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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual 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. 32847 Based on interview and record review, the facility failed to submit facility initiated transfers (such as an emergency transfer to the hospital with intent to take the resident back) to the Ombudsman on a monthly basis. The census was 92. During an interview on 4/16/24 at 11:07 A.M., Ombudsman F said the facility had not sent their monthly transfer notifications to the ombudsman office since November of 2022. Review of the email communication between the facility Social Service Director and the ombudsman office, dated 4/18/24 at 9:13 A.M., showed an admission/discharge log dated 4/1/24 through 4/18/24. During an interview 4/18/24 at 9:35 A.M., the Administrator said the social worker will be responsible to submit hospital transfer logs monthly to the Ombudsman. It has not been done since she started two weeks ago and that is about the same time the Social Service Director started. She is not sure when the last submission was completed. The Social Service Director just turned in a submission today for April 2024 and will be submitting them at the end of each month ongoing.

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on interview and record review, the facility failed to complete a comprehensive resident assessment for one of 12 residents investigated for comprehensive assessment completion (Resident #30). The census was 92. Review of the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) version 3.0 Resident Assessment Instrument (RAI) User's Manual, showed: -For all non-Admission assessments, the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD); -For the Admission assessment, the MDS Completion Date must be no later than 13 days after the entry date; -Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). Review of Resident #30's medical record, showed: -admitted [DATE]; -An annual MDS assessment, dated 4/1/24 with ARD date 2/24/24, in progress. During an interview on 4/22/24 at 10:09 A.M., the MDS Coordinator said she has been the MDS Coordinator for 5 years. The facility just hired a new MDS staff who is in training. She has been the only MDS Coordinator since 2021. If an MDS shows in progress, this means it either still needs to be completed or needs to be signed off on. Comprehensive MDS assessments are completed on admission and at least annually. She is aware she is behind on MDS assessments. The facility has been without a social worker for about a year and a half, so the business office manager, director of rehab, and herself have been filling the role.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on interview and record review, the facility failed to complete quarterly resident assessments for nine of 19 residents investigated for quarterly assessment completion (Residents #54, #6, #53, #43, #2, #7, #29, #14 and #23). The census was 92. Review of the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) version 3.0 Resident Assessment Instrument (RAI) User's Manual, showed: -For all non-Admission assessments, the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD); -For the Admission assessment, the MDS Completion Date must be no later than 13 days after the entry date; -Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). 1. Review of Resident #54's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 1/25/24 with ARD date 1/25/24, in progress. 2. Review of Resident #6's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 12/29/23 with ARD date 12/29/23, in progress. 3. Review of Resident #53's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/13/24 with ARD date 2/13/24, in progress. 4. Review of Resident #43's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/18/24 with ARD date 2/18/24, in progress. 5. Review of Resident #2's medical record, showed: -admitted [DATE]; (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A quarterly MDS assessment, dated 2/8/24 with ARD date 2/8/24, in progress. 6. Review of Resident #7's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 1/27/24 with ARD date 1/28/24, in progress. 7. Review of Resident #29's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/17/24 with ARD date 2/17/24, in progress. 8. Review of Resident #14's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/15/24 with ARD date 2/15/24, in progress. 9. Review of Resident #23's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/4/24 with ARD date 2/4/24, in progress. 10. During an interview on 4/22/24 at 10:09 A.M., the MDS Coordinator said she has been the MDS Coordinator for 5 years. The facility just hired a new MDS staff who is in training. She has been the only MDS Coordinator since 2021. If an MDS shows in progress, this means it either still needs to be completed or needs to be signed off on. Quarterly assessments are completed quarterly, in between the comprehensive assessments. She is aware she is behind on MDS assessments. The facility has been without a social worker for about a year and a half, so the business office manager, director of rehab, and herself have been filling the role.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on interview and record review, the facility failed to encode and transmit resident assessment data within 7 days after a facility completes a resident's assessment for 12 of 19 residents investigated for MDS encoding and transmission, as indicated by the MDS showing in progress (Residents #22, #51, #54, #6, #53, #43, #2, #7, #29, #14, #30, and #23). The census was 92. Review of the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) version 3.0 Resident Assessment Instrument (RAI) User's Manual, showed: -For all non-Admission assessments, the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD); -For the Admission assessment, the MDS Completion Date must be no later than 13 days after the entry date; -Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). 1. Review of Resident #22's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 3/25/24 with ARD date 3/25/24, in progress. 2. Review of Resident #51's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/20/24 with ARD date 2/20/24, in progress. 3. Review of Resident #54's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 1/25/24 with ARD date 1/25/24, in progress. 4. Review of Resident #6's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 12/29/23 with ARD date 12/29/23, in progress. 5. Review of Resident #53's medical record, showed: (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-admitted [DATE]; -A quarterly MDS assessment, dated 2/13/24 with ARD date 2/13/24, in progress. 6. Review of Resident #43's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/18/24 with ARD date 2/18/24, in progress. 7. Review of Resident #2's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/8/24 with ARD date 2/8/24, in progress. 8. Review of Resident #7's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 1/27/24 with ARD date 1/28/24, in progress. 9. Review of Resident #29's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/17/24 with ARD date 2/17/24, in progress. 10. Review of Resident #14's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/15/24 with ARD date 2/15/24, in progress. 11. Review of Resident #30's medical record, showed: -admitted [DATE]; -An annual MDS assessment, dated 4/1/24 with ARD date 2/24/24, in progress. 12. Review of Resident #23's medical record, showed: -admitted [DATE]; -A quarterly MDS assessment, dated 2/4/24 with ARD date 2/4/24, in progress. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. During an interview on 4/22/24 at 10:09 A.M., the MDS Coordinator said she has been the MDS Coordinator for 5 years. The facility just hired a new MDS staff who is in training. She has been the only MDS Coordinator since 2021. If an MDS shows in progress, this means it either still needs to be completed or needs to be signed off on. She would expect MDS assessments to be encoded and transmitted per the RAI manual. Comprehensive MDS assessments are completed on admission and at least annually. Quarterly assessments are completed quarterly, in between the comprehensive assessments. She is aware she is behind on MDS assessments. The facility has been without a social worker for about a year and a half, so the business office manager, director of rehab, and herself have been filling the role.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35394

Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans to address specific needs of the residents for two of 19 sampled residents (Residents #175 and #59) and one of three sampled closed records (Resident #174). The census was 92.

1. Review of Resident #175's medical record showed:

-admitted on [DATE];

-Diagnoses included encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (deepest layer of the skin), severe sepsis (complication of an infection) without septic shock (widespread infection causing organ failure and dangerously low blood pressure), iron deficiency anemia (low red blood cells) secondary to blood loss, unspecified open wound left leg, necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), muscle weakness, and difficulty walking.

Review of the resident's electronic Physician's Orders Sheet (ePOS), dated April 2024, showed:

-An order dated 2/28/24, for Roxicodone (opioid, treats severe pain) oral tablet 5 milligram (gm). Give two tablet by mouth every six hours as needed (PRN) for severe pain;

-An order dated 3/29/24, to cover lower left extremity wound with normal saline (NS), apply xeroform gauze (fine mesh gauze used on low drainage wounds) and bacitracin (topical antibiotic ointment) to entire wound, cover with dry kerlix (dry sterile bandage roll) and secure with ace wrap (compression bandage designed to wrap snugly). Change daily and PRN, every day shift for necrotizing fasciitis.

Review of the resident's progress notes, showed:

-On 2/28/24 at 10:03 P.M., resident admitted to room via stretcher from the hospital. Resident alert and oriented x 3-4 (person, place, time, situation). Skin assessment done. Resident has wound to lower left leg with approximately 111 staples. Dressing done. All medications verified;

-On 3/25/24 at 1:36 P.M., met with resident today related to requesting housing. At this time, resident does not have income. He/She was made aware that social services will assist and refer him/her to a program after income starts. Per resident statement, he/she had no stable prior living arrangements and previously worked at McDonalds. He/She plans to remain long term care (LTC) at this time. Will continue to follow up as needed;

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/17/24 at 1:36 P.M., office visit with resident today to check on well-being. Resident is pleasant but sad stating he/she would like to go home. At this time, resident does not have a home to go to. He/She is currently applying for Social Security disability benefits. Social services made him/her aware that assist will be offered to help him/her with housing once income is established. Resident states he/she has family support but sometimes gets upset with his/her sibling. He/She is unable to live with his/her family and wants his/her own place. Resident made aware this writer is here for room visits and to offer assistance. He/She also agreed to behavioral health services. Nurse Practitioner in office after visit and signed new patient referral and will write order. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Activities of Daily Living (ADL) assistance and therapy services needed to maintain or attain the highest level of function; -Goal: Resident wishes to attain prior level of function; -Interventions: Assist with mobility and ADLs as needed. Therapy services as ordered; -Focus: Resident express pain/discomfort related to (blank); -Goal: The resident will express pain relief; -Interventions: Evaluate the effectiveness of pain interventions. Pain medications as ordered; -The care plan did not show focus, goals, and interventions related to the resident's diagnosis of Necrotizing Fasciitis of the lower left extremity, discharge planning goals, and mental health concerns. Location of pain cause was not documented. Observation and interview on 4/17/24 at 11:47 A.M., showed the resident in his/her bed. He/She had a bandage wrapped around the left leg. The dressing was dated 4/16. Drainage visible on the bottom of the wrapped leg that leaked onto the resident's sheet. The resident said he/she had a skin graft (donor tissue surgically applied to an area of tissue loss). He/She receives pain medication. He/She was trying to figure out what is next after his/her treatment. He/She had no care plan meeting with staff. Observation and interview on 4/18/24 at 8:10 A.M., showed the resident in his/her bed. The left leg wrapped in ace wrap, no drainage noted. Resident said he/he was in pain and always had pain with his/her leg. 2. Review of Resident #59's medical record, showed: -admitted on [DATE]; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body) following unspecified cerebrovascular disease (disease of the vascular system in the brain) affecting left dominant side, dysphagia (difficulty swallowing) following other cerebrovascular disease, gastrostomy status (tube surgically inserted into the stomach for fluid, medications, and nutrition), other speech and language deficits following stroke, and need for assistance with personal care. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 2/21/24, showed: -Diagnoses included stroke, hemiplegia or hemiparesis, high blood pressure, and heart failure; -No swallowing disorders; -Nutritional approaches: Feeding tube; -Proportion of total calories the resident received through parenteral (administered or occurring elsewhere in the body than the mouth and alimentary canal) or tube feeding: 51% or more; -Average fluid intake per day by intravenous (IV) or tube feeding: 501 cubic centimeter (cc)/day or more. Review of the resident's ePOS, dated April 2024, showed: -An order dated 11/14/23, for enteral feed (tube feeding) order every four hours. Verify position of enteral access device by comparing the documented length or numerical marking at the exit site of the device to the previously documented length. If changes have occurred and concern for migration exist, contact provider; -An order dated 11/14/23, enteral feed order for every 8 hours as needed. Verify position of enteral access device prior to feeding/medication administration, compare documented length or numerical marking at the exit site to the previously documented length. If changes have occur/concern for migration, contact provider; -An order dated 11/14/23, for enteral feed order every day shift. Assess the tube exit site for new or increasing pain and signs of skin breakdown, redness, edema (swelling), leakage, induration (when soft tissue becomes thicker), bleeding, and wear and tear; -An order dated 11/14/23, for enteral feed order every shift. Administer at least 15 milliliter (ml) of purified water via enteral access device after administration of each medication; -An order dated 11/14/23, for enteral feed order every shift. At least 15 ml purified water flush before and after medication administration; -An order dated 11/14/23, for enteral feed order every shift. Check residual at beginning of shift and record amount. Flush tube with 30 ml of water following residual check. Notify physician if residual is greater than 60 ml or if resident has nausea, abdominal distension (bloating or swelling) or bleeding; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order dated 11/14/23, for enteral feed order every shift. Head of bed elevated at least 30 degrees; -An order dated 11/14/23, for enteral feed order every shift. If percutaneous endoscopic gastrostomy (PEG, feeding tube through the skin and stomach wall) tube bumper not snugly against the skin, hold tube firmly with one hand and slide the bumper against the abdominal with the other. Do not place bumper too tightly against skin as it will result in skin breakdown; -An order dated 11/14/23, for enteral feed order every shift. Verify position of external bumper on PEG tube. Bumper to remain snugly flush against abdominal with dry slit gauze placed underneath; -An order dated 12/19/23, for regular diet, puree (smooth, crushed, or blended food) texture. Add ice cream to lunch and dinner tray for nutrition; -An order dated 4/6/24, for Jevity 1.5 calorie (therapeutic nutrition that provides complete, balanced nutrition for long or short term tube feeding)/fiber oral liquid, nutritional supplement. Give 237 ml by mouth after meals and at bedtime for one hour after meals. Review of the resident's progress notes, showed: -On 4/14/24 at 10:27 A.M., alert and oriented 1-2 to self. Able to make some needs known. Dysphagia present. Take medication by mouth. Gastric tube (G-tube, feeding tube) patent and intact flushes without difficulties. Jevity bolus (single, large dose of medicine) 237 ml given and tolerated well; -On 4/6/24 at 2:36 P.M., resident can take medicine by mouth per physician. New order Bolus feed x 4 at bedtime. Observation on 4/18/24 at 8:08 A.M., showed the resident lay in bed. He/She was served a puree meal. Observation on 4/17/24 at 1:10 P.M., showed the resident in his/her room and ate a meal. He/She was served a puree meal on a divided plate. Jevity 1.5 bottle sat on the bedside table next to the bed. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident is at risk for rehospitalization due to (blank); -Goal: Resident will not have an avoidable rehospitalization related to current medical diagnosis within the first 30 days; -Interventions: Interdisciplinary team to meet as needed to discuss resident's condition and interventions. Labs as ordered. Staff to provide timely communication to physician and nurse practitioner regarding any change in resident condition; -Focus: Resident is at risk for falls; -Goal: Blank; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Blank; -Focus: Bowel incontinence; -Goal: Will have no skin breakdown related to bowel incontinence; -Interventions: Blank; -The care plan did not show focus, goals, and interventions related to the resident's dietary status, difficulty swallowing, and PEG tube. There was no documentation of the resident's rehospitalization , falls, and bowel incontinence focus, goals, and interventions. 3. Review of Resident #174's medical record, showed: -admitted on [DATE]; -Diagnoses included encounter for surgical aftercare following surgery on the respiratory system, malignant (cancer) neoplasm of pharynx (throat), tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) status, cognitive communication deficit; -discharged on [DATE]. Review of the resident's hospital record, dated 1/16/24, showed patient with pharyngeal (pharynx) mass, dysphagia, and weight loss who presented 1/16/24 for planned awake tracheotomy, direct laryngoscopy (procedure to examine the larynx (voice box), PEG and biopsy. Biopsy showed p16 (tumor suppressor protein) negative invasive keratinizing (cancer cells producing keratin) squamous cell carcinoma (SCC, skin cancer). Computed Tomography (CT, diagnostic imaging test) chest and neck performed showing large heterogeneously (different gene mutations (changes) cause the same disease or condition) enhancing mass extending from the right posterior oropharynx (middle part of the throat) inferiorly to involve the hypopharynx (bottom part of the pharynx) and supraglottic (upper part of the larynx) larynx. Patient now status post total laryngectomy with bilateral neck dissection, right pharyngectomy (surgery to remove all or part of pharynx) right thyroidectomy (surgical removal of all or part of the thyroid gland), right anterolateral (both anterior and lateral) thigh free flap and pharyngeal (group of muscles) repair on 1/29. Salivary bypass tube (directs the saliva into the distal esophagus and allows for spontaneous closure of the fistula) removed 2/9 and subsequent esophogram (x-ray of the esophagus) without leak. Review of the resident's progress notes, showed: -On 2/23/24 at 2:47 P.M., resident arrived via stretcher at 1:05 P.M. Resident alert and uses dry erase board for communication. Resident with [NAME] box (voice box), and g-tube. Physician here and reviewing discharge orders at this time. Received call from physician with reports of follow up radiation oncology appointment on 2/28/24 at 10:30 A.M.; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/22/24 at 3:33 P.M., call to resident's adult child for care plan and pre discharge planning. Resident's children have moved into home and will be primary caretakers for him/her. Resident lives in a house with bedroom and bathroom on main level. There are 3 steps, walkway and 5 steps to enter house. Patient has no durable medical equipment (DME) at home. Adult Child stated patient has never had to use any DME prior to hospitalization . Patient uses store delivery for medications. Adult Child inquired about activating Medicaid for chore worker services when discharged home. Referred to Business Office Manager (BOM). Educated on education needed for [NAME] tube (flexible silicone tube designed to maintain the stoma right after the laryngectomy surgery) care and g-tube care. Adult Child requested patient to also learn how to administer tube feeding herself. Stated when visits the resident, will ask nurses to start [NAME] tube and g-tube training. Explained to adult child since resident receives an oral diet and tube feeding insurance will not pay for tube feeding at home and recommendations will be made at time of discharge. Home health for physical therapy (PT)/ occupational therapy (OT) and speech therapy (ST) referrals will be made and any equipment needed will be ordered closer to discharge date . Adult child had no further questions/concerns at this time; -On 2/24/24 at 3:43 P.M., resident remains on observation for new admit. Resident has [NAME] tube in place suctioned x 3. Disposable tube changed during this shift. Bed side commode placed in resident room. Resident assisted x 3 to commode during this shift. Resident is nonverbal, but able to write all needs down on paper; -On 3/12/24 at 2:48 P.M., home health referral sent to company and wheelchair request along with trach supplies sent to medical company for pending discharge home 3/15. Requested wheelchair be delivered to the facility; -On 3/13/24 at 10:53 A.M., met with patient and niece this morning with MDS and Director of Rehabilitation (DOR) to discuss discharge for 3/15. Patient's family is to speak with adult child to have him/her come tomorrow for training in [NAME] tube and g-tube and for training with therapy. Home health referrals sent to companies; -On 3/13/24 at 1:50 P.M., spoke with nurse practitioner regarding tube feeding orders for discharge. Received orders Ensure plus (nutritional health shake) 4 cans/day with calories goal of 1200-1500 calories per day; -On 3/21/24 at 5:11 P.M., instructed resident on how to remove and replace Heat Moisture Exchange (HME, provide humidification to adult tracheostomy patients) cap while [NAME] tube has been removed for cleaning, repeat demonstration given successfully; -On 3/22/24 at 11:49 A.M., resident left via stretcher at 11:20 A.M. for radiation. Ambulance to transport resident home after radiation treatment. Resident's family at his/her bedside and this nurse sent remaining medications and discharge instructions home after reviewing all with him/her. States nurse to meet family at home for continuing care. Resident provided [NAME] tube care this morning, suctioned per his/her request, had puree diet with good food and fluid intake. Resident also administered all peg-tube medications per order without difficulty. Resident alert and appeared stable upon leaving. Review of the resident's ePOS, dated April 2024, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of St Louis		STREET ADDRESS, CITY, STATE, ZIP CODE 3520 Chouteau Ave Saint Louis, MO 63103	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order dated 2/23/24, for enteral feed order as needed. Enteral access site care; verify tube securement in place; -An order dated 2/23/24, for enteral feed order every six hours, 200 ml water/ hour via peg tube; -An order dated 2/23/24, for enteral feed order every day shift. Assess the tube exit site for new or increasing pain and signs of skin breakdown, redness, edema, leakage, induration, bleeding, and wear and tear; -An order dated 2/23/24, for enteral feed order every day shift. Enteral access site care. Verify tube securement is in place; -An order dated 2/23/24, for enteral feed order every shift. Administer at least 15 ml of purified water via enteral access device after administration of each medication; -An order dated 2/23/24, for enteral feed order every shift. At least 15 ml purified water flush before and after medication administration; -An order dated 2/23/24, for enteral feed order every shift. Check residual at beginning of shift and record amount. Flush tube with 30 ml of water following residual check. Notify physician if residual is greater than 60 ml or if resident has nausea, abdominal distension or bleeding; -An order dated 2/23/24, for enteral feed order every shift for nutrition nocturnal tube feeding. Jevity 1.5 start 8:00 P.M. to 6:00 A.M. at 40 cc. Increase as tolerated in 12-24 hours to 60 cc; -An order dated 2/23/24, for enteral feed order every shift. Head of bed elevated at least 30 degrees; -An order dated 2/23/24, for enteral feed order every shift. Verify position of external bumper on PEG tube. Bumper to remain snugly flush against abdominal with dry slit gauze placed underneath; -An order dated 2/23/24, for enteral feed order two times a day for feedings. Jevity 1.5 bolus 240 ml via gravity twice a day (BID); -An order dated 2/23/24, may suction [NAME] stoma as needed; -An order dated 3/12/24, for high humidity [NAME] (HHC) at 35%. Review of the resident's care plan and in use during the resident's stay, showed: -Focus: Resident is at risk for falls; -Goal: blank; -Interventions: Assist with ADLs as needed. Call light within reach. Complete fall risk assessment. Education provided to dietician on safe weighing of residents; -Focus: At risk for weight fluctuation related to current health status; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: Resident wishes to maintain current weight; -Interventions: Diet order (blank). Enteral feeding as ordered; -Focus: At risk for respiratory illness related to recent hospitalization ; -Goal: blank; -Interventions: Monitor for change in condition and notify practitioner of findings; -The care plan did not show focus, goals, and interventions related to the resident's dietary status, [NAME] tube, current radiation treatments, and discharge planning. There was no documentation of the resident's rehospitalization and fall goals. 4. During an interview on 4/23/24 at 9:54 A.M., the Administrator said she would expect the dietary, [NAME] tube, g-tube, and discharging planning to be care planned. Each department is expected to go and address the needs of the resident. The MDS coordinator is responsible for going over the care plans. 5. During an interview on 4/23/24 at 10:47 A.M., MDS Coordinator said she updates the care plans annually and quarterly. She also works with nursing when updating the care plans. A resident's use of g-tube is care planned. Any dietary needs such as mechanical or renal (kidney) diets are expected to be care planned. After the admission MDS is completed, she will complete the care plan. Nursing is also able to enter information and possibly the Certified Nurse Aides (CNA), but they have access to Kardex (summary of patient information such as medications, clinical follow up, and daily care schedules). The information on the Kardex comes from the care plan. Discharge planning is expected to be on the care plan. The MDS Coordinator confirmed that Resident #174 had only a baseline care plan. She would expect the care plans to meet the resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plans are expected to be completed timely.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed ensure a safe resident discharge to the community by failing to ensure referrals to local contact agencies and orders for medical equipment were sent timely for one of two residents reviewed with an order to discharge home (Resident #174). The resident was discharged without home health set up or durable medical equipment after a change in the discharge date . This has the potential to affect all residents who discharge from the facility. The census was 92. Review of the facility's Discharge Plan policy, reviewed 8/9/23, showed: -Policy: The discharge planning process will address each resident's discharge goals and needs including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan; -Procedure: Identify the patient's needs and goals regarding discharge upon or as soon as practicable after admission; -Social Services or Care Management associates will complete the initial discharge plan evaluation form within 48 hours of admission to collect data that will assist in development of the discharge plan; -The Discharge Plan is incorporated into the Interdisciplinary Care Plan. It originates on the baseline care plan and will be included on the patient's comprehensive care plan, once developed; -Involve the patient and patient representative. Consider the patient's support/care giver's availability, capacity, and capability to perform required care when identifying discharge needs. Document the patient/patient representative involvement in the discharge plan development; -Involve other interdisciplinary team (IDT) members in the identification of needs and development of the plan. The IDT should include but is not limited to: -The attending physician; -The registered nurse (RN) with responsibility for the patient; -The nurse aide with responsibility for the patient; -A member of food and nutrition services staff; -To the extent it is practicable the patient and their representative; if this is not practicable document why; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Other appropriate staff or professionals in disciplines as determined by the patient's needs or as requested by the patient; -After the needs and goals are identified, ensure this results in the development of a discharge plan for the patient; -Address the patient's goals and treatment preferences in the plan; -Inform the patient and patient's representative of the final plan; -Document that the patient has been asked about their interest in receiving information regarding returning to the community; -Document any referrals to local contact agencies or other appropriate entities made based on the patient's choices and interest returning to the community; -Document if the discharge to the community is not feasible, who made the determination, and why; -Involve the patient, patient's representative, and the IDT with any re-evaluation of the patient's needs or goals that require modification of the discharge plan and update the plan as needed; -Document the date and any updated information in the discharge plan; -Include if the discharge plan was updated based on information received from referrals to local contact agencies or other appropriate entities; -The discharge plan will identify the discharge destination, and ensure it meets the residents' health and safety needs as well as preferences. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs or appears unsafe, the facility must: -Discuss with the resident, (and/or representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to get the information as to why the resident is selecting that location; -Document that other, more suitable options of locations that are equipped to meet the needs of the resident were presented and discussed; -Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings; -Determine if a referral to Adult Protective Services or other state entity charge with investigating abuse and neglect is necessary. The referral will be made at the time of discharge, if appropriate. Review of Resident #174's medical record, showed: (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted on [DATE]; -Diagnoses included encounter for surgical aftercare following surgery on the respiratory system, malignant (cancer) neoplasm of pharynx (throat), tracheotomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) status, cognitive communication deficit; -discharged on [DATE]. Review of the resident's hospital record, dated 1/16/24, showed patient with pharyngeal (pharynx) mass, dysphagia (difficulty swallowing), and weight loss who presented 1/16/24 for planned awake tracheotomy, direct laryngoscopy (procedure to examine the larynx (voice box), Percutaneous Endoscopic Gastrostomy (PEG, feeding tube) and biopsy. Biopsy showed p16 (tumor suppressor protein) negative invasive keratinizing (cancer cells producing keratin) squamous cell carcinoma (SCC, skin cancer). Computed Tomography (CT, diagnostic imaging test) chest and neck performed showing large heterogeneously (different gene mutations (changes) cause the same disease or condition) enhancing mass extending from the right posterior oropharynx (middle part of the throat) inferiorly to involve the hypopharynx (bottom part of the pharynx) and supraglottic (upper part of the larynx) larynx. Patient now status post total laryngectomy with bilateral (both sides) neck dissection, right pharyngectomy (surgery to remove all or part of pharynx), right thyroidectomy (surgical removal of all or part of the thyroid gland), right anterolateral (both anterior and lateral, front and side) thigh free flap and pharyngeal (group of muscles) repair on 1/29. Salivary bypass tube (directs the saliva into the distal esophagus and allows for spontaneous closure of the fistula) removed 2/9 and subsequent esophogram (x-ray of the esophagus) without leak. Review of the resident's care plan and in use during the survey, showed the care plan did not show focus, goals, and interventions related to the resident's discharge planning. Review of the resident's progress notes, showed: -On 2/23/24 at 2:47 P.M., resident arrived via stretcher at 1:05 P.M. Resident alert and uses dry erase board for communication. Resident with [NAME] box (artificial voice box), and gastric tube (g-tube, feeding tube). Physician here and reviewing discharge orders at this time. Received call from physician with reports of follow up radiation oncology appointment on 2/28/24 at 10:30 A.M.; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/22/24 at 3:33 P.M., call to resident's adult child for care plan and pre discharge planning. Resident's children have moved into home and will be primary caretakers for him/her. Resident lives in a house with bedroom and bathroom on main level. There are 3 steps, walkway and 5 steps to enter house. Patient has no durable medical equipment (DME) at home. Adult child stated patient has never had to use any DME prior to hospitalization . Patient uses store delivery for medications. Adult child inquired about activating Medicaid for chore worker services when discharged home. Referred to Business Office Manager (BOM). Educated adult child on education needed for [NAME] tube (flexible silicone tube designed to maintain the stoma right after the laryngectomy surgery) care and g-tube care. Adult child requested patient to also learn how to administer tube feeding him/herself. Adult child stated when visits the resident, will ask nurses to start [NAME] tube and g-tube training. Explained to adult child since resident receives an oral diet and tube feeding, insurance will not pay for tube feeding at home and recommendations will be made at time of discharge. Home health for physical therapy (PT)/ occupational therapy (OT), and speech therapy (ST) referrals will be made and any equipment needed will be ordered closer to discharge date . Adult child had no further questions/concerns at this time; -On 3/12/24 at 2:48 P.M., home health referral sent to company and wheelchair request along with trach supplies sent to medical company for pending discharge home 3/15. Requested wheelchair be delivered to the facility; -On 3/13/24 at 10:53 A.M., met with patient and family this morning with Minimum Data Set (MDS) and Director of Rehabilitation (DOR) to discuss discharge for 3/15. Patient's family is to speak with adult child to have him/her come tomorrow for training in [NAME] tube and g-tube and for training with therapy. Home health referrals sent to companies; -On 3/13/24 at 1:50 P.M., spoke with nurse practitioner regarding tube feeding orders for discharge. Received orders for Ensure plus (nutritional health shake) 4 cans/day with calories goal of 1200-1500 calories per day; -On 3/15/24, (no documentation the resident was discharged or why the discharge date changed. No documentation the home health or DME companies were notified of the new discharge date); -On 3/21/24 at 5:11 P.M., instructed resident on how to remove and replace Heat Moisture Exchange (HME, provide humidification to adult tracheostomy patients) cap while [NAME] tube has been removed for cleaning, repeat demonstration given successfully; -On 3/22/24 at 11:49 A.M., resident left via stretcher at 11:20 A.M. for radiation. Ambulance to transport resident home after radiation treatment. Resident's niece at his/her bedside and this nurse sent remaining medications and discharge instructions home after reviewing all with him/her. States nurse to meet family at home for continuing care. Resident provided [NAME] tube care this morning, suctioned per his/her request, had puree diet with good food and fluid intake. Resident also administered all peg-tube medications per order without difficulty. Resident alert and appeared stable upon leaving; -No documentation of change to resident's discharge date or home health referrals sent for an anticipated discharge date of [DATE]. Review of the resident's discharge order, dated 3/11/24, showed: (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Discharge home with family, with home health, status post laryngectomy and esophagectomy (removal of part or all esophagus); -Expected to discharge on 3/15/24; -The following services are medically necessary home health services: -Physical therapy evaluation and treat; -Occupational therapy evaluation and treat; -Speech therapy evaluation and treat; -Registered nurse; -Evaluate and treat on disease process management with a focus strength and balance as it applies to home safety and independence with activities of daily living (ADLs); -Evaluate and treat on disease state management regarding education and instruction on intravenous (IV), j-peg, g-tube, tracheostomy care, and ostomy care; -Patient will need the following medical equipment: -Wheeled walker; -Trach supplies for [NAME] tube; -Two referrals for home health were faxed on 3/11/24 with a documented discharge date of [DATE]. Review of the resident's discharge summary, dated 3/18/24, showed: -discharged to home; -Accompanied by family; -Reason for discharge: Patient's health improved sufficiently so patient no longer needs services provided by facility; -Special instructions: [NAME] tube, g-tube care and administration of medications and food; -Cognitive status: Resident understands and able to communicate his/her needs; -Nutritional status: Nocturnal PEG tube feeding and bolus during wake hours; -Patient needs, strength, goals, life history, and preferences: Resident progressed in skilled therapy; -Participants in patient's assessment: Resident included and educated; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Additional discharge planning information: Continue radiation per schedule. Resident to follow up with his/her primary doctor within 7-10 days of discharging home; -Does patient need outpatient rehab services after discharge: yes; -Follow-up physician care: Call physician to schedule an appointment; -Recapitulation of stay: blank; -Rehabilitation/therapy: blank; -Copy of instructions given to: blank; -Name of patient/patient representative giving consent: blank; -Received by and date: blank; -Nurse signature and date: blank. Review of the resident's medical record, showed no documentation of an updated home health referral with the resident's new discharge date . During an interview on 3/29/24 at 1:55 P.M., Hospital Representative V said the resident presented to the hospital after he/she was sent home from the facility without proper equipment. Emergency medical services dropped him/her off at home but did not leave him/her at home because he/she did not have the necessary equipment delivered to care for him/herself (oxygen, suction, etc.). During an interview on 4/23/24 at 9:22 A.M., the Social Services Director said she had been at the facility for only three weeks. There was no Social Service Director at the time when she arrived. It had been a long time since the facility had one. If a resident is ready to be discharged , there is a 72 hour care plan if a referral is needed, she will ask the resident their discharge plan and go over it in the 72 hour care plan meeting. They try to send out the referral right away. They home health agencies need a discharge date so it cannot be sent too early. She likes to do it after the 72 hour care plan. If there are already services in place, then she will notify home health agency and let them know they are going home. If the resident does not discharge on their anticipated date, she will either call or email the home health agency and document it in the record. If there is a delay in discharge, the home health agency would let her know if they have anything available or not. If not, she would notify the family and let them know they would have to use another agency. The DME takes a while, but she will put the orders in. She cannot promise it will be available, the facility tries to work something out with the family. During an interview on 4/23/24 at 10:40 A.M., the Administrator would expect the referrals to be resent if the discharge date was changed. MO00233936

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49992 Based on observation, interview and record review, the facility failed to provide care and services related to communication, by failing to provide speech assistive devices for one of one sampled resident (Residents #32) who is deaf. The facility also failed to ensure staff were knowledgeable on how to locate information regarding how the resident communicated with staff. The census was 92. Review of Resident #32's quarterly assessment Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/14/24, showed: -Hearing highly impaired- absence of useful hearing; -Diagnoses included stroke, high blood pressure, and seizures; -No hearing aid or other hearing appliances used. Review of the resident's care plan, dated 5/30/19, showed: -Focus: I have a hearing deficit/deaf and I have difficulty understanding. I prefer to have an American Sign Language (ASL) interpreter to assist me with understanding; -Goal: My needs will be anticipated and met by staff by next review date, and I will be able to communicate my needs through next review date; -Interventions: Anticipate and meet needs, be conscious of resident position when in groups, activities, dining room to promote proper communication with others, allow adequate time to respond, repeat as necessary, do not rush, requestion clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Review of the MDS Kardex Report (a report to direct care staff on how to care for residents), printed 4/22/24, showed: -Communication is highly impaired; -No directions/guidance on how to communicate with the resident. During an observation and interview with the resident on 4/17/24 at 11:20 A.M., it was noticed that the resident had difficulty hearing questions, would make grunt like noises, and point. The resident pointed to his/her ears and said deaf. He/She was able to convey that he/she could read lips but not very well. There was no communication device available to the resident during the interview. With written questions on paper, the resident was able to answer yes and no questions. The resident communicated that he/she liked living at the facility, had no complaints, and the staff treated him/her well. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/19/24 at 9:09 A.M., Certified Nursing Assistant (CNA) G said that he/she is aware that the resident is deaf. He/She gets information on how to care for the residents from the nurses during report. He/She is not aware of other resources available to get information regarding care for the residents. During an interview on 4/19/24 at 9:09 A.M., CNA H said he/she worked for a staffing agency and is aware that there is a resident who is deaf. He/She gets information on resident care while listening to report from the nurses and information from full-time staff. He/She works on different floors at the facility and is unaware of resources available regarding resident care. During an interview on 4/22/24 at 10:49 A.M., the Administrator provided a Kardex for the resident. She said that the interventions on the care plan have not been transferring over to the Kardex and this is something that she and the Director of Nursing (DON) would be addressing. She expects the staff to review to the Kardex, that is located in the computer, when performing resident care. During an interview on 4/23/24 at 7:31 A.M., CNA I said that he/she gets information from the nurse during report or reviews the report sheet. He/She does not have access to the computer and is unaware of other resources to get information on resident care. CNA I said being able to communicate allows the staff to know if the resident is hungry, needs to use the restroom, take a shower, or needs to be turned. During an interview on 4/23/24 at 7:41 A.M., Registered Nurse (RN) J said that he/she gets information about resident care during report. He/She has access to the Care Plan in the computer. During an interview on 4/23/24 at 7:46 A.M., the Assistant Director of Nursing (ADON) said that she expects the staff to access the computer and to review the Kardex to provide care to the residents. She is aware that there are CNAs who do not have access to the computer. The ADON said she expects the staff to report if they are unable to access the computer and it is her responsibility to create access for the CNAs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32847 Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one resident with chronic wounds (Resident #4). The resident readmitted from the hospital on 3/29/24. Hospital records indicated wounds present to the left knee. The facility admission nursing assessment identified open areas on the left knee and lower extremities. The facility did not complete a full wound assessment until 4/3/24. Treatment orders were not obtained for the left plantar (foot) until 4/11/24 and left knee until 4/19/24. The census was 92. Review of the facility's Skin Integrity and Pressure Ulcer/Injury prevention and Management policy, dated 10/3/19 and last revised 8/25/21, showed: -Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury (skin injuries as a result of prolonged pressure or friction), complete wound assessment/documentation, and provide treatment and care of skin and wound utilizing professional standers; -A comprehensive skin inspection/assessment on admission and re-admission to the center may identify re-existing signs of possible deep tissue damage already present; -A skin assessment/inspection occurs on admission/readmission. Skin observations also occur throughout points of care provided by Certified Nursing Assistant (CNAs) during activities of daily living (ADL) care. Any changes or open areas are reported to the nurse; -A risk assessment tool, Braden Scale or Norton Scale, determines the resident's risk for pressure injury development. The score is documented on the tool and placed in the resident's medical record using the appropriate form; -A skin assessment/inspection should be performed weekly by a licensed nurse; -Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission area considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services; -When skin breakdown occurs, it is requires attention and a change in the plan of care may be indicated to treat the resident. Review of the facility's Documentation and Assessment of Wounds, effective 10/3/19 and last revised 8/23/21, showed: -To guide the associates and licensed nurse in the assessment of wound to include pressure ulcer/injuries, venous (wounds caused by poor venous blood flow), atrial (wounds caused by poor atrial blood flow), diabetic (wounds caused by poor blood flow and poor wound healing associated with diabetes), dehisced surgical wound (surgical wounds that re-open), and other; (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-A wound assessment/documentation is required to occur at a minimum weekly.

Review of Resident #4's medical record, showed diagnoses included high blood pressure, paraplegia (paralysis of the legs and lower body), diabetes, and weakness.

Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 1/3/24, showed:

-Cognitively intact;

-Rolling left to right: Partial/moderate assistance required;

-No venous and atrial ulcers.

Review of the resident's wound observation tool, showed:

-On 2/28/24, left lateral knee atrial ulcer. Overall impression, unchanged. Wound measurements: Length 2.4 centimeters (cm), by width 3.0 cm, by depth 0.1 cm. Current treatment orders: Cleanse with normal saline. Apply Aquacell AG (antimicrobial absorbent dressing), cover with Allevyn (foam dressing);

-On 2/28/24, left plantar foot arterial ulcer. Overall impression, unchanged. Wound measurements: Length 2.1 cm by width 4 cm by depth 0.1 cm.

Review of the resident's progress notes, dated 3/5/24 at 8:06 P.M., showed a transfer to hospital summary. Resident was complaining of feeling sick. He/She also complained about his/her heart fluttering. Sent to hospital for observation via ambulance.

Review of the resident's hospital records, showed:

-admitted to the hospital on 3/5/24;

-Diagnoses: Severe sepsis (systemic reaction to an infection);

-Wound left plantar foot, multiple areas measured as one: Healed on 3/27/24;

-Wound left knee. On 3/29/24 assessed as pink/red, excoriated (redness), exposed fascia (the connective tissue that surrounds organs, bone, and muscles to keep them in place). Serosanguinous (blood tinged drainage) drainage. No measurements documented.

Review of the resident's readmission assessment, dated 3/29/24 at 3:00 P.M., showed:

-admitted from the hospital with diagnosis of sepsis;

-Open area/wound bottom of both lower extremities;

-See nurses notes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's admission/readmission process note, dated 3/29/24 at 1:00 P.M., showed: -Resident readmitted to the facility at approximately 12:45 P.M. from the hospital. Foam dressing noted to the left knee. Multiple areas of broken skin noted to lower extremities; -No wound measurements or descriptions. Review of the resident's medical record, from 3/30/24 through 4/2/24, showed no further description of the left knee or lower extremity skin conditions. Review of the resident's March 2024 Treatment Administration Record (TAR), showed no treatment orders for the left knee wound or the left lower extremity open areas as noted on the admission nursing progress note. Review of the resident's wound observation tool, showed: -On 4/3/24, left knee atrial ulcer. Overall impression, unchanged. Wound measurements: Length 3 cm, width 3 cm, depth 0.1 cm. Current treatment plan: Normal saline, Aquacel AG, Allevyn; -On 4/3/24, left plantar foot atrial ulcer. Overall impression, unchanged. Wound measurements: Length 3 cm by width 1.7 cm by depth 0.1 cm. Current treatment plan: Normal saline, ABD (absorbent dressing), gauze wrap. Review of the resident's April 2024 TAR, showed: -An order dated 4/10/24 and start date 4/11/24, to cleanse left plantar foot with normal saline/wound cleanser, apply wound gel (used to maintain a moist wound environment to aide in wound healing), cover with ABD pad and wrap with kerlix (gauze wrap) and secure with tape daily: -No documentation of a treatment ordered or completed prior to 4/11/24; -An order dated 4/18/24 and start date 4/19/24, cleanse left knee with wound cleanser/normal saline, apply Alginate and cover wit Allevyn daily, every day shift for wound: -No documentation of a treatment ordered or completed prior to 4/19/24. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Date initiated 4/18/24, left knee atrial wound, left plantar venous ulcer; -Goal: Minimize risk for symptoms of infection; -Interventions/tasks: Educate resident and/or family regarding skin problem and treatment. Pressure reducing mattress. Treatment as ordered. Weekly skin checks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/19/24 at 1:35 P.M., showed the Wound Nurse entered the resident's room to provide wound care. The resident wore heel protector boots on both lower extremities. A dressing intact to the left foot/plantar. The Wound Nurse removed the dressing and exposed a small irregular shaped wound with a small amount of bloody drainage. The Wound Nurse cleaned the wound with wound cleanser spray. The wound began to bleed slightly. Wound gel and an ABD dressing applied over the wound, the area wrapped with gauze wrap, then secured with tape. A dressing was intact to the left outer knee. The Wound Nurse removed the dressing and exposed a round bloody wound. The dressing had both dried and wet blood on it. The Wound Nurse cleansed the wound with wound cleansing spray, applied Alginate and covered with Allevyn. During an interview on 4/22/24 at 9:45 A.M., Resident #4 said regarding his/her leg and foot wounds, in the hospital one of his/her wounds dried up and then opened back up when he/she came back to the facility. Staff were treating the wounds. During an interview on 4/22/24 at 2:53 P.M., the Wound Nurse said all wounds should have treatment orders and all treatments should have corresponding orders. Wounds are assessed weekly. The assessment includes wound characteristics, size, location, drainage and treatment order. Wounds should be assessed upon arrival. If there are no treatment orders, the admitting nurse should notify the physician of the areas and obtain treatment orders when they call to verify orders. For the resident, if the nurse documented a knee treatment in place and open areas to the lower extremities, there should be orders. The documentation is vague, so it is hard to say exactly where on the lower extremity wounds were or their condition. The resident was readmitted on the weekend by an agency nurse. The Wound Nurse said she had just accepted the position as the wound nurse and was not yet filling the role. She was working on completing skin assessments on all the residents. It was Wednesday when she assessed the wounds on the resident and obtained treatment orders. The orders must have been missed when adding orders into the computer.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 36151 Based on interview and record review, the facility failed to ensure that residents receive proper treatment to maintain vision when staff failed to make transportation arrangements for one sampled resident (Resident #224) out of 19 sampled residents, to go to a follow-up appointment for eye surgery and failed to reschedule the appointment after it was missed. The census was 92. Review of the facility's Transportation Coordination and Services Policy, issued 1/27/23 and reviewed on 7/17/23, showed: -Policy: The facility will assist residents in making necessary appointments for services not provided in the facility and arranging for transportation to and from appointments; -Procedure: The facility will assist the resident and or resident representative in the making of necessary appointments, such as, but not limited to Medical Specialists, Laboratory and Vision Services; -The facility will provide transportation through facility transportation or through a contracted service. Review of Resident #224's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/1/24, showed: -Cognitively intact; -Diagnoses included heart disease/heart failure, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and depression. Review of the resident's physician's orders, showed an order dated 4/9/24, to arrange transportation for ophthalmology (a physician who diagnoses and treats eye diseases) clinic follow up appointment on Wednesday 4/17/24 at 11:00 A.M. Review of the resident's care plan, showed: -Problem: Activity of daily living (ADL) Assistance and Therapy Services needed to maintain or attain highest level of function; -Interventions: Assist with mobility and ADLs as needed, therapy services; -Problem: At risk for an ADL self-care performance deficit due to comorbidities; -Interventions: Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use bell to call for assistance. Review of the resident's nurse progress notes, showed: (continued on next page)

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F 0685

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-On 3/27/2024 at 11:09 A.M., Alert Note, resident scheduled for right eye cataract surgery on 3/28/24. Resident ok to have surgery tomorrow;

-On 3/30/2024 10:17 Type: Health Status: Resident has no acute distress noted. Resident had appointment on 3/28/24 for a procedure to the right eye, no redness, no irritation noted, no signs of infection noted. Resident able to make all needs known, vital signs stable.

During an observation and interview on 4/17/24 10:55 A.M., the resident entered his/her room, visibly upset, and said he/she had been waiting downstairs for transportation and they never arrived. He/She said they failed to get transportation for him/her to see his/her eye doctor.

Review of the transportation log on 4/18/24 at 8:39 A.M., located at the fourth floor nurse's station, showed:

-Passenger's name: Resident #224;

-Service required: Round trip/wheelchair;

-Pick up 4/17/24 at 11:00 A.M., lobby;

-Special notes, need escort, *needs rescheduled;

-No additional information regarding a reschedule date.

During an interview on 4/22/24 at 2:18 P.M., Nurse B said nursing sets up the resident's physician's appointments and the front desk schedules transportation. They then place the transportation sheet in the binder. He/she was unaware of the resident's optometrist appointment that needed rescheduled.

During an interview on 4/22/24 3:06 P.M., the Receptionist said he/she is responsible for scheduling transportation for the resident's appointments. Nursing lets him/her know about an appointment and he/she sets up the appointment with transportation. He/She does not have access to the resident's electronic medical records. There is a transportation log on each floor where the resident's transportation's information is kept and the log has all the transportation services he/she has booked. He/She was unaware the resident missed his/her optometrist appointment on 4/17/23 and was unaware if the appointment was rescheduled.

During an interview on 4/23/24 at 9:35 A.M., Nurse U said the resident just left for his/her appointment at the vascular lab. Nursing is supposed to check the transportation log daily to see if a resident has an appointment. He/She was unaware of any rescheduling needs for the missed optometrist appointment on 4/17/24.

During an interview on 4/25/26 at 10:40 A.M., the optometrist's secretary said he/she is the one who schedules appointments for patients. The resident had eye surgery on 3/28/24, and did not show up for his/her follow up appointment. Their office would not know if a resident is not able to go to an appointment unless someone calls and lets them know they cannot make the appointment. The resident's appointment is marked as a no show, and no one has called or made a follow up appointment for the visit.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/24 at 10:51 A.M., the Administrator said nursing enters the orders for the residents' appointments and notifies the Receptionist regarding transportation needs. The Receptionist makes the appointment with transportation. She did not know why the resident missed the appointment. She expected physician's orders to be followed and transportation provided for the residents.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 35394 Based on interview and record review, the facility failed to ensure eight of 10 randomly selected Certified Nurse Aides (CNAs) received the required annual 12 hour resident care training. The census was 92. Review of the facility assessment, showed: -Staff training/Education and Competencies: Facility provides staff training/education and competencies through a variety of methods such as new employee orientation, impromptu small group training during the regular course of business, scheduled in-house in-services, webinars, classes, seminars, memos, Healthcare Academy, etc. on subjects that are either required for continued certification or in areas determined to need education or re-education. The facility provides or arranges for personnel to receive outside education to meet staff certification and re-certification requirements as applicable. The facility provides or arranges for training in the following subject areas. This is not an inclusive list: -Communication; -Resident's right and facility responsibilities; -Abuse, neglect, and exploitation; -Infection control; -Medication administration; -Measurements; -Resident assessment and examinations; -Caring for persons with Alzheimer's disease or other dementia; -Specialized care; -Caring for residents with mental and psychosocial disorders. Review of the CNA individual in-service records, showed the following: -CNA L hired 7/7/98, showed no documentation of an in-service education tracking record; -CNA M hired 3/15/07, with 0 hours of in-service education; -CNA N hired 6/2/02, with 7.49 hours of in-service education; -CNA O hired 11/23/22, with 0 hours of in-service education; (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA P hired 10/14/22, with 0 hours of in-service education; -CNA Q hired 2/3/23, with 0 hours of in-service education; -CNA R hired 8/24/23, with 0 hours of in-service education; -CNA S hired 5/11/22, with 0 hours of in-service education. During an interview on 4/22/24 at 1:05 P.M., the Administrator said CNA L was not logged into the system to take any trainings. During an interview on 4/23/24 at 9:50 P.M., the Administrator said the facility did not currently have a Staff Development Coordinator (SDC), who would be responsible for tracking the in-service training for CNAs. Healthcare academy would send the report and the SDC would pull the report to see what was due. Since there was no one in that position, that is why it is deficient.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35394 Based on observation, interview and record review, the facility failed to post the required nurse staffing in a prominent place, readily accessible to residents and visitors on a daily basis. The census was 92. Review of the facility assessment, showed: -Scheduling plan: 8 + full-time per unit on 6:30 A.M. to 2:30 P.M. shift; -8 + full-time per unit on 2:30 P.M. to 10:30 P.M. shift; -6 + full-time per unit on 10:30 P.M. to 6:30 A.M. shift. Observations from 4/17/24 through 4/19/24 and 4/22/23 and 4/23/24, showed a board on the wall behind the front desk reception desk. The board contained categories for date, census, total number and actual hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA) per shift; -On 4/17/24 at 10:10 A.M., 4/18/24 at 6:20 A.M., and 4/19/24 at 6:44 A.M., showed a date of 4/4/24 and census of 92. There was no documentation of the total number and actual hours worked by RNs, LPNs, and CNAs per shift; -On 4/22/24 at 12:35 P.M. and 4/23/24 at 8:59 A.M., showed a census of 92. The date showed only the month and year. There was no documentation of the total number and actual hours worked by RNs, LPNs, and CNAs per shift. During an interview on 4/23/24 at 9:50 A.M., the Administrator said the nursing staffing information is to be written on the board, but the Director of Nursing (DON) had put the information on a paper copy to be framed. The frame was kept on the reception desk. Since the DON was not there during the survey, no one completed it. The Administrator would expect the nurse staffing information to be completed daily.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 32847 Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors for one resident who did not receive his/her ordered routine insulin (Resident #29). The census was 92. Review of the facility's Administration of Medications policy, dated 4/24/19 and last revised 2/13/23, showed: -The policy will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms; -Medication error- this means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: -Physician order; -Manufacturer's specifications regarding the preparation and administration of the medication or biologicals; -Accepted professional standards and principals which apply to professionals providing services; -Significant medication error- this means one which causes the resident discomfort or jeopardizes his or her health and safety. Significance may be subjective or relative depending on the individual situation and duration; -Staff who are responsible for medication administration will adhere to the 10 rights of medication administration: Right drug, right resident, right dose, right route, right time and frequency, right documentation, right assessment (note the resident's history and any parameters around drug administration), right to refuse, right evaluation/response, right education and information; -High-alert medications include, but are not limited to: Insulins- all formulations and strengths. Review of Resident #29's medical record, showed: -Diagnoses included diabetes; -An order dated 3/5/24, for Admelog SoloStar (fast acting insulin pen injector) 100 unit/milliliter (ml). Inject 10 units subcutaneously (under the skin) two times a day for diabetes before breakfast and dinner: -Scheduled administration times of 7:30 A.M. and 4:30 P.M.; -No directions to hold if blood sugar levels are within normal range; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order dated 4/17/24 at 1:22 P.M., for Admelog SoloStar subcutaneous solution, 100 units/ml. Inject as per sliding scale: -For a blood sugar result of less than 250, no direction to give sliding scale insulin; -Call the physician if results below 60 or above 500. During an observation on 4/17/24 at 4:35 P.M., Licensed Practical Nurse (LPN) C checked the resident's blood sugar and obtained results of 138 (a blood sugar of less than 140 and more than 70 is considered normal). LPN C said he/she will not administer the resident any insulin because the results were normal. Review of the resident's progress notes, showed Admelog insulin (fast acting insulin) ordered 10 units twice a day before breakfast and dinner. On 4/17/24 at 5:54 P.M., LPN C documented held due to blood sugar within normal limits. No documentation the physician was notified the insulin was held or an order to hold the insulin. During an interview on 4/18/24 at 11:56 A.M., the Assistant Director of Nursing (ADON) said medications should be administered as ordered. Following medication orders can be a nursing judgement, but staff should then call the physician and inform the resident that the medication was not administered. If a resident has an order for both sliding scale and routine insulin and the residents blood sugar is within normal limits and not requiring the sliding scale, the routine insulin should not be held unless the physician is called and notified. Insulin is considered a high risk medication, however, she does not believe that holding a high risk medication, such ask insulin, without a physician order constitutes a significant medication error. The resident is a very brittle diabetic. Giving his/her insulin too far away from a meal can cause his/her blood sugar to drop. It is scheduled to be administered at 4:30 P.M., but that time needs to be changed. Nursing staff should have gotten an order to change the time.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

32847

Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored per acceptable standards of practice for one of four medication carts reviewed and one of one treatment cart reviewed. The medication cart contained insulin pens not labeled when removed from refrigeration to indicate when they expire. The treatment cart contained ointments for 2 residents (Residents #74 and #224) with the cap off. The facility had 10 medication/treatment carts. The census was 92.

Review of the facility's Storage and Expiration Dating of Medications, Biologicals policy, dated 12/1/07 and last revised 8/7/23, showed:

-This policy sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes, and needles;

-Facility should ensure that medications and biologicals that have an expiration dates on the label, have been retained longer that recommended by manufacturer or supplies guidelines, or have been contaminated or deteriorated, are stored separate from other medication until destroyed or returned to the pharmacy or supplier;

-Once any medication or biological package is opened, facility should follow manufacturer/supplier guideline with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened;

-Facility staff may record the calculated expiration date base on date opened on the primary medication container;

-Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the united states pharmacopeia guidelines for temperature range.

1. Observation on 4/17/24 at 11:12 A.M., of the nurse medication cart for the 320-330 hall, showed:

-Two insulin glargine injection pens (generic form of Lantus, long acting insulin), in the top drawer of the cart and not labeled with the date it was removed from refrigeration or the date it expires after being removed from refrigeration;

-Two insulin lispro pens (generic for Humalog, short acting insulin), in the top drawer of the cart and not labeled with the date it was removed from refrigeration or the date it expires after being removed from refrigeration;

(continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One Novolin 70/30 insulin pen (a mix of both long and short acting insulin), in the top drawer of the cart and not labeled with the date it was removed from refrigeration or the date it expires after being removed from refrigeration. During an interview on 4/17/24 at 11:12 A.M., Registered Nurse (RN) A said staff label insulin when opened. The insulin in the cart is not currently in use and is still unopened. He/She did not know when it was removed from the refrigerator and placed in the medication cart. All pens have expiration dates printed on the pen. Review of the manufacturer's recommendations for Lantus (insulin glargine injection pen), showed: -Always store unopened pens in the refrigerator; -After the first use, don't refrigerate the pen. Keep it at room temperature only; -After 28 days, throw your opened pen away, even if it still has insulin in it. Review of the manufacturer's recommendations for Humalog (insulin lispro), showed: -Unopened pens should be stored in a refrigerator and can be used until the expiration date on the carton or label; -Opened cartridges or prefilled pens should be kept at room temperature; -Once opened, prefilled pens and cartridges should be thrown away after 28 days. Review of the manufacturer's recommendations for Novolin 70/30 insulin, showed: -Insulin should be stored in a cold place, preferably in a refrigerator, but not in the freezer; -Keep Novolin 70/30 PenFill cartridges in the carton so that they will stay clean and protected from light; -The Novolin 70/30 PenFill cartridge that you are currently using should not be refrigerated but should be kept as cool as and away from direct heat and light;U -Unrefrigerated Novolin 70/30 PenFill cartridges must be discarded 10 days after the first use, even if they still contain Novolin 70/30 insulin. 2. Review of Resident #74's medical record, showed an order dated 2/8/24 for Lotrisone cream 1-0.05% (clotrimazole-betamethasone, used to treat fungal infections). Apply to PEG (type of gastric tube used to administer medications, food, and fluids) site topically every day and every evening shift for yeast rash. Review of Resident #224's medical record, showed an order dated 3/12/24, for gentamicin sulfate (antibiotic) external cream 0.1%. Apply to dorsal (top) medial (middle) left toe topically every day shift for treatment. Apply gentamicin and dry dressing. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/17/24 at 11:28 A.M., of the 4th floor treatment cart, showed: -One tube of clotrimazole-betamethasone cream labeled for Resident #74, opened and lay directly in the top drawer of the treatment cart and without a lid; -One tube of gentamycin ointment labeled for Resident #224, opened and lay directly in the top drawer of the treatment cart and without a lid. During an interview on 4/17/24 at 11:28 A.M., Licensed Practical Nurse (LPN) B said the facility has a wound nurse who maintains the treatment cart. 3. During an interview on 4/18/24 at 11:56 A.M., the Assistant Director of Nursing (ADON) said insulin pens should be refrigerated until they are opened and dated when opened. If insulin pens are removed from the refrigerator prior to use, they should be dated when removed from the refrigerator. Ointment and creams should be stored with their lids on.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49992 Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection prevention and control when staff failed to change gloves while administering medication via an enteral nutrition device (feeding tube) and left suction equipment at the bedside uncovered for one resident (Resident #1), and not testing new hire employees for Tuberculosis (TB) per their policy for eight of eight employees sampled. The census was 92. 1. Review of the facility's Administration of Medications policy, dated 8/24/23, showed: -The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Review of the facility's Enteral Nutrition Therapy policy, dated 8/8/23, showed: -The facility will provide bolus enteral nutrition therapy in accordance with physician orders and professional standards of practice. This facility will utilize the Lippincott procedures, Enteral tube feeding, gastric; -Lippincott Nursing Procedures, Ninth Edition, 2023, page 295 Enteral tube feedings shows: Implementation: Perform hand hygiene. Review of the facility's Oral Suctioning policy, dated 8/22/23, showed: -The facility will provide oral suctioning in accordance with professional standards of practice and physicians order, to clear secretions from the mouth in the event a resident in unable to remove secretions or foreign matter by effective coughing; -General Considerations: Yankauer (brand of suction device) and tubing should be stored in a patient setup bag when not in use. Review of Resident #1's Medication Administration Record (MAR) for April 2024, showed: -An order dated 11/21/20, for Aspirin Tablet Chewable 81 milligram (mg). Give 81 mg via Gastronomy Tube (G-Tube, tube inserted into the stomach to provide fluid, medication, and nutrition) one time a day for heart health; -An order dated 3/3/22, for Famotidine (used to treat heart burn) tablet 20 mg, give 20 mg via G-Tube one time a day for acid reflux; -An order dated 10/25/22, for Atenolol (used to treat high blood pressure) tablet 100 mg, give one tablet via G-Tube one time a day for high blood pressure; -An order dated 1/31/24, for Amlodipine Besylate (used to treat high blood pressure) oral tablet 5 mg, give one tablet via G-Tube in the morning for high blood pressure; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order dated 2/1/24, for Iron oral tablet, give 325 mg via G-Tube one time a day for low iron. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: The resident requires tube feeding related to trouble swallowing and his/her stomach has difficulty processing food dated 4/18/19; -Goal: The resident will remain free of the side effects or complications related to tube feeding dated 3/18/24. The resident will maintain adequate nutritional and hydration states as evidenced by having a stable weight, no signs or symptoms of malnutrition or dehydration dated 3/18/24. Observation on 4/18/24 at 8:20 A.M., showed Licensed Practical Nurse (LPN) T near the nurse's station, put on a pair of gloves, pushed the medication cart passed two residents rooms and stopped at the resident's room. LPN T prepped the medications in the doorway of the room, on the medication cart. LPN T did not remove gloves or wash his/her hands. He/she brought medications into the resident's room, administered medications via the G-tube, and returned to the medication cart. LPN T did not remove his/her gloves or wash his/her hands. LPN T proceeded to the next resident room. During an interview on 4/23/24 at 7:41 A.M., Registered Nurse (RN) J said that anytime a nurse puts on and takes off gloves they should wash their hands. Nurses should not put gloves on at the nurse's station and proceed to administer medications or treatments to residents. The importance of handwashing is to prevent the spread of infection. During an interview on 4/23/24 at 7:46 A.M., the Assistant Director of Nursing (ADON) said that the nurses should wash their hand or use alcohol gel every time the nurses take off their gloves. Nurse should not put gloves on the nurse's station and go to provide care to the residents. The G-Tube is an entry way for bacteria and that is why the nurses should wash their hands and wear gloves. Observation of care provided for the resident on 4/19/24 at 7:20 A.M., showed Certified Nursing Assistant (CNA) H assisted the resident to turn to his/her side to perform care. During care, the resident began drooling from the left side of his/her mouth. CNA H used the Yankauer connected to the suction machine and lay it directly, uncovered on the bedside table to remove the drool from the resident's mouth and then placed the Yankauer back on the top of the machine, uncovered. The Yankauer and tubing was left uncovered on 4/22/24 at 9:14 A.M. and 4/23/24 at 7:37 A.M. During an interview on 4/23/24 at 7:41 A.M., RN J said that the suction tubing and Yankauer should be covered when not in use to decrease the chance of introduction of bacteria. During an interview on 4/23/24 at 7:46 A.M., the ADON said that after each use of the suction equipment, it should be disposed of but she had to check the policy. 2. Review of the facility's Tuberculosis-Testing and Screening (Associates and Volunteers) policy, dated 6/6/23, showed: -The facility will evaluate each associate and volunteer for tuberculosis in accordance with current Centers for Disease Control and Prevention (CDC) guidelines, unless more stringent guidance is provided by local or state regulation; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New Associate or Volunteer Testing: (1) New associates or volunteers who have been made a conditional offer shall be screened for presence of infection through the following measures; (b) The facility should also perform skin test for M Tuberculosis using the Mantoux TST skin test. Skin testing will employ the two-step procedure. (If the reaction to the first is less than 10 millimeters (mm) induration (swelling and redness), a second test will be given 1-3 weeks later). A positive second test is indicative of boosted reaction and not a new infection. If the second test remains negative, the person is classified as uninfected. Review of the employee files, showed: -Employee AA date of hire 9/20/23. No documentation for TB testing; -Employee BB date of hire 8/23/23. No documentation for TB testing; -Employee CC date of hire 1/25/24. No documentation for TB testing; -Employee DD date of hire 3/27/24. First step TB test completed on 3/27/24 and read negative on 3/29/24. No documentation of a second step TB test; -Employee EE date of hire 1/24/24. No documentation for TB testing; -Employee FF date of hire 3/10/23. No documentation for TB testing; -Employee GG date of hire 3/20/24. First step TB test completed on 3/27/24 and read negative on 3/29/24. No documentation of a second step TB test; -Employee HH date of hire 2/24/23. No documentation for TB testing. During an interview on 4/23/24 at 7:48 A.M., the ADON said that she expects new hires to have the Tuberculosis Screening per policy. The process is done in 2 steps and there is one to three weeks between them. The Director of Nursing (DON), ADON, Unit Managers (UM), and the wound nurse could administer, assess, and document the results of the testing. The importance of the testing is to prevent the spread of the disease.