STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265703	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebird Wellness and Rehabilitation	9350 Green Park Road Saint Louis, MO 63123

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15950 Based on interview and record review, the facility failed to protect one resident from misappropriation of property when a Certified Nurse Aide (CNA) took the resident's debit card and used it without the resident's permission. The debit card charges amounted to $3,051.32 (Resident #46). The sample was 5. The census was 160. The facility was notified of past non-compliance on 10/15/24. Facility staff notified administration, contacted the police and suspended the employee. The employee was terminated on 9/17/24. Staff were in-serviced on 8/30/24. This deficiency was corrected on 9/17/24. Review of the facility's Theft/Loss Prevention policy, dated 8/2020, showed: -Purpose: To assist residents in safeguarding their personal property; -Policy: The Facility is committed to preventing the misappropriation of resident property. The Facility will exercise reasonable care for the protection of the resident's property from theft or loss. The Facility investigates all reports of stolen items, makes reports to authorities as required by law, and maintains documentation of all reports of lost or stolen property. Upon admission, Facility staff provides the resident and/or his/her representative with the Facility's policy regarding theft prevention and the relevant sections of the state law relating to theft and loss. All inquiries regarding lost or stolen items are reported to the Administrator; -B. When an alleged or suspected case of misappropriatior of resident property is reported, the Administrator, or designee, notifies the following persons or agencies within twenty-four (24). hours of such incident:, -i. Department of,Public Health/Aging; -ii. Ombudsman; -iii. Resident's Representative; -iv. Adult Protective Services; and -v. Law Enforcement Officials. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-While the investigation is being conducted: -ii.Facility staff who are the subject of the investigation are reassigned to non-resident contact duties or suspended without pay until the investigation is complete, the results of the investigation are reviewed by the Administrator, and the Administrator has made a determination of disciplinary action to be taken. -D. If the Administrator is not personally con.ducting the investigation,, results of the investigation must be reported to the Administrator promptly. -E. Upon completion of the investigation, the Administrator or designee is responsible for notifying the resident and/or the resident's representative of the results of the investigation and for taking corrective action in a timely manner. -F. The Administrator reports the results of the investigation to the local police department, the Ombudsman, and to the Department of Public Health/Aging in a timely manner, as indicated, or as consistent with state law. Review of the Certified Nursing Assistant Job Description, signed by Certified Nurse Aide CNA F, dated 8/5/24, showed: -Residents Rights: -Understands, upholds, and promotes the rights of the residents. - Ensures residents can exercise rights without interference, coercion, discrimination, or reprisal from the facility. -Ensures protected health information is kept confidential. Ensures resident concerns/complaints are responded to with tact and urgency. -Reports allegations of resident abuse, neglect and/or misappropriation of resident property. Coordinates effective communication with Residents and Companions by assuring all arrangements for providing interpreters and/ or other auxiliary aids and services needed by Residents and Responsible Party are made, including scheduling interpreters through outside agencies and scheduling staff interpreters, if any; and ensuring appropriate maintenance, repair, replacement and distribution of auxiliary aids. Review of the facility's investigation, showed the following: -Resident admitted on [DATE]. He/She was alert and oriented. Resident's family member reported to staff on 8/30/24 that after reviewing financial records, he/she noticed that an excessive amount of money was missing. The resident stated that he/she usually keeps his/her card in a purse and couldn't remember the last time he/she had seen it. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Facility Action after the incident: Staff members reported the incident to the police as well as the Administrator and Director of Nurses (DON). Police officer stated that he would investigate. Family member reported it to the police as well. Social Services and DON worked with the officer to investigate the alleged misappropriation. Facility awaited report from Police. On 9/17/24, Officer came to the facility and reported that the identity of the thief had been determined and he/she was in fact an employee of our facility. Video proof was received by police from several stores. Charges have been brought against the previous staff member, CNA F. Staff member was terminated on 9/16/24. Resident's money was returned to him/her by his/her bank. Staff education was completed on Abuse Prevention, Reporting Abuse, Customer Service and Misappropriation. -Future Preventative/Corrective Action for resident(s) health and safety: Social Services completed a safe survey questionnaire on resident and he/she felt that the facility was good to him/her and this incident was out of our control. -Conclusion: The investigation determined: Staff member, CNA F, did steal money from the resident. It was reported to the police and his/her money was returned to his/her account by his/her bank. -The investigation concluded the resident was a very nice alert and oriented man/woman that had been taken advantage of by a staff member whose care he/she had entrusted. CNA F was caught on video by multiple stores using the resident's card. The facility acted appropriately and reported to the police and terminated the employee. The resident's money was returned to him/her by his/her bank. Resident and his/her family member were happy with the outcome. -If allegations of abuse/neglect/exploitation: Substantiated. Review of inservices, titled Abuse, Neglect and Misappropriation, showed staff were inserviced on 8/30/24. During an interview on 8/31/24 at 12:33 P.M., the DON said the resident was not sure if he/she had the debit card when he/she was admitted , but it is not in his/her possession. The first charge was on 8/5/24 and the last charge was on 8/26/24. The card was used at various stores such as Walmart, Ross, Wing Stop, and a gas station. Review of the police report, showed the following: -Police were contacted on 8/30/24 for the report of a fraud; -Family reported a stolen debit card belonging to the resident; -Review of the fraudulent transactions amounted to $3,051.32; -Police cropped photos obtained from businesses where some of the transactions occurred; -On 9/17/24 and 9/18/24, the DON identified CNA F; -On 10/4/24, the police took custody of CNA F and booked for Stealing a Credit Device and Fraudulent Use of a Credit Device. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 12:51 P.M., the DON said the police showed at least five pictures from video surveillance at stores where the card was used. She could tell it was CNA F in every picture. The pictures were clear and she could see CNA F's face. Some of the transactions were also from the vending machines in the facility. During an interview on 10/22/24 at 12:53 P.M., the Human Resources Manager said the pictures were very clearly CNA F. She could clearly see CNA F's face and in one of the pictures, CNA F looked into the camera. The Human Resources Manager knows CNA F well enough to identify him/her. CNA F came to the Human Resources Manager's office a lot. CNA F denied it was him/her in the pictures. Review of a corrective action memo, dated 9/17/24 and signed by the DON, showed: -Type of Violation: Violation of Policy or Procedure and Unsatisfactory Customer Service; -Employer Statement: Police followed up with facility about a resident's missing debit card and the leads on the case. Police provided videos and photos of CNA F using the resident's missing debit card at several store locations, spending thousands of dollars; -Action being taken: Termination. MO00241375

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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** 22409 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice when staff failed to ensure one resident wore a compression suit (applied to reduce edema (swelling) and increase circulation) on the lower extremities every night for one hour (Resident #28). In addition, staff failed to ensure one resident received a glucose monitoring device as ordered (Resident #6). The sample size was 28. The census was 156. 1. Review of Resident #28's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/24/24, showed: -Adequate hearing; -Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; -Moderately impaired cognition; -Rejection of Care: Behavior not exhibited; -Diagnosis of high blood pressure. Review of the resident's Physician's Order Sheet (POS), showed: -5/30/24: Apply compression suit to the bilateral lower extremities at hour of sleep (HS). Stockings are to be worn for one hour and assist resident to remove stocking after one hour at bed time. For edema to bilateral lower extremities. Review of the resident's current care plan, showed: -2/15/24: Focus: Communication Problem. Goal: Will maintain/improve current level of communication. Interventions: Allow resident time to respond, repeat as necessary. Do not rush. Request feedback; -The care plan did not identify the resident's compression suit to be applied to the bilateral lower extremities, including the reason why it should be applied, when it should be applied or who was responsible to apply it. Review of the resident's Medication Administration Record (MAR), showed: -7/8/24: Bumetanide (diuretic/water pill) 2 milligrams (mg) one tablet daily two times a day. Review of the resident's Treatment Administration Record (TAR), dated 8/1/24 through 8/31/24, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/30/24: Apply compression suit to bilateral lower extremities at HS. Stockings are to be worn for one hour and assist resident to remove stocking after one hour at bedtime for edema to bilateral lower extremity. Remove compression stocking in one hour; -Review of the TAR showed staff initialed (an initial is an indication a treatment was completed as ordered) the compression suit was worn as ordered. During an interview on 8/19/24 at 12:10 P.M., the resident said he/she is supposed to wear a compression suit for one hour every night. He/She is unable to put the compression suit on by himself/herself. He/She has never worn it because no one ever helps him/her to put it on. During observation and interview on 8/20/24 at 6:39 A.M., the resident was dressed and sat in a wheelchair in his/her room. He/She said no one came in last night to help him/her put the compression suit on. During an interview on 8/20/24 at 7:20 A.M., Licensed Practical Nurse (LPN) H, (7:00 P.M. - 7:00 A.M. shift), said he/she did not put the resident's compression suit on last night because the resident was sleeping. He/She did not wake the resident to see if he/she wanted to put the compression suit on. Review of the resident's TAR, showed LPN H documented 9 (other - see nurse's note) on 8/19/24. Review of the resident's progress notes, showed no documentation as to why LPN H documented 9 on 8/19/24. During an interview on 8/26/24 at 6:58 A.M., the resident said staff are still not putting his/her compression suit on. He/She would not refuse to wear the compression suit. The best time for staff to put the compression suit on him/her would be any time after he/she finished dinner. Review of the resident's TAR, dated 8/23/24 through 8/25/24, showed LPN Z initialed he/she applied the resident's compression suit as ordered. During an interview on 8/26/24 at 7:00 A.M., LPN Z said he/she worked 7:00 P.M. - 7:00 A.M. on 8/23/24, 8/24/24, and 8/25/24. He/She is not aware of any compression suit the resident should wear. He/She reviewed the resident's orders in the Electronic Health Record and said he/she thought the order was ace wraps (an elastic wrap) which the wound clinic puts on him/her once a week. He/She went to the resident's room. The compression suit lay on a chair next to the resident's bed. He/She said he/she had never put the compression suit on the resident. During an interview on 8/27/24 at 8:17 A.M., the Director of Nursing (DON) said she expected staff to apply the resident's compression suit as ordered. LPN Z should not have initialed he/she applied the compression suit if he/she did not. 2. Review of the resident's annual MDS, dated [DATE], showed the following: -Diagnoses of respiratory failure, seizures, diabetes and seizures; -Totally dependent on staff for all activities of living (ADLs); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received insulin injections seven days per week. Review of the resident's care plan, dated 7/13/24, showed the following: -Problem: Diabetes with insulin use; -Goal: Will be free of signs/symptoms of high/low blood sugar; -Interventions: Administer insulin as ordered. Obtain blood sugars as ordered. Administer medications as ordered. Report abnormal findings to medical provider, resident/resident representative. Review of the resident's After Visit Summary, dated 7/17/24, showed the following; -The following issues were addressed: Uncontrolled diabetes mellitus and hyperglycemia (high blood sugar); -Start continued glucose monitoring (CGM, a device used to monitor blood glucose 24/7) . Review of the resident's POS, showed no order for the continued glucose monitoring device. During an interview on 8/21/24 at 10:34 A.M., Registered Nurse (RN) B said he/she received the order for the continuous glucose monitoring device on 7/17/24. The order was entered into the electronic medical record, but was rejected. He/she didn't call the pharmacy. During an interview on 8/21/24 at 11:50 A.M., the pharmacist said they had not received an order for the glucose monitoring device for the resident. Orders are sent electronically to the pharmacy. They have the device in stock. The system would have alerted them if the device required prior authorization and they would have contacted the resident's physician for the authorization. During an interview on 8/21/24 at 1:59 P.M., the DON said the pharmacy has been contacted and the glucose monitor will be sent as ordered. She would have expected the nurse to call the pharmacy in regards to the order. The nurse inserted the order, but it failed to go through. He/she should have called the pharmacy at that time to ensure the resident received the device. 27723

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview, and record review, the facility failed to follow their policies by failing to promptly assess one resident's right hip wound after a Certified Nursing Assistant (CNA) reported the wound to a Licensed Practical Nurse (LPN) the day before it was assessed and a treatment had been started (Resident #36). Another resident said he/she had reported his/her bottom was sore to staff and no one assessed his/her bottom until two days later when a wound was identified (Resident #39). Both residents complained the facility's largest incontinent briefs were too small and caused the wounds. In addition, staff failed to promptly assess and treat one resident with a right palm laceration. After waiting approximately one hour for staff to treat the laceration, the resident returned to his/her room without receiving treatment (Resident #3). The census was 156. Review of the facility Wound Management policy, revised on 6/2020, showed the following: -Purpose: To provide a system for the treatment and management of residents with wounds including pressure and non-pressure injury (pressure injury, a localized area of skin damage that occurs when there is prolonged pressure on the skin or underlying tissue); -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: Skin Tears, Lacerations, Cuts, and Abrasions: Wounds that usually result from impact (or related incidents) to extremely fragile skin; -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 Management Record will be completed for each wound; implement a wound treatment per physician's order; -Wound Management: the attending physician will be notified to advise on appropriate treatment promptly; the Licensed Nurse will notify the responsible party of the presence of a pressure injury; the attending physician and interdisciplinary team (IDT) will be notified of: new pressure injuries or wounds; pressure injuries or wounds that do not respond to treatment; pressure injuries or wounds that worsen or increase in size; complaints of increased pain, discomfort or decrease in mobility by a resident; signs of ulcer sepsis (infections), presence on exudates (drainage), odor or necrosis (necrotic/dead/non-viable tissue), if not already noted by the Attending Physician; residents refusing treatment; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Documentation: new pressure injuries or wounds will be documented on the 24 hour log; wound documentation will occur at a minimum of weekly until the wound is healed; -Documentation will include: location of wound; length, width, and depth measurements recorded in centimeters; direction and length of tunneling and undermining (if applicable); appearance of the wound base; drainage amount and characteristics including color, consistency, and odor; appearance of wound edges; description of the peri-wound (skin around the wound) condition or evaluation of the skin adjacent to the wound; presence or absence of new epithelium at the wound rim; presence of pain; -IDT will document discussion and recommendations for: pressure injury and wounds that do not respond to treatment; pressure injuries and wounds that worsen or increase in size; complaints of increased pain, discomfort or decrease in mobility by a resident; signs of ulcer sepsis, presence on exudates, odor or necrosis; residents refusing treatment; -Licensed Nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis; -Update the resident's care plan as necessary. Review of the facility Documentation Nursing Policy, revised on 6/20, showed: -Purpose: To provide documentation of resident status and care given by nursing staff; -Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts, and other documentation tools will be used as appropriate. Nursing staff will not falsify or improperly correct nursing documentation; -Procedure: -I. Nursing documentation: -C. The Licensed Nurse will review the Plan of Care on a weekly basis and document the resident's response and progress towards the goal; -D. Any communications with family, durable power of attorney (DPOA), or physician is to be noted in nurse's notes; -F. Nurse's notes are dated, timed, and signed when written; -H. Medication administration records and treatment administration records are completed with each medication or treatment completed; -I. Glucose measuring is documented as per physician's order; -J. Treatments completed and documented as per physician's order; -K. Documentation will be completed by the end of the assigned shift; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-II. Alert Charting: -A. Alert charting is documentation done to track a medical event for a period of 72 hours or longer; -B. Alert charting is completed by professional staff rather than non-professional staff; -C. Events may include but are not necessarily limited to: -(a) New physician orders; -(b) Suspected or actual change in condition; -(c) Initiation of new medical treatment; -(d) Fall with or without injury; and/or; -(e) Resident-to-resident event. -D. Alert charted describes what is going on: -(a) Describe the resident's condition, include what you see, hear, smell, feel, etc.; -(b) Use the resident's own words if needed; -(c) Describe what you have done in response to what is going on with the resident; -(d) Describe how the resident responded to the actions; -III. Activities of daily living (ADLs, activities related to personal care bathing, toileting, dressing, etc.) Documentation: -A. The CNA will document the care provided on the facility's method of documentation, manually or electronic; -B. The CNA will sign each entry on the ADL Flow Sheet in the appropriate area of the record according to the date and shift that services were performed; -C. Documentation will be completed by the end of the assigned shift. Review of the facility LPN job description, revised 12/2023, showed: -Position Description: Responsible for ensuring the delivery of efficient and effective nursing care while achieving positive clinical outcomes and resident/family satisfaction in accordance with accepted standards of practice, state and federal regulations and licensing requirements. Responsible for resident care and direction of nursing care during assigned shift; includes staff assignments, mentoring and educating nursing personnel, working with physicians and other medical professional; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Direct Care Responsibilities: charts progress notes in an informative, factual manner that reflects the care administered as well as the resident's response to care; follows established procedure for charting and reporting all reports on incident/accidents; identifies and reports changes in condition to supervisor, physician, and family; accurately identifies skin changes and follows the company skin management protocols. 1. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/16/24, showed: -Adequate hearing; -Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; Cognitively intact; -Rejection of Care: Behavior not exhibited; -Other Ulcers, Wounds and Skin Problems: Blank. Review of the resident's care plan, located in the electronic heath record (EHR), showed: -1/14/24: Focus: ADL Self-care performance deficit. Goal: Will maintain current level of function. Interventions: Requires a sit-to-stand lift (a machine that transfers residents capable of bearing weight) with two person support; -1/18/24: Focus: Incontinent of urine. Goal: Will remain free of skin break down due to incontinence. Interventions: Apply barrier creams as needed. Check resident for incontinence. Resident uses XXL disposable briefs, change as needed; -6/21/21: At risk for impaired skin integrity. Goal: Will be without impaired skin integrity. Interventions: Complete weekly skin checks. Review of the resident's weekly skin check, dated 8/16/24, showed: -Does the resident have any skin impairments? Yes. Under bilateral breasts/abdominal folds/groin - redness; -No documentation regarding the resident's right hip. During an interview on 8/19/24 at 8:15 A.M., CNA D said there were a few bariatric residents that needed larger incontinent briefs. They were breaking down between their legs because staff had to squeeze the briefs on the bariatric residents. During an interview on 8/19/24 at 8:23 A.M., the resident said he/she thought he/she had an open area on his/her right hip because the incontinent brief was too tight. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/19/24 at 8:31 A.M., CNA C said the resident had on open area on his/her right hip. He/She noticed it that morning and told LPN O. He/She thought the open area was because the resident's incontinent briefs were too small to fit. Review of the resident's physician's progress notes, physician's order sheets (POS), and treatment administration record (TAR) on 8/19/24 and located in the EHR, showed no documentation or treatment order for an open area on the resident's right hip. Observation on 8/20/24 at 7:00 A.M., showed the resident lay in bed. Unit Manager (UM) M removed the resident's cover and unfastened the resident's incontinent brief, revealing an open area on the resident's right hip that had a small amount of yellow slough (yellow or white layer of dead skin or tissue in a wound that can slow down or prevent healing) with a scant amount of drainage. There was no dressing on the open area. The resident said the open area was there yesterday. He/She thought the Certified Medication Technician (CMT) was aware of it and told the nurse. He/She thought his/her incontinent briefs caused the open area because they were too tight. He/She had been told by staff the facility no longer had his/her size of incontinent briefs. UM M said if the open area was there yesterday and reported to the nurse on duty, that nurse should have assessed the open area, called the physician and obtained a treatment order. It should be documented in the progress notes and added to the POS and TAR. Observations and interviews on 8/20/24 at 7:30 A.M., showed the resident lay in bed. The facility Wound Nurse (WN) measured the open area and said it was 0.8 centimeters (cm) by 1.6 cm by 0.3 cm with 10% yellow slough. The WN also found an open area that measured 0.4 cm by 0.8 cm by 0.2 cm on the resident's left posterior (back) knee, and an open area that measured 3.8 cm by 0.1 cm on the resident's right posterior thigh. She identified all the open area as trauma related, not pressure. If the nurse on duty was told about the open area on the right hip, he/she should have assessed it, called the physician and got a treatment started. The nurse should have filled out the form at the nurse's station so the WN would have known about it today. She did not work yesterday and did not receive a completed form today. Review of the resident's progress note, dated 8/20/24 at 4:45 P.M. and completed by the WN, showed: Reddened area noted to right hip measuring 0.8 cm by 1.6 cm by 0.3 cm. Wound bed with 10% slough noted. Area to right posterior thigh measuring 3.8 cm by 0.1 cm. Area to left posterior knee, red without odor measuring 0.4 cm by 0.8 cm by 0.2 cm. Antifungal cream applied. During an interview on 8/20/24 at 7:40 A.M., LPN O said he/she worked yesterday. He/She did not recall CNA C telling him/her the resident had an open area on the right hip, but he/she was very busy yesterday so it was possible CNA C did tell him/her and he/she forgot. Any new open area should be assessed, the physician should be notified and any new treatment should be documented in the progress notes, POS and TAR. During an interview on 8/20/24 at 9:15 A.M., the Director of Nursing (DON) said she would have expected LPN O to have assessed the resident's right hip when CNA C told him/her about it. The nurse should have notified the resident's physician, and documented any new treatment order in the progress notes, MAR and TAR. LPN O should have let the facility WN know about the new area. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/22/24 at 7:48 A.M., the facility WN said the resident was seen by the wound company on 8/21/24. The open area on the right hip was trauma related caused by the resident's brief. The wound company ordered calcium alginate (dressing which absorbs wound fluid) daily. Review of the resident's POS and TAR, showed an order dated 8/22/24, to cleanse the right hip with wound cleanser, apply a small piece of calcium alginate and cover with a border dressing daily and PRN. 2. Review of Resident #39's annual MDS, dated [DATE], showed: -Adequate hearing; -Makes Self Understood: Usually understood - difficulty communicating some words of finishing thoughts but is able if prompted or given time; -Ability To Understand Others: Understands - clear comprehension; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -Dependent for toileting hygiene, shower/bathing, upper/lower dressing and personal hygiene; -Frequently incontinent of bowel and bladder; -Diagnoses of diabetes mellitus (high blood glucose/sugar) and renal (kidney) insufficiency; -Other Ulcers, Wounds and Skin Problems: Blank. Review of the resident's care plan, located in the EHR, showed: -11/11/21: Focus: Is at risk for altered skin integrity. Goal: Will be without impaired skin integrity. Interventions: Complete skin assessment upon admission/readmission, quarterly, and as needed; -11/11/21: Focus: ADL self-care performance deficit. Goal: Will maintain current level of function. Interventions: Totally dependent on one staff for lower body dressing, personal hygiene and shower and bathing; -11/29/21: Focus: Incontinent of bladder and bowel. Goal: Will remain free of skin break down due to incontinence. Interventions: Apply barrier creams as needed. Check resident for incontinence. Review of the resident's progress notes, POS and TAR on 8/22/24, showed no documentation or treatment order for the right buttock/ischium (the lower and posterior part of the hip bone). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observations and interviews on 8/22/24 at 11:00 A.M., showed the resident lay in bed wearing an incontinent brief. The resident said it was too small and had been cutting into his/her skin. CNA DD told the resident there were not any larger incontinent briefs. The resident had a sore on his/her buttock for a couple of days. He/She told the nurse yesterday and the day before, but no one had come to look at his/her bottom. The WN said she worked the last two days and no one had told her the resident's bottom was sore. Had she known, she would have assessed the resident. The WN assisted the resident to turn onto his/her side and noted an open area at the top of the posterior right thigh and bottom of the buttock where the resident's incontinent brief fit between the legs. The WN said the open area was 0.5 cm by 2.5 cm by 0.1 cm, was non-pressure and located where the incontinent brief wrapped around the leg. 3. During an interview on 8/20/24 at 8:59 A.M., CNA/Central Supply Clerk DD said the facility had small, medium, large, X-large and XX-large incontinent briefs in stock. Prior to the facility being sold to the new company on 8/1/24, he/she was able to order incontinent briefs that were larger than the XX-large briefs. The new company had an Amazon account that would not allow him/her to purchase the larger incontinent briefs. The larger incontinent briefs were still available, but the system wouldn't allow him/her to purchase more. He/She discussed this with the Administrator a couple of weeks ago, but he/she still could not order those incontinent briefs. Resident #36 and Resident #39 used the larger incontinent briefs he/she could no longer order. During an interview on 8/20/24 at 8:59 A.M., CNA EE said there were about 15 residents, including Resident #36 and Resident #39. who needed the briefs they no longer had. They had not had those incontinent briefs since the facility changed ownership. The residents that need the larger incontinent briefs said the largest ones available were uncomfortable and cut into their skin. During an interview on 8/22/24 at 1:32 P.M., the DON said she started at the facility on 8/12/24. No on had informed her the the largest incontinent briefs the facility had were too small for some of the residents. She was unaware the residents had been complaining the incontinent briefs were too small and cutting into their skin. She would make sure the previous incontinent briefs the resident felt were comfortable were ordered. 4. Review of Resident #3's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Upper and lower extremity impairment on one side; -Toileting: Substantial/maximal assistance; -Transfer: Partial/moderate assistance; -Dressing upper body: Set up or clean up; -Dressing lower body: Partial/moderate assistance; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Diagnosis included diverticulitis (inflammation of the intestine) of large intestine without perforation (a hole in the intestine causing contents to leak into the abdomen) or abscess without bleeding, hemiplegia (severe or complete loss of strength) and hemiparesis (mild or partial weakness on one side of the body) following cerebral infarction (stroke) affecting unspecified side, high blood pressure and weakness. Review of the resident's care plan, in use during the survey, showed: -Focus: ADL self-care performance related to hyperlipidemia (high cholesterol), weakness, iron deficiency, anemia (body does not have enough red blood cells), history of hemiplegia and hemiparesis following cerebral infarction; -Goal: The resident will exhibit improved function at discharge; -Interventions: -Assistance required with ADLs may fluctuate based on time of day, mood, pain, or fatigue. Adjust and document as indicated. Report significant changes to charge nurse; -Chair to bed transfer: Totally dependent of two, two or more helpers do all the effort. Resident does none of the effort; -Identify tasks events that cause frustration. Provide assistance as needed; -Observe and anticipate resident's needs: thirst, food, body positioning, pain toileting needs; -Place call light within reach. Remind resident to call for assistance if cognitively intact; -Focus: Resident has impaired skin integrity, or at risk for altered skin integrity; -Goal: Resident will maintain current skin status through next review date; -Interventions: -Complete skin at risk assessment upon admission, readmission, quarterly, and as needed; -Complete weekly skin checks. Review of the resident's progress notes, dated 8/26/24 through 8/27/24, showed, no progress note related to a laceration on the palm of the right hand. Review of the resident's electronic physician order summary (ePOS), dated 8/27/24 at 12:49 P.M., showed no order for wound care to the palm of right hand. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/26/24 at 6:34 A.M., the resident sat up in his/her wheelchair and propelled up the hall to the nurse's station. When the resident reached the nurse's station, he/she said his/her hand was bleeding. The resident held up his/her right hand that showed a laceration on the right palm between the thumb and index finger. It measured approximately one cm in length and was lightly bleeding. The resident was holding a washcloth in his/her right hand to absorb the bleeding from the laceration. The resident said his/her armrest on the right side of the wheelchair was broken and caused the laceration when he/she was adjusting himself/herself in the wheelchair that morning. The resident showed the area on the right armrest under the padding towards the front of the armrest where the plastic was broken that caused the laceration. The resident said there was no nurse last night and that was why he/she could not get help with the cut on his/her hand. The resident said he/she just needed a Band-Aid so he/she didn't bleed everywhere. The resident was worried about getting blood on his/her clothing. Observation and interview on 8/26/24 at 6:49 A.M., showed the Minimum Data Set Coordinator (MDSC) walked up to the nurse's station and the resident showed her his/her right hand and said it was bleeding and he/she needed help. The MDSC said she would go and find the nurse and left the nurse's station. The MDSC returned to the nurse's station at 7:04 A.M. The resident asked for help again and the MDSC said she did not have keys to the nurse's cart. Around 7:20 A.M. the day shift nurse, Registered Nurse (RN) L walked to the nurse's station and was attempting to make the schedule. The resident continued to ask for assistance with his/her hand to any staff around the nurse's station. The staff at the nurse's station included one CNA, four nursing assistants (NA), one CMT, and one RN. None of the staff assisted the resident when the resident asked. At 7:33 A.M. the resident propelled himself/herself down the hallway to his/her room. He/She said he/she needed to finish getting ready to go to therapy. The resident went to his/her room without receiving any assistance to the laceration to his/her right hand. During an interview on 8/27/24 at 10:21 A.M., CMT V said the resident was at the nurse's station yesterday morning requesting assistance for the cut on his/her right hand. CMT V said the resident came up to the nurse's station again yesterday afternoon and was going off and upset because nobody helped him/her with the cut on his/her hand. CMT V said RN L was sitting at the nurse's station with him/her when the resident came up to the nurse's station. RN L gave CMT V the nurses' keys to the treatment cart and CMT V went to the treatment cart and got wound cleanser and gauze. CMT V said he/she cleaned the cut on the resident's right hand at the nurse's station with wound cleanser and then wrapped the resident's hand with gauze. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/27/24 at 10:31 A.M., the resident said CMT V cleaned his/her hand with wound cleanser and then wrapped it with gauze yesterday afternoon after he/she went to the nurse's station and asked again. The resident's hand did not have a dressing. The resident said he/she removed the gauze wrap from his/her hand this morning because it was getting caught on everything. A nurse did not look at the cut yesterday or today. The resident said he/she and all the other residents did not get enough attention when it was needed; especially without a nurse there. It took all day to get his/her hand taken care of and he/she had to go and request help with it again in the afternoon because he/she could not get help yesterday morning. The resident said he/she showed the broken armrest on his/her wheelchair to therapy, and the therapy person placed black tape around the broken area of the wheelchair. The resident said it was scary that residents could not get care when they need it. The resident then said, What if something worse happened and there wasn't a nurse over here? The resident said it was a very scary thought. The resident said he/she was at the facility to try and get better so he/she could leave and go to an independent living. That was why he/she was working so hard in therapy. During an interview on 8/27/24 at 10:53 A.M., RN W said if a resident reported they had a laceration to the right hand, he/she would first assess the hand and ask how it happened. RN W said if he/she determined the laceration was caused by the resident's wheelchair, RN W would get the resident another wheelchair and give the broken wheelchair to maintenance to repair. RN W would call the physician and get a treatment order and notify the resident representative (RR) if the resident had one. RN W would then enter the treatment order into the Electronic Medical Record (EMR), fill out an incident report in the EMR and make a progress note in the EMR that covered the assessment of the wound and new order. RN W said the resident would be monitored for 72 hours after the incident and a progress note would be entered each shift that would discuss if there were any changes with the resident, how the area looked, if the treatment was in place and vital signs (temperature, blood pressure, oxygen saturation, and pulse). RN W said he/she would not give the nurses' keys for the treatment cart to a CMT and allow a CMT to clean and dress a wound on a resident. During an interview on 8/27/24 at 1:33 P.M., the DON said if a resident reported they had a laceration on their hand, she expected a nurse to assess the laceration and determine how it occurred. If it was determined the laceration was caused by the wheelchair, she expected the nurse to contact therapy and have the wheelchair repaired. The DON expected the nurse to call the physician and get a treatment order and notify the RR. The nurse should document a progress note in the EMR that included the assessment of the laceration, how it happened, any interventions that were put in place, the notifications to the physician and RR, and the new treatment order. Follow up documentation should be completed by a nurse on each shift in a progress note that included assessment of the wound and vital signs for 72 hours. The DON said it was not acceptable for a nurse to give a CMT the treatment cart keys and have a CMT clean and apply a dressing to the wound.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview, and record review, the facility failed to ensure treatments were completed as ordered by the physician for three residents (Resident #19, #21, and #22). Facility nursing staff documented the treatments as completed, although they were not completed. The facility identified 15 residents with pressure ulcers. Four were sampled and problems were found with three. The census was 164. Review of the facility's undated Skin Care & Wound Management Overview policy and procedure, included the following: -Definitions: Pressure ulcer is defined as a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure in combination with shear and/or friction; -Policy: -The facility staff strives to prevent resident skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying conditions(s) contributing to it and description of impairment to determine appropriate treatment; -Skin care and wound management program includes, but is not limited to: Application of treatment protocols based on clinical best practice standards for promoting wound healing. Daily monitoring of existing wound; -Treatment: Review and select the appropriate treatment for the identified skin impairment. Obtain a physician's order. Communicate interventions to the care giving team. Document treatment on the Treatment Administration Record (TAR). Monitor and document progress. Evaluate effectiveness of interventions during clinical meeting. Communicate changes to the care giving team. 1. Review of Resident #19's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/17/24, showed: -Adequate hearing; -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands - clear comprehension; -Cognitively intact; -Rejection of Care: Behavior not exhibited; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses of paraplegia (impairment in motor or sensory function of the lower extremities), manic depression (bipolar disorder, causes extreme mood swings) and schizophrenia (a mental disorder that affects the way a person thinks, acts, expresses emotions, and perceives reality); -Unhealed Pressure Ulcer(s): Yes; -Number of Stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon or muscle. Slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) 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) may be present on some parts of the wound bed. Often includes undermining (caused by erosion under the wound edges resulting in a large wound with a small opening) and tunneling (a narrow passageway under the skin in a wound): 4. Review of the resident's care plan located in the electronic healthcare record (EHR), review date of 6/17/24, showed: -Focus: Activities of daily living (ADL) self care performance related to paraplegia. Goal: Will improve current level of function. Intervention/Tasks: Partial/moderate assistance required for toilet hygiene, shower/bathe, and chair/bed to chair transfers; -Focus: Wound infection/osteomyelitis (bone infection). Goal: Will be free of signs/symptoms of complications related to infection. Interventions/Tasks: Administer antibiotics per providers orders. Evaluate for signs/symptoms of skin infection: drainage, heat, redness, swelling and report abnormal findings to medical provider; -Focus: Impaired skin integrity related to Stage 4 pressure ulcer to right heel, sacrum (the area between the bottom of the small of the back and the center upper buttocks) and left ischium (the area between the lower buttock and back of the upper thigh). Review of the resident's Physician's Order Sheet (POS), located in the EHR, showed: -Start Date: 6/12/24 End Date: 7/23/24: Ceftolozane-tazobactam/brand name Zerbaxa (antibiotic for osteomyelitis) 1.5 grams (1500 milligrams (mg) intravenous (IV)); -6/13/24: Right heel. Cleanse with wound cleanser, apply silver alginate (an antimicrobial dressing), cover with bordered dressing daily and as necessary (PRN); -7/10/24: Sacrum. Clean with wound cleanser, apply Dakins (diluted bleach solution) moist gauze, cover with dry dressing. Change daily every day shift; -7/11/24: Left ischium. Clean with wound cleanser, apply Dakins moist gauze, cover with dry dressing. Change daily. Review of the resident's TAR, dated 7/1/24 through 7/31/24, showed: -6/13/24: Right heel. Cleanse with wound cleanser, apply silver alginate, cover with bordered dressing daily and PRN; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-7/10/24: Sacrum. Clean with sound cleanser, apply Dakins moist gauze, cover with dry dressing. Change daily every day shift; -7/11/24: Left ischium. Clean with wound cleanser, apply Dakins moist gauze, cover with dry dressing. Change daily. Review of the resident's wound company progress notes, dated 7/10/24, showed: -Wound/Ulcer #2; -Location: Right Heel; -Type: Pressure Ulcer/Injury: Stage 3 (Full thickness tissue loss. Subcutaneous (situated under the skin) fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling); -Wound Bed Description: 100% pink epithelial tissue (New skin growing in superficial ulcer. It can be light pink and shiny); -Measurements: 1.1 centimeters (cm) (length) x 0.5 cm (width) x 0.2 cm (depth); -Peri-Wound (the area around the wound opening): Normal - No signs of infection noted; -Exudate (drainage): Moderate; -Color: Sero-sanguineous (a thin watery fluid with a light red or pink hue); -Debridement (tissue removal) that has been completed at this site: Mechanical debridement completed via normal saline (NS) and 4x4s (gauze squares); -Goal: Adequate offloading (pressure relief) to alleviate pressure for optimal wound healing and display healing by reduction in measurement/characteristic every 2 weeks; -Wound Status: Improved - continue current treatment plan; -Treatment: Cleanse with wound cleanser, apply Silver Alginate, wrap with Kerlix and secure with tape daily and PRN; -Wound/Ulcer #4; -Location: Sacrum; -Type: Pressure Ulcer/Injury: Stage 4; -Wound Bed Description: 80% granulation tissue (pink or red tissue with shiny, moist, granular appearance) and 20% slough tissue; -Measurements: 6.0 cm x 7.3 cm x 1.2 cm; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Undermining: 1.3 cm from 3 o'clock to 5 o'clock (undermining and tunneling is associated with a clock face); -Exudate: Moderate; -Color: Sero-sanguineous; -Debridement that has been completed at this site: Mechanical debridement completed via NS and 4x4s; -Goal: Adequate offloading to alleviate pressure for optimal wound healing and display healing by reduction in measurement/characteristic every 2 weeks; -Wound Status: Declined; -Treatment: Cleanse with wound cleanser, apply Dakins moist Kerlix, then cover with dry dressing daily and PRN; -Wound/Ulcer #5; -Location: Left ischium; -Type: Pressure Ulcer/Injury: Stage 4; -Wound Bed Description: 90% granulation tissue and 10% slough; -Measurements: 3.6 cm x 3.5 cm x 2.0 cm; -Undermining: 12-12 greatest at 12 o'clock of 5.4 cm; -Peri-Wound: Normal - No signs of infection noted; -Exudate: Moderate; -Color: Sero-sanguineous; -Debridement that has been completed at this site: Mechanical debridement completed via NS and 4x4s; -Goal: Adequate offloading to alleviate pressure for optimal wound healing and display healing by reduction in measurement/characteristic every 2 weeks; -Wound Status: Declined; -Treatment: Cleanse with wound cleanser, apply Dakins moist Kerlix, then cover with dry dressing. Change daily and PRN. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 7/11/24 at 10:55 A.M., showed the resident lay in bed. He/She said facility staff change his/her pressure ulcer dressing daily most of the time, but not always. The resident said he/she is receiving IV antibiotics for his/her pressure ulcers; Observation and interview on 7/12/24 at 9:33 A.M., showed the resident lay in bed. The facility Wound Nurse (WN) assisted the resident onto his/her right side and prepared to change the resident's pressure ulcer dressings. The dressings on the resident's sacrum, right heel, and left ischium were intact and dated 7/10/24. The facility WN said all of the pressure ulcers should have been changed yesterday, 7/11/24. He/She was doing paperwork yesterday and had asked the floor nurses to complete the treatments. She measured the resident's pressure ulcers: Sacrum 8.0 cm x 6.3 cm x 3.6 cm. 75% yellow slough and 20% granulation tissue. Right heel 1.2 cm x 0.4 cm x 0.1 cm. 100% granulation tissue. Left ischium 3.7 cm by 4.0 cm x 1.6 cm. 15% yellow slough and 85% granulation tissue. Review of the resident's TAR on 7/12/24, showed the floor nurse had initialed the resident's treatments had been completed as ordered on 7/11/24. 2. Review of Resident #21's admission MDS, dated [DATE], showed: -Adequate hearing; -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands - clear comprehension; -Cognitively Intact; -Rejection of Care: Behavior not exhibited; -Diagnoses of paraplegia and diabetes mellitus; -Unhealed Pressure Ulcers: Yes; -Number of Stage 2 pressure ulcers (Partial thickness loss of dermis (middle layer of the skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister): 3; -Number of Stage 4 pressure ulcers: 1. Review of the resident's care plan located in the EHR, a review date of 6/19/24, showed: -Focus: ADL self care performance. Goal: Will improve current level of function. Interventions/Tasks: Partial/Moderate assist required for toileting/hygiene, and showers/baths; -Focus: Impaired skin integrity related to Stage 4 pressure ulcer of the sacrum. Goal: Will have improved current skin status. Interventions/Tasks: Encourage resident to turn and reposition. Complete weekly skin assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebird Wellness and Rehabilitation	9350 Green Park Road Saint Louis, MO 63123

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's POS located in the EHR and TAR, dated 7/1/24 through 7/31/24, showed: -6/25/24: Sacrum, clean with Vashe (wound cleanser), gently pack with 1 inch iodoform rope (an antiseptic), cover with pad and secure with dry dressing. Change every shift and PRN. Review of the resident's weekly wound care company progress notes, dated 7/10/24, showed: -Wound/Ulcer #4; -Location: Sacrum; -Type: Pressure Ulcer/Injury: Stage 4; -Wound Bed Description: 90% granulation tissue and 10% slough; -Measurements: 4.0 cm x 3.5 cm x 0.9 cm with undermining from 10 to 7 at 3 o'clock of 1.9 cm; -Peri-Wound: Normal - No signs of infection noted; -Exudate: Moderate; -Color: Serosanguineous; -Debridement that has been completed at this site: Mechanical debridement completed via NS and 4x4s; -Goal: Adequate offloading to alleviate pressure for optimal wound healing; -Wound Status: Unchanged; -Treatment: Clean with Vashe, gently pack with 1 inch iodoform rope, cover with pad and secure with dry dressing. Change every shift and PRN. Observation and interview on 7/12/24 at 7:55 A.M., showed the resident lay in bed. He/She said he/she could not recall if his/her treatment was done the previous day, but he/she does not think they did. Certified Nursing Assistant (CNA) G and CNA H assisted the resident onto his/her left side. The resident had an intact dressing on his/her sacrum. The dressing was dated 7/10/24. Both CNAs confirmed the date written on the dressing. Observation and interview on 7/12/24 at 11:06 A.M. showed the resident lay in bed. The facility WN assisted the resident onto his/her left side to administer the resident's treatment. The dressing dated 7/10/24, remained on the resident's sacrum. The facility WN said nurses work 12 hour shifts so the resident's treatment should have been done twice on 7/11/24. The sacrum pressure ulcer measured 3.7 cm x 3.6 cm x 1.2 cm and was 10% yellow slough and 90% granulation tissue. Review of the resident's TAR on 7/12/24, showed the floor nurses initialed the treatment had been completed as ordered on the day and night shift on 7/11/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Review of Resident #22's quarterly MDS, dated [DATE], showed: -Adequate hearing; -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to Understand Others: Understands - clear comprehension; -Rejection of Care: Behavior not exhibited; -Diagnoses of malnutrition and depression; -Unhealed Pressure Ulcers: Yes; -Number of Stage 4 Pressure Ulcers: 1. Review of the resident's current care plan showed: -Focus: At risk of infection related to wound. Goals: Resident will be free of signs/symptoms of infection. Interventions/Tasks: Administer treatments per medical provider's orders; -Focus: ADL self care performance. Goals: Will maintain current level of function. Interventions/Tasks: Totally dependent for toileting/hygiene and showering/bathing. Review of the resident's TAR, dated 7/1/24 through 7/31/24, showed the following order: -6/26/24: Wound care sacrum. Clean with Vashe, Blastx (wound gel) and collagen powder, cover with calcium alginate, secure with bordered dressing daily and PRN. Review of the resident's weekly wound care company progress notes, dated 7/10/24, showed: -Wound/Ulcer #1; -Location: Sacrum; -Type: Pressure Ulcer/Injury: Stage 4; -Wound Bed Description: 100% granulation tissue; -Measurements: 2.8 cm x 1.0 cm x 0.4 cm; -Undermining: None; -Peri-Wound: Normal - No signs of infection noted; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Exudate: Moderate; -Color: Serosanguineous; -Debridement that has been completed at this site: Mechanical debridement completed via NS and 4x4s and autolytic (uses the body's own enzymes and moisture beneath a dressing to liquefy non-viable tissue); -Goal: Adequate offloading to alleviate pressure for optimal wound healing; -Wound Status: Improved; -Treatment: Clean with Vashe, apply collagen powder (a protein), apply calcium alginate (an absorbent dressing), cover with bordered dressing. Change daily and PRN. During an interview on 7/12/24 at 8:55 A.M., showed the resident said he/she thought staff had completed his/her sacrum treatment the previous day, on 7/11/24. He/She then said, you know, now that he/she thought about it, staff did not do his/her sacrum treatment yesterday; Observation on 7/12/24 at 9:03 A.M. the resident lay in bed. Licensed Practical Nurse (LPN) H assisted the resident onto his/her left side showing a pressure ulcer with no dressing on the resident's sacrum. The pressure ulcer had a red floor and no slough. The LPN said he/she was not aware there was not a dressing on the resident's sacrum and did not know how long the pressure ulcer did not have a dressing. Review of the resident's TAR on 7/12/24, showed the floor nurse initialed the resident's treatment had been completed as ordered on 7/11/24. 4. During an interview on 7/12/24 at 9:00 A.M., Registered Nurse (RN) G said the facility WN is responsible to do the treatments Monday through Friday in both buildings. The floor nurses do the treatments on the weekends or when the facility WN is not here. 5. During an interview on 7/12/24 at 9:14 A.M., the facility WN said she worked the previous day, 7/11/24. She did the treatments in the long term care building, but then she had paperwork to do. She asked the floor nurses in the rehab building, where Residents #19, #21 and #22 reside, to do the treatments. She did not know why they did not do the treatments. 6. During an interview on 7/12/24 at 12:06 P.M., the Director of Nursing said treatments should be completed as ordered. If a treatment cannot be done as ordered, she expected that to be communicated to the next shift so the treatment could be completed. No one told her the previous day the treatments were not completed. She was not aware the facility WN had told the nurses to do the treatments in the rehab building. The floor nurse who worked in the rehab building is not in the facility today, so she did not know if the facility WN told him/her to do the treatments or not. The facility's policy is current and she expected staff to follow that policy. MO00238714

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27723 Based on interview and record review, the facility failed to provide appropriate nursing assessments per facility policy for residents with a tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), diagnosed with respiratory infection and vomiting. The facility identified seven residents with tracheostomy, three were sampled and failures were found with two (Resident #6 and #44). The census was 156. Review of the facility's Tracheostomy (Trach) Care policy, dated 6/2020, showed: -Tracheostomy care will be performed as ordered by the Attending Physician. -Licensed Nurses or a Respiratory Therapist (RT) may perform tracheostomy care. -Report any unusual observations to the Attending Physician immediately. -Document the care provided, the resident's response, any unusual observations, and physician notification as indicated in the medical record. Monitor vital signs and report abnormal findings to the medical provider. Review of the facility's Change of Condition policy, undated, showed the following: -Policy: An acute change of condition is a sudden, clinically important deviation from the a patient's baseline in physical, cognitive, behavioral or functioning domains. Clinically important means a deviation that, without intervention, may result in complications or death; -Procedure: The licensed nurse will notify the resident's Attending Physician when there is: C. A significant change in the resident's physical, mental psychosocial status, deterioration health, mental or psychosocial status, life threatening conditions or clinical complications; -Documentation: A licensed nurse will document the following: A. Date, time, and pertinent details of the incident and the subsequent assessment in the nurses notes. Review of the facility Documentation Nursing Policy, revised on 6/2020, showed: -Purpose: To provide documentation of resident status and care given by nursing staff; -Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts, and other documentation tools will be used as appropriate. Nursing documentation will not contain error-prone abbreviations. See Error -Prone Abbreviations. Abbreviations identified in industry accepted standards such as Steadman's Medical Dictionary or Taber's Cyclopedic Medical Dictionary that are not specifically excluded by the list in Error Prone Abbreviations are acceptable abbreviations. Nursing staff will not falsify or improperly correct nursing documentation; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Procedure: -I. Nursing documentation: -C. The Licensed Nurse will review the Plan of Care on a weekly basis and document the resident's response and progress towards the goal; -D. Any communications with family, durable power of attorney (DPOA), or physician is to be noted in nurse's notes; -F. Nurse's notes are dated, timed, and signed when written; -H. Medication administration records and treatment administration records are completed with each medication or treatment completed; -I. Glucose measuring is documented as per physician's order; -J. Treatments completed and documented as per physician's order; -K. Documentation will be completed by the end of the assigned shift; -II. Alert Charting: -A. Alert charting is documentation done to track a medical event for a period of 72 hours or longer; -B. Alert charting is completed by professional staff rather than non-professional staff; -C. Events may include but are not necessarily limited to: -(a) New physician orders; -(b) Suspected or actual change in condition; -(c) Initiation of new medical treatment; -(d) Fall with or without injury; and/or; -(e) Resident-to-resident event. -D. Alert charted describes what is going on: -(a) Describe the resident's condition, include what you see, hear, smell, feel, etc.; -(b) Use the resident's own words if needed; -(c) Describe what you have done in response to what is going on with the resident; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-(d) Describe how the resident responded to the actions; -III. Activities of daily living (ADLs, activities related to personal care bathing, toileting, dressing, etc.) Documentation: -A. The Certified Nurse Aide (CNA) will document the care provided on the facility's method of documentation, manually or electronic; -B. The CNA will sign each entry on the ADL Flow Sheet in the appropriate area of the record according to the date and shift that services were performed; -C. Documentation will be completed by the end of the assigned shift. 1. Review of Resident #6's physician orders, showed the following: -Order dated 6/1/24, for trach care every shift and as needed (PRN); -Titrate (adjust or lower amount) oxygen to room air, oxygen at 3 Liters PRN every shift; -No order for Respiratory Therapy Care. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/13/24, showed the following: -Diagnoses of respiratory failure, seizures, diabetes and seizures; -Totally dependent on staff for all Activities of Daily Living (ADLs); -No antibiotic use; -Oxygen use; -Trach care. Review of the resident's care plan, dated 7/13/24, showed the following: -Problem: Trach Care; -Goal: Will be free of signs/symptoms (s/sx) of complications from trach use. Will have clear and equal breath sounds bilaterally; -Interventions: Administer medications as ordered. Evaluate changes in mental status, agitation, restlessness and confusion. Report abnormal findings to medical provider. Evaluate lung sounds, and respiratory status. Observe for s/sx of pulmonary infection: fever, tachycardia (rapid heartbeat), discolored sputum, foul order, increased secretions, thick secretions, abnormal lung sounds. Report abnormal findings to medical provider, resident/resident representative. Monitor vitals. Review of the progress notes, showed the following: (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-7/15/24 at 11:38 A.M. completed by the RT: Oxygen Saturation (O2 Sat) 97% (normal 95% to 100%), via 6 liters per minute (LPM) oxygen trach collar mask, heart rate (HR) 80 (normal HR, 60 to 100), respiratory rate (RR) 18 (normal rate, 12 to 18), Breath Sounds (BS) coarse (normal: smooth, soft sound), Suction moderate amount of cream thick mucus (normal secretions, white or clear); -No other nurses notes regarding respiratory status or respiratory assessment notes until 7/16/24; -No documentation staff notified the physician of cream thick secretions; -7/16/24 at 11:01 A.M., completed by the RT: O2 Sat 97%, via 6 LPM per oxygen trach collar mask, HR 88, RR 16, BS coarse. Suction moderate amount of cream thick secretions; -No other nurses notes regarding respiratory status or respiratory assessment notes until 7/17/24; -No documentation staff notified the physician of cream thick secretions -7/17/24 at 11:17 A.M., completed by the RT: O2 Sat 97%, via 5 LPM per oxygen trach collar mask, HR 75, RR 16, BS coarse. Suction moderate amount of thick cream mucus; -No other nurses notes or respiratory assessment notes until 7/22/24; -No documentation whether staff notified the physician of the thick cream colored secretions; -7/22/22 at 11:32 A.M., completed by the RT: O2 Sat 99%, HR 78, RR 18, BS decreased. Suction moderate amount of cream thick mucus; -No other nurses notes regarding respiratory status or respiratory assessment notes until 7/23/24; -No documentation whether staff notified the physician of cream thick secretions; -7/23/24 at 11:21 A.M., completed by RT: O2 Sat 98% via room air, trach capped, HR 78, RR 16, BS decreased. Oral suction clear; -7/24/24 at 11:21 A.M., completed by RT: O2 Sat 98% via room air, trach capped, HR 76, RR 16, BS coarse. Suction moderate amount of thick pale mucus;. -No other nurses notes regarding respiratory status or respiratory assessment notes until 7/29/24; -No documentation whether staff notified the physician of thick pale secretions; -7/29/24 at 11:34 A.M., completed by RT: O2 Sat 98% via room air (RA), trach capped with Heat Moisture Exchanger (HME, special trach cap to help provide moisture to trach) HR 86, RR 18, BS decreased. Suction small amount of thick pale mucus;. -No other nurses notes regarding respiratory status or respiratory assessment notes until 7/30/24; -No documentation whether staff notified the physician of thick pale mucus; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-7/30/24 at 11:02 A.M., completed by RT: O2 Sat 99% via room air (RA), trach capped with HME on, HR 80, RR 18, BS coarse. Suction scant amount of thin tan secretions;. -No other nurses notes regarding respiratory status or respiratory assessment notes; -No documentation whether RT notified the nurse of the thin tan secretions; -No documentation whether the physician was notified of the thin tan secretions; -No further documentation regarding the resident's respiratory status until 8/8/24; -8/8/24 at 8:22 P.M., completed by the nurse: [NAME] mucus with a foul smell coming from tracheostomy; -MD notified and ordered Bactrim DS (a combination of two antibiotics) for 7 days; -No further notes of the resident's respiratory status were entered until 8/14/24 at 11:29 P.M. Review of the Medication Administration Record (MAR), showed the following orders: -Bactrim DS, documented as administered from 8/9 through 8/15/24; -Vital signs every shift while on antibiotics every shift for antibiotic monitoring for 7 days (start date 8/9/24). Vital signs not recorded on the second shift for 8/9, 8/10, 8/11, 8/14 and 8/15/24; -Trach Care every shift and as needed: Day shift: Documented as completed: 8/7, 8/8, 8/10 through 8/16/24. Nightshift: 8/6 through 8/16/24. Day shift: Blank 8/1 through 8/6, 8/9/24, Night shift: Blank 8/1 through 8/5/24. Review of the progress notes, showed the following: -8/14/24 at 11:29 A.M., completed by the RT: O2 Sats 98% on room air, HME on, HR 74, RR 18, BS decreased, suctioned small amount of thick tan mucus; -No other nurses notes regarding respiratory status or respiratory assessment notes from 8/14/24 at 11:29 A. M. until 8/16/24; -8/16/24 at 10:22 P.M., (First note of the day) showed staff noted the family said the resident has not responded properly/normally since 8/12 when they visited and demanded hospitalization . Resident's physician notified. New order received to send to the hospital. Review of hospital admission notes, showed the following: -8/16/24 at 9:13 P.M.: the resident presented with altered mental status, green sputum coming from the trach, tachycardia and tachypenia (rapid breathing); -Blood pressure: 106/75, Heart Rate:108, Respirations: 15, Pulse:107, Temperature: 100.6 degrees Fahrenheit (F); (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Review of the resident's blood work results showed a white blood count of 10.7, (normal 4.5 to 11.0) blood urea nitrogen (BUN, measures how much urea nitrogen is in the blood) of 80 (normal 7 to 20), Glucose 256 (normal blood sugar (70 to 100); -Workup in the emergency department concerning for sepsis (life threatening complication of an infection), particularly urinary tract infection (UTI); -Started on broad-spectrum antibiotics; -Labs also concerning for dehydration, hypernatremia (high concentration of sodium in the blood); -Diagnosis: Sepsis, UTI, tracheitis (inflammation of the trachea) hypernatremia, dehydration, acute kidney injury; -Computed Tomography (CT) scan of chest and abdomen showed suspected right lower lobe pneumonia; -Plan to admit for additional workup and monitoring. Review of the resident's hospital discharge notes, dated 8/20/24, showed the following: -Discharge diagnoses of Acute Metabolic Encephalopathy (caused by a deficiency of vitamins, oxygen or glucose), pneumonia and sepsis; -Discharge medications: amoxicillin-clavulante (antibiotic) 250-62.5 mg/5 milliliter (ml) 10 ml per gastrostomy (g-tube, flexible tube surgically inserted through the abdomen into the stomach. Used to administer nourishment and medications) every 8 hours for 5 days and doxycycline hyclate (antibiotic) 100 mg every 12 hours for 5 days. Review of the resident's Physician Order Sheet (POS), showed the following: -Doxycycline Hyclate 100 mg via g-tube every 12 hours for pneumonia for 5 days; -Amoxicillin 10 ml via g-tube every 8 hours for pneumonia for 5 days. Review of the MAR, showed the following orders: -Doxycycline Hyclate 100 mg via g-tube every 12 hours for pneumonia for 5 days. Administration not documented for the second dose on 8/25/24 and the last dose 8/26/24. -Amoxicillin 10 ml via g-tube every 8 hours for pneumonia for 5 days. Administration documented three times on 8/22/24, two times on 8/23/24, three times on 8/24/24, two times on 8/25/24 and one time on 8/26/24; -Vital signs every shift for antibiotic use monitoring every shift for 5 days. Vitals were not documented on the day shifts of 8/23/24, 8/24/24 and not documented on either shift of 8/25/24. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/20/24 at 1:37 P.M., CNA E said he/she has taken care of the resident and assisted other CNAs with the resident. The resident required total care. Several days prior to the resident going to the hospital, the resident was very sleepy and had smelly brown mucus coming from his/her trach. This had been going on awhile. CNA E knew the resident was on an antibiotic but the drainage wasn't getting any better. He/She thought the resident's sleepiness was due to him/her being on antibiotics. CNA E would report the trach drainage to the charge nurse. The nurses knew about the drainage and would go in to suction. During early morning rounds, the resident's trach would be full of brown secretions. When Registered Nurse (RN) B was off, the other nurses would not check on the resident. During an interview on 8/27/24 at 10:15 A.M., CNA W said he/she frequently takes care of the resident on the day shift. The resident normally is awake, looking around while up in his/her wheelchair at the nurses station. Prior to the resident going to the hospital, he/she had a lot of thick white, brown and green drainage from his/her trach. CNA W reported the drainage to the charge nurse so he/she could be suctioned. The resident was tired and very sleepy, which was unusual for him/her. CNA W said the CNAs would report their concerns to nursing staff but some nurses, RN L would ignore these concerns so he/she would stop saying anything. During an interview on 8/27/24 at 10:08 A.M., Certified Medication Technician (CMT) V said he/she did the resident's blood glucose fingersticks three times per day. Prior to him/her going to the hospital, the resident was coughing up a lot of slimy mucus. CMT V doesn't recall an odor. The nurse, RN B would hear him/her coughing and go in to suction. CMT V didn't report the drainage because the nurse would hear the resident coughing and go into the room. During an interview on 8/21/24 at 10:34 AM, RN B said he/she could hear from the nursing station if the resident was gurgling and needed suctioning. RT did not report any changes or concerns. On 8/8/24, the physician was notified of foul smelling brown mucus coming from the resident's trach. Orders were obtained for an antibiotic. RN B said staff nurses should assess the resident every shift and document the findings in the progress notes. He/She should have documented his/her assessment in the nurse's notes. During a second interview on 8/27/24 at 10:55 A.M., RN B said trach care included suctioning as needed, breath sounds, O2 Sats, vital signs and changing the trach collar ties. Staff nurses are to document what the secretion color was, consistency and whether their was any odor. RN B said the nurses needed an inservice on what to do because not enough is being documented regarding trach residents' conditions. The change in the resident's secretions should have been reported to the physician and documented in the nurses notes. The RT must report any findings to the charge nurse so that he/she can notify the physician. No one reported any changes in the resident's condition on 8/16/24. The family came in later that evening and requested for the resident to be sent to the hospital. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/20/24 at 10:58 A.M., the RT said he/she must report to the nurse any changes in the resident's condition. This would include breath sounds, color of secretions, decreased O2 saturations and increase in heart rate. He/She reported changes to the charge nurse but was unable to say which charge nurse he/she spoke to. He/She failed to document it because he/she had no access to the electronic record. The RT said he/she documented the changes on paper notes but was unable to produce the documentation. He/She would assess the resident once a shift, usually on Monday, Wednesday and Friday. The charge nurse is responsible to assess the resident during the rest of the shift and on the days he/she is not at the facility. He/She doesn't recall any changes in the resident's condition but he/she was off several days between 7/30/24 and 8/16/24. He/She noted the different consistency of the trach secretions but failed to document that he/she notified the charge nurse. During an interview on 8/27/24 at 1:33 P.M., the Director of Nurses (DON) said trach care consists of lung sounds, appearance of trach secretions, odor if any, changing of trach ties, and should be completed every shift and documented in the nurses notes. If the nurse observes odor, changes in color of secretions and change in mental status, he/she should notify the physician. When receiving antibiotics, the nurse should document the resident's response to the medication. If the resident does not improve or the condition changes, he/she should document and notify the physician. Staff should have administered the antibiotics as ordered. During an interview on 8/20/24 at 12:07 P.M., the resident's physician and Medical Director said he expected staff to follow the facility's policy and assess the resident's condition and document while he/she was receiving antibiotic therapy. The nurses should notify him of any changes in the resident's condition. 2. Review of Resident #44's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for all ADLs; -Received 51% or more of nutrition by tube feeding (used to give medicines and liquids, including liquid nutrition, through a small tube placed through abdomen into the stomach) -Trach care; -Oxygen therapy; -Diagnosis included respiratory failure, tracheostomy, gastrostomy (g-tube, surgical procedure used to insert a tube through the abdomen and into the stomach used for medication, liquids and liquid nutrition), contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of left and right hand, shortness of breath (SOB), venous thrombosis (blood clots in the veins) and embolism (obstruction or blockage in a blood vessel), sudden cardiac arrest (the heart stops beating suddenly), high blood pressure, muscle weakness, and obstructive sleep apnea (sleep related breathing disorder. The throat muscles relax and block the airway). Review of the resident's care plan, in use during the survey, showed: (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Focus: Resident is receiving tracheostomy care; -Goal: -Trach site will remain patent (open and unobstructed) through review date; -Resident will be free of s/sx of complications from tracheostomy, through review date; -Resident will have clear and equal breath sounds bilaterally, through review date; -Interventions: - Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/resident representative (RR); -Administer treatments per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Evaluate lung sounds, and respiratory status. Observe for s/sx of pulmonary infection: fever, tachycardia, discolored sputum, foul order, increased secretions, thick secretions, abnormal lung sounds. Report abnormal findings to medical provider, resident/RR; -Focus: Resident requires, tube feeding; -Goal: Resident will remain free of complications through review date; -Interventions: -Administer medications via tube, per orders; -Administer flushes per medical provider's order; -Check for placement and residuals per policy; -Head of bed elevated 30 degrees or higher; -Monitor intake of enteral tube feeding; -Focus: Resident is at risk of nutritional decline related to: obesity, wound, high blood pressure, hypothyroid (thyroid doesn't create and release enough thyroid hormone into your bloodstream), fluid retention (swelling, edema). Current nothing by mouth (NPO) diet, receives tube feeding of Jevity 1.5 (liquid balanced nutrition) at 65 milliliters (ml) per (/) hour (hr) for 20 hours. Weight loss is desired; -Goal: Receive/tolerate diet as ordered; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Interventions: Observe for s/sx of aspiration (when something enters your lungs by accident), dysphagia (difficulty swallowing) i.e. choking, coughing, pocketing food, loss of liquids, solids from mouth when eating, drinking, difficulty, pain when swallowing. Review of the resident's progress notes, showed: -8/22/24 at 12:54 P.M., Nurses note: resident has vomiting. Primary care physician (PCP) notified, received new order for Zofran (used to prevent nausea and vomiting) three times daily. -8/22/24 at 1:38 P.M., eMAR note: resident had metoclopramide (used to treat nausea and vomiting) scheduled; -8/22/24 at 1:41 P.M., eMAR note: guaifenesin-DM (used to relieve cough and loosen mucus) liquid 100-10 mg/5 ml, give 5 ml via g-tube every six hours as needed for congestion: given for cough; -8/22/24 at 5:38 P.M., eMAR note: clonidine HCL (used to treat high blood pressure) 0.2 mg, give one tablet via g-tube three times a day for high blood pressure, hold for systolic blood pressure (First number of blood pressure, measures the force of the blood flow when blood is pumped out of the heart) of less than 100 or heart rate less than 50: was not given due to low blood pressure and vomiting; -8/23/24 at 7:50 A.M., electronic medication record note: COVID testing as needed: Result negative; During an interview on 8/27/24 at 10:53 A.M., RN B said if he/she has patient with a trach and tube feeding who was vomiting, he/she would make sure the head of the bed was elevated, he/she would stop the tube feeding, wait until the resident stopped vomiting and would take vital signs and do an assessment. The assessment of the resident would consist of how much vomited, what it looked like, how many times the resident vomited, listen to lung sounds, and what the vital signs are. RN B said he/she would then call the doctor and explain the resident assessment to the PCP. RN B said the PCP might want to order a chest x-ray and go from there to ensure the resident did not aspirate while vomiting. RN B said he/she would follow the orders the PCP gave. RN B would the notify the RR of the change in condition and any new orders. The full assessment and notifications to the PCP and RR would be documented in the progress notes. RN B said the facility used to have a change of condition assessment, but it is not available anymore so he/she would document the change of condition and full assessment in a progress note. RN B would automatically ask for an x-ray to make sure the resident did not aspirate. RN B said the resident would need to be assessed each shift for five days. The assessment each shift would be documented in the progress note with vital signs and lung assessments. RN B would pass information about the resident and change of condition to the next nurse during shift-to-shift report. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/26/24 at 2:33 P.M., the DON said if a resident with a trach and tube feeding was vomiting, she expected the nurse to complete an assessment for change of condition. The change of condition assessment includes taking all vital signs, that also includes listening to lung sounds. When the nurse calls the PCP, the nurse should inform the PCP of the change in condition, vital signs, assessment of lungs and describing the vomiting such as color, how much, and how many times the resident vomited and see what orders the PCP gives. The nurse should request an x-ray to ensure the resident did not aspirate. If the PCP gave an order for Zofran for nausea and vomiting and the nurse noticed that the resident was already on a medication for nausea and vomiting, the nurse should call the PCP back and get clarification on the order. She expected the nurse to complete the change of condition assessment, document the orders received in the orders and a progress note, notify the RR and document all notifications and what was said in a progress note. The DON also expected the nurses to complete follow up documentation on that resident each shift for 72 hours in the progress notes, that would include vital signs, lung sounds, and if it was noted the resident was not at baseline, the nurse should be notifying PCP and RR of any changes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure a sufficient number of skilled licensed nurses were on duty each shift to provide nursing care to all residents in accordance with resident care plans and per the facility assessment. The facility failed to ensure a licensed nurse was on duty each shift, for the rehab building. This resulted in four residents (Residents #16, #44, #6, and #45) not receiving tube feedings (enteral nutrition, used to give medicines and liquids, including liquid nutrition, through a small tube placed through abdomen into the stomach) and not receiving medication as ordered. Three residents (Residents #16, #44, and #6) did not receive tracheostomy (trach, a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) care. The sample was 28. The census was 156. 1. Review of the facility's Facility Assessment Tool, last reviewed on 8/2/24, showed: -Requirement: Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents; -Average daily census: 146; -Staff type, included: -Licensed nurses providing direct care: six per day; -Nurses aides: 30 per day; -Other nursing personnel (e.g., those with administrative duties): 11 per day weekdays; -Respiratory care services staff: one; -Administrator, Director of Nursing (DON), two Assistant Director of Nursing (ADON), Wound Nurse, Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Medication Technicians (CMTs) and Certified Nursing Assistants (CNAs); -Staffing plan: Total number needed, average, or range: -DON: one; -RN or LPN, ADON: two ADON; -RN or LPN Wound/Treatment Nurse: one for five days a week; -Licensed nurse and CMTs to residents: 2 (licensed/certified staff):30 residents; -Licensed nurse ratio evenings/nights: 1:30; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Licensed nurse ratio nights: 1:50; -Direct care staff (total licensed or certified (CNAs or CMTs): -5:30 ratio days; -2:30 ratio evenings; -2.5:30 ratio nights. Review of the census per hall, dated 8/25/24, showed: -Rehab building: -Memory care unit: 29; -Rehab hall: 34; -Total residents in rehab building: 63; -Long term care (LTC) building: -North hall: 39; -South hall: 56; -Total residents in the LTC building: 95. Review of the facility tube feeding, total parenteral nutrition (TPN, IV-administered nutrition) policy, revised 12/2020, showed: -Purpose: To ensure that the Facility meets the nutritional guidelines and resident's nutritional requirements per physician orders; -Policy: A physician order is required to administer tube feedings/TPN/Commercial formula tube feedings will only be used for residents as prescribed; -Procedure: -I. The physician's order for tube feedings and TPN are considered diet orders and should be communicated by the nursing staff to the Nutrition Services Department utilizing Diet Order & Communication Form; -II. The physician order and information communicated to the Nutrition Services Department should include: -A. Type of formula; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-B. Amount of formula and fluid; and; -C. Frequency and amount of feeding. Review of the facility Nursing Care of Tracheostomy policy, revised 6/2020, showed: -Purpose: -I. To ensure airway patency by keeping the tube free from mucous build-up; -II. To maintain mucous membrane and skin integrity; -Policy: -I. Tracheostomy care will be performed as ordered by the Attending Physician; -II. Licensed Nurses or a Respiratory Therapist may perform tracheostomy care; -III. In addition to routine care, stoma dressings and trach ties will be changed when wet or soiled; -Procedure: -XV. Report any unusual observations to the Attending Physician immediately; -XVI. Document the care provided, the resident's response, any unusual observations, and physician notification as indicated in the medical record. Review of the facility Documentation Nursing Policy, revised on 6/20, showed: -Purpose: To provide documentation of resident status and care given by nursing staff; -Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts, and other documentation tools will be used as appropriate. Nursing documentation will not contain error-prone abbreviations. See Error -Prone Abbreviations. Abbreviations identified in industry accepted standards such as Steadman's Medical Dictionary or Taber's Cyclopedic Medical Dictionary that are not specifically excluded by the list in Error Prone Abbreviations are acceptable abbreviations. Nursing staff will not falsify or improperly correct nursing documentation; -Procedure: -I. Nursing documentation: -C. The Licensed Nurse will review the Plan of Care on a weekly basis and document the resident's response and progress towards the goal; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-D. Any communications with family, durable power of attorney (DPOA), or physician is to be noted in nurse's notes; -F. Nurse's notes are dated, timed, and signed when written; -H. Medication administration records and treatment administration records are completed with each medication or treatment completed; -I. Glucose measuring is documented as per physician's order; -J. Treatments completed and documented as per physician's order; -K. Documentation will be completed by the end of the assigned shift. Review of the facility staffing sheet dated 8/25/24, showed: -Rehab: -Night nurse: LPN FF: Walked out; -Night nurse: LPN GG: Called out sick; -No nurse listed on the schedule for night shift on rehab. 2. Review of Resident #16's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/10/24, showed: -Severe cognitive impairment; -Dependent on staff for all activities of daily living (ADLs, activities related to personal care); -Received 51% or more of nutrition by tube feeding (used to give medicines and liquids, including liquid nutrition, through a small tube placed through abdomen into the stomach); -Trach care; -Suctioning; -Oxygen therapy; -Diagnoses included respiratory failure, tracheostomy, unspecified tracheostomy complication, gastrostomy (g-tube, surgical procedure used to insert a tube through the abdomen and into the stomach used for medication, liquids and liquid nutrition), contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left shoulder, right and left elbow, right and left wrist, right and left hand, right and left knee, quadriplegia (paralysis (the loss of the ability to move) of all four limbs), sudden cardiac arrest (the heart stops beating suddenly), high blood pressure, muscle weakness, and persistent vegetative state(state of brain dysfunction in which a person shows no signs of awareness). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, in use during the survey, showed: -Focus: Resident has ADL self-care performance deficit, requires assistance with ADL, traumatic brain injury (TBI), quadriplegia, persistent vegetative state, contractures; -Goal: Resident will maintain current level of function; -Interventions: -Eating via g-tube: Totally dependent of one = one Helper does all the effort. Resident does none of the effort; -Personal hygiene: Totally dependent of two = two or more Helpers do all the effort. Resident does none of the effort; -Toileting hygiene: Totally dependent of two = two or more Helpers do all the effort. Resident does none of the effort; -Focus: Resident requires enteral nutrition related to dysphagia (difficulty swallowing). Receives Jevity 1.5 at 80 milliliters (ml) per (/) hour (hr) with 200 ml water flushes every four hours for 20 hours daily; -Goal: Resident will be maintain adequate nutrition and hydration status though review date; -Interventions: -Administer flushes per medical provider's order; -Check for placement and residuals per policy; -Head of bed elevated 30 degrees or higher; -Monitor intake of enteral tube feeding; -Provide tube feeding per medical provider orders; -Focus: Resident is currently receiving tracheostomy care for respiratory failure; -Goal: -Resident will be free of signs and symptoms (s/sx) of complications from tracheostomy, through review date; -Resident will have clear and equal breath sounds bilaterally (both sides), through review date; - Trach site will remain patent through review date; -Interventions: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/resident representative (RR); -Administer treatments per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Evaluate lung sounds, and respiratory status. Observe for s/sx of pulmonary infection: fever, tachycardia (increased heart rate), discolored sputum, foul order, increased secretions, thick secretions, abnormal lung sounds. Report abnormal findings to medical provider, resident/RR; -Provide humidified oxygen per medical providers orders; -Provide trach care and suctioning per orders; -Focus: Resident is at risk for aspiration (when something enters your lungs by accident), related to gastrostomy status; -Goal: Resident will exhibit no s/sx of aspiration through the review date; -Interventions: -Crush pills as needed per medical providers order; -Position resident properly for eating/swallowing; -Suction equipment at bedside. Suction as needed; -Focus: Resident is at risk for nutritional decline related to high blood pressure, history of malnutrition (lack of sufficient nutrients in the body), wound, and nothing by mouth (NPO) status; receives enteral nutrition to meet estimated needs; -Goal: -Maintain weight without significant change; -Receive/tolerate diet as ordered; -Exhibit no signs/symptoms (s/sx) of aspiration through the review date; -Interventions: -Provide meals per diet order; -Observe for s/sx of aspiration/dysphagia i.e. choking, coughing, pocketing food, loss of liquids/solids from mouth when eating /drinking, difficulty/pain when swallowing; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Oxygen Therapy related to respiratory failure, hypoxia (low levels of oxygen in your body tissues); -Goal: Will have no s/sx of poor oxygen absorption through the review date; -Interventions: -Four liters (L) by trach collar route for hypoxia and respiratory failure; -Monitor for s/sx of respiratory distress and report to medical provider as needed (PRN): Respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis (excessive sweating), headaches, lethargy (fatigue), confusion, atelectasis (complete or partial collapse of a lung), hemoptysis (coughing up blood or bloody mucus), cough, pleuritic pain (sharp chest pain that worsens during breathing), accessory muscle usage (contraction of any muscle other than the diaphragm (muscle below the lungs and heart that separates the chest from the abdomen) during breathing), skin color. Review of the resident's electronic Medication Administration Record (eMAR) and electronic Treatment Record (eTAR), dated 8/25/24 through 8/27/24, showed: -Juven (nutritional support for wound healing) two times a date for wound healing via g-tube. Mix with 120 milliliters (ml) of water, start 3/19/24 at 5:00 P.M.: -8/25/24: Mid-day/Evening medication pass 4:00 P.M. through 8:00 P.M. (PM): coded 3 (Absent from home); -8/26/24: PM: coded 3; -Enteral feed order at bedtime, closed system container (prefilled container that comes in a sterile, prefilled formula container) is used: change feeding administration with each new bottle, start 6/25/24 at 9:00 P.M.: -8/25/24: Hour of sleep (HS) medication pass 8:00 P.M. through 12:00 A.M. (HS): Blank; -8/26/24: HS: Blank; -Enteral Feed Order at bedtime. Label the formula container, syringe, and administration set with resident's name, date, time and nurse's initials, start 6/25/24 at 9:00 P.M.: -8/25/24: HS: Blank; -8/26/24: HS: Blank; -Enteral feed order every shift for enteral tube flush (water flushes for resident hydration and to prevent g-tube from clogging), flush enteral tube with 200 ml of water every four hours, start 6/25/24 at 7:00 P.M.: -8/25/24: Night (NOC) medication pass 7:00 P.M. through 7:00 A.M., Blank, ml administered: Blank; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebird Wellness and Rehabilitation	9350 Green Park Road Saint Louis, MO 63123

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/25/24: NOC: Blank, ml: Blank; -8/26/24: NOC: Blank, ml: Blank; -Enteral feed order every shift for formula intake 20 hours total, start 6/25/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Enteral feed order every shift for formula intake each shift with 24 hour total, start 3/19/24 at 7:00 P.M.: -8/25/24: NOC: Blank, ml: Blank; -8/26/24: NOC: Blank, ml: Blank; -Enteral feed order every shift on at 2:00 P.M., off at 10:00 A.M. Enteral Pump Jevity 1.5 at 80 ml/hr for 20 hours per day, start 3/19/54 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Enteral feed order every shift for placement of tube prior to tube feed, medication administration or flush, check placement of tube by aspiration (to pull contents from stomach with a syringe attached to the tube to observe color and consistency) of content or auscultation (sound generated by air blown through the tube is used to determine tube placement in the gastrointestinal tract), start 6/25/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Enteral feed order every shift for tube flush tube with at least 30 ml of water before and after each medication pass and feeding, start 6/25/24 at 7:00 P.M.: -8/25/24: NOC (total of 16 NOC shift spaces to be documented per night): All 16 spaces blank; -8/26/24: NOC: All 16 spaces blank; -Enteral feed order every shift for tube flush tube with at least 5 ml with each medication administration, start 6/25/24 at 7:00 P.M.: -8/25/24: NOC: All 16 spaces blank; -8/26/24: NOC: All 16 spaces blank; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral feed order every shift head of bed (HOB) elevated at least 30 degrees or higher while receiving tube feeding, start 6/25/24 at 7:00 P.M.: -8/25/24: NOC: All 16 spaces blank; -8/26/24: NOC: All 16 spaces blank; -Enteral feed order every shift mouth care every shift, start 6/25/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Full personal protective equipment (PPE) donning (put on), which includes the N-95 (disposable filtering facepiece respirator mask) mask with aerosolized treatments (mist that delivers medication directly into airway) and trach care every shift for nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) and trach care, start 3/14/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -HOB maintained at 30 degrees or greater, if not contraindicated every shift, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Levetiracetam (Keppra, used to treat seizures) tablet 500 MG, give 1000 mg via g-tube two times a day for seizures, start 3/7/24 at 7:00 A.M.: -8/25/24: PM: Code 9 (other/see progress note); -8/26/24: PM: Code 3; -Monitor for Pain every shift, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Oxygen 6 LPM via trach collar (used to hold a tracheostomy tube in place) mask/may titrate to maintain oxygen saturation (spO2, percentage of oxygen in the blood) above 90% every shift, start 3/8/24 at 7:00 P.M.: -8/25/24: NOC: Blank; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/26/24: NOC: Blank; -Pulse oximeter (used to measure the spo2) every shift and PRN to maintain spo2 above 90%, start 5/1/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Respiratory/COVID Screener: Any of the following signs or symptoms noted: Fever/chills, shortness of breath (SOB), body aches, cough dry/ productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, sore throat. If any signs or symptoms noted, complete the Respiratory/COVID symptoms evaluation user defined assessment (UDA) every shift for screener, start date 3/30/24 at 7:00 A.M. : -8/25/24: NOC: Blank, s/sx: Blank, Night: Blank, s/sx: Blank; -8/26/24: Day: Blank, s/sx: Blank, NOC: Blank, s/sx: Blank; -Senna-S (used to treat constipation) tablet 8.6-50 mg, give two tablets via g-tube two times a day for constipation, start 3/7/24 at 7:00 A.M.: -8/25/24: PM: Code 9; -8/26/24: PM: Code 3; -Suction and PRN lung sounds (LS) before (pre) and after (post), O2 (spo2) pre and post) every shift for trach care, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC, Pre LS: Blank, Pre O2: Blank, Post LS: Blank, Post O2: Blank; -8/26/24: NOC, Pre LS: Blank, Pre O2: Blank, Post LS: Blank, Post O2: Blank; -Trach care every shift and PRN, start 3/7/24 at 1:59 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Trach: Ambu Bag (device known as a bag valve mask (BVM), which is used to provide respiratory support to patients who are not breathing or not breathing adequately) at bedside every shift, start 3/8/24 7:00 P.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral feed order every eight hours for tube patency (openness and lack of blockage), check for residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) every eight hours during continuous feeding; If greater than or equal to 100 cubic centimeter (cc), hold tube feeding. Check residual again in two hours. Notify physician and/or nurse practitioner (NP) when appropriate, start 6/25/24 at 2:00 P.M.: -8/25/24: 10:00 P.M.: Blank; -8/26/24: 10:00 P.M.: Blank; -Guaifenesin (used to relieve chest congestion) liquid 100 mg/5 ml, give 15 ml via g-Tube three times a day for congestion, start 3/7/24 at 7:00 A.M.: -8/25/24: HS: Blank; -8/26/24: HS: Blank; -Ritalin (Schedule II substance under the controlled substance act. Schedule II drug have a high potential for abuse. Methylphenidate HCl, used to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy (excessive uncontrollable daytime sleepiness)) tablet 20 mg, give 20 mg via g-tube three times a day related to hypoxic ischemic encephalopathy (HIE, brain damage caused by lack of oxygen), start 4/8/24 at 1:00 P.M.: -8/25/24: HS: Blank; -8/26/24: HS: Blank; -Catheter (CATH, tube that is inserted into the bladder to drain the urine from bladder into a collection bag outside of the body): Indwelling urinary (Foley) catheter care: cleanse with soap and water every shift for Foley CATH care, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -CATH: Indwelling urinary catheter: measure and record output every shift for Foley catheter care, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC, ml: Blank; -8/26/24: NOC, ml: Blank; -Clotrimazole Cream 1 % (used to treat fungal infections) apply to coccyx (tailbone) topically two times a day for skin infection, start 3/7/24 at 7:00 A.M.: -8/25/24: PM: code 9; -8/26/24: PM: code 3; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Foley catheter care every shift and PRN with soap and water. Secure straps if applicable, document output every shift every shift for Foley catheter care, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank; -Once Foley catheter is removed - If no void within six hours, notify MD every shift, start 3/7/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -8/26/24: NOC: Blank. Review of the resident's progress notes dated 8/25/24 through 8/27/24, showed: -8/26/24 at 5:42 P.M., eMAR administration note: Change trach every three months and PRN every day shift every three months starting on the 6th for 84 days: Trach does not need changing; -8/25/24 at 6:02 P.M.: eMAR administration note: Clotrimazole Cream 1%, apply to coccyx topically two times a day for skin infection, leave of absence (LOA); -8/25/24 at 6:00 P.M.: eMAR administration note: LOA; -No progress notes entered showing when resident left for LOA or when resident returned from LOA. 3. Review of Resident #44's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for all ADLs; -Received 51% or more of nutrition by tube feeding; -Trach care; -Suctioning; -Oxygen therapy; -Diagnosis included respiratory failure, tracheostomy, gastrostomy, contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of left and right hand, SOB, venous thrombosis (blood clots in the veins) and embolism (obstruction or blockage in a blood vessel), sudden cardiac arrest (the heart stops beating suddenly), high blood pressure, muscle weakness, and obstructive sleep apnea (sleep related breathing disorder. The throat muscles relax and block the airway). Review of the resident's care plan, in use during the survey, showed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident is receiving tracheostomy care; -Goal: -Trach site will remain patent (open and unobstructed) through review date; -Resident will be free of s/sx of complications from tracheostomy, through review date; -Resident will have clear and equal breath sounds bilaterally, through review date; -Interventions: - Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Administer treatments per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Evaluate lung sounds, and respiratory status. Observe for s/sx of pulmonary infection: fever, tachycardia, discolored sputum, foul order, increased secretions, thick secretions, abnormal lung sounds. Report abnormal findings to medical provider, resident/RR; -Focus: Resident requires, tube feeding; -Goal: Resident will remain free of complications through review date; -Interventions: -Administer medications via tube, per orders; -Administer flushes per medical provider's order; -Check for placement and residuals per policy; -Head of bed elevated 30 degrees or higher; -Monitor intake of enteral tube feeding; -Focus: Resident is at risk of nutritional decline related to: obesity, wound, high blood pressure, hypothyroid (thyroid doesn't create and release enough thyroid hormone into your bloodstream), fluid retention (swelling, edema). Current NPO diet, receives tube feeding of Jevity 1.5 at 65 ml/hr for 20 hours. Weight loss is desired; -Goal: Receive/tolerate diet as ordered; -Interventions: Observe for s/sx of aspiration, dysphagia i.e. choking, coughing, pocketing food, loss of liquids, solids from mouth when eating, drinking, difficulty, pain when swallowing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's eMAR and eTAR, dated 8/25/24 through 8/27/24, showed: -Monitor for Pain every shift, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -Pulse oximeter every shift and PRN to maintain SPO2 above 90%, start 4/11/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every night shift, closed system container is used: change feeding administration with each new bottle, start 3/28/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every night shift for tube patency change enteral feeding tubing and flushing syringe daily, start 3/28/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every night shift label the formula container, syringe, and administration set with resident's name, date, time and nurse's initials, start 3/28/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Terazosin HCl (used to treat high blood pressure) capsule 2 MG, give 1 capsule via g-tube at bedtime related to high blood pressure, start 3/28/24 at 9:00 P.M.: -8/25/24: NOC: Blank; -Carvedilol (used to treat high blood pressure) tablet 12.5 MG, give 1 tablet by mouth two times a day for high blood pressure hold for systolic blood pressure (SBP, First number of blood pressure, measures the force of the blood flow when blood is pumped out of the heart) of less than 100 or heart rate less than 50, start 3/28/24 at 7:00 A.M.: -8/25/24: PM, BP, pulse: Not applicable (NA); -Enhanced barrier precautions related to: Carbapenem-Resistant Acinetobacter Baumannii (CRAB, highly antibiotic-resistant bacteria) when dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting and peri care (washing the genitals), providing care to resident with history of CRAB every shift, start 3/29/24 at 7:00 A.M.; -8/25/24: NOC: Blank; -Enteral feed order every shift for enteral tube flush for hydration. Flush enteral tube with 160 ml water every four hours, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral feed order every shift for Formula intake 20 hours total, start 4/3/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every shift for nutrition, enteral pump Jevity 1.5 (liquid balanced nutrition) at 65 ml/hr for 20 hours per day, with 160 ml water flush every four hours, on at 2:00 P.M., off at 10:00 A.M., start 6/19/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every shift for placement of tube. Prior to tube feed, medication administration or flush, check placement of tube by aspiration of content or auscultation, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -Enteral feed order every shift flush tube with at least 30 ml of water before and after each med pass and feeding, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: All 16 spaces blank; -Enteral feed order every shift flush tube with at least 5 ml with each medication administration, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: All 16 spaces blank; -Enteral feed order every shift for tube patency. Check for residual prior to each intermittent feeding; If greater than or equal to 100 cc, hold tube feeding. Check residual again in two hours. Notify physician and/or NP when appropriate, start 3/28/24 6:00 A.M.: -8/25/24: NOC: All 16 spaces blank; -Enteral feed order every shift Formula: Jevity 1.5 through g-tube, start 4/3/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Enteral feed order every shift HOB elevated at least 30 degrees or higher while receiving tube feeding, start 3/28/27 at 7:00 A.M.: -8/25/24: NOC: All 16 spaces blank; -Enteral feed order every shift mouth care every shift, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -Full PPE donning, which includes the N-95 mask with aerosolized treatments every shift for trach care, start 4/27/24 at 7:00 A.M.: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/25/24: NOC: Blank; -HOB maintained at 30 degrees or greater, if not contraindicated every shift, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -Oxygen via trach collar mask 6 LPM may titrate to maintain spo2 above 90% every shift for to maintain spo2 above 90%, start 3/28/24 at 7:00 P.M.: -8/25/24: NOC: Blank; -Respiratory/COVID Screener: Any of the following signs or symptoms noted: Fever/chills, SOB, body aches, cough dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, sore throat. If any signs or symptoms noted, complete the Respiratory/COVID symptoms evaluation UDA every shift for screener, start date 3/28/24 at 7:00 A.M.: -8/25/24: NOC, s/sx: Blank; -Trach care every shift and PRN, start 3/28/24 at 2:30 A.M.: -8/25/24: NOC: Blank; -Trach: Ambu Bag at bedside every shift, start 3/28/24 at 7:00 A.M.: -8/25/24: NOC: Blank; -Enteral feed order every eight hours for tube patency. Check for residual every eight hours during continuous feeding; If greater than or equal to 100 cc, hold tube feeding. Check residual again in 2 hours. Notify physician and/or NP when appropriate, start 3/28/24 at 6:00 A.M.: -8/25/24: 10:00 P.M.: Blank; -8/26/24: 6:00 A.M.: Blank; -Hydralazine HCl (used for high blood pressure) 25 MG, give 1 tablet via g-tube every eight hours for high blood pressure, start 3/28/24 at 6:00 A.M.: -8/25/24: 10:00 P.M.: Blank; -8/26/24: 6:00 A.M.: Blank; -Metoclopramide HCl (used to treat nausea and vomiting in patients with gastroesophageal reflux disease (GERD, stomach contents move up into the esophagus) 5 mg, give 1 tablet via g-tube every eight hours for GERD, start 3/28/24 at 6:00 A.M.: -8/25/24: 10:00 P.M.: Blank; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/26/24: 6:00 A.M.: Blank; -Sodium Chloride Inhalation Nebulization Solution 3% (used to help cough to thin and loosen mucus, making it easier cough and clear the lungs) 1 vial inhale orally via nebulizer every six hours related to SOB, start 3/28/24 at 6:00 A.M.: -8/26/24: 12:00 A.M.: Blank; -8/26/24: 6:00 A.M.: Blank. 4. Review of Resident #6's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent on staff for all ADL; -Received 51% or more of nutrition by tube feeding (used to give medicines and liquids, including liquid nutrition, through a small tube placed through abdomen into the stomach); -Trach care; -Oxygen therapy; -Diagnoses included respiratory failure, tracheostomy, gastrostomy, seizures, diabetes and high blood pressure. Review of the resident's care plan, dated 7/13/24, showed the following: -Focus: Resident has high blood pressure; -Goals: Resident to be free of s/sx of high blood pressure through the review date; -Interventions: Administer medications per medical providers orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Focus: Resident has poor neurological function (how the brain receives and sends information to the rest of the body) and history of seizures; -Goals: Resident will not have increased s/sx of neurologic complications, through target date; -Interventions: Administer medications per medical providers orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; -Focus: Resident is at risk for nutritional decline related to diabetes and NPO status; receives enteral nutrition for nutrition needs. Tube feeding order: Glucerna 1.5 (liquid balanced nutrition) at 65 ml/hr for 20 hrs with 45 ml water flushes every hour by g-tube; -Goals: Maintain adequate nutritional status through review date; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Provide supplements per medical provider's orders; -Focus: Resident is currently receiving trach care; -Goals: Resident will be free of s/sx of complications from use, through review date; -Interventions: Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; Evaluate lung sounds, and respiratory status. Observe for s/sx of pulmonary infection: fever, tachycardia, discolored sputum, foul order, increased secretions, thick secretions, abnormal lung sounds. Report abnormal findings to medical provider, resident/RR; -Focus: Resident requires tube feeding related to dysphagia. Receives Glucerna 1.5 at 65 ml/hr for 20 hours daily; -Goals: Will be maintain adequate nutrition and hydration status though review date; -Interventions: Administer flushes per medical provider's order; Administer medications via tube, per orders; Monitor intake of enteral tube feeding; Provide tube feeding per medical provider orders. Review of the resident's eMAR and eTAR, dated 8/25/24 through 8/26/24, showed: -Enteral feed order every night

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 43 opportunities for errors, seven errors occurred, resulting in an 16.28% medication error rate (Residents #11, #3, #8, #10 and #9). The medication pass sample size was five, and problems were found with all five. The census was 157. Review of the facility's Physician Orders policy, undated, included the following: -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The safety of residents, staff and visitors is of primary importance. The purpose of this policy is to provide guidance for licensed nurses and licensed therapist to accurately document physician and provider orders as determined by the licensee's Scope of Practice; -Procedure: I. Medical Orders Transcription; II. Taking the order: a. Write down the order as stated; f. Place orders in electronic Medical Record (EMR); h. Contact pharmacy for changes; III. Execution of Order and Notifications: a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse; ii. The medication administration record (MAR) should automatically be updated with the new orders if a schedule has been assigned; 9. If a medication is not available in the emergency kit, then contact pharmacy, resident representative, and notify provider (physician); 11. Sign off medication after administration of each drug to resident. Review of the facility's Medication Administration policy, undated, included the following: -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The safety of residents, visitors and employees is top priority of care. The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Procedure: General Procedures: a. Administer medication only prescribed by provider; b. A resident-centered, individualized approach to medication administration will be used for administering medications as possible; e. Licensed or authorized personnel may administer prescribed medication; f. Observe the five rights in giving each medication: The right resident, the right time, the right medicine, the right dose and the right route; j. Full attention should be given during preparation of medications; l. Read medication label three times before administering medication: First when pulling the medication from the drawer. Second, when comparing the label to the MAR. Third, when preparing to administer the medication; x. Report medication errors; dd. Medications will be charted when given; gg. Medications that are refused or withheld or not given will be documented; IV. Documentation: a. Documentation of medication will be current for medication administration; b. Documentation of medications will follow accepted standards of nursing practice. Review of the facility's Missed Medication/Medication Error policy, undated, included the following: -Definitions: Medication error/incident: any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication. Medication errors/incidents may include medications: a. Given incorrectly (wrong dose, wrong resident, wrong time, wrong route, wrong drug); -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner; -Resident's rights compliance includes providing for timely medical needs in which the physician has the opportunity to adjust and/or change medication(s) for the resident, including an awareness of risk factors when a resident does not receive medication in an appropriate time frame; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Procedure: For any medication(s) not available during a routine medication pass: 1. The Charge Nurse will check the emergency kit to attempt to offer medication in a timely a manner; 3. In the event the medication is not available from the emergency kit, the Charge Nurse will notify the Physician immediately and receive guidance on how to proceed; 4. The Charge Nurse will notify the pharmacy and attempt to obtain the medication; 5. The Charge Nurse will notify the Director of Nurses (DON) of any medication that is not available: a. Failure to administer a prescribed medication as ordered is considered a medication error regardless of reason or drug category and provided new orders; b. Medication error rates will be monitored by the QAPI (Quality Assurance Performance Improvement) committee for benchmarking and process improvement. 1. Review of Resident #11's medical record, showed: -Diagnoses included chronic bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lungs) and chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that makes it difficult to breathe); -An order, dated 12/30/22, for fluticasone propionate nasal suspension (steroid nasal spray used for the management of COPD) 50 micrograms (MCG) 2 sprays into each nostril in the morning; -An order, dated 9/21/23, Symbicort Inhalation Aerosol 160-4.5 MCG/MCG (used for the treatment of COPD) 1 puff orally twice a day. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/6/24, showed the resident: -Was cognitively impaired; -Had no refusal of care. During a medication administration observation on 6/17/24 at 8:57 A.M., Certified Medication Technician (CMT) B: -Did not administer fluticasone propionate nasal suspension; -Did not administer the Symbicort inhaler. Review of the resident's medication administration record (MAR), dated 6/17/24, showed the fluticasone propionate nasal spray and the Symbicort inhaler had been administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #3's medical record, showed: -admitted to facility on 4/26/24; -A order dated 4/27/24 for fluticasone propionate inhalation aerosol powder (inhaler used to treat COPD) 50 MCG, 2 sprays inhale orally in the morning. An admission MDS, dated [DATE], showed the resident was cognitively intact. During a medication administration observation on 6/17/24 at 9:12 A.M., CMT B did not administer fluticasone propionate inhaler 2 puffs. Review of the resident's MAR, dated 6/17/24, showed the fluticasone propionate inhaler had been administered. 3. Review of Resident #8's medical record, showed: -admitted to facility on 5/10/24; -A order dated 5/11/24 for multivitamin with minerals, (used to treat or prevent vitamin deficiency due to poor diet or certain illnesses. An admission MDS, dated [DATE], showed the resident was cognitively intact. During a medication administration observation on 6/17/24 at 8:33 A.M., CMT B administered a multivitamin. He/She did not administer a multivitamin with minerals. Review of the resident's MAR, dated 6/17/24, showed the multivitamin with minerals had been administered. 4. During an interview on 6/17/24 at 1:14 P.M., CMT B said he/she did not administer the medications to Resident #11 and #3 because the nasal spray and inhaler were out of stock. He/She would order the medications today. He/She thought he/she had administered Resident #8 a multivitamin with minerals. He/She did not read the label thoroughly. He/She should not have documented the medications were provided when they were not. 5. Review of Resident #10's quarterly MDS, dated [DATE], showed diagnoses of anemia (low red blood cell count), malnutrition and depression. Review of the resident's physician's order sheets (POS), located in the electronic EMR, included the following medications: -An order dated 11/28/23 for Pyridoxine HCl (Vitamin B6) 200 mg. Give one tablet in the morning; -An order dated 12/4/23 for Lactinex (A bacteria that exists naturally in the body and used to prevent diarrhea. May also be used to treat lactose intolerance.). Give one packet three times a day for health maintenance. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, located in the EMR, showed: -8/8/23, Focus: At risk for nutritional decline related to malnutrition and anemia. Lactose intolerant. Interventions: Provide supplements per medical provider's orders; -11/28/23, Focus: Activity of daily living (ADL, self-care) deficit. Observation on 6/17/24 at 8:30 A.M., showed CMT A prepared the resident's medications. He/She said he/she could not find the Lactinex or pyridoxine HCl in the medication cart. He/She just reordered the Lactinex from the pharmacy through the facility computer system. The pyridoxine HCL should be available in the facility medication stock room. He/She locked the medication cart and went to look for the pyridoxine HCL. He/She returned and said there was none available in the medication stock room so he/she would not give the pyridoxine HCL. During an interview on 6/18/24 at 12:08 P.M., CMT A said he/she reordered the pyridoxine HCL yesterday from the pharmacy. He/She did not know if it had been reordered prior to him/her reordering it. He/She did not usually work that floor. 6. Review of Resident #9's annual MDS, dated [DATE], showed diagnoses of renal failure (kidney insufficiency), diabetes mellitus (high blood glucose/sugar levels), and dementia. Review of the resident's care plan, located in the EMR, showed: -10/6/20, Focus: Impaired thought processes related to dementia; -6/6/22, Focus: ADL self-care deficit. Requires assistance with ADLs. Review of the resident's POS, located in the EMR, included an order dated 8/18/22 for Normal saline (mixture of sodium chloride (salt) and water) eye drops (used to reduce swelling of the cornea (the front surface of the eye)) instill one drop in the right eye in A.M. Observation on 6/17/24 at 8:58 A.M., showed CMT A prepared the resident's morning medications. He/She could not find the resident's normal saline in the medication cart. CMT A said the medication was an over the counter (OTC) medication. He/She went to the facility medication stock room to look for a new bottle of normal saline eye drops. CMT A returned to the medication cart and said he/she could not find a replacement bottle of the normal saline eye drops and he/she would tell the charge nurse. 7. During an interview on 6/18/24 at 10:55 A.M., the Interim Director of Nurses (DON) said she expected staff to follow facility policies. Prescription medications should be reordered from the pharmacy within 7 days prior to running out. The central supply clerk was responsible to ensure OTC were ordered and available in the medication supply room. There was no reason why residents should run out of prescription or OTC medications unless the medications were on back order and could not be obtained. MO00236225 MO00236238

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 27723 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. Staff failed to administer seizure medication for three residents (Residents #45, #6, and #16). Staff failed to administer two antibiotics to one resident (Resident #6). Staff failed to administer an anticoagulant (medication used to prevent blood clots) to one resident (Resident #45). The facility staff failed to notify the physician and resident representative (RR) of the medication errors. This failure put the residents at risk for significant medication errors that go unreported to the physician, resulting in potential for compilations related to missed doses. The sample was 28. The census was 156. 1. Review of the facility's Facility Assessment Tool, last reviewed on 8/2/24, showed: -Requirement: Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents; -Average daily census: 146; -Staff type, included: -Licensed nurses providing direct care: six per day; -Nurses aides: 30 per day; -Other nursing personnel (e.g., those with administrative duties): 11 per day weekdays; -Respiratory care services staff: one; -Administrator, Director of Nursing (DON), two Assistant Director of Nursing (ADON), Wound Nurse, Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Medication Technicians (CMTs) and Certified Nursing Assistants (CNAs); -Staffing plan: Total number needed, average, or range: -DON: one; -RN or LPN, ADON: two ADON; -RN or LPN wound/treatment nurse: one for five days a week; -Licensed nurse and CMTs to residents: 2 (licensed/certified staff):30 residents; -Licensed nurse ratio evenings/nights: 1:30; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Licensed nurse ratio nights: 1:50; -Direct care staff (total licensed or certified (CNAs or CMTs): -5:30 ratio days; -2:30 ratio evenings; -2.5:30 ratio nights. Review of the census per hall, dated 8/25/24, showed: -Rehab building: -Memory care unit: 29; -Rehab hall: 34; -Total residents in rehab building: 63; -Long term care (LTC) building: -North hall: 39; -South hall: 56; -Total residents in the LTC building: 95. Review of the facility tube feeding, total parenteral nutrition (TPN, IV-administered nutrition) policy, revised 12/2020, showed: -Purpose: To ensure that the Facility meets the nutritional guidelines and resident's nutritional requirements per physician orders; -Policy: A physician order is required to administer tube feedings/TPN/Commercial formula tube feedings will only be used for residents as prescribed; -Procedure: -I. The physician's order for tube feedings and TPN are considered diet orders and should be communicated by the nursing staff to the Nutrition Services Department utilizing Diet Order & Communication Form; -II. The physician order and information communicated to the Nutrition Services Department should include: -A. Type of formula; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-B. Amount of formula and fluid; and; -C. Frequency and amount of feeding. Review of the facility's Documentation Nursing Policy, revised 6/2020, showed: -Purpose: To provide documentation of resident status and care given by nursing staff; -Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts, and other documentation tools will be used as appropriate. Nursing documentation will not contain error-prone abbreviations. See Error -Prone Abbreviations. Abbreviations identified in industry accepted standards such as Steadman's Medical Dictionary or Taber's Cyclopedic Medical Dictionary that are not specifically excluded by the list in Error Prone Abbreviations are acceptable abbreviations. Nursing staff will not falsify or improperly correct nursing documentation; -Procedure: -I. Nursing documentation: -C. The Licensed Nurse will review the Plan of Care on a weekly basis and document the resident's response and progress towards the goal; -D. Any communications with family, durable power of attorney (DPOA), or physician is to be noted in nurse's notes; -F. Nurse's notes are dated, timed, and signed when written; -H. Medication Administration Records (MAR) and Treatment Administration Records (TAR) are completed with each medication or treatment completed; -I. Glucose measuring is documented as per physician's order; -J. Treatments completed and documented as per physician's order; -K. Documentation will be completed by the end of the assigned shift. Review of the facility staffing sheet, dated 8/25/24, showed: -Rehab: -Night nurse: LPN FF: Walked out; -Night nurse: LPN GG: Called out sick; -No nurse listed on the schedule for night shift on rehab. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #45's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/7/24, showed: -Severe cognitive impairment; -Dependent on staff for all activities of daily living (ADLs, activities related to personal care); -Received 51% or more of nutrition by tube feeding (used to give medicines and liquids, including liquid nutrition, through a small tube placed through abdomen into the stomach); -Diagnosis included gastrostomy (g-tube, surgical procedure used to insert a tube through the abdomen and into the stomach used for medication, liquids and liquid nutrition), seizures, high blood pressure, muscle weakness, need for assistance with personal care and protein calorie malnutrition. Review of the resident's care plan, in use during the survey, showed: -Focus: Resident is at risk for abnormal bleeding or hemorrhage due to anticoagulant (used to prevent blood clots) use; -Goal: Will be free from abnormal bleeding through review date; -Interventions: -Monitor for signs and symptoms of bleeding (bruising, petechiae (tiny round brown-purple spots due to bleeding under the skin), epistaxis (bleeding from the nose), gastrointestinal (GI) bleeding, hematuria (blood in your urine), nose bleeds, tarry/black stools, bleeding gums). Notify medical provider, Resident/RR; -Provide anticoagulant, antiplatelet (used to prevent blood clots) medication per medical provider order. Monitor for effectiveness, and side effects (bleeding, embolism (obstruction or blockage in a blood vessel). Report abnormal findings to medical provider, resident/RR. Review of the resident's electronic MAR (eMAR) and TAR (eTAR), dated 8/25/24 through 8/26/24, showed: -Eliquis (Apixaban, anticoagulant, used to prevent blood clots) medication used to treat and prevent blood clots and to prevent stroke) tablet 5 milligrams (mg), give one tablet via g-tube two times a day for deep vein thrombosis (DVT, is a blood clot in a vein, usually in the leg), start 3/2/24 at 9:00 A.M.: -8/25/24: 6:00 P.M.: Blank; -Gabapentin (used to treat seizures and nerve pain) capsule 100 mg, give one capsule via g-tube two times a day for pain, start 3/2/24 at 9:00 A.M.: -8/25/24: 6:00 P.M.: Blank: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keppra oral solution 100 milligrams (mg) per (/) milliliters (ml), give 10 ml via g-tube two times a day for seizures, start 3/2/24 at 5:00 P.M.: -8/25/24: PM: Blank. Review of the resident's progress notes, dated 8/25/24 through 8/27/24, showed no progress notes related to medication that was not administered, medication errors, physician or RR notifications. 3. Review of Resident #6's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent on staff for all ADLs; -Received 51% or more of nutrition by tube feeding; -Trach care; -Oxygen therapy; -Diagnoses included respiratory failure, tracheostomy (trach, a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), gastrostomy, seizures, diabetes and high blood pressure. Review of the resident's care plan, dated 7/13/24, showed the following: -Focus: Resident has poor neurological function (how the brain receives and sends information to the rest of the body) and history of seizures; -Goals: Resident will not have increased signs and symptoms (s/sx) of neurologic complications, through target date; -Interventions: Administer medications per medical providers orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident/RR; Review of the resident's eMAR and eTAR, dated 8/25/24 through 8/26/24, showed: -Doxycycline Hyclate (antibiotic) 100 mg via g-tube every 12 hours for pneumonia for 5 days, start 8/21/24 at 8:00 P.M.: -8/25/24: 8:00 P.M.: Blank; -Lacosamide (used to treat seizures) 10 mg/ml, give 200 mg via g-tube every 12 hours for seizures, start 6/13/24 at 8:00 P.M.: -8/25/24: 8:00 P.M.: Blank; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Amoxicillin-Pot Clavulanate (antibiotic) 250-62.5 mg/5 ml, give 10 ml via g-tube every eight hours for pneumonia for 5 days, start 8/22/24 at 6:00 A.M.: -8/25/24: 10:00 P.M.: Blank; -8/26/24: 6:00 A.M.: Blank. Review of the resident's progress notes, dated 8/25/24 through 8/27/24, showed no progress notes related to medication that was not administered, medication errors, physician or RR notifications. 4. Review of Resident #16's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for all ADLs; -Received 51% or more of nutrition by tube feeding; -Trach care; -Suctioning; -Oxygen therapy; -Diagnoses included respiratory failure, tracheostomy, unspecified tracheostomy complication, gastrostomy, contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left shoulder, right and left elbow, right and left wrist, right and left hand, right and left knee, quadriplegia (paralysis (the loss of the ability to move) of all four limbs), sudden cardiac arrest (the heart stops beating suddenly), high blood pressure, muscle weakness, and persistent vegetative state (state of brain dysfunction in which a person shows no signs of awareness). Review of the resident's eMAR and eTAR, dated 8/25/24 through 8/27/24, showed: -Levetiracetam (Keppra, used to treat seizures) tablet 500 mg, give 1000 mg via g-tube two times a day for seizures, start 3/7/24 at 7:00 A.M.: -8/25/24: Mid-day/Evening medication pass 4:00 P.M. through 8:00 P.M. (PM): Code 9 (other/see progress note); -8/26/24: PM: Code 3 (Absent from home). Review of the resident's progress notes, dated 8/25/24 through 8/27/24, showed: -8/26/24 at 5:42 P.M., eMAR administration note: Change trach every three months and PRN every day shift every three months starting on the 6th for 84 days: Trach does not need changing; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/25/24 at 6:02 P.M.: eMAR administration note: Clotrimazole Cream 1%, apply to coccyx topically two times a day for skin infection, leave of absence (LOA); -8/25/24 at 6:00 P.M.: eMAR administration note: LOA; -No progress notes entered showing when resident left for LOA or when resident returned from LOA; -No progress notes related to medication errors, physician or RR notifications. 5. During an interview on 8/21/4 at 9:49 A.M., the DON said if there is not documentation, such as a blank on the eMAR or eTAR, that means it wasn't done. On 8/22/24 at 1:32 P.M., the DON said she expected staff to be knowledgeable of and follow the facility policies. The DON expected physician orders to be followed and staff to complete the documentation showing the orders were followed. She expected if coding was used in the documentation, the coding should be used correctly. If code 9 was used, a progress note would be entered explaining why the medication was not given. She expected if medication or treatments were not completed as ordered, the nurse should notify the physician and RR and document the notifications and any new orders in a progress note. During an interview on 8/26/24 at 7:35 A.M., RN L said there was not a nurse who worked on the rehab floor last night, 8/25/24. RN L said CMT U said he/she worked the rehab building by himself/herself last night. RN L said none of the residents who were scheduled to receive medication through g-tubes last night had medication because CMTs cannot administer medications through g-tubes. During an interview on 8/26/24 at 8:29 A.M., CMT U said he/she worked as a CMT on night shift last night on the memory care unit and passed medication to the rehab hall. CMT U said there were two nurses in the other building. CMT U said the Staffing Coordinator (SC) was aware there was not a nurse in the rehab building and she was trying to find someone to come in. CMT U said he/she informed the two nurses in the LTC building knew there was not a nurse on the rehab floor, and they were supposed to reach out to the SC. CMT U said he/she did not give medication through the g-tube or hang the tube feedings for the four residents with g-tubes. During an interview on 8/26/24 at 9:11 A.M., LPN HH said he/she was told late in the shift that there was not a nurse in the rehab building. LPN HH said the SC sent a group text to him/her and LPN Z that a nurse needed to go over to the rehab building. LPN HH said he/she responded to the text and said he/she was passing medication on the North hall and was the nurse and the CMT and had been working since 3:00 P.M. LPN HH told the SC that he/she could not go to the rehab building. LPN Z did not reply to the text and LPN HH was not sure if LPN Z went over to the rehab building. LPN HH did not go over to the rehab building during the shift. During an interview on 8/26/24 at 9:30 A.M , LPN Z said he/she did not go to the rehab building overnight. LPN Z said nobody reached out to him/her to go over to the rehab building to give medication to the residents with g-tubes, hang the tube feedings, or to go and provide trach care. LPN Z said nobody called him/her. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24 at 10:23 A.M., the SC said on nights for the rehab building, there are two or three CNAs scheduled on the rehab floor and one nurse. In the memory care hall (located in the rehab building), there are two CNAs and one CMT scheduled for nights. The SC said last night, she had two nurses scheduled for the rehab building, LPN GG called off sick and the other nurse, LPN FF, ended up walking out. The SC said she gave direction to the two nurses working in the LTC building that she needed someone to go over to the rehab building by sending a group text. The SC said LPN HH responded to the text that he/she had been working on North Hall since 3:00 P.M. and he/she did not have a CMT. The SC said the South Hall was supposed to have two CMTs but one called out sick and the other one was sent home because that CMT was on orientation. The SC said she did not get a response from LPN Z through the group text. The SC said she just sent the group text, and she did not notify anyone else that there was not a nurse in the rehab building. The SC thought one of the nurses from the LTC building would go over to the rehab building. The SC said someone was supposed to be on call, but she did not have an updated on-call schedule, so she did not know who was supposed to be on call. The SC said she did send a text to the DON at 8:50 P.M. informing her that there was no nurse in the rehab building. The DON responded and asked who was going to be on rehab and the SC texted the DON that she gave direction to the LTC building nurses that one needed to go over to the rehab building. When LPN HH responded to the group text, the SC was already asleep. The SC said she did not follow up with LPN HH or LPN Z this morning to see who went to the rehab building. The SC said the MDS Coordinator informed her this morning that there was not a nurse in the rehab building this morning when she did rounds. During an interview on 8/26/24 at 11:46 A.M., the DON said she was aware that one nurse called out who was scheduled for the rehab building last night and the other nurse who was scheduled left around 9:30 P.M. The DON said she was told by the SC that she had reached out to the nurses in the LTC building to go to the rehab building to do trach care and g-tube medication and tube feedings. CMT U told the SC that both nurses LPN HH and LPN Z refused to go over to the rehab building. The DON expected the SC to confirm who was going to the rehab building prior to going to sleep. The DON expected the SC to call and talk to the nurses if she did not receive a response from the nurses through text. The DON said she expected the SC to reach out to the nurse on call and she expected the SC to have an updated on call schedule. If the SC did not have an updated on call schedule, the SC should have reached out to the DON. The DON said the CMT who was on the memory care unit and passing medications to the rehab could not do trach care, medications through g-tubes or hang tube feedings. The DON expected physician orders to be followed and for a nurse to be in the rehab building on every shift. During an interview on 8/27/24 at 1:33 P.M., the DON said if medication is not administered to residents per the physician's orders, that would be a medication error. If a medication error occurs, the DON expected the nurse to notify the physician and the RR. The nurse should follow any new orders given by the physician. The medication error, new orders, and notifications to the physician and RR should be entered in a progress note. The DON said there was not adequate staffing in the rehab building on Sunday night 8/25/24, and due to the staffing, residents who had g-tubes did not receive medications. The DON said the physicians and RRs had not been notified of the medication errors that occurred but they would be notified today. The DON said after the physician and RR are notified, the medication errors and notifications would be documented in the progress notes in the residents' medical records.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on interview and record review, the facility failed to ensure staff did not document medications as provided on the medication administration record when the medications were not actually provided. Staff failed to document why the medications were not provided for 5 of 6 sampled residents that were observed for a medication administration pass (Residents #11, #3, #8, #9, #10). The census was 157. Review of the facility Physician Orders policy, undated, included the following: -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The safety of residents, staff and visitors is of primary importance. The purpose of this policy is to provide guidance for licensed nurses and licensed therapist to accurately document physician and provider orders as determined by the licensee's Scope of Practice; -Procedure: I. Medical Orders Transcription; II. Taking the order: a. Write down the order as stated; f. Place orders in electronic Medical Record (EMR); h. Contact pharmacy for changes; III. Execution of Order and Notifications: a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse; ii. The medication administration record (MAR) should automatically be updated with the new orders if a schedule has been assigned; 9. If a medication is not available in the emergency kit, then contact pharmacy, resident representative, and notify provider (physician); 11. Sign off medication after administration of each drug to resident. Review of the facility's Medication Administration policy, undated, included the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The safety of residents, visitors and employees is top priority of care. The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer; -Procedure: General Procedures: a. Administer medication only prescribed by provider; b. A resident-centered, individualized approach to medication administration will be used for administering medications as possible; e. Licensed or authorized personnel may administer prescribed medication; f. Observe the five rights in giving each medication: The right resident, the right time, the right medicine, the right dose and the right route; j. Full attention should be given during preparation of medications; l. Read medication label three times before administering medication: First when pulling the medication from the drawer. Second, when comparing the label to the MAR. Third, when preparing to administer the medication; x. Report medication errors; dd. Medications will be charted when given; gg. Medications that are refused or withheld or not given will be documented; IV. Documentation: a. Documentation of medication will be current for medication administration; b. Documentation of medications will follow accepted standards of nursing practice. Review of the facility's Missed Medication/Medication Error policy, undated, included the following: -Definitions: Medication error/incident: any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication. Medication errors/incidents may include medications: a. Given incorrectly (wrong dose, wrong resident, wrong time, wrong route, wrong drug); -Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident's rights compliance includes providing for timely medical needs in which the physician has the opportunity to adjust and/or change medication(s) for the resident, including an awareness of risk factors when a resident does not receive medication in an appropriate time frame; -Procedure: II. For any medication(s) not available during a routine medication pass: 1. The Charge Nurse will check the emergency kit to attempt to offer medication in a timely a manner; 3. In the event the medication is not available from the emergency kit, the Charge Nurse will notify the Physician immediately and receive guidance on how to proceed; 4. The Charge Nurse will notify the pharmacy and attempt to obtain the medication; 5. The Charge Nurse will notify the Director of Nurses (DON) of any medication that is not available: a. Failure to administer a prescribed medication as ordered is considered a medication error regardless of reason or drug category and provided new orders; b. Medication error rates will be monitored by the QAPI (Quality Assurance Performance Improvement) committee for benchmarking and process improvement. 1. Review of Resident #11's medical record, showed: -Diagnoses included chronic bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lungs) and chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that makes it difficult to breathe); -An order, dated 12/30/22, for fluticasone propionate nasal suspension (steroid nasal spray used for the management of COPD) 50 micrograms (MCG) 2 sprays into each nostril in the morning; -An order, dated 9/21/23, Symbicort Inhalation Aerosol 160-4.5 MCG/MCG (used for the treatment of COPD) 1 puff orally twice a day. A quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/6/24, showed the resident: -Was cognitively impaired; -Had no refusal of care. During a medication administration observation on 6/17/24 at 8:57 A.M., Certified Medication Technician (CMT) B: -Did not administer fluticasone propionate nasal suspension; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Did not administer the Symbicort inhaler. Review of the resident's medication administration record (MAR), dated 6/17/24, showed staff documented the fluticasone propionate nasal spray and the Symbicort inhaler had been administered. 2. Review of Resident #3's medical record, showed: -admitted to facility on 4/26/24; -An order dated 4/27/24, for fluticasone propionate inhalation aerosol powder (inhaler used to treat COPD) 50 MCG, 2 sprays inhale orally in the morning. An admission MDS, dated [DATE], showed the resident was cognitively intact. During a medication administration observation on 6/17/24 at 9:12 A.M., CMT B did not administer fluticasone propionate inhaler 2 puffs. Review of the resident's MAR, dated 6/17/24, showed staff documented the fluticasone propionate inhaler had been administered. 3. Review of Resident #8's medical record, showed: -admitted to facility on 5/10/24; -A order dated 5/11/24, for multivitamin with minerals, (used to treat or prevent vitamin deficiency due to poor diet or certain illnesses). An admission MDS, dated [DATE], showed the resident was cognitively intact. During a medication administration observation on 6/17/24 at 8:33 A.M., CMT B administered a multivitamin, he/she did not administer a multivitamin with minerals. Review of the resident's MAR, dated 6/17/24, showed staff documented the multivitamin with minerals had been administered. 4. During an interview on 6/17/24 at 1:14 P.M., CMT B said he/she did not administer the medications to Residents #11 and #3 because the nasal spray and inhaler were out of stock. He/She would order the medications today. He/She thought he/she had administered a multivitamin with minerals to Resident #8. CMT B did not read the label thoroughly. The MAR had codes staff needed to use if a medication was unavailable. He/She should not have documented the medications were provided when they were not. 5. Review of Resident #9's annual MDS, dated [DATE], showed a diagnoses of renal disease (kidney insufficiency), diabetes mellitus (high blood glucose/sugar levels), and dementia. Review of the resident's care plan, located in the EMR, showed: -10/6/20, Focus: Impaired thought processes related to dementia; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/6/22, Focus: ADL self care deficit. Requires assistance with ADLs. Review of the resident's POS, located in the EMR, included the following medication: -A order dated 8/18/22, for Normal saline eye drops instill one drop in the right eye in A.M.; -A order dated 5/28/24, Start Date: 5/29/24 for Gabapentin 400 mg two times a day for neuropathy (nerve damage) for 10 days (medication to be administered 5/29/24 through 6/7/24). Observation on 6/17/24 at 8:58 A.M., showed CMT A prepared the resident's morning medications. He/She could not find the resident's normal saline eye drop in the medication cart. He/She said the medication was an OTC medication and they should have it in the medication stock room. He/She went to the facility medication stock room to look for a new bottle of the normal saline eye drops. CMT A returned to the medication cart and said he/she could not find a replacement bottle of the normal saline eye drops. He/She looked for the resident's gabapentin on the medication cart and could not find it. CMT A said he/she would reorder it from the pharmacy and tell the charge nurse. Review of the resident's MAR on 6/17/24 at 12:22 P.M., showed CMT A initialed he/she administered the normal saline eye drop on 6/17/24. Review of the gabapentin showed staff initialed the medication had been administered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, and CMT A initialed he/she administered it on 6/17/24. During an interview on 6/18/24 at 12:08 P.M., CMT A said since he/she did not administer the normal saline eye drop as ordered, CMT A should have coded the MAR as a 9 for Other See/Nurses Note. He/She did not document a 9 code because he/she was nervous about passing medications with the surveyor observing. He/She did not notice the order on the MAR for the gabapentin to be completed in 10 days (6/7/24). He/She thought the resident should have received the gabapentin but ran out. CMT A did not notify the resident's physician or resident representative about the resident missing the saline eye drop. During an interview on 6/18/12 at 10:55 A.M. and 12:08 P.M., the Interim DON reviewed the resident #9's POS and MAR. She said the gabapentin should have been discontinued on 6/7/24. The nurse who entered the original order did not put the order in for a 10 day duration, so there was not a stop date. She said CMT A should not have initialed the medications as administered. The CMT should have added the 9 code and documented the reason why the medication was not administered. 6. Review of Resident #10's quarterly MDS, dated [DATE], showed diagnoses of anemia (low red blood cell count), malnutrition and depression. Review of the resident's physician's order sheet (POS), located in the EMR, included the following medications: -A order dated 11/28/23, for Pyridoxine HCl 200 mg. Give one tablet in the morning; -A order dated 12/4/23, for Lactinex. Give one packet three times a day for health maintenance. Review of the resident's care plan, located in the EMR, showed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/8/23, Focus: At risk for nutritional decline related to malnutrition and anemia. Lactose intolerant. Interventions: Provide supplements per medical provider's orders; -11/28/23, Focus Activity of daily living (ADL) self care deficit. Observation on 6/17/24 at 8:30 A.M., showed CMT A prepared the resident's medications. He/She could not find the resident's Lactinex or pyridoxine HCl in the medication cart. He/She said he/she just reordered the Lactinex from the pharmacy through the facility computer system. The pyridoxine HCL was an over the counter (OTC) medication and should be available in the facility medication storage room. He/She locked the medication cart and went to look for the pyridoxine HCL. CMT A returned and said there was none available in the medication storage room so he/she would not be give the Lactinex or pyridoxine HCL. Review of the resident's MAR on 6/17/24 at 12:22 P.M., showed CMT A initialed he/she had administered the Lactinex and pyridoxine HCL as ordered. During an interview on 6/18/24 at 12:08 P.M., CMT A said since he/she did not administer the medication as ordered, he/she should have coded the MAR as a 9 for Other See/Nurses Note. He/She did not document the 9 code on the MAR because he/she was nervous about passing medications with the surveyor. He/She did not notify the resident's physician or representative about the resident missing the medications yesterday. During an interview on 6/18/12 at 10:55 A.M. the Interim DON reviewed the resident's MAR. She said CMT A should not have initialed the medications as administered. The CMT should have added the 9 code and documented the reason why the medication was not administered. 7. During an interview on 6/18/24 at 10:55 A.M., the Interim DON said she expected staff to follow facility policies. If a medication could not be administered, whether it was an OTC medication or prescription medication, she expected staff to document on the MAR why the medication could not be administered. Then, contact the resident's representative and physician to inform them the medication was not administered. This should all be documented. MO00236225 MO00236238