| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>22409<br><br>See Event ID 56TT13.<br><br>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. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>22409<br><br>See Event ID 56TT13.<br><br>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. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>22409<br><br>See Event ID 56TT13.<br><br>This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 7/12/24.<br><br>Based on observation, interview and record review, the facility failed to ensure staff followed facility policies by failing to ensure nurses assessed and notified the physician of Resident #29's right buttock/right ischium (lower and back part of the hip bone) when Certified Nursing Assistants (CNAs) alerted the nurses of issues for the resident's skin and documented open areas on bath sheets. The resident also requested the facility's former Wound Nurse (WN) assess his/her bottom, but she refused. The resident's request was witnessed by CNA N. The resident was later hospitalized for assessment and treatment of an unstageable pressure injury (slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) and/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) to the right ischium that was infected and required intravenous (IV) antibiotics and surgical debridement (a procedure that removes dead, infected, or nonviable tissue from a wound to promote healing). The facility also failed to ensure the wound care company communicated new treatment orders to the facility prior to leaving on the days they made rounds. Two residents (Residents #42 and #35) had treatment order changes that were not implemented timely. One of those residents, Resident #42, was also observed to not have had his/her dressing changed as ordered. In addition, the facility failed to ensure the wound care company provided their progress notes timely to the facility for all three residents. The facility identified 14 residents with pressure ulcers. Six residents were sampled and failures were found with three of the sampled residents. The census was 156. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0695<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>22409<br><br>See Event ID 56TT13.<br><br>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. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>22409<br><br>See Event ID 56TT13.<br><br>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. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>22409<br><br>See Event ID 56TT13.<br><br>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. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265703 | A. Building<br>B. Wing | 08/27/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>22409<br><br>See Event ID 56TT13.<br><br>This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 6/18/24 and 7/12/24.<br><br>Based on interview and record review, the facility failed to maintain complete and accurate resident records and follow their policy for resident change in condition. On 8/4/24, one resident had a change in condition and went to the hospital where he/she was admitted . The resident's electronic health record (EHR) showed no documentation on 8/4/24, regarding the resident's change in condition, physician notification, and/or the time the resident eventually went to the hospital (Resident #29). In addition, the facility failed to ensure two residents' electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) were completed per facility policies and procedures. Both residents' eMAR and eTAR had numerous blanks with no documentation as to why there were blanks (Residents #3 and #24). The sample size was 28. The census was 156. |