a physician's order for the use of side rails (Residents #76, #175, #25, #11, #38, and #116). The facility identified 25 residents with side rails in use, and did not include Residents #76, #175, #25, #38 and #116 on the list. The sample was 24. The census was 120. Review of the facility's safe use of bed rails policy, undated, showed: - Policy: It is the policy of this facility to provide resident centered care that meets the safety, psychosocial, physical and emotional needs and concerns of the residents. The corporation prohibits the use of bed rails as a restraint. The facility will assess the residents' cognition and therapeutic need of the bed rail to assist the resident in reaching their highest potential of independence. A physician order is required to implement the use of bed rails; -Procedure: Assessment of residents with bed rails include: level of independence with bed mobility, review of prior interventions and outcomes prior to the initiation of bed rails, medical diagnosis, conditions, symptoms, and/or behavioral symptoms should be evaluated prior to initiation and bed meets manufacturer's recommendations and specifications pertaining to resident's height and weight. -Monitoring: Bed Safety Evaluation is completed upon admission, quarterly, and as needed such as a significant change in condition. -Documentation: Physician Orders (POS) is required, completion of Bed Safety Evaluation, consent obtained for bed rail use, education provided to the resident or, if applicable, resident representative and care plan for the use/need for bed rails. 1. Review of Resident #76's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/15/24, showed: -Cognitively intact; -Lower extremity impairment on one side; -Partial/moderate assistance required to roll left and right; -Diagnoses included morbid obesity, acquired absence of the right leg above the knee, and acquired absence of the left leg below the knee. (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, in use at the time of survey, showed no documentation regarding the use of side rails. Review of the resident's medical record, showed: -No physician orders for the use of side rails; -No therapy or nursing assessment for the use of side rails; -No consent for the use of side rails. Review of the facility's maintenance bed rail log, dated 8/14/24, showed the resident not listed. Observation on 8/9/24 at 6:49 A.M., showed half-length side rails raised on both sides at the head of the bed. During an interview, the resident said he/she uses the side rails to pull him/herself up in bed. Observation on 8/12/24 at 6:19 A.M., showed the resident on his/her back in bed with half-length side rails raised on both sides at the head of the bed. 2. Review of Resident #175's medical record, showed: -admitted [DATE]; -Diagnoses included person injured in motor-vehicle accident, stroke, and unspecified multiple injuries sequela (after-effect of a disease, condition, or injury); -No physician order for the use of side rails; -No therapy or nursing assessment for the use of side rails; -No consent for the use of side rails. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Activities of Daily Living (ADL) self-care performance deficit; -Interventions included: Lying to sitting on side of bed - totally dependent of two or more (helpers do all the effort, resident does none of the effort). Roll left and right - totally dependent of one (helper does all the effort); -No documentation regarding the use of side rails. Review of the facility's maintenance bed rail log, dated 8/14/24, showed the resident not listed. Observations on 8/8/24 at 11:47 A.M., 1:41 P.M., and 5:12 P.M., showed the resident on his/her right side in bed with quarter-length side rails raised on both sides at the head of the bed. The resident was nonverbal and unable to be interviewed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/9/24 at 6:46 A.M., 8:58 A.M., 9:32 A.M., 10:28 A.M., 12:02 P.M., and 1:31 P.M., showed the resident on his/her right side in bed with quarter-length side rails raised on both sides at the head of the bed. Observations on 8/12/24 at 5:19 A.M., 6:19 A.M., 8:22 A.M., 11:44 A.M., and 1:25 P.M., showed the resident on his/her back in bed with quarter-length side rails raised on both sides at the head of the bed. Observations on 8/13/24 at 7:02 A.M., 9:02 A.M., and 11:10 A.M., showed the resident on his/her back in bed with quarter-length side rails raised on both sides at the head of the bed. 3. Review of Resident #25's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Lower extremity impairment on both sides; -Substantial/maximal assistance required to roll left and right; -Diagnoses included multiple sclerosis (disease of the central nervous system), Parkinson's disease (brain disorder causing unintended or uncontrolled movements), unspecified tremors, generalized muscle weakness, other lack of coordination, and repeated falls. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding the use of side rails. Review of the resident's medical record, showed: -No physician orders for the use of side rails; -No therapy or nursing assessment for the use of side rails; -No consent for the use of side rails. Review of the facility's maintenance bed rail log, dated 8/14/24, showed the resident not listed. 4. Review of the Resident #111's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Lower extremity impairment on both sides; -Dependent on assistance to roll left and right; -Diagnoses included other lack of coordination, generalized muscle weakness, and other reduced mobility. Review of the resident's care plan, in use at the time of survey, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident has an ADL self-care performance deficit, requires assistance with ADLs; -Interventions included: Quarter rail to enable independent bed mobility. Review of the resident's medical record, showed no physician order for the use of side rails. Observations on 8/8/24 at 12:03 P.M. and 2:14 P.M., showed the resident on his/her back in bed with U-shaped rails raised on both sides at the head of the bed. Observations on 8/9/24 at 9:01 A.M., 10:31 A.M., and 12:02 P.M., and 8/12/24 at 8:26 A.M. and 11:43 A.M., showed the resident in bed with U-shaped rails raised on both sides at the head of the bed. 5. Review of Resident #38's quarterly MDS, dated [DATE] showed the following: -Diagnoses included quadriplegia (paralysis that affects the limbs and body from the neck down) and muscle weakness; -Cognitively intact. Review of the resident's medical record, showed: -A physician order dated 4/30/24, for 1/4 bilateral side rails to promote independence with activities of daily living. -No therapy or nursing assessment for the use of side rails; -No consent for the use of side rails. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding the use of side rails. Review of the facility's maintenance bed rail log, dated 8/14/24, showed the resident not listed. Observation on 8/9/24 at 10:24 A.M., showed assist rails on the resident's bed. 6. Review of Resident #116's quarterly MDS, dated [DATE], showed the following: -Diagnoses included acute kidney failure, diabetes, and Behcet's disease (inflammatory disorder that affects the body's blood vessels); -Severe cognitive impairment. Review of the resident's medical record, showed: -No physician orders for the use of side rails; -No therapy or nursing assessment for the use of side rails; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No consent for the use of side rails. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding the use of side rails. Review of the facility's maintenance bed rail log, dated 8/14/24, showed the resident not listed. Observation on 8/8/24 at 10:26 A.M., showed 1/4 bilateral side rails on the bed. 7. During an interview on 8/13/24 at 7:08 A.M., Licensed Practical Nurse (LPN) E said therapy assesses residents for the use of side rails. The resident should have a physician order for the use of side rails, specifying what type of side rail is used. The order shows up as a treatment for nurses on the treatment administration record (TAR) and nurses complete side rail risk assessments quarterly. Maintenance installs side rails on resident beds. During an interview on 8/13/24 at 11:58 A.M., LPN A said nurses do a side rail assessment on residents upon admission. The nurse obtains a physician order for the side rails. The order does not specify what type of side rail is used, it just says side rail. Once an order is obtained, the nurse notifies maintenance and they install the side rail on the resident's bed. During an interview on 8/14/24 at 8:24 A.M., LPN D said therapy determines whether or not a resident needs a side rail. Nursing can let therapy know if they think a side rail would be helpful for a resident. Therapy screens the resident and they can get the physician order for the use of side rail. Maintenance installs the side rail. 8. During an interview on 8/14/24 at 9:35 A.M., the Maintenance Director said nursing tells him if a resident needs side rails. He installs the side rails that correspond to the resident's bed and then inspects them weekly. He does not know to inspect side rails unless he is aware the resident has side rails on their bed. Sometimes residents change rooms and he needs to be informed of this so he can track the side rails. He was not aware Residents #76 and #175 had side rails on their beds. 9. During an interview on 8/17/24 at 10:49 A.M., the Director of Nurses (DON) said the facility changed ownership about two weeks ago. Prior to the change in ownership, side rails were assessed by therapy and the Administrator. Under the new ownership, nurses will be assessing for the use of side rails. She does not recall Resident #76 being on the list of residents with side rails. Any resident with side rails should have physician orders and resident/resident representative consent for the use of side rails. The facility has not had a clinical meeting yet to discuss implementation of the new policies under the new ownership. 10. During an interview on 8/17/24 at 12:17 P.M., the Administrator said under the previous ownership, therapy assessed for the appropriateness of side rails, then nursing completed a side rail assessment. Nursing would get a physician order for the use of side rails and add the use of side rails to the resident's care plan. Nursing would get consent from the resident or resident representative for the use of side rails and then maintenance would install the side rails. Maintenance inspects side rails weekly. If a resident moves rooms or has new orders for side rails, this should be communicated to maintenance. Under the new ownership, the process for side rails may be different. Clinical training with staff regarding the new ownership's policies has not taken place yet.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40290 Based on observation and interview, the facility failed to offer and provide snacks at bedtime. The sample was 24. The census was 120. During a group interview on 8/12/24 at 10:36 A.M., four residents, who the facility identified as alert and oriented, were in attendance. The residents said the facility used to offer snacks at night, after dinner, and the snacks were kept at the nurse's station. The facility stopped serving snacks in the evening about two to three weeks ago. Observation on 8/12/24 at 6:00 A.M., showed no snacks at the nurse's station on the Serenity hall. Observation on 8/12/24 at 6:17 A.M., showed no snacks at the nurse's station on the Harmony hall. Observation on 8/13/24 at 7:08 A.M., showed no snacks at the nurse's station on the Harmony hall. During an interview, Licensed Practical Nurse (LPN) E said there were no snacks kept at the nurse's station or in the medication room by the nurse's station. Snacks are provided during day shift. Observation on 8/14/24 at 6:33 A.M., showed no snacks at the nurse's station on the Serenity hall. During an interview on 8/14/24 at 8:02 A.M., Certified Nurse Aide (CNA) C said he/she works day and evening shift. Staff pass around snacks during the day. Snacks used to be put out at the nurse's station for evening shift to pass out, but dietary stopped doing this at least a few weeks ago. He/She has not seen snacks on the evening shift in a while now. During an interview on 8/14/24 at 7:42 A.M., the Dietary Manager said residents are supposed to be offered snacks at night. She has dietary staff send out one tray of snacks for each hall at 8:00 P.M. The snacks are kept at the nurse's station. There has been a problem with the nursing staff eating the snacks. During an interview on 08/14/24 at 10:49 A.M., the Director of Nurses (DON) said evening snacks used to be kept at the nurse's station. She was not aware residents were not provided with snacks at bedtime. She expected evening snacks to be provided to residents. During an interview on 8/14/24 at 12:17 P.M., the Administrator said dietary started a new process a couple weeks ago where snacks were put out at each nurse's station, and a cart of snacks was put out at the nurse's station on the Serenity hall. She was not aware snacks were not provided at night. She expected residents be offered and provided snacks at night.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to provide appropriate assistive devices to residents who needed them to assist the residents in eating independently (Residents #25 and #110). The sample was 24. The census was 120. 1. Review of Resident #25's medical record, showed diagnoses included Parkinson's disease (brain disorder causing unintended or uncontrolled movements) with dyskinesia (uncontrolled, involuntary muscle movements), abnormal posture, muscle weakness and other lack of coordination. Review of the resident's electronic Physician Order Sheet (ePOS), showed: -An order, revised 1/15/24, for divided plate for meals; -An order, dated 2/27/24, for built-up utensils for meals. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/30/24, showed: -Cognitively intact; -Setup or clean-up assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has activities of daily living (ADLs) self-care performance deficit; -Interventions included: Eating - supervision/touching assist (helper cues and/or touches/steadies resident); -Focus: Resident is at risk for nutritional decline related to Multiple Sclerosis (MS, disease in which the immune system eats away at the protective covering of nerves) and Parkinson's disease, receives a regular diet with risks for weight changes and variable intake; -Interventions included: Provide assistance with meals as needed; -The care plan failed to identify the resident's need for a divided plate and built-up utensils for meals. Review of the resident's dietary ticket, showed divided plate. No documentation regarding built-up utensils. Observation on 8/9/24 at 8:24 A.M., showed the resident eating breakfast in the dining room, using regular utensils. Scrambled eggs were served in a divided plate. The resident struggled to use his/her left hand to hold the regular fork, [NAME] small bits of eggs onto the fork. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/12/24 at 8:29 A.M., showed the resident eating breakfast in the dining room, using regular utensils. A scoop of scrambled eggs was in a small bowl and two slices of bacon were served on a small plate. Scrambled eggs were all over the resident's lap. During an interview, the resident said he/she is supposed to receive all meals in a divided plate, but his/her breakfast was served in small bowls and plates today. The kitchen staff said they can't find his/her divided plate. He/She is supposed to get built-up utensils because of his/her hands. His/Her hands are in pain and have shakiness, which is why he/she should get the bigger utensils to help him/her eat. He/She spilled his/her eggs on his/her lap because he/she shakes too much. Observation on 8/13/24 at 8:03 A.M., showed the resident eating breakfast in the dining room, using regular utensils. Scrambled eggs were served in a divided plate. The resident struggled to use his/her left hand to hold the regular fork with the scrambled eggs. During an interview, the resident said he/she had a hard time eating some of the food without built-up utensils. Observation on 8/14/24 at 7:40 A.M., showed the resident in the dining room, eating cold cereal with a regular spoon. During an interview on 8/14/24 at 8:02 A.M., Certified Nurse Aide (CNA) C said the resident is supposed to get a divided plate at all meals. He/She gets very upset when he/she does not get the divided plate and he/she will leave the table instead of eating. CNA C did not know the resident was supposed to get built-up utensils. This should be on his/her dietary ticket. 2. Review of Resident #110's medical record, showed diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following stroke affecting left non-dominant side, dysphagia (swallowing disorder), abnormal posture, generalized muscle weakness, other lack of coordination, and disorientation. Review of the resident's ePOS, showed an order, dated 1/26/24, for a divided plate for meals. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Upper extremity impairment on one side; -Setup or clean-up assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has an ADL self-care performance deficit; -Interventions included: Eating - setup/clean-up assistance (helper sets up or cleans up). -Focus: Resident is at risk for nutritional decline related to diabetes, history of stroke, and high blood pressure. Receives a regular diet with risks for weight changes and variable intake, dysphagia; -Interventions included: Divided plate with meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's dietary ticket, showed no documentation regarding a divided plate. During an interview on 8/8/24 at 12:46 P.M., the resident exhibited some confusion when asked about meals and assistance. Observation on 8/9/24 at 8:32 A.M., showed the resident was served mechanical-soft meat and scrambled eggs on a regular plate. Observation on 8/9/24 at 1:03 P.M., showed the resident was served mechanical-soft meat and macaroni and cheese on a regular plate. Observation on 8/13/24 at 8:09 A.M., showed the resident sat in the dining room with scrambled eggs on a regular plate. Scrambled eggs were on the table surrounding the plate and on the resident's lap. During an interview on 8/14/24 at 8:02 A.M., CNA C said he/she did not know the resident was supposed to get a divided plate. The resident feeds him/herself ok, but gets food all over his/her lap. Maybe the resident would not get food all over his/her lap if he/she had a divided plate. 3. During an interview on 8/13/24 at 7:50 A.M., Dietary Aide (DA) L said he/she was not sure how many sets of built-up utensils the kitchen had. The residents' dietary tickets show dietary staff which residents require divided plates and built-up utensils. The nurse manager or dietician notifies dietary staff. 4. During an interview on 8/14/24 at 7:31 AM., CNA B said dietary staff should ensure adaptive equipment goes out on the resident's tray at meals. Nursing staff should help ensure these items are there by checking the resident's dietary ticket. 5. During an interview on 8/14/24 at 8:02 A.M., CNA C said nursing staff should check dietary tickets before passing trays to make sure everything is there that is supposed to be there. Adaptive equipment should be indicated on the resident's dietary ticket. 6. During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said dietary staff is responsible for ensuring residents are provided with adaptive equipment, such as divided plates and built-up utensils. He/She expected residents to be provided with adaptive equipment as ordered to help residents with eating. 7. During an interview on 8/14/24 at 8:24 A.M., LPN D said dietary staff should ensure residents have adaptive equipment during meals. Adaptive equipment should be listed on a resident's dietary ticket. Nursing staff should check the dietary ticket to make sure the adaptive equipment is there, and then notify dietary if the item is missing. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. During an interview on 8/14/24 at 7:42 A.M., the Dietary Manager (DM) said the kitchen has a sufficient supply of divided plates and built-up utensils. Nursing staff enter diet orders into the electronic medical record (EMR), and that information imports over to the tickets used by dietary. If therapy issues orders for a resident to have adaptive equipment, they should bring her that recommendation. Dietary staff rely on the dietary tickets when setting up trays and she expected staff to follow the instructions on the tickets. Resident #25 normally gets his/her meals served on a divided plate. The DM did not know the resident was supposed to have built-up utensils. She did not know Resident #110 was supposed to receive meals on a divided plate. 9. During an interview on 8/14/24 at 10:49 A.M., the Director of Nurses (DON) said she expected residents to receive adaptive equipment as needed at meals. Dietary and nursing staff should ensure residents have the adaptive equipment noted on their dietary ticket. If an item is not listed on a resident's dietary ticket, staff won't know to make sure the item is there. The DM creates dietary tickets. 10. During an interview on 8/14/24 at 12:17 P.M., the Administrator said therapy assesses residents for the use of adaptive equipment used at meals, such as divided plates and built-up utensils. They communicate this with dietary and the DM updates the resident's dietary ticket to indicate the equipment needed. She expected residents to be provided with adaptive equipment as ordered to assist them with eating.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 44948 Based on interview and record review, the facility failed to ensure medication administration and assessments, including skin assessments, Braden assessments (pressure ulcer risk assessment), Abnormal Involuntary Movement Scale (AIMS, aides in the early detection of tardive dyskinesia (involuntary movements)), bed safety assessments, smoking assessments, elopement assessments, and fall risk assessments were documented and maintained for 11 residents (#175, #115, #76, #1, #83, #75, #40, #107, #36, #67 and #58). The sample was 24. The census was 120. Review of the facility's clinical documentation standards policy, undated, showed: -Policy: it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff, and visitors. Maintaining the integrity, quality, and safety of medical records can help to provide an effective communication between practitioners that may serve to enhance resident outcomes. This facility uses both electronic medical records and paper medical records. A complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual resident is known, and a plan of care has been identified to meet the care needs identified in the medical record. -Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record, documenting legibly in English using only acceptable medical abbreviations. Where an abbreviation may be unclear, the nurse will write out the word instead of using the abbreviation. -Timeliness and accuracy: chart in real time when an event is occurring or shortly thereafter, as is practicable. Review of the facility's Admission Review checklist, showed: -Complete Skin-Non Pressure within the admission assessment User-Defined Assessment (UDA); -Complete Skin-Pressure within admission assessment UDA; -Smoking assessment must be completed prior to resident smoking (found within the admission assessment UDA); -Complete Bed Safety UDA; -Admission progress notes: Complete a progress note every shift for 72 hours, including vital signs and assessment of resident condition and interventions in place; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Family/patient/Certified Nurse Aide (CNA) initiate Personal Inventory UDA, print, complete, and have family/patient/staff sign, place in chart; -For all assessments completed prior to locking the Admission Observation Tool, leave weekly Braden's (assessment tool used to assess a resident's risk for developing a pressure ulcer) and weekly fall observations; -Baseline vital signs, obtain vital signs for seven days; -AIMS, as well as providing a method for ongoing surveillance) complete for antipsychotic medications. 1. Review of Resident #175's medical record, showed: -admitted [DATE]; -Diagnoses included person injured in motor-vehicle accident, stroke, unspecified multiple injuries sequela (aftereffect of a disease, condition, or injury), and depression; -No signed admission paperwork; -No Skin-Non Pressure or Skin-Pressure UDAs documented; -No Bed Safety UDA documented; -No Admission progress notes documented on 7/30/24 or 8/1/24; -No Braden or fall risk assessments documented; -No Personal Inventory UDA documented; -No AIMS documented. Review of the resident's electronic Physician Order Sheet (ePOS) and Medication Administration Records (MARs) for July and August 2024, showed: -An order, dated 7/29/24, to obtain vital signs every shift for 72 hours, then daily every shift for establish baseline. Vital signs not documented on 7/30/24 night shift, 7/31/24 day, evening, and night shift, and on 8/1/24 day and evening shift; -An order, dated 7/29/24, for gabapentin (used to treat seizures and nerve pain) oral capsule 400 milligrams (mg), three times a day for neuropathy pain. Medication not documented as administered six out of 36 opportunities; -An order, dated 7/29/24, for famotidine (used to treat and prevent heartburn) tablet 20 mg, one tablet twice daily for gastroesophageal reflex disease (GERD, stomach contents leak backwards into the esophagus). Medication not documented as administered five out of 18 opportunities; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An order, dated 7/29/24, for baclofen (muscle relaxer) oral tablet 20 mg, two tablets three times a day for muscle spasms. Medication not documented as administered six out of 36 opportunities; -An order, dated 7/29/24, for quetiapine fumerate (antipsychotic) oral tablet 25 mg, one tablet twice daily for depression. Medication not documented as administered four out of 18 opportunities; -An order, dated 7/29/24, for propranolol (used to treat high blood pressure) hydrochloric acid (HCl) oral tablet 60 mg, 60 mg every eight hours for high blood pressure. Medication not documented as administered seven out of 36 opportunities; -An order, dated 7/29/24, for mirtazapine (antidepressant) oral tablet 15 mg, one tablet once daily for appetite stimulant. Medication not documented as administered two out of nine opportunities; -An order, dated 7/29/24, for amantadine (used to treat symptoms of Parkinson's disease (brain disorder causing unintended or uncontrolled movements)), HCl 100 mg, two tablets twice daily for Parkinson's disease. Medication not documented as administered five out of 18 opportunities; -An order, dated 7/29/24, for Senna-S (laxative stool softener) oral tablet 8.6-50 mg, two tablets twice daily for constipation. Medication not documented as administered four out of 18 opportunities; -An order, dated 7/29/24, for bisacodyl (laxative) rectal suppository 10 mg, insert one suppository rectally twice a day for constipation. Medication not documented as administered four out of 18 opportunities; -An order, dated 7/29/24, for aspirin low dose oral tablet 81 mg, one tablet once a day for stroke. Medication not documented as administered three out of nine opportunities. Observations on 8/8/24 at 11:47 A.M., 1:41 P.M., and 5:12 P.M., showed the resident on his/her right side in bed with quarter-length side rails raised on both sides at the head of the bed. The resident was nonverbal and unable to be interviewed. 2. Review of Resident #115's medical record, showed: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), heart failure, hyperlipidemia (high cholesterol), diabetes, hypokalemia (low potassium), adult failure to thrive, GERD, panic disorder, depression and nicotine dependence; -No signed admission paperwork; -No Skin-Non Pressure or Skin-Pressure UDAs documented; -No Braden or fall risk assessments documented; -No Personal Inventory UDA documented; (continued on next page)

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	265607	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No AIMS documented. Review of the resident's ePOS and MARs from 7/31/24 through 8/8/24, showed: -An order, dated 7/6/24, for fluticasone furoate-vilanterol (combination medication used to treat COPD) inhalation aerosol powder, breath activated, 100-25 micrograms (mcg)/asthma control test (ACT), one puff inhaled orally once daily. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/6/24, for folic acid 1 mg, one tablet by mouth (PO) once daily for supplement. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/6/24, for furosemide (diuretic) oral tablet 80 mg, one tablet PO in the afternoon. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/7/24, for furosemide oral tablet 80 mg, one tablet PO in the morning for heart failure. Medication not documented as administered for three out of nine opportunities; -An order, dated 7/6/24, for lexapro (used to treat anxiety and depression) oral tablet 10 mg, one tablet PO once daily for depression. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/5/24, for Lipitor (used to treat high cholesterol) oral tablet 10 mg, one tablet PO once daily for hyperlipidemia. Medication not documented as administered for three out of nine opportunities; -An order, dated 7/5/24, for mirtazapine oral tablet 15 mg, 7.5 mg PO at bedtime for depression. Medication not documented as administered for three out of nine opportunities; -An order, dated 7/6/24, for nicotine patch 24 hour 21 mg, apply one patch transdermally once daily for smoking cessation. Medication not documented as administered for seven out of nine opportunities; -An order, dated 7/5/24, for olanzapine (antipsychotic) oral tablet 10 mg, two tablets PO at bedtime for panic disorder. Medication not documented as administered for three out of nine opportunities; -An order, dated 7/6/24, for olanzapine oral tablet 10 mg, one tablet PO once daily for panic disorder. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/6/24, for omeprazole (used to treat GERD) oral capsule delayed release 20 mg, one capsule PO once daily for GERD. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/6/24, for potassium chloride extended release tablet 20 mg, two tablets PO once daily for hypokalemia. Medication not documented as administered for six out of nine opportunities; -An order, dated 7/6/24 for spironolactone (diuretic) oral tablet 25 mg, one tablet PO once daily for heart failure. Medication not documented as administered for seven out of nine opportunities; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An order, dated 7/5/24, for Trintellix (antidepressant) oral tablet 10 mg, one tablet PO at bedtime for depression. Medication not documented as administered for three out of nine opportunities; -An order, dated 7/5/24, for Eliquis (blood thinner) oral tablet 5 mg, one tablet PO twice daily for heart failure. Medication not documented as administered for nine out of 18 opportunities; -An order, dated 7/5/24, for gualfenesin (loosens congestion) extended release (ER) tablet 1200 mg, one tablet PO every 12 hours for COPD. Medication not documented as administered nine out of 18 opportunities; -An order, dated 7/5/24, for metoprolol tartrate (blood pressure medication) oral tablet 25 mg, one tablet PO twice daily for heart failure. Medication not documented as administered 10 out of 18 opportunities; -An order, dated 7/25/24, for Senna-S oral tablet 8.6-50 mg, two tablets PO twice daily for constipation. Medication not documented as administered nine out of 18 opportunities; -An order, dated 7/5/24, for Boost (nutritional supplement) oral liquid, 237 ml PO four times a day for supplement. Supplement not documented as administered 18 out of 36 opportunities; -An order, dated 7/5/24, for magnesium oxide supplement oral capsule 400 mg, one capsule PO four times a day for supplement. Medication not documented as administered 18 out of 36 opportunities. 3. Review of Resident #76's medical record, showed: -admitted [DATE]; -Diagnoses included heart disease, atrial fibrillation (irregular heart beat), high blood pressure, diabetes with diabetic neuropathic arthropathy (nerve damage affecting the joints of the foot), diabetes with hyperglycemia (high blood sugar), hyperlipidemia, and anemia (decrease in the number of red blood cells); -No signed admission paperwork; -No smoking assessment documented; -No Bed Safety UDA documented; -No Skin-Non Pressure or Skin-Pressure UDAs documented; -No Braden or fall risk assessments documented; -No Personal Inventory UDA documented. Review of the facility's list of residents who smoke, showed the resident listed as a smoker. Review of the resident's ePOS and MARs from 7/31/24 through 8/7/24, showed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An order, dated 3/9/24, aspirin oral tablet chewable 81 mg, one tablet PO once daily for pain/circulation/atrial fibrillation. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for fish oil oral capsule 1200 mg, one capsule PO once daily for supplement. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for furosemide oral tablet 20 mg, one tablet PO once daily for diuretic. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for Jardiance (used to control blood sugar and treat diabetes) oral tablet 25 mg, one tablet PO once daily for diabetes. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for metolazone (diuretic) tablet 2.5 mg, one tablet PO once daily for fluid retention. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for polyethylene glycol (laxative) 3350 oral powder 17 gram (gm)/scoop, one scoop PO once daily for constipation. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for Senna-plus oral tablet 8.6-50 mg, two tablets PO once daily for constipation. Medication not documented as administered three out of eight opportunities; -An order, dated 3/9/24, for gabapentin oral capsule 300 mg, one capsule PO twice daily for neuropathy. Medication not documented as administered five out of 16 opportunities; -An order, dated 3/9/24, for lisinopril (used to treat high blood pressure) oral tablet 5 mg, one tablet PO twice daily for hypertension. Medication not documented as administered five out of 16 opportunities; -An order, dated 3/9/24, for metformin (used to treat diabetes) HCL ER oral tablet 500 mg, two tablets PO twice daily for diabetes. Medication not documented as administered five out of 16 opportunities; -An order, dated 3/9/24, for metoprolol tartrate oral tablet 25 mg, one tablet PO twice daily for diabetes. Medication not documented as administered five out of 16 opportunities; -An order, dated 3/9/24, for methocarbamol (muscle relaxer) tablet 500 mg, one tablet PO four times a day for muscle spasm. Medication not documented as administered 10 out of 32 opportunities. Observation on 8/9/24 at 6:49 A.M., showed half-length side rails raised on both sides at the head of the bed. During an interview, the resident said he/she uses the side rails to pull him/herself up in bed. 4. Review of Resident #1's medical record, showed: -admitted [DATE]; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Diagnoses included gout, hypertension, human immunodeficiency virus (HIV, virus that attacks cells that help the body fight infection), Vitamin D deficiency, depression, dementia, psychotic disturbance with mood disturbance and anxiety, dyspepsia (indigestion), tobacco use, and nicotine dependency; -No signed admission paperwork; -No smoking assessment documented; -No Skin-Non Pressure or Skin-Pressure UDAs documented; -No Braden or fall risk assessments documented; -No Personal Inventory UDA documented; -No AIMS documented. Review of the facility's list of residents who smoke, showed the resident listed as a smoker. Review of the resident's ePOS and MARs from 7/31/24 through 8/7/24, showed: -An order, dated 3/19/24, for allopurinol oral tablet 300 mg, one tablet PO daily for gout. Medication not documented as administered three out of eight opportunities; -An order, dated 3/19/24 for aripiprazole (antipsychotic) oral tablet 10 mg, one tablet PO once daily for (blank). No corresponding diagnosis for the medication listed. Medication not documented as administered three out of eight opportunities; -An order, dated 3/19/24, for aspirin oral tablet chewable 81 mg, one tablet PO in the morning. Medication not documented as administered three out of eight opportunities; -An order, dated 3/21/24, for Biktarvy (used to treat HIV) oral tablet 50-200-25 mg, one tablet PO once daily for HIV. Medication not documented as administered three out of eight opportunities; -An order, dated 3/19/24, for cholecalciferol tablet 1000 unit, one tablet PO once daily for nutritional support. Medication not documented as administered three out of eight opportunities; -An order, dated 3/19/24, for fluoxetine (antidepressant) HCl oral capsule 40 mg, two capsules PO once daily for depression. Medication not documented as administered three out of eight opportunities; -An order, dated 3/19/24, for omeprazole oral capsule delayed release 20 mg, one capsule PO once daily before breakfast. Medication not documented as administered three out of eight opportunities. 5. Review of Resident #83's face sheet, undated, showed his/her diagnoses included above the knee amputation (AKA), open wound left foot, peripheral vascular disease (PVD, a condition in which the blood flow is restricted to the lower extremities), diabetes and breast cancer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility incident and accident list provided by the facility, the resident had a fall on 5/20/24. Review of the resident's record, showed no fall risk assessments. Review of the resident's POS dated August, 2024, showed an order dated, 6/1/24, weekly skin assessment to be completed; Documentation to be completed in weekly skin assessment. Review of the resident's record, showed no skin assessments. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is at risk impaired immunity related to new diagnosed left breast cancer; The resident had a left breast lumpectomy and lymph node biopsy on 6/10/24; The resident started breast radiation therapy on 7/22/24; -Interventions: Monitor and document report to physician signs and symptoms of infection, fever, redness, drainage or swelling to wounds; Ensure adequate rest and fluid intake; Monitor changes in behavior. Review of the resident's record, showed no hospital records. During an interview on 8/13/24 at 8:37 A.M., the Medical Records Manager said all scanned medical records have disappeared since the recent ownership change. She did not know how to retrieve the scanned documents. 6. Review of Resident #75's face sheet, undated, showed his/her diagnoses included pressure ulcers, (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body), PVD, chronic (long term) ulcers of left and right lower extremities. Review of the resident's ePOS, dated August, 2024, showed no order for skin checks. Review of the resident's record, showed no skin assessments. During an interview on 8/14/24 at 10:50 A.M., the Director of Nurses (DON) said all residents are expected to have weekly skin check assessments. The residents who currently have wounds still need to have skin checks to identify new open areas. 7. Review of Resident #40's, face sheet, undated, showed his/her diagnoses included muscle spasms, anoxic (lack of oxygen) brain injury and quadriplegia (paralysis of arms and legs). Review of the resident's ePOS dated August, 2024, showed: -An order dated, 6/4/24, weekly skin assessment to be completed; Documentation to be completed in weekly skin assessment. Review of the resident's record, showed no skin assessments. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Review of Resident #107's medical record, showed: -Diagnoses included gastrostomy(feeding tube), muscle weakness, and morbid obesity; -No skin assessments. Review of the resident's ePOS dated, August, 2024, showed: -An order, dated 5/24/24, weekly skin assessment to be completed. Documentation to be completed on weekly skin assessment. 9. Review of Resident #36's medical record, showed: -Diagnoses included bipolar disorder, hemiplegia (partial or complete paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis) affect the right side; -No smoking assessment documented. Review of the facility's list of residents who smoke, showed the resident listed as a smoker. 10. Review of Resident #67's medical record, showed: -Diagnoses included type 2 diabetes mellitus, muscle weakness, and obesity; -No smoking assessment documented. Review of the facility's list of residents who smoke, showed the resident listed as a smoker. 11. Review of Resident #58's medical record, showed: -Diagnoses included acute kidney failure, muscle weakness, and type 2 diabetes mellitus; -No skin assessments were available for review. Review of the resident's ePOS dated August, 2024, showed: - An order, dated 5/21/24, weekly skin assessment to be completed. Documentation to be completed on weekly skin assessment. 12. During an interview on 8/13/24 at 11:58 A.M., Licensed Practical Nurse (LPN) A said nurses should document vital signs during each shift for the first 72 hours following a resident's admission to the facility. Nurses complete the admission assessment in the resident's electronic medical record (EMR). Nurses complete fall risk assessments under the assessment tab in the EMR. Nursing staff also complete other routine assessments under the assessment tab the EMR, including smoking and side rail assessments. The facility changed ownership around two weeks ago, which impacted the information in the EMR. For the first few days under new ownership, staff documented medication administration on paper rather than the EMR. Medication administration is documented in the EMR again. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/14/24 at 8:24 A.M., LPN D said the Admissions checklist provides nurses with a rough estimate of all assessments required to be completed upon admission. He/She is unsure if this checklist will carry over with the new company that took over the facility two week ago. Upon admission, nurses complete a full set of vital signs each shift for the first 72 hours to establish a baseline. Nurses have been completing a full admission assessment, including skin assessment, Braden assessment, AIMS, smoking assessment, elopement assessment, and fall risk assessment. These assessments were completed under the Assessment tab in the EMR. All assessments completed prior to the new ownership did not carry over in the EMR when it was changed two weeks ago. 13. During an interview on 8/13/24 at 11:17 A.M., the Admissions Director said all paperwork signed by residents upon admission was saved electronically. The facility does not have access to the signed admission paperwork anymore, due to the facility's change in ownership that occurred approximately two weeks ago. 14. During an interview on 8/14/24 at 10:49 A.M., the DON said the facility changed ownership on 7/30/24. The facility continues to use the same EMR system, but access to the EMR has changed. Staff did not have access to the EMR until 8/2/24, so staff was documenting medication administration on paper for the first few days under the new ownership. When they found out about the change in ownership on 7/30/24, nursing staff got access to the EMR the next day and printed out the MARs for all residents. Most nursing staff switched back to documenting in the EMR on 8/2/24. She cannot find the paper MARs that staff used for documenting medication administration from 7/31/24 through 8/2/24. Upon admission, the facility has been using a checklist from the former company to guide staff on all assessments to be completed by the nurse. Admission and routine assessments included weekly skin assessments, Braden assessments, fall risk assessments, elopement risk assessments, and smoking assessments. These assessments drive how staff provide care. Resident assessments and documents did not carry over to the EMR under the new ownership. Nursing staff have not received guidance from the new ownership about what assessments will be required going forward. She expects all residents to have complete and accurate medical records. 15. During an interview on 8/14/24 at 12:17 P.M., the Administrator said the facility changed ownership on 7/30/24. All documentation uploaded to the EMR prior to this date, including hospitalization records and paperwork signed by residents, is gone. Nursing assessments are no longer accessible. Documentation maintained by the Business Office has been lost. The new ownership is working on trying to obtain the missing documentation, but there is no current timeline for a resolution. She expected resident records to be complete and accurate. MO00233757 MO00235206 46888