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	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebird Wellness and Rehabilitation	9350 Green Park Road 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff provided adequate supervision and assistance to prevent accidents for one resident (Resident #2) when one staff repositioned the resident, who had a diagnosis of quadriplegia (loss or partial loss of movement and sensation in all four limbs) onto their side and left the resident unattended to obtain supplies. When the staff member returned to the room, the resident was on the floor. The sample was 16. The census was 158.The administrator was notified on 10/9/25 at 6:30 P.M., of past noncompliance which began on 8/9/25. Once the nurse was made aware of the incident, he/she assessed the resident, completed a skin and pain assessment, administered pain medication, started neurological checks, and notified the Medical Doctor (MD). The resident complained of pain and requested to go to the hospital. The resident was sent out to be evaluated. The facility obtained a statement from the Certified Nurse Aide (CNA) and the resident. Staff were in-serviced on proper incontinence care, taking supplies with them when they entered the room, and not leaving residents unattended. In addition, the Administrator and Director of Nursing (DON) had a care plan meeting with family. The CNA is no longer employed by the facility. This deficient practice was corrected on 8/11/25. Review of the facility's Activities of Daily Living (ADL) policy, dated March, 2018, showed the following:-Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good personal hygiene;-A resident's ability to perform ADLs will be measured using clinical tools, including the [NAME] Data Set (MDS). The following MDS definitions: total dependence - full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. Review of Resident #2's medical record, showed:-Alert to person, place, time, and situation;-Diagnoses included: generalized muscle weakness and quadriplegia;-Used a low air loss mattress (a specialized type of mattress that used a pump to circulate air through the mattress). Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident had an ADL Self Care Performance Deficit:--Goal: Resident will improve current level of function in (bed mobility, transfers, eating, dressing, toilet use and personal hygiene, ADL score) through the review date;--Interventions included: Bed mobility: roll left to right: dependent; Personal and toilet hygiene: dependent;-Focus dated 8/11/25: Resident has had an actual fall, 8/9/25 minor injury,:--Goal: The resident will resume usual activities without further incident through the review date; the resident's injured areas will resolve without complication by review date;--Interventions included: Educate staff that there is to be two people providing ADL care, such as turning, bathing, dressing, transfers, and incontinent care, at all times; for no apparent acute injury, determine and address causative factors of the fall; monitor/document /report as needed for 72 hours to medical doctor (MD) for signs and symptoms for pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Review of the facility's Fall report dated 8/9/25 at 4:46 P.M., showed the following for the resident:-Fall: no injury;-Nursing description: CNA informed the nurse that as he/she had the resident on his/her right side to provide personal care, he/she (the resident) had a spasm causing his/her legs to jump, making him/her fall out of bed. Upon entering the room, resident was noted to be on the floor, lying on his/her back with his/her bedside table overturned next to him/her. Upon assessment, no injury was noted at this time. Resident complained of pain to his/her neck and back of head. Resident stated that he/she hit his/her head on the bedside table on the way down. Resident stated that he/she fell when being changed and hit the back of his/her head on the bedside table on his/her way to the floor;-Was this incident witnessed? No;-Mental Status: Oriented to person, place, time, and situation. Review of the resident's progress notes dated 8/9/25, showed:-At 4:30 A.M., and late entry 11:16 A.M., CNA informed the nurse that as he/she had resident on his/her right side to provide personal care, he/she had a spasm causing his/her legs to jump, making him/her fall out of bed. Upon entering room resident was noted to be on the floor, lying on his/her back with his/her bedside table overturned next to him/her. Upon assessment no injury was noted at that time. Resident complained of pain to his/her neck and back of head. Resident stated that he/she hit his/her head on the bedside table on the way down. Resident assisted to bed and personal care provided. Requested to be sent out. MD notified. Gave orders to send to hospital for further eval. Spouse made aware via phone;-At 5:37 A.M., Emergency Medical Service (EMS) here to transport resident via stretcher times two;-At 10:39 A.M., resident returned from hospital ER by ambulance. Computed tomography (CT, a diagnostic imaging procedure that used X-rays and computer technology to