

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2024
NAME OF PROVIDER OR SUPPLIER  Beauvais Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3625 Magnolia Avenue Saint Louis, MO 63110	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29948</b></p> <p>Based on interview and record review, the facility failed to provide services to promote the highest practicable physical well-being for two of seven sampled residents (Residents #2 and #1). One resident's resistance to repositioning and transfers due to a stiff painful knee from osteoarthritis (a degenerative joint disease which causes tissues in the joint to break down over time) experienced recurring issues with moisture associated skin damage (MASD, inflammation and erosion of the skin). Nursing staff also failed to consistently carry out physician's orders to get the resident out of bed for meals to improve intake as well as a need for pressure relief (Resident #2). Another resident resisting staff attempts to open and clean his/her contracted (a condition of shortening and hardening of muscles, tendons or other tissue, often leading to deformity and rigidity of joints) hand resulted in hand hygiene deficits (Resident #1). The census was 137.</p> <p>Review of the facility policy titled, Pain Management, revised 10/24/22, showed the purpose of the policy was to ensure accurate assessment and management of a resident's pain. A licensed nurse was to assess residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility staff was responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. The licensed nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR). The licensed nurse will assess the resident for pain and document results on the MAR each shift using the 1-10 pain scale. The shift pain score will indicate the highest pain level that occurred on that shift. If there is a new onset of pain, if the pain has changed in nature, or the pain has not been relieved with current medication, the licensed nurse will notify the attending physician for a review of medications. The Interdisciplinary Team (IDT) Committee will review the resident's pain assessment. The licensed nurse will notify the resident/responsible party regarding new pain medication orders. Nursing staff will implement timely interventions to reduce the increase in severity of pain. The nursing staff will attempt to become familiar with cognitive, cultural, familial or gender-specific influences on the resident's ability or willingness to verbalize pain. Nursing staff will also use non-pharmacological interventions by adjusting the resident's environment to reduce pain. The licensed nurse will document the resident's pain and response to interventions in the medical record on the weekly summary and as indicated on the progress notes. The licensed nurse will update the care plan for pain management with any change in treatment or medication.</p> <p>Review of the facility's policy titled, Physician Orders, 10/24/22, showed the purpose was to ensure that all physician orders are complete and accurate. Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/26/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Diagnoses included osteoarthritis unspecified site, pain in right knee, progressive neurological conditions, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), other specified disorders of muscle shoulder region, abnormalities of gait and mobility, anemia and high blood pressure;</li> <li>-Wheelchair mobility;</li> <li>-Mechanically altered diet;</li> <li>-Weight: 127 pounds, height 63 inches;</li> <li>-No weight loss of 5% or more in the last month or loss of 10% or more in the last six months;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-No unhealed pressure ulcers;</li> <li>-Required substantial/maximal assistance with eating, oral hygiene, dressing, personal hygiene, bed mobility;</li> <li>-Dependent on full performance by staff of toileting hygiene, shower/bathing and transfers.</li> </ul> <p>Review of the resident's undated physician's orders, showed the following:</p> <ul style="list-style-type: none"> <li>-6/2/20, snack at bedtime (HS) for hypoglycemia (low blood sugar);</li> <li>-6/28/20, assess pain level every shift for pain monitoring;</li> <li>-11/3/20, weekly skin assessment every night shift every Thursday for skin monitoring. Please document assessment in progress notes. Notify MD/Nurse Practitioner (NP)/ Family/Director of Nurses (DON) of any skin changes/abnormalities;</li> <li>-4/2/21, acetaminophen, give 650 mg every 6 hours as needed (PRN) for pain/headache/temp greater than 100 Fahrenheit;</li> <li>-5/19/22, admit to Palliative Services, Dx (diagnosis): Alzheimer's disease;</li> <li>-12/19/22, add snacks between meals and at HS;</li> <li>-5/22/23, Ready Care three times a day for weight management 120 cubic centimeters (cc) health shakes;</li> <li>-6/19/23, nurse please make sure resident is up for all meals;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7/3/23, Lidocaine external gel 4% (used to prevent and treat chronic pain), apply to right knee topically 1 time a day related to unspecified osteoarthritis unspecified site;</p> <p>-7/3/23, remove Lidocaine patch 4% at HS.</p> <p>Review of the resident's undated weight summary, showed on 10/1/23 at 9:39 P.M., the resident weighed 132.0 lbs. On 11/1/23, the resident weighed 130 lbs.</p> <p>Review of the resident's shower sheets/skin condition reports, showed the following:</p> <p>-11/2/23, shower and skin check done. None of the descriptors for the skin condition were selected and the diagram was blank;</p> <p>-11/6/23, open area to coccyx (tailbone). Additional notes: order for coccyx;</p> <p>-11/9/23, open area to coccyx.</p> <p>Review of the resident's progress notes, dated 11/9/23 at 11:44 A.M., showed the following order administration note at 11:44 A.M., acetaminophen 650 mg tablet given at 10:00 A.M. for right knee pain. At 4:05 P.M., the PRN administration was effective.</p> <p>Review of the resident's shower sheets/skin condition reports, showed the following:</p> <p>-11/13/23, showed abnormal skin with open area to coccyx;</p> <p>-11/16/23, area to coccyx selected on diagram. Skin condition descriptors unchecked;</p> <p>-11/20/23, red area to right buttock. Skin condition descriptors unchecked. Note: orders in place;</p> <p>-11/23/23, right buttock marked with an x. Skin condition descriptors unchecked;</p> <p>-11/27/23, right buttock marked with an x. Skin condition descriptors unchecked. Note: red area right (R) butt.</p> <p>Review of the resident's weekly skin observation, dated 11/29/23, showed skin issues on the right buttock: red area, calmoseptine (multipurpose moister barrier that protects and helps heal skin irritation) applied.</p> <p>Review of the resident's shower sheets/skin condition reports, dated 11/30/23, showed there was a red area on the resident's right buttock.</p> <p>Review of the resident's shower sheets/skin condition report, dated 12/4/23 and 12/7/23, showed shower and skin check done. None of the descriptors for the skin condition were selected and the diagram was blank.</p> <p>Review of the resident's undated weight summary, dated 12/10/23 at 11:05 A.M., showed the resident weighed 127.4 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's shower sheets/skin condition report, dated 12/14/23 and 12/18/23, showed shower and skin check done. None of the descriptors for the skin condition were selected and the diagram was blank.</p> <p>Review of the resident's physician progress note, dated 12/18/23, showed his/her right buttock wound was healed.</p> <p>Review of the resident's undated physician's orders, showed an order dated 12/18/23, for Ensure two times a day as a supplement. There was also an order dated 12/28/23, which showed the resident was at risk for malnutrition. Interventions included: Registered Dietitian (RD) to monitor, labs PRN, as well as monitoring of weights and medications.</p> <p>Review of the resident's shower sheets/skin condition report, dated 12/21/23, 12/25/23, 12/28/23 showed shower and skin checks were done. None of the descriptors for the skin condition were selected and the diagram was blank.</p> <p>Review of the resident's undated care plan, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident has limited physical mobility/activities of daily living (ADL) self-care deficit related to weakness and osteoarthritis;</li> <li>-Extensive assistance required with bed mobility, eating and dressing;</li> <li>-The resident requires total assistance with bathing, personal hygiene, toileting, and locomotion;</li> <li>-He/she is resistive to care and has a history of refusing assistance with transfers related to dementia;</li> <li>-He/she has a communication problem. Weak or absent voice;</li> <li>-Anticipate and meet the resident's needs;</li> <li>-Impaired cognitive function related to Alzheimer's disease;</li> <li>-Monitor/document physical/nonverbal indicators of discomfort or distress and follow-up PRN;</li> <li>-The resident has a nutritional problem or potential nutritional problem and is at risk for malnutrition;</li> <li>-He/she is at risk for generalized pain;</li> <li>-Monitor/record/report to nurse the resident's complaints of pain or requests for pain treatment;</li> <li>-Notify physician if interventions are unsuccessful or if current complaint is a significant change from the resident's past experience of pain;</li> <li>-The resident has potential/actual impairment to skin integrity.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's weekly skin observations, dated 1/2/24 and 1/5/24, showed the skin of his/her right and left buttocks had blanchable redness (red skin which turns white when pressed with a fingertip, then immediately turns red again when the pressure is removed).</p> <p>During an interview on 1/16/24 at 1:15 P.M., the Assistant Director of Rehab (ADR) said when she first started working at the facility in November of last year, staff were not getting the resident up. The resident complained about pain but needed to be up in his/her wheelchair for social interactions and brain stimulation. Staff getting the resident up at least three days a week would help with contractures, positioning and skin breakdown from pressure.</p> <p>During an interview on 1/11/24 at 4:24 P.M., Certified Nurse Aide (CNA) A said the resident allowed staff to get him/her out of bed, but complained about knee pain. He/She was not good with staff repositioning, because the stiffness of his/her right knee bothered him/her. Sometimes, the resident could feed him/herself, but often needed help and other than dessert or snacks, he/she would not eat regular food in bed.</p> <p>During an interview on 1/11/24 at 3:32 P.M., Nurse C said when he/she started working at the facility in December of last year, staff were not getting the resident out of bed. So, Nurse C made sure staff got him/her up into a wheelchair. The resident refused showers a lot, complaining the water was too cold.</p> <p>During an interview on 1/11/24 at 4:04 P.M., CNA D said staffing issues made it challenging to get residents out of bed daily. Residents frequently refused showers because the water did not get warm. Another issue with ADL care was the fact that supplies like soap, briefs and towels were always low.</p> <p>During an interview on 1/26/24 at 10:05 A.M., the DON said her Assistant Directors of Nursing (ADONs) had reported in clinical meetings about having to go to Resident #2's floor and have conversations with the resident's family member in the evening about the resident being in bed and not up for the meal, the ADONs subsequently going and having staff get the resident out of bed. After this surveyor requested copies of the resident's shower sheets, the DON saw the documented blanchable redness on the resident's buttocks and spoke with the Wound Nurse. According to the Wound Nurse, the resident had a history of recurring breakdown in that area which would heal and go away. The resident had really dry skin and did not like to get out of bed. He/She had to be encouraged to get out of bed. Staff had to stay on top of rotating the resident in bed. A combination of dry skin and pressure were responsible for the blanchable redness on the resident's buttocks.</p> <p>During an interview on 1/24/24 at 12:20 P.M., Physician B said he/she had issued an order for staff to get the resident up for all three meals each day, after the resident's family phoned Physician B six months ago with concerns about staff not getting the resident up for meals. The resident ate much better, when he/she staff got him/her up for meals. Also, getting the resident up for meals helped with preventing skin breakdown from pressure. The blanchable redness on the resident's buttocks was due to a combination of prolonged exposure to moisture and pressure.</p> <p>2. Review of Resident #1's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses including hemiplegia, malnutrition, encephalopathy (disease, damage, or malfunction of the brain), muscle weakness (generalized), dysphagia oropharyngeal phase (difficulty in either the oral or throat phases of swallowing, such as in chewing, initiating the swallow, or propelling the bolus through the throat to the esophagus- the muscular tube connecting the throat and stomach), unspecified abdominal pain, difficulty in walking not elsewhere classified, fractures and other multiple trauma, subluxation of C7/T1 cervical vertebrae subsequent encounter (partial dislocation of the segment of the spine connecting the neck with the upper back), anemia, high blood pressure, aphasia (loss of ability to understand or use words correctly, caused by brain damage) and cerebrovascular disease (CVA, stroke);</p> <p>-Required substantial/maximal assistance with eating, oral hygiene, dressing and mobility;</p> <p>-Dependent on full performance by staff of showers/bathing, putting on/removing footwear, chair/bed-to-chair transfers, wheelchair mobility.</p> <p>Review of the resident's undated physician's orders, showed the following:</p> <p>-1/4/24, pain assessment every shift;</p> <p>-1/8/24, acetaminophen Oral Tablet 325 mg, give 2 tablets via gastrostomy tube, (g-tube, a tube inserted through the belly that delivers nutrition directly to the stomach) every 6 hours PRN for pain-moderate;</p> <p>-1/9/24, weekly skin checks every evening shift every Monday. Please document assessment in progress notes. Notify MD/NP/Family/DON of any changes/abnormalities;</p> <p>-1/8/24, Lidocane external patch 5%, apply to lower back two times a day for pain, on at 9:00 AM off at 9:00 PM.</p> <p>Review of the resident's undated care plan, showed the following:</p> <p>-The resident has an ADL self-care performance deficit;</p> <p>-He/She requires extensive assistance with bathing/showering, personal hygiene/oral care, bed mobility, and dressing;</p> <p>-The resident has limited physical mobility related to contractures/CVA;</p> <p>-He/She has impaired cognitive function;</p> <p>-The resident has a communication problem. He/She can make his/her needs known;</p> <p>-He/She has chronic pain;</p> <p>-Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor/record pain characteristics. Quality (e.g. sharp, burning). Severity (1-10 scale), anatomical location, onset, duration (e.g. continuous, intermittent), aggravating factors, relieving factors;</p> <p>-Monitor/record/report to nurse any signs/symptoms of non-verbal pain;</p> <p>-Monitor/record/report to nurse resident's complaints of pain or requests for pain treatment;</p> <p>-Notify physician if interventions are unsuccessful or if current complaint is a significant change from the resident's past experience of pain.</p> <p>Review of the resident's therapy screen/referral form, signed 1/16/24, showed the following:</p> <p>-Decreased range-of-motion (ROM)/contracture: LLE (hand);</p> <p>-Need for splint/orthotic/prosthetic: has palm protector;</p> <p>-Pain/edema: resident complaints of pain at times;</p> <p>-Decline in ADLs: requires max assistance per staff;</p> <p>-The resident would benefit from therapy services to address ADL function, contracture/splint, pain, transfers.</p> <p>Review of the resident's Occupational Therapist (OT) evaluation and plan of treatment, signed 1/18/24, showed the start of care was on 1/18/24. Diagnoses included contracture of left hand, contracture of left elbow, encephalopathy and muscle weakness (generalized). A new goal was completion of hygiene and grooming tasks such as cleaning his/her left hand. His/Her baseline was total dependence without attempts to initiate.</p> <p>Review of the resident's OT treatment encounter notes, dated 1/29/24, showed the following:</p> <p>-Precautions/contraindications: contractures upper and lower extremity;</p> <p>-Warm water soak of L hand/wrist/digits in preparation for stretching and hand hygiene. Pain with stretching of distal phalangeal joint (connects the bones at the tips of the fingers) and proximal inter-phalangeal (the first joint of the finger between the first two bones of the finger) joints.</p> <p>-Pain limits the following functional activities: stretching of joints in left hand;</p> <p>-Pain at rest: 3/10;</p> <p>-Pain with movement: 5/10;</p> <p>-Frequency: other (during stretching and warm soak);</p> <p>-Location: L hand/wrist;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Pain description/type: N/A (not applicable).</p> <p>During an interview on 1/11/24 at 3:32 P.M., Nurse C said the resident's left hand was contracted due to a stroke. Staff had not been instructed to place a rolled towel or orthotic carrot in the resident's hand. The resident would not always allow staff to open the resident's hand and clean it. A lot of the time, he/she said, stop messing with me or don't do that.</p> <p>During an interview on 1/16/24 at 1:15 P.M., the ADR said the resident had a contracted hand which he/she did not usually allow anyone to mess with it. Staff were not keeping a rolled towel or orthotic carrot in the resident's hand. The therapy department had evaluated him/her a couple of weeks prior to the interview and began treating it with warm water soaks and electrical muscle stimulation (stimulates muscle contractions and strengthens tissue, particularly muscles which have become shortened, weakened or atrophied due to injury or disease). They need to get the hand open, so that he/she could at least wear a palm protector.</p> <p>During an interview on 1/26/24 at 10:05 A.M., the DON said she was unaware the resident was not allowing staff to clean his/her contracted hand. If the resident was refusing care due to pain, then she expected staff to notify her if the pain was new or out of the ordinary.</p> <p>During an interview on 1/24/24 at 12:20 P.M., Physician B said the resident had left-sided hemiplegia. The muscles on that side of his/her body did not work well and his/her left hand was paralyzed. Physician B was concerned about a buildup of moisture in the resident's closed left hand leading to infection, so Physician B asked staff if they washed the resident's hand and was told the resident was refusing. Physician B instructed them to use alcohol to clean the resident's hand. Staff did not report the refusals were due to the pain caused when they opened the resident's hand. The resident had orders for pain medication. Physician B expected staff to let him/her know if the resident was experiencing breakthrough pain.</p> <p>3. During an interview on 1/26/24 at 12:13 P.M., the Administrator said his expectation was that nursing staff follow nursing standards of care in accordance with facility policy, as long as the resident was in agreement with it.</p> <p>MO00229385</p> <p>MO00229867</p> <p>MO00229879</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>29948</p> <p>Based on observation, interview and record review, the facility failed to adequately address the pain of one of seven sampled residents (Resident #3). The facility failed to assess, monitor and implement interventions to adequately address breakthrough pain (a sudden and brief flare-up of pain from a chronic condition like arthritis which breaks through doses of administered pain medication) which impacted the provision of rehabilitation services and assistance with activities of daily living (ADLs). Nursing staff also failed to consistently carry out physician's orders for a neurological assessment to secure Botox treatments to relax the resident's tightly contracted joints. The census was 137.</p> <p>Review of the facility policy titled, Pain Management, revised 10/24/22, showed the purpose of the policy was to ensure accurate assessment and management of a resident's pain. A licensed nurse was to assess residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility staff was responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. The licensed nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR). The licensed nurse will assess the resident for pain and document results on the MAR each shift using the 1-10 pain scale. The shift pain score will indicate the highest pain level that occurred on that shift. If there is a new onset of pain, if the pain has changed in nature, or the pain has not been relieved with current medication, the licensed nurse will notify the attending physician for a review of medications. The Interdisciplinary Team (IDT) Committee will review the resident's pain assessment. The licensed nurse will notify the resident/responsible party regarding new pain medication orders. Nursing staff will implement timely interventions to reduce the increase in severity of pain. The nursing staff will attempt to become familiar with cognitive, cultural, familial or gender-specific influences on the resident's ability or willingness to verbalize pain. Nursing staff will also use non-pharmacological interventions by adjusting the resident's environment to reduce pain. The licensed nurse will document the resident's pain and response to interventions in the medical record on the weekly summary and as indicated on the progress notes. The licensed nurse will update the care plan for pain management with any change in treatment or medication.</p> <p>Review of the facility's policy titled, Physician Orders, 10/24/22, showed the purpose was to ensure that all physician orders are complete and accurate. Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order.</p> <p>Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/15/23, showed the following:</p> <p>-Cognitively intact;</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included chronic pain, low back pain, osteoarthritis unspecified site, pain in left hip, unspecified orthopedic conditions (medical conditions that affect the bones, joints, muscles, tendons and ligaments), spinal stenosis lumbar region with neurogenic claudication (condition resulting from spinal nerve compression from narrowing of the spinal canal exerting pressure on the nerve roots of the lumbar spine resulting in symptoms such as pain, weakness or heaviness in the legs, tingling and cramping), sciatica left side (pain affecting the back, hip and outer side of the leg caused by compression of a spinal nerve root in the lower back), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body), malnutrition, need for assistance with personal care, high blood pressure;</p> <p>-Manual wheelchair mobility;</p> <p>-Required substantial/maximal assistance with eating, oral hygiene, dressing, and bed mobility;</p> <p>-Dependent on full performance by staff of toileting and personal hygiene, bathing, tub/shower transfers;</p> <p>-Moderate pain;</p> <p>-Scheduled pain medication regimen in the last five days;</p> <p>-No as needed (PRN) pain medications received in the last five days.</p> <p>Review of the resident's undated physician's orders, showed the following:</p> <p>-5/10/22, assess pain level every shift;</p> <p>-11/14/22, tramadol HCL (hydrochloride) tablet 50 milligrams (mg), give 1 tablet two times a day for pain;</p> <p>-1/18/23, Tylenol Extra Strength Tablet 500 mg, give 1 tablet every 4 hours PRN for elevated temperature/mild pain;</p> <p>-5/31/23, turn and reposition frequently with siderails for safety and mobility;</p> <p>-8/14/23, Cyclobenzaprine HCL (muscle relaxant) 5 mg, give 1 tablet two times daily;</p> <p>-11/27/23, neurologist consult for cerebral vascular accident (CVA, stroke) with hemiplegia with newer contraction;</p> <p>-12/8/23, Biofreeze Cool the Pain External Gel 4%, apply bilateral upper extremities (BUE) and bilateral lower extremities (BLE) topically every 8 hours PRN for pain/discomfort;</p> <p>-1/8/24, occupational therapy (OT) clarification order: treat 4 times per week/4 weeks for skilled OT therapy.</p> <p>Review of the resident's healthcare provider visit note, dated 9/11/23, showed the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Beauvais Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3625 Magnolia Avenue Saint Louis, MO 63110	
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Verbal pain scale: 4;</p> <p>-Description of pain: aching;</p> <p>-What eases the pain: position change and medication;</p> <p>-Pain notes: resident has chronic left hip pain described as severe ache. Takes tramadol routinely which relieves the pain;</p> <p>-Plan: resident has a history of osteoarthritis in the left hip. He/She has pain with transfers and movement. No redness or swelling noted to joints. Continue routine tramadol. Call with any change in condition any redness or swelling in joints. Encourage him/her to ask for PRN Tylenol for breakthrough pain. Contingency pain: consider scheduled Norco (a combination of acetaminophen and hydrocodone for relief of moderate to severe pain) three times daily if pain persists or worsens and discontinue tramadol.</p> <p>Review of the resident's progress notes, showed the following:</p> <p>-10/13/23 at 7:42 A.M. and 10/30/23 at 4:53 P.M., the resident's lower back and right hip hurt really bad;</p> <p>-11/27/23 7:29 P.M., physician in to see the resident. New orders written for neurologist consult for CVA with left hemiplegia and newer contraction, add Ensure plus (nutritional shake) twice daily (BID), keep Ensure 1 three times daily with meals.</p> <p>Review of the resident's care plan, revised 12/15/23, showed the following:</p> <p>-The resident has chronic pain related to low back;</p> <p>-Anticipate his/her need for pain relief and respond immediately to any complaint of pain;</p> <p>-Evaluate the effectiveness of pain interventions;</p> <p>-Monitor/record/report to the nurse any signs or symptoms of non-verbal pain;</p> <p>-Notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain.</p> <p>Review of the resident's December 2023 MAR showed Diclofenac Sodium Gel 1% was administered on 12/1 for a pain level of 3 at 9:00 P.M. Tylenol Extra Strength 500 mg administered on 12/7 for a pain level of 8. The resident's pain level was rated at 5 on the nights of 12/16, 12/17, 12/21 and 12/28 as well as on the evening of 12/28. Tramadol HCL tablet 50 mg was administered on the following dates:</p> <p>-Pain level of 2 in the AM on 12/10;</p> <p>-Pain level of 4 in the AM and PM on 12/30 and 12/31;</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Pain level of 5 in the AM on 12/1, 12/4, 12/6, 12/8, 12/11-12/13, 12/15, 12/18, 12/20, 12/22, 12/27, 12/29;</p> <p>-Pain level of 5 in the AM and PM on 12/5, 12/7, 12/14, 12/19, 12/21, 12/28;</p> <p>-Pain level of 8 in the PM on 12/16.</p> <p>Review of the resident's progress notes, dated 12/18/23 at 4:16 P.M., showed the physician was in to see the resident this shift and stated the resident needs a neurology consult for possible Botox injections for contractures to be scheduled ASAP.</p> <p>Review of the resident's physical therapy (PT) recertification/progress report, dated 12/28/23, showed severe joint contracture in left (L) hip and knee rendered the resident bedbound. BLE orthotics pending. No orthotic being used on the left hand to promote extension of fingers. The resident had a palm protector, but lost it or it was not being put on. Precautions/contraindications: Late effect CVA with L hemiplegia, left lower extremity (LLE) sciatica, significant LLE contractures, risk for skin breakdown.</p> <p>Review of the resident's January 2024 MAR, showed the resident's pain level on the night of 1/9 was rated at 5. Tramadol HCL tablet 50 mg was administered on the following dates:</p> <p>-Pain level of 5 in the AM on 1/2, 1/3, 1/5, 1/8 and 1/10;</p> <p>-Pain level of 5 in the AM and PM on 1/1, 1/4 and 1/9.</p> <p>Review of the resident's PT treatment encounter note, dated 1/24/24, showed the following:</p> <p>-Pain with movement: 7/10;</p> <p>-Location: BLE hips and LLE knee;</p> <p>-Pain description/type: shooting and sharp;</p> <p>-Pain limits the following functional activities: bending and extension;</p> <p>-What relieves pain: remaining still;</p> <p>-What exacerbates pain: bending, prolonged activity.</p> <p>Review of the resident's PT discharge summary, dated 1/25/24, showed the resident would benefit from additional skilled PT upon arrival of LE orthotics.</p> <p>Observation on 1/9/24 at 11:00 A.M., 1:00 P.M. and 3:11 P.M. and 1/20/24 at 10:15 A.M. and 2:10 P.M., showed the resident lay in bed with his/her right hand gripping the bed rail and the extended right arm propping the resident up on his/her left side, with the left leg bent and his/her foot up near the right hip. No wedges were underneath the resident. No pillow was placed between his/her legs.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/24 at 11:00 A.M., the resident said lying in bed with his/her right hand gripping the bed rail and the right arm propping the resident up on the left side with his/her left leg bent and his/her foot up near the right hip was the only way he/she could comfortably lie in bed due to left hip pain. Lying flat in bed caused him/her joint pain. The resident said he/she experienced joint pain all the time in his/her left hip, flank, and knee. During PT sessions, the therapist told him/her to breathe deeply and work through the pain, but the pain was too intense. The resident's pain medications were not potent enough; they only helped with mild spasms not the severe spasms of pain he/she experienced. He/She never got to see a neurologist.</p> <p>During an interview on 1/11/24 at 4:24 P.M., Certified Nurse Aide (CNA) A said the resident always complained of arm and leg pain. CNA A could tell by the resident's facial expressions, he/she was uncomfortable sitting up in a wheelchair. When staff tried to change the resident's adult brief or clothing, moving him/her caused joint pain. The resident was only comfortable in bed, when using his/her right hand on the bedrail to push up onto the left side with the left leg bent behind the right leg. Whenever CNA A attempted to move the resident's right hand from the bedrail and reposition him/her, the resident said Ow, ow don't move it. Just leave it be. The resident was in pain a lot. His/Her medications just quieted down the pain.</p> <p>During an interview on 1/16/24 at 1:15 P.M., the Assistant Director of Rehab (ADR) said she was aware the resident laid in a contorted position in bed, with his/her left foot and leg underneath his/her bottom. To aid with comfortable positioning, the ADR would like staff to use the wedges provided by the therapy department and apply the palm protector which the resident had in his/her room. Staff should also place a pillow between the resident's knees and bottom. The resident experienced a lot of joint pain. The therapy department was working on obtaining a hip abduction device to halt the rotation of the resident's left hip. The resident also had an issue with a contracted left knee which made it uncomfortable to straighten that leg. Therapy staff allowed gravity to help straighten it. A few times, therapy staff had nursing administer the resident's pain medications prior to his/her therapy session. They tried to work around the resident's scheduled afternoon pain medications, going to nursing one hour prior to the session and requesting the pain medications be administered. Botox injections would be really good for the resident, who had a lot of tone (tension/resistance to movement) in his/her muscles, which made the muscles feel like they were closing or tight. Botox was used for severe contractures, to help the muscles relax.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/26/24 at 10:05 A.M., the Director of Nurses (DON) said physician's orders in November and December of last year for the resident to be seen by a neurologist were not carried out due to transportation issues, which were not specific to the resident. There had been issues with transport drivers not showing up. There had also been instances of the transporter canceling medical appointments without notifying the nursing department. When a resident missed a medical appointment, the DON's expectation was that a nurse either notified the DON or physician as soon as the appointment was missed, the nurse became aware that it would be missed or there would be a delay in carrying out the order to schedule the appointment. As for the resident's issues with pain, CNAs were expected to report breakthrough pain to the nurse. Once the nurse became aware of it, then he/she was expected to notify the resident's physician or make a note of it which the DON would subsequently see. If the DON saw a lot of documented pain scores or PRN pain medication being administered repeatedly, it was an indication the physician should be asked about ordering routine pain medication or non-pharmaceutical measures should be explored. The DON did not know if staff employed wedges to assist the resident with comfortable positioning in bed. If therapy had provided wedges for the resident's positioning in bed, then therapy orders would have been given to the restorative aides, along with a program on use of the wedges. There was nothing in physician's orders regarding wedges for the resident and she did not see any documentation of a program for use of wedges with the resident.</p> <p>During an interview on 1/24/24 at 12:20 P.M., Physician B said the resident experienced pain due to a left-sided contraction. Physician B ordered a consult with a neurologist who could administer Botox injections to release the resident's joint tightness, ease his/her painful muscle spasms and help the resident lie flat. Last year, when Physician B learned staff had not carried out the order he/she issued in November, he/she reissued the order in December. Staff never reported any transportation issues, they just said they were working on it. If transportation issues prevented a resident from keeping medical appointments, then the physician expected staff to let him/her know so other transportation arrangements could be made.</p> <p>During an interview on 1/26/24 at 12:13 P.M., the Administrator said the facility has contracts with transportation companies as well as a facility driver. The only way a medical appointment got cancelled was if a transportation company driver did not show up. In those situations, the facility driver is used as a failsafe, to ensure the resident still made it to his/her appointment. The residents normally waited up front in the facility to be picked up for appointments. If the driver was a no show, then whichever staff person became aware of the no-show: the resident's nurse, the Administrator, Social Services Worker or IDT member was responsible for following up and to ensure nursing was aware. His expectation was that a nurse would then inform the physician that the driver did not show up and reschedule the appointment. The transporter should not cancel resident medical appointments, because they are not clinical staff. Only the nursing staff should cancel medical appointments. In regard to pain issues, the Administrator's expectation was that nursing staff follow nursing standards of care in accordance with facility policy, as long as the resident was in agreement with it.</p>		