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	08/08/2025

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. (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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor one resident's Durable Power of Attorney (DPOA, a legal document that allows a person to appoint another person to manage their financial and/or healthcare matters) to act on their behalf on financial matters (Resident #174). The facility failed get signed authorization from the resident's DPOA to open a resident trust account and to have his/her Social Security directly deposited into the resident trust account. In addition, the facility failed to notify the resident and his/her DPOA of a debited care cost at the time the resident was discharged from the facility. The census was 165. Review of Resident #174's face sheet, showed:-admitted on [DATE];-discharged on 7/11/25. Review of the resident's medical record, showed:-A Durable Power of Attorney (DPOA, a legal document that allows someone to appoint another person to act on their behalf in financial and/or medical matters), signed on 4/22/23, showed:-The DPOA was designated to act as initialed below, in the resident's name and for the resident's benefit, benefit, hereby revoking any and all financial powers of attorney resident may have executed in the past;-Resident grant attorney-in-fact the powers set forth herein immediately upon the execution of this document. These powers shall not be affected by any subsequent disability or incapacity resident may experience in the future;-Resident's attorney-in-fact shall exercise powers in the resident's best interest and for his/her welfare, as a fiduciary. His/Her attorney-in-fact shall have the following powers: -Banking: To receive and deposit funds in any financial institution, and to withdraw funds by check or otherwise to pay for goods, services, and any other personal and business expenses for resident's benefit. If necessary to effect my attorney-in-fact's powers, my attorney-in-fact is authorized to execute any document required to be signed by such banking institution. Review of the resident's Fund Authorization and Agreement, showed:-Transferring account (automatic care cost payments due to the facility) with a $50 monthly allowance;-Direct deposit: Social Security;-Signed by the resident on 8/15/24;-No signature from resident's DPOA;-No signature from witness. Review of the resident's benefit status, showed a monthly benefit in the amount of $1,512.47. Review of the resident's cash receipt report, showed:-On 3/24/24, a patient liability payment in the amount of $675.00;-On 4/1/24, a patient liability payment in the amount of $675.00;-On 5/1/24, a patient liability payment in the amount of $675.00;-On 6/26/24, a patient liability payment in the amount of $761.00. Review of the resident's progress notes, showed:-On 12/16/24, sent Social Security letter of income to County O for budget review;-On 12/19/24, resident does get his/her money when he/she asks for it. He/She has not been in lately to ask so I will also remind him/her that he/she can come in anytime and get money if his/her account shows it available. The invoices are old invoices from the facility. His/Her money comes into Resident Fund Management Service (RFMS) and the invoice gets care costed. I am also currently working with Medicaid to get his/her surplus adjusted because they have him/her paying more then he/she actually receives. I have sent Medicaid an email with supporting documentation;-On 5/1/25, sent another email to County O asking if they can tell me where resident's pension is coming from;-On 5/6/25, pension is coming from Company P. That is the only information we have;-On 6/3/25, resident tried calling Company P and unfortunately, they are not able to give him/her any info as resident could not remember any info about where/or which company the pension is coming from. They did give a fax number and also an email address to send request to;-On 6/25/25, call placed to resident's DPOA. He/She stated that he/she has all the paperwork from Company P for the pension. He/She stated he/she has concerns about the things that go on around at the facility. He/She asked that we hold a care plan meeting to discuss these concerns and to also ask resident if he/she would like to go live with him/her. Social Services aware and will set this up.During an interview on 7/10/25 at 11:41 A.M., the resident's DPOA said the facility did not respect his/her Power of Attorney (POA) status. They did not notify him/her of anything or give the DPOA any information. He/She did not want the resident's money switched to the facility because the resident had dementia. The DPOA asked the Business Office Manager (BOM) who gave the BOM the authority to call Social Security and have the resident's check moved? The BOM said the resident understood the question. The BOM was the bookkeeper. The BOM started asking where the resident's pension was. During an interview on 8/7/25 at 9:30 A.M., the BOM said the facility was not the representative payee for the resident's Social Security. The resident opened a new resident trust account at a new bank. He/She enrolled in direct deposit, so the Social Security was deposited into the resident trust. The resident's DPOA was contacted but refused to answer. He/She never answered the phone and did not

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure recommendations from a Level two Pre-admission Screening and Resident Review (PASARR) were incorporated into the plan of care for 1 of 3 residents reviewed for PASARR (Resident #119). This failure had the potential to negatively affect the resident's mental and psychosocial well-being. The census was 165.Review of Resident #119's medical record, showed:-The resident was admitted on [DATE];-The resident resided in a Medicaid certified bed;-A PASARR Level II Evaluation, Section II, dated 6/25/25, showed diagnoses included cerebral palsy (disorder of movement, muscle tone, or posture), learning disorder, and paraplegia (paralysis of both legs);-A PASARR Level II Summary of Findings, dated 6/27/25, showed:-The PASARR Level II Evaluation indicated the following supports and services are to be provided by the facility;-Medication therapy;-Crisis intervention services;-Discharge planning;-Structured development;-Personal support network. Review of the resident's care plan in use at the time of survey, did not address the resident's PASARR Level II recommendations. During an interview on 8/7/25 at 12:56 P.M., the Social Worker Assistant in the Long-Term Care (LTC) unit said he/she was not involved in following-up with the residents' PASARRs. The Social Services Director (SSD) in the Rehab side would have the information, including for the LTC residents. During an interview on 8/7/25 at 1: 49 P.M., the SSD said he/she was not responsible for following-up the residents' PASARRs recommendations and findings. He/She just made sure they were completed and filed in the residents' record but had no part to complete them. The admission Director was responsible for completing the residents' PASARR. During an interview on 8/7/25 at 2:53 P.M., the admission Coordinator said the residents' PASARR should always be included in the residents' record during admission. If the resident triggered for Level II, their liaison was responsible for completing it. Levels I and II need to be part of the admission process. Social Services would be responsible to make sure PASARRs are complete. The Minimum Data Set (MDS) staff will do their part, then will be filed in the medical records. During an interview on 8/7/25 at 3:27 P.M., the MDS Rehab nurse said he/she completes the second half or the nursing part of the residents' PASARR. He/She verified the resident had a Level II evaluation, and the recommendations were not included in the care plan. He/She said the care plan should reflect the resident's individual care and needs. During an interview on 8/8/25 at 10:58 A.M., the Director of Nursing (DON) said she expected the resident's Level II PASARR recommendations to be incorporated into the plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with acceptable standards of practice, for one resident who had a fall. Staff failed to follow their fall policy and failed to document the circumstances of the fall, assessment of the resident, and/or complete neurological checks on the shift that the fall occurred. In addition, the staff present at the time of the fall failed to report the fall to the physician or the oncoming shift. During the next shift, approximately 8 hours after the fall, the resident was found with significant facial bruising of unknown origin that was only determined to be a fall after interview with the resident and the resident's roommate (Resident #22). The census was 165. The sample was 33. Review of the facility's undated Fall Management Program policy, showed:-Purpose: To prevent resident falls and minimize complications associated with falls through the development of a fall management program;-The facility will provide the highest quality care in the safety environment for the residents residing in the facility. The facility has developed a fall management program that strives to prevent resident halls through meaningful assessments, interventions, education, and reevaluation;-Post-fall: -Following a resident's fall, the licensed nurse will complete an incident report and a post-fall assessment and investigation within 24 hours or as soon as practicable. Review of the facility's Fall Evaluation and Prevention policy, dated 8/2020, showed:-Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents;-Following a fall, the following steps should be undertaken: -Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. The evaluation should include vital signs and neurological status; -If there was a loss of conscious or the fall was unwitnessed, neurological signs should be initiated and checked for at least 72 hours (refer to the procedure on neurological checks); -Following the resident's evaluation, transfer the resident to the appropriate surface and evaluate further if indicated. Monitor closely for indications of pain or discomfort in any area, reddened or discolored areas, or other signs of an injury; -Ask the resident what happened prior to the fall or what may have caused the fall. Root cause analysis; -Complete the accident/incident report and notify the physician and responsible party. Document the physician orders and/or response from the physician and responsible party; -If the fall was un-witnessed, initiate the investigation including witness statement from staff and residents. Try to determine who was the last person to see the resident prior to the fall and the resident's condition at that time. Review of the facility's Neurological Assessment policy, dated 2, 2019, showed:-Purpose: To provide guidelines for the performance of neurological assessment on residents;-Nursing staff will perform a neurological assessment in the following circumstances: Following an unwitnessed fall;-Neurological checks will be performed as follows or otherwise as ordered by the attending physician: every 30 minutes x4, then every hour x4, then every 4 hours x4, then every shift for a combined total of 72 hours;-The following information will be documented in the resident's medical record: -The date and time the procedure was performed; -The name and title of the individual(s) who performed the procedures; -All assessment data obtained during the procedure, including: Eye opening, verbal response, motor response, pupillary response, limb response. Review of Resident #22's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 5/26/25, showed:-Resident is rarely/never understood;-Roll left and right, sit to lying, lying to sitting, sit to stand: Substantial/maximal assistance;-Chair/bed-to-chair transfer: Dependent;-Unable to determine fall history. Review of the resident's medical record, showed diagnoses included generalized weakness, repeated falls, abnormalities of gait and mobility, and dementia. Review of the resident's care plan, in use at the time of the investigation, showed:-Focus: At risk for falls related to confusion, incontinence, poor communication/comprehension, repeated fall history;-Goal: Not sustain serious injury;-Interventions included: Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Review of the resident's medical record, showed a progress note dated 8/5/25 at 8:30 A.M., certified nursing assistant (CNA)reported to this nurse that the resident has some bruising noted to the face. Upon assessment, noted resident's face to have a purple bruising. No distress noted. Sitting in a wheelchair at the dining room table eating with assist of one staff member. The physician was notified. New order received for a full facial x-ray. Administrator and the DON made aware. Call placed to the x-ray company. Statements from staff collected at this time regarding this incident. Observation on 8/5/25 at 9:41 A.M., showed the resident in bed on his/her right side. The bed in the low position. Visible bruising to his/her

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's were free from accident hazards during resident smoking and in the smoking areas. The smoking area showed evidence of unsafe smoking practices such as trash in the ash bins and cigarette butts on the ground. Residents who smoke were not accurately and completely assessed for their ability to smoke safely. In addition, the facility did not follow their smoking policy as it relates to assessment, supervision, and securing smoking materials for three of four residents investigated for safe smoking practices (Residents #94, #4, and #16). The census was 165. The sample was 33. Review of the facility's Smoking by Residents policy, dated 6, 2020, showed:-To respect resident choices to smoke and to maintain a safe healthy environment for both smokers and non-smokers;-The facility permits smoking only in area(s) designated by the facility's safety committee;-The facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely;-Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke in these areas;-Residents who are not able to smoke safely will be accompanied by facility staff while smoking;-Smokers shall be identified at the time of admission;-A licensed nurse will complete a safe smoking assessment for residents who wish to smoke. The assessment will be completed in the electronic medical record system;-The interdisciplinary team shall create a smoking care plan for the resident;-All smoking materials will be stored in a secure area to ensure they are kept staff;-All smoking sessions will be supervised by facility staff members;-Cigarette butts are disposed of only in provided receptacles. 1. Observation on 8/5/25 at 9:23 A.M., of the smoking area on the Long-Term Care (LTC) side of the facility, showed a sign on the door that no oxygen is allowed in the smoking area. There are two separate areas, a covered and screened-in porch and an open-air area. A sign posted near the entrance to the smoking area read: LTC and rehab smoke times 8a, 10a, 2p, 4p, and 8p. [NAME] Zone designated smoke area. Observation of the open-air area of the smoking area showed two self-closing red ash bins stuck in the open position. One with two packs of cigarettes and one with one cigarette pack in it. Cigarette butts also in the ash bins along with the trash. Multiple cigarette butts scattered around the grounds, in the grass, on the mulched areas, and on the concrete walkways. On the ground near the building, there are approximately 2-4 cigarette butts per square foot of Random cigarette butts on the concrete. Two residents smoke in the screened-in area of the smoke area. There was a door from the outside to the screened-in area. No staff present. At 9:37 A.M., a resident walked out to the outdoors smoking area with a cigarette that hung out of his/her mouth. He/She sat down and lit the cigarette. 2. Review of Resident #94's medical record, showed:-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease);-A Safe Smoking Evaluation, dated 5/23/25: Does the resident smoke: No. Review of the resident's care plan, in use at the time of the investigation, showed:-Focus: The resident smokes. Has been advised of the facility smoking policy. The resident requires supervision with smoking;-Goal: The resident will be compliant with the facility smoking policy;-Interventions included: Observe the resident during smoking for unsafe smoking. Reassess the resident's smoking ability quarterly and after reports of unsafe practices. Remind the resident and family that all cigarettes, lights, matches, and smoking paraphernalia must be kept at the nurse's station. During an interview on 8/4/25 at 9:42 A.M., the resident said when he/she smokes, he/she can go by him/herself. There are other residents who require staff assistance. He/She can go out whenever he/she wants. He/She is able to keep his/her own smoking supplies, lighters, and cigarettes. Observation on 8/5/25 at 8:09 A.M., showed the resident in his/her scooter, propelled away from the smoking area and said he/she just got done smoking. At 11:42 A.M., the resident propelled him/herself outside to the smoking area in his/his scooter. He/She grabbed cigarettes and a lighter out of his/her pocket and began to smoke with no staff present. 3. Review of Resident #4's medical record, showed:-Diagnoses included complete paraplegia (paralysis of both legs), COPD, and asthma;-A Safe Smoking Evaluation, dated 6/6/25: Does the resident smoke: No. During an interview on 8/4/25 at 9:40 A.M., the resident said he/she smokes. He/She prefers to go every two hours, he/she keeps his/her own cigarettes and lighter. He/She did not require staff assistance compared to the other residents. Observation on 8/6/25 at 12:15 P.M., showed the resident in his/her motorized chair, propelled to the smoking area. The resident was upset because he/she was instructed to come back inside because his/her chair tilted all the way back in a supine position and was unable to return to a sitting position. The staff assisted the resident back in the room to have the chair fixed. The resident said he/she

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to follow their policy for dialysis (a procedure that cleanses the blood of its impurities) when staff failed to document pre/post dialysis assessments. The facility identified five residents who received dialysis services. Two residents were sampled, and issues was found with one (Resident #150). The sample was 33. The census was 165. Review of the facility's Dialysis Care Policy, revised 6/20, showed:-Policy: the facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing for all non-- dialysis needs of the resident including during the time period when the resident is receiving dialysis;-Arteriovenous (AV) Shunt/Fistula (surgically created by connecting an artery and vein to provide a stable access point for dialysis), inspect shunt site area for color, warmth, redness, tenderness, pain, edema, drainage, and bruit (a pulsation felt of blood flow anastomosis (connection made surgically between adjacent blood vessels) once per shift;-To check for a bruit place fingertip slightly over the vein and feel for the thrill. Place the stethoscope over the vein and listen for the buzz or bruit. Document the findings in the medical record;-All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. Review of Resident #150's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/20/25, showed:-Severe cognitive impairment;-No behaviors or rejection of care;-Diagnoses included end stage renal disease (ESRD, chronic irreversible kidney failure);-Dialysis while a resident was not checked. Review of the care plan, in use at the time of survey, showed:-Focus: resident needs dialysis (hemodialysis, a medical procedure used to remove waste products and excess fluid from the blood when the kidneys are unable to perform this function adequately) related to renal failure;-Goal: will have no signs and symptoms of complications from dialysis through the review date;-Interventions: monitor/document/report to MD as needed any signs and symptoms of infection to access site: redness, swelling, warmth or drainage;-Monitor/document/report to MD as needed for signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds;-Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately;-The care plan failed to show the location of the access site and failed to show staff should document the bruit and thrill once per shift. Review of the physician order sheet, in use at the time of survey, showed:-A physician order for pre-dialysis assessment to be completed and sent with patient to dialysis every Tuesday, Thursday and Saturday,-A physician order for dialysis every Tuesday, Thursday, Saturday. Review of the Treatment Administration Record, dated 7/1/25 through 7/31/25, showed:-A physician order for pre-dialysis assessment to be completed and sent with patient to dialysis every Tuesday, Thursday and Saturday; -Documentation showed 7/8 and 7/19 were blank;-No documentation the access site was assessed for color, warmth, redness, tenderness, pain, edema, drainage and bruit once per shift. Review of the Dialysis Communication Forms, dated 7/1 through 8/7/25, showed:-12 forms were provided;-Two out of 12 nursing facility pre-dialysis documentation for thrill and bruit, dressing clean, dry, intact were blank;-Eight out of 12 nursing facility post-dialysis documentation, most recent temperature, pulse, respiration, blood pressure, oxygen saturation, location of access site, thrill and bruit, dressing clean, dry and intact, any new orders and assessment were blank;-Two out of four remaining nursing facility post-dialysis documentation, location of access site, thrill and bruit, dressing clean, dry and intact, any new orders and assessment were blank. Review of the progress notes, showed:-On 7/31/25, pre-dialysis assessment completed and sent with resident, bruit and thrill present, dressing remains clean and intact to right forearm, vital signs within normal limits (VSWNL); returned form dialysis, resident noted congestion with cough. MD made aware and stat chest x-ray ordered; -On 8/2/25, returned from dialysis, dialysis access site remains intact;-No other documentation the access site was assessed for color, warmth, redness, tenderness, pain, edema, drainage and bruit once per shift. During an interview on 8/8/25 at 7:45 A.M., Assistant Director of Nursing (ADON) L said the facility completed a pre and post dialysis assessment. The pre assessment would include the vital signs, weight, if the resident had pain, if they have eaten, any medications given and their Covid status. The post assessment would include vital signs and how the resident was feeling after dialysis. The assessment should be documented on the dialysis communication sheet or in the computer. During an interview on 8/8/25 at 11:00 A.M., the Director of Nursing (DON) said the physician's order should include the dialysis access site location. The bruit and thrill should be documented