STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265672	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff consistently notified physicians when residents' high blood glucose levels exceeded the ordered parameters. The facility identified 10 residents with orders for routine blood glucose level checks, four were sampled and problems were found with two (Residents #13 and #3). The census was 86. Review of the facility Change of Condition - Observing, Reporting and Recording policy, dated 5/17, showed: -Policy: It is the policy of this home to inform the resident, the resident's physician and if indicated the resident's responsible party of the following: -A significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental or psychosocial status, in life-threatening conditions or clinical complications; -A need to alter treatment significantly; -The attending physician should be notified as soon as possible when immediate attention is required; -Documentation: -Date, time condition change was identified. Pertinent assessment findings. Who was notified and when. Disposition of resident. 1. Review of Resident #13's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/24/25, showed: -Makes Self Understood: Understood; -Ability To Understand Others: Usually understands; -Moderately impaired cognition; -Diagnoses of diabetes mellitus (DM, high/low blood sugar), high blood pressure and dementia. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, located in the electronic medical record (EMR), showed: -5/9/23: Focus: diabetes mellitus requiring insulin and accu-checks (blood glucose monitoring). Goal: Will have no complications related to DM. Interventions/Tasks: diabetes medication as ordered. Monitor/document/report as necessary (PRN) any signs/symptoms of hyperglycemia (high blood glucose level) and hypoglycemia (low blood glucose level). Review of the resident's Physician's Order Sheet (POS), located in the EMR, showed: -9/14/23: Basaglar KwikPen (long-acting insulin) inject 25 units (u) one time a day for DM; -3/22/24: metformin HCl (DM oral medication) 1000 milligrams (mg) twice a day; -3/23/24: glipizide ER (DM oral medication) tablet 10 mg) daily; -5/6/24: blood sugar (glucose) every A.M. and P.M. Call physician if blood sugar is below 59 or 250 or above. Review of the resident's blood glucose levels located on the Medication Administration Record (MAR), showed: -2/1/25 through 2/28/25: 2/4 - 301, and 2/25 - 272; -3/1/25 through 2/25/25: 3/3 - 274, 3/21 - 285, and 3/22 - 401; -Review of the February and March MARs, showed no documentation the resident's physician was notified when the resident's blood glucose levels exceeded the ordered parameters of 250. Review of the resident's progress notes, dated 2/1/25 through 3/26/25, showed no documentation the resident's physician was notified when the resident's blood glucose level exceeded the ordered parameters of 250. During an interview on 3/25/25 at 1:26 P.M., the Director of Nurses (DON) said she did not find documentation staff updated the resident's physician on 2/4, 2/25, 3/3, 3/21, or 3/22 regarding the resident's blood glucose levels that exceeded the ordered parameters. Review of the resident's progress note, dated 3/25/25 at 11:48 A.M., showed the DON contacted the resident's physician regarding the blood glucose levels. The physician gave an order to increase the resident's basaglar insulin to 30 u every A.M., continue the blood glucose monitoring, update him in three days with the blood glucose level results and obtain a hemoglobin A1C (a lab that measures the average blood glucose level over the past two to three months). 2. Review of Resident #3's admission MDS, dated [DATE], showed: -Makes Self Understood: Usually understands; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of diabetes mellitus, dementia and malnutrition. Review of the resident's care plan, showed: -2/25/25: Focus: Diabetes Mellitus. Goal: Will be free from any signs/symptoms of hyperglycemia/hypoglycemia. Interventions/Tasks: Diabetes medication as ordered by the physician. Monitor/document/report to physician any signs/symptoms of hyperglycemia/hypoglycemia. Review of the resident's POS, showed: -3/20/25: Oolong (fast-acting insulin) FlexPen. Inject per sliding scale (the glucose level determines the amount of insulin that is administered) three times a day. Call physician if blood glucose level is less than 60 or greater than 400; -3/20/25: Lantus (long-acting insulin) SoloStar 10 u one time daily. Review of the resident's MAR, dated 3/1/25 through 3/31/25, showed a glucose level on 3/7 of 540 with no documentation staff contacted the resident's physician. Review of the resident's progress notes, showed no documentation staff contacted the resident's physician on 3/7/25, regarding the blood glucose level of 540. During an interview on 3/25/25 at 1:26 P.M., the DON said she did not find documentation staff updated the resident's physician on 3/7/25 about the resident's glucose level of 540. 3. During an interview on 3/25/25 at 7:20 A.M., Licensed Practical Nurse (LPN) J said if a resident's blood sugar exceeds the parameters the physician orders, he/she would contact the physician with the blood glucose results and document it in the progress notes along with any new order given by the physician. 4. During an interview on 3/25/25 at 7:24 A.M., LPN O said if a resident's blood sugar exceeds the parameters the physician orders, he/she would contact the physician with the blood glucose results and document it in the progress notes along with any new order given by the physician. 5. During an interview on 3/25/25 at 8:44 A.M., the DON said if a resident's blood glucose level exceeds the the physician's parameters for low or high blood glucose levels, she expected staff to contact the physician. Staff should document contacting the physician along with any new orders in the resident's progress notes. MO00251124

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview and record review, the facility failed to ensure Resident #3's physician was notified and monitoring was started after staff documented on shower review forms the resident had blisters on his/her bilateral feet. In addition, the facility failed to ensure staff initialed treatments had been completed and failed to ensure the resident wore his/her protective boots. Three residents were sampled and problems were found with one. The census was 86. Review of the facility Wound Management policy, dated 06/2020, showed: -Purpose: To provide a system for the treatment and management of residents wit wounds including pressure and non-pressure injury; -Policy: A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing; -Definitions: -Diabetic Neuropathic Ulcer: requires that the resident be diagnosed with diabetes mellitus (DM, high/low blood sugar) and peripheral neuropathy (damage or disease affecting the nerves). The diabetic ulcer characteristically occurs on the foot; -Assessment: -A licensed Nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident; -Upon identification of a new wound the Licensed Nurse will: measure the wound (length, width, depth). Initiate a Wound Monitoring Record sheet. A wound Monitoring Record will be completed for each wound. If the Wound Monitoring Record is not used, documentation will be recorded within the medical record which may include nurse's notes, treatment records or care plans. Implement a wound treatment per physician's order;; -An assessment of care needs for wound management will be made with emphasis on, but not limited to: identifying Risk factors. Treatment. Mechanical offloading and pressure reducing devices. Reducing skin friction, sheer, and moisture; -Wound Management: -The Attending Physician will be notified to advise on appropriate treatment promptly; -A Licensed Nurse will develop a care plan for the resident based on recommendations from Dietary, Rehabilitation and the Attending Physician; -Documentation: -New wounds will be documented on the 24 hour log; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation will include: Location of wound. Length, width, and depth measurements recorded in centimeters (cm). Appearance of the wound base. Drainage amount and characteristics including color, consistency, and odor. Appearance of wound edges. Description of the peri-wound (the area that surrounds the wound) or evaluation of the skin adjacent to the wound; -Licensed Nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis; -Document notifications following a change in the resident's skin; -Update the resident's care plan as necessary. Review of the facility's Showering a Resident policy, undated, showed: Report any broken skin, bruises, rashes, cuts, skin discoloration or reddened areas to the Charge Nurse. Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/1/25, showed: -Makes Self Understood: Usually understands; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Short and long term memory problem; -Functional limitations of both upper extremities and one lower extremity; -Dependent on staff for shower/bathing, roll left and roll right, lying to sitting on the side of the bed, chair/bed to chair transfer; -Diagnoses of DM, dementia and malnutrition; -Feeding Tube: Gastrostomy tube feeding (g-tube, a tube inserted into the stomach through the abdomen to provide nutrition, hydration and medicine); -Number of Venous and Arterial Ulcers: 0. Review of the resident's care plan, located in the electronic medical record (EMR), showed: 2/25/25: Focus: Diabetes Mellitus. Goal: Will be free from any signs/symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). Interventions/Tasks: Check all of body for breaks in skin and treat promptly as ordered by physician. Inspect feet daily for open sores, pressure areas, blisters, edema (swelling) or redness; -No focus/goal/interventions/tasks documented regarding actual/current wound on the resident's feet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review forms (completed on scheduled shower days by a CNA and co-signed by a Licensed Nurse) showed: -2/26/25, the anatomical figure on the form had both feet circled and blisters documented. Charge Nurse Assessment: under wound care. Interventions: pressure relief boots. Forwarded to Director of Nurses (DON): blank. The shower form was signed by the CNA and co-signed by the Assistant Director of Nurses (ADON); -3/3/25, an anatomical figure on the form that showed both feet circled and blisters documented. Charge Nurse Assessment: under wound care. Interventions: pressure relief boots. Forwarded to DON: blank. The shower form was signed by the CNA and co-signed by the ADON. Review of the Weekly Skin Check (completed by a Licensed Nurse) dated 3/5/25 (the last skin assessment prior to the resident being sent to the hospital on 3/14/25), showed: does the resident have any skin impairments? Yes. Description: Abdomen - g-tuber. Right and left hand - edema. Right toes - edema. Left toes - edema. No documentation about blisters or open areas on the feet. Review of the resident's physician's order sheet (POS) located in the EMR, showed no order from 2/26/25 through 3/13/25, for the blisters/open areas on the resident's feet. Review of the resident's progress note, from 2/26/25 through 3/14/25, showed no documentation if the physician had been notified about the blisters or open areas on the resident's feet. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form, dated 3/13/25, showed the anatomical figure on the form had both feet circled and blister treatment bandage documented. Charge Nurse Assessment: blisters and open area to left foot dressings in place. Intervention: under wound care physician and treatment nurse in house. Review of the resident's POS, showed: -3/14/25: wound care for bilateral lower extremity. Apply calcium alginate (an absorbent wound dressing) and dry dressing daily. The treatment order did not show how many wounds were on each foot. Review of the resident's Treatment Administration Record (TAR), showed an order dated 3/14/25, for wound care to the bilateral lower extremities. Apply calcium alginate and dry dressing daily. Staff initiated the treatment had been completed on 3/14/25. Review of the resident's progress notes, showed: -3/13 and 3/14/25: No documentation about the wounds on the resident's feet; -3/14/25 at 2:22 P.M.: Resident has an abnormal lab glucose level of 521. Resident's physician was notified; -3/14/25 at 2:45 P.M.: Talked to physician and was advised to send resident to emergency room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital report, dated 3/15/25 at 2:09 P.M., showed the resident came to the emergency room on 3/14/25 around 3:40 P.M. Resident arrived with wounds on the outside edge of left foot (is the worst), and right and left heel. Review of the resident's progress note, dated 3/19/25 4:10 P.M., showed the resident arrived at the facility via Emergency Medical Services (EMS) stretcher. Wound to left foot medial (middle) anterior (front) side and two open blisters on the right posterior heel. Review of the resident's TAR, showed an order dated 3/19/25, for calcium alginate to the bilateral feet daily and as necessary (PRN). Staff did not initial the treatment was completed on 3/19 and 3/20/25. Staff initialed the treatment as completed on 3/22, 3/23 and 3/24/25. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form, dated 3/22/25, showed blisters, open area documented. Charge Nurse Assessment: wound care treatment. Interventions: heel protectors. Forwarded to DON: blank. Observation on 3/24/25 at 8:45 A.M., showed the resident lay in bed. CNA L said Resident #3 was the only resident residing in the room. The resident did not currently have a roommate. Licensed Practical Nurse (LPN) H entered the resident's room and removed the resident's covers to complete a skin assessment. The resident had a pillow between his/her knees, but no pressure relieving boots. Observation showed two green pressure relieving boots on the second bed at that time. The resident had undated dressings on both feet. The LPN lifted the dressing, showing an open area on the left lateral heel with a moderate amount of slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) and drainage, an open area on the left medial foot with a moderate amount of slough and drainage, an open area on the right small toe with a scant amount of slough and drainage, and an red beefy colored open area on the right heel. The LPN confirmed there were no dates on the dressings. He/She said he/she did not work the past weekend and did not know when the dressings had been applied. After the skin assessment, the LPN covered the resident and left the room. The green protective boots remained on top of the second bed in the room. Observation at 1:13 P.M., showed no protective boots on the resident's feet and the green protective boots remained on the second bed in the resident's room. During an interview on 3/26/25 at 8:20 A.M., Registered Nurse K and LPN J said CNAs give them the shower sheet after the shower is completed. If the CNA identifies anything abnormal, they are responsible to assess the resident's skin. If there is not a current treatment order in place, they are responsible to call the physician for a treatment order. They are responsible to put the new order on the POS and TAR and document in the resident's progress notes. They would notify the facility Wound Nurse. During an interview on 3/26/25 at 8:43 A.M., the ADON reviewed the shower sheets dated 2/26 and 3/3, and confirmed she signed them. Although she did assess the resident's feet, she never notified the physician because she assumed the facility Wound Nurse was already aware and had updated the physician. She never documented her assessments in the progress notes. She did not look at the POS or TAR to see if orders were in place and she never discussed the blisters and open areas with the facility Wound Nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/25 at 9:25 A.M., the facility Wound Nurse reviewed the 2/26 and 3/3 shower sheets and said she was not notified by the ADON or anyone about the blisters or open areas. Had she been notified, she would have contacted the physician for treatment orders. She was not aware until 3/13 or 3/14, when the first treatment order was obtained and started. The resident should be wearing the protective boots. Review of the Wound Care Company physician's progress note, dated 3/26/25, no time documented, showed: -Location: left lower lateral (to the side) heel; -Measurements: 3.0 cm by 2.0 cm by 0.3 cm; -Etiology: diabetic ulcer; -Granulation (pink or red tissue with shiny, moist, granular appearance): 40%, and 60% slough; -Periwound: intact; -Exudate (drainage): moderate. Exudate appearance: serous (clear to yellow fluid that leaks from a wound); -Treatment: calcium alginate and cover with a dry dressing; -Location: left lower, medial (middle) foot; -Measurements: 3.0 cm by 2.0 cm by 0.3 cm; -Etiology: diabetic ulcer; -Granulation: 40% and 60% slough; -Periwound: intact; -Exudate: moderate; -Treatment: calcium alginate and cover with a dry dressing; -Location: right lateral 5th toe; -Measurements: 0.5 cm by 0.8 cm by 0.2 cm; -Etiology: diabetic ulcer; -Granulation: 80% and 20% slough: -Periwound: intact; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Exudate: light; -Treatment: calcium alginate and cover with a dry dressing; -Location: right medial heel; -Measurements: 2.0 cm by 23.0 cm by 0.10 cm; -Etiology: diabetic ulcer; -Epithelial (thin tissue that covers the exposed surfaces of the body): 100%; -Periwound: intact; -Exudate: none; -Treatment: Skin Prep (a liquid that when applied to the skin forms a protective film or barrier). During an interview on 3/25/25 at 8:44 A.M., the DON said she expected staff to write the date and their initials on dressings after they are completed. If there are blanks on the TAR, then she would have to assume the treatment had not been completed as ordered. At 1:26 P.M., the DON said the CNA fills out the shower sheet after every shower and gives it to the Licensed Nurse. If the CNA had documented anything abnormal about the skin, the Licensed Nurse has to assess the area(s) and if the area is new, they must call the physician and get a treatment. The new treatment should be documented on the POS and TAR. The Licensed Nurse should also document the assessment of the wound in the progress notes, including the measurement and description of the wound. She and the facility Wound Nurse should be notified. MO00251124

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services and/or treatment to increase or prevent reduction of range of motion. The facility failed to maintain a measurable, goal oriented restorative nursing program, and/or exercise program, to ensure residents requiring physical assistance were assisted by staff to maintain or improve their physical abilities, per facility policy. The facility provided a list of 11 current residents who had been discharged from skilled therapy services. Of those 11, two were identified with concerns of not getting recommended restorative therapy (Residents #21 and #19). The census was 87. Review of the facility Restorative Nursing Program Guidelines, dated 6/20, showed the following: -Purpose: The Restorative Nursing Program provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning; -Policy: -I. A resident may be started on a Restorative Nursing Program: -A. Upon admission to the Facility with restorative needs, but is not a candidate for formalized rehabilitation therapy; -B. When restorative needs arise during the course of a longer-term stay; -C. In conjunction with formalized rehabilitation therapy; or -D. When a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. -II. The Director of Nursing Services (DNS), or their designee, manages and directs the Restorative Nursing Program. Licensed rehabilitation professionals, (physical therapists, occupational therapists, and speech therapists) provide ongoing consultation and education for the Restorative Nursing Program; -A. General restorative nursing care is that which does not require the use of a qualified professional therapist to render such care. The basic restorative nursing categories include: -i. Active range of motion (AROM); -ii. Passive range of motion (PROM); -iii. Splinting or bracing; -iv. Amputation/Prosthesis management; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-v. Bladder training or bowel training; -vi. Bed mobility; -vii. Transfer training; -viii. Dressing or grooming; -ix. Walking; -x. Eating or swallowing; -xi. Communication. -Procedure: -I. Residents will be reviewed by the Interdisciplinary Team (IDT) upon admission, readmission, quarterly, and as needed to identify any decline in activity of daily living (ADL) function. If a decline is identified, the IDT will evaluate whether the resident is an appropriate candidate for restorative services; -II. The Attending Physician, Licensed Nurse or Therapist may refer the resident to the rehabilitation department for rehabilitative screening; -III. The Licensed Therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation or from unskilled therapy (e.g. restorative nursing services that can be provided by caregivers); -IV. In conjunction with the Attending Physician and staff, therapists will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes; -V. If a potential to benefit from rehabilitation therapies or restorative therapy (either skilled or unskilled) is identified, the Attending Physician will order a relevant therapy evaluation; -VI. An order will be obtained from the Attending Physician as indicated for participation in the Restorative Nursing program or for skilled rehabilitation services (e.g. physical, occupational, or speech therapy). -Documentation: -A. Restorative programs developed by therapy will be completed on paper and the facility will enter Restorative Nursing Program (RNP) in Point Click Care (PCC, electronic medical record) as appropriate; -B. The documentation will be done in PCC; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-C. The care plan will reflect the restorative needs of each resident including problems/needs, measurable goals and individualized approaches; -i. The care plan for each resident will be reviewed quarterly or as needed by the IDT; -ii. The Restorative Nurse's Aide (RNA) carries out the restorative program according to the care plan and documents daily. In addition, the RNA completes a written weekly summary for residents on a Restorative Nursing Program; -C. The Restorative Nursing Program Coordinator (or designee) reviews RNA weekly summary notes on a regular basis; -D. Licensed Nurses reflect participation in and progress of residents in the Restorative Nursing Program in their weekly/monthly summaries; -E. The following criteria must be met in order to code 00500 in the Minimum Data Set (MDS); -i. Measurable objectives and interventions must be documented in the care plan and in the medical record; -ii. Evidence of periodic evaluation by the Licensed Nurse must be present in the resident's medical record; -a. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a Licensed Nurse is sufficient to document the Restorative Nursing Program once the purpose and objectives of treatment have been established; -iii. Nursing assistants/aides are trained in the techniques that promote resident involvement in the activity; -iv. A Licensed Nurse must supervise the activities in the Restorative Nursing Program. 1. Review of Resident #19's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/24/25, showed the following: -Severe cognitive impairment; -No behaviors; -Impairment on one side for an upper and lower extremity; -Required partial to moderate assistance with ADLs; -Wheelchair mobility (manual or electric); -Diagnoses of high blood pressure, diabetes, and stroke; -Zero days of restorative therapy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Wellness Center	3421 Gasconade Saint Louis, MO 63118

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's occupational therapy (OT) Discharge summary, dated [DATE], showed Discharge Recommendation: Restorative Program Established/Trained-Restorative Dining Swallowing Program, Restorative Range of Motion Program. Review of the resident's medical record, showed no documentation the resident's physician was notified regarding the restorative therapy recommendation. Review of the resident's care plan, dated 10/5/24, showed the following: -Focus: The resident has an ADL self care performance deficit related to stroke; -Interventions: Eating: The resident is able to hold cup, feed him/herself and eat finger foods independently. -No documentation regarding ROM; -No interventions regarding restorative therapy. Review of the resident's Range of Motion-Indicate Passive or Active ROM form, dated 4/25/25, showed the following: -Goal: To maintain full ROM; -Training Approaches: Bilateral Upper Extremity (BUE); -No documentation of frequency. Review of the resident Eating form, dated 4/25/25, showed the following: -Goal: To maintain minimum of self feeding: -Training Approaches: Position at table with assistance with scooping hand to mouth as needed; -No documentation of frequency. During an interview on 4/30/25 at 7:43 A.M., the resident said he/she has not received any restorative therapy. He/she did not know how long it had been since he/she was evaluated. The resident said restorative therapy is important to him/her because he/she would like to get out of his/her wheelchair at some point. 2. Review of Resident #21's annual MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Wheelchair for mobility (manual or electric); -Dependent with ADLs; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of anemia (a condition where the blood doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), congestive heart failure, and high blood pressure; -Zero days for restorative therapy. Review of the resident's medical record, showed an order dated 3/4/25, for an OT evaluation and treatment as indicated. Review of the resident's medical record, showed OT evaluation completed as ordered. Review of the resident's OT Discharge summary, dated [DATE] through 4/9/25, showed the following: -Discharge Recommendation and Status: -Discharge Recommendation: Potential need for scoop bowl for increased independence with feeding; -Restorative Programs: Restorative Program Established/Trained=Restorative Dining/Swallowing Program. Dining/Swallowing Program Established/Trained: Resident has difficulty obtaining items due to decreased coordination as well as attention to continue to self-feed. Resident to increase ability to self feed with appropriate adaptations like scoop bowl as needed and attention to meal. Review of the resident's medical record, showed no documentation the resident's physician was notified regarding the restorative therapy recommendation. Review of the resident's care plan, dated 10/5/24, showed the following: -Focus: Resident has an ADL self care performance deficit related to dementia; -Intervention: The resident is able to a hold cup, feed him/her self and eat finger foods independently. -The care plan did not identify OT recommendations or use of a scoop bowl; -No interventions regarding restorative therapy. Review of the resident's Eating Form, dated 4/9/25, showed the following: -Goals: Increase attention and ability to self feed; -Training Approaches: Blank. 3. During an interview on 4/29/25 at 9:33 A.M., the Restorative Aide (RTA) said he/she had not done any restorative exercises for any of the residents. The RTA said he/she has been busy taking his/her Certified Medication Technician classes. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 9:52 A.M., the Area Director of Rehabilitation said the purpose of restorative therapy program is to prevent decline in the resident's achievement from skilled therapy. A protocol of exercises will be given to the RTA regarding each resident and kept in a book. The Director of Nursing (DON) will oversee the RTA and the duties. The Area Director of Rehabilitation said she was aware the restorative program was not active due to the RTA being in another school. During an interview on 4/30/25 at 12:33 P.M., the MDS Coordinator said the therapy department will send over the restorative orders via email. He/She did not know what to do with the tasks. He/She has spoken with the DON on what to do, but was not given any clear guidance. The MDS Coordinator said a Registered Nurse (RN) should oversee the restorative aide and he/she is not an RN. During an interview on 4/30/25 at 12:07 P.M., the DON said the purpose of restorative therapy is to prevent decline after skilled therapy. The DON said the Director of Rehabilitation (DOR) will send the recommendations to the MDS Coordinator. He/She will call the doctor for orders for restorative therapy. Once the order is obtained, the orders are given to the RTA to follow through. The DOR will oversee the RTA for the duties. The DON should be kept updated. The facility has an active RTA, but he/she did not feel comfortable doing the tasks. At that time, the Administrator said he agreed with the DON's statements about who should monitor the RTA and the tasks for the RTA. MO00253381

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 34 opportunities observed, nine errors occurred resulting in a 26.47% error rate (Residents #11, #7, #12 and #4). In addition, Resident #1, Resident #4, and residents attending the 3/3/25 Resident Council meeting complained about receiving medications late. The census was 86. Review of the facility Medication-Administration policy, dated 5/2017, showed: -Policy: It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations; -Procedure: -Medications are prepared, administered, and recorded only by licensed nursing, Certified Medications Technicians (CMTs), medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications; -Current medications and dosage schedules are listed on the resident's Medication Administration Record (MAR); -Medications are administered within 60 minutes of scheduled time (60 minutes before or after the scheduled time); -If a dose of regularly scheduled medication is withheld or refused, the space provided on the front of the MAR for that dosage administration is initialed and circled; -Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 1. Review of the facility 3/24/25, resident census report showed 39 residents resided on the 100 hall. During an interview on 3/24/25 at 10:05 A.M., CMT I, who was on the floor passing the morning medications said he/she is the only CMT who passes medications on the 100 hall on day shift. He/She arrived at work at 7:00 A.M., and started the med pass around 7:30 A.M. He/She has about 40 residents to pass medications to. He/She just finished passing medications to the 153-168 hall and some residents while they were in the dining room. He/She still had about 9 residents left to pass medications to in the 112-127 hall. By the time he/she finished the morning medication pass, it was about time to begin the noon medication pass. The facility really needs a second person to help pass the morning medications. Observation at 11:10 A.M., showed the CMT finished his/her morning medication pass. 2. Observation on 3/25/25 at 10:00 A.M., showed CMT I prepared Resident #11's morning medications which included baclofen (muscle relaxant) 10 milligrams (mg) two times a day at 8:00 A.M. and 8:00 P.M. At 10:09 A.M. The CMT administered the medications to the resident at 10:09 A.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 3/25/25 at 10:11 A.M., showed CMT I prepared Resident #7's morning medication, levetiracetam (anti seizure medication) 1000 mg every 12 hours at 8:00 A.M. and 8:00 P.M. The CMT administered the medication to the resident at 10:12 A.M. 4. Observation on 3/25/25 at 10:13 A.M., showed CMT I prepared Resident #12's morning medications which included gabapentin (used to treat nerve pain) 400 mg three times a day at 8:00 A.M., 12:00 P.M., and 4:00 P.M. Pentoxifylline (improves blood flow) 400 mg three times a day at 9:00 A.M., 1:00 P.M., and 5:00 P. M. Risperidone (antipsychotic) 0.5 mg two times a day at 8:00 A.M., and 5:00 P.M. Oxycarbazepine (anti seizure medication) 300 mg twice a day at 8:00 A.M., and 5:00 P.M. The CMT administered the medication to the resident at 10:26 A.M. 5. Observation on 3/25/25 at 10:28 A.M., showed CMT I prepared Resident #4's morning mediations which included Oyster Shell Calcium (used to prevent calcium deficiency) 250 mg twice a day at 8:00 A.M. and 4:00 P.M., and Eliquis (used to prevent blood clots and lower the risk of stroke) 5 mg twice a day at 8:00 A. M. and 4:00 P.M. The CMT administered the medication to the resident at 10:36 A.M. During an interview on 3/24/25 at 7:30 A.M., Resident #4 said he/she gets his/her morning medications late all the time. Sometimes not until 11:00 A.M. or 12:00 P.M. 6. During an interview on 3/25/25 at 10:36 A.M., CMT I said medications should be administered one hour prior to, or one hour after the medication administration time. He/She had four more residents to administer medications to before the morning medication pass was finished. 7. Review of the Resident Council minutes, dated 3/3/25 at 11:12 A.M. - 11:35 A.M.,, attended by 14 residents, showed residents raised concerns about not getting their medications on time. 8. During an interview on 3/25/25 at 12:27 P.M., Resident #1 said when they start passing medications on his/her hall he/she gets his/her medications on time. When they start passing on the other hall first it can be close to noon before he/she gets his/her 8:00 A.M. medication. 9. During an interview on 3/25/25 at 8:44 A.M., the Director of Nurses said the residents are supposed to be on a liberalized med pass (flexible med pass times such as A.M. (7 A.M. to 11:00 A.M.)). She did not know the meds were still being passed on traditional set times. In that case, an 8:00 A.M. med can be passed from one hour before (7:00 A.M. to one hour after (9:00 A.M.)). Anything out of that range would be considered a medication error. 10. During an interview on 3/25/25 at 12:52 A.M., the Administrator said he thought the medication pass was liberalized. He did not know the residents had specific times scheduled. If there are specific times scheduled, the medication should be received one hour prior to the time scheduled or up to one hour after the time scheduled. Anything out of those time parameters would be considered a medication error. MO00246938 MO00248935 MO00250663

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who required enhanced barrier precautions (EBP) for infection control interventions had a sign on their door or wall next to the room entrance instructing staff to use EBPs while providing personal care. In addition, the facility failed to ensure personal protective equipment (PPE, gloves, gowns, masks and goggles/face shields) were readily accessible for residents requiring EBP, and staff were inserviced on EBP and which residents required EBPs. The facility identified 18 residents who required EBPs, and this had the potential to affect all residents (Residents #5, #6 and #3). The census was 86. Review of the facility's Standard and Enhanced Precautions policy, dated 4/1/24, showed: -Purpose: To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents; -Policy: The facility will utilize current guidelines from the Centers for Disease Control (CDC) and the Censers for Medicare & Medicaid Services (CMS) to determine the appropriate PPE to be utilized during the care of residents to minimize the risk of infection or spread of infection; -Definitions: Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (e.g., urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters and wound or unhealed pressure ulcers; -For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care use such as feeding tubes, and wound care for any skin opening requiring a dressing; -EBP are intended to be in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at high risk; -The Infection Preventionist will follow the guidelines for Enhanced Standard Precautions for Long-Term Care Facilities for residents at high risk for MDRO colonization and transmission. Review of the facility's Enhanced Barrier Precaution signage (to be placed on the door or wall next to the door of residents that meet EBP requirements), showed: -EBP Everyone Must: -Clean their hands, including before entering and when leaving the room; -Providers and Staff Must Also: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. 1. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 2/24/25, showed: -Diagnoses of stroke and malnutrition; -Feeding Tube: Gastrostomy tube feeding (g-tube, inserted into the stomach through a surgical opening on the abdomen to provide nutrition, hydration and medicine); -Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: Yes; -One Stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles not exposed. Slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling); -One Stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). Review of the resident's care plan, located in the electronic medical record (EMR), showed: -10/23/24: Focus: Activity of daily living self care performance deficit. Goal: Will maintain current level of function. Interventions/Tasks: Bedfast most of the time. Requires two staff with transfers and bed mobility. Requires a skin inspection every shift; -11/19/25: Focus: Potential nutritional problem, receives tube feeding. Goal: Will have stable weight. Interventions/Tasks: -12/31/24: Focus: resident has a Stage 4 pressure ulcer (injury) to his/her sacrum (a large, triangular bone at the base of the spine). Goal: Will have no complications related to pressure ulcer. Interventions/Tasks: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow facility protocols to treatment of injury; -No documentation about staff using EBP during care. Review of the facility's weekly Pressure Injury Trending Report for the third week of March, 2025, showed: -Midline sacrum Stage 4 pressure injury measuring 8.0 centimeters (cm) length by 7.5 cm width by 2.5 cm depth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/24/25 at 8:00 A.M., showed the resident lay in bed. There was no EBP sign on the door and no PPE supplies outside or inside the room, except gloves. Licensed Practical Nurse (LPN) A and Certified Nursing Assistant (CNA) B entered the room to complete a skin assessment. Both the LPN and CNA donned gloves, but did not don a gown. The LPN placed the resident's g-tube feeding on hold, lowered the head of the bed, removed the resident's covers and turned the resident onto his/her right side revealing a pressure ulcer on the sacrum with no dressing covering it. The CNA lifted the corner of the dressing on the feeding tube stoma (surgical opening) for observation. The LPN applied a new dressing to the resident's sacrum wearing gloves but no gown. 2. Review of Resident #6's quarterly MDS, dated [DATE], showed: -Diagnoses of seizure disorder and malnutrition; -Feeding tube. Review of Resident #6's care plan located in the EMR, showed: -2/3/25: Focus: Tube feeding. Goal: Will remain free of side effects or complications related to tube feeding. Interventions/Tasks: Clean insertion site daily as ordered; -No documentation about staff using EBP during care. Observation on 3/24/25 at 8:21 A.M., showed the resident lay in bed. There was no EBP sign on the door and no PPE supplies outside or inside the room, except gloves. LPN A entered the room to complete a skin assessment. The LPN donned a pair of gloves, but no gown. The resident's tube feeding was off and disconnected. The LPN lowered the head of the bed, removed the covers and turned the resident from side to side, and lifted up the resident's tube feeding dressing covering the feeding tube stoma site for observation. 3. Review of Resident #3's admission MDS, dated [DATE], showed: -Diagnoses of diabetes mellitus (DM, high/low blood sugar), dementia and malnutrition; -Feeding Tube; -Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: No; -Number of Venous and Arterial Ulcers: 0. Review of the resident's care plan located in the EMR, showed: -2/25/25: Focus: Diabetes mellitus. Goal: Will be free from signs/symptoms of hyperglycemia and hypoglycemia. Interventions/Tasks: Check all of body for breaks in skin and treat promptly as ordered by physician. Diabetes medication as ordered. Inspect feet daily for open areas, sores, pressure areas, blisters, swelling or redness. Monitor/document/report to physician signs/symptoms of hypoglycemia and hyperglycemia; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2/25/25: Focus: Requires a tube feeding due to dysphagia (difficult swallowing). Goal: Will be free of aspiration (food/fluids enters the lungs). Interventions/Tasks: Monitor and report any signs of aspiration; -No focus area for pressure injuries or wounds; -No documentation about staff using EBP during care. Observation on 3/24/25 at 8:45 A.M., showed the resident lay in bed. There was no EBP sign on the door and no PPE supplies outside or inside the room, except gloves. LPN H entered the room to complete a skin assessment. The LPN donned a pair of gloves but no gown. The resident's tube feeding was off and disconnected. The LPN lowered the head of the resident's bed, removed the covers and turned the resident from side to side. The LPN peeled back the dressings on the resident's feet and the tube feeding stoma for observation. 4. Observation of the 100 and 200 halls on 3/24/25 from 9:00 A.M. until 9:20 A.M., showed no EBP signs on any resident room doors, and no PPE supplies in the halls with the exception of room [ROOM NUMBER] that had a contact precaution sign on the door. 5. During an interview on 3/24/25 at 9:25 A.M., CNA C said to his/her knowledge, the only resident who required EBP is the resident in room [ROOM NUMBER]. No other residents require EBP when providing care. He/She was not aware he/she should wear a gown in addition to gloves while providing personal care to residents with urinary catheters, wounds or feeding tubes. 6. During an interview on 3/24/25 at 10:00 A.M., CNA D said he/she just started today and does not know which residents require EBP supplies when providing care. So far today, he/she had only worn gloves while providing personal care. 7. During an interview on 3/24/25 at 10:10 A.M., CNA E said he/she uses gloves when providing care to residents with g-tubes, urinary catheters and wounds. He/She had not been told to wear a gown in addition to gloves while providing personal care to those residents. 8. During an interview on 3/24/25 at 10:13 A.M., LPN A said he/she had not seen the facility's EBP policy, but was aware gloves and gowns should be worn while providing care to residents with pressure injuries, wounds, feeding tubes and intravenous (IVs). He/She should have worn a gown today, when he/she did Resident #5's treatment and Resident #6's skin assessment. There should be signs on the doors for those residents requiring EBP and there should be PPE supplies outside those residents' rooms. 9. During an interview on 3/24/25 at 10:20 A.M., LPN F (agency staff) said he/she was aware gloves and gowns should be used when providing care to residents with tube feeding, wounds, and IVs. He/She had not been wearing the gowns because they are not available. He/She would wear them if available. 10. During an interview on 3/24/25 at 10:31 A.M., CNA G said he/she had never seen any EBP signs on the resident doors. He/She wears gloves when providing care to all residents, but does not wear gowns. No one told him/her to wear the gowns. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During an interview on 3/25/25 at 8:44 A.M., the Director of Nurses (DON) said she was aware of the EBP requirements. The facility has the EBP signs but have not put them on the doors of residents requiring EBP supplies. Last week or the week before, the facility ordered containers to hold the EBP supplies, but they have not come in yet, She was going to have the signs put on the residents' doors when the containers came in. They should have put the signs up even if they did not have the containers. The facility has the necessary EBP supplies on hand. 12. Review of the facility list of residents who meet the EBP requirements received from the DON on 3/25/25 at 12:00 P.M., showed 18 of 86 residents, including Resident #5, Resident #6 and Resident #3 should have EBP signs posted on their doors with PPE supplies readily available for staff use. 13. During an interview on 3/26/25 at 8:43 A.M., the ADON/Infection Preventionist said she had been at the facility for about two weeks. The facility had EBP signs and supplies but they had not put them up on the doors of residents requiring EBPs. They were waiting on the container to hold the EBP supplies which should be in any day.