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	06/24/2026

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 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. Based on interview and record review, the facility failed to follow physician orders and facility policy when anti-anxiety medications were not administered as ordered for one resident (Resident #4). The sample was 8. The census was 151.Review of the facility's undated Medication - Administration policy showed:-Purpose: To provide practice standards for safe administration of medications for residents in the facility;-Policy:--Medication will be administered by a Licensed Nurse per the order of an attending physician or licensed independent practitioner, or as consistent with state law;--Medications must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law;--Medications may be administered one hour before or after the scheduled medication administration time;--Medications and treatments will be administered only by Licensed Medical or Licensed Nursing Staff;-Procedure:--If resident is refusing to take medication, the Licensed Nurse who is passing the medications will initial and draw a circle around his/her initials in the designated area on the medication administration record (MAR). Documentation will be entered on the back of the MAR stating the reason for the refusal;--If the resident repeatedly refuses medication, the Licensed Nurse will contact the physician to discuss alternative measures for medication administration. The plan of care will be updated as indicated;--The Licensed Nurse will chart the drug, time administered, and initial his/her name with each medication administration and sign full name and title on each page of the MAR;-Holding Medications:--Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason for the medication was held on the back of the MAR. Review of the facility's Unavailable Medications policy, dated 09/2018, showed:-Policy: Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident;-Procedures:-The pharmacy staff shall:--Notify nursing staff that the order product(s) is/are unavailable;--Notify nursing staff of when it is anticipated that the drug(s) will become available;--Suggest alternative, comparable drug(s} and dosage of drug(s} that is/are available;-The nursing staff shall:--Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available;.--If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction;--Obtain a new order and cancel/discontinue the order for the non-available medication.--Notify the pharmacy of the replacement order. Review of Resident #4's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/27/26, showed:-Cognitively intact;-Adequate vision and hearing;-Makes self-understood and understand others;-Diagnoses included high blood pressure, anxiety disorder, and depression;-Received anti-anxiety medication for the past seven days. Review of the resident's care plan, revised 04/01/26, showed:-Focus: Resident uses anti-anxiety medications related to anxiety disorder;-Goal: Resident will be free from discomfort (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or adverse reactions related to anti-anxiety therapy;-Interventions/Tasks included give anti-anxiety medications as ordered by the physician. Review of the resident's Mental Status Exam (MSE), dated 06/03/26, showed:-Problem List: Generalized anxiety disorder;-Plan of Treatment Overview: Will begin Ativan 0.5 mg twice daily. Review of the resident's electronic physician's order sheet (ePOS), showed an order, dated 06/03/26, for Ativan (anti-anxiety medication) oral tablet 0.5 milligram (mg). Give one tablet by mouth twice daily. Review of the resident's MAR for Ativan 0.5 mg. and progress notes, showed:-Ativan 0.5 mg scheduled for administration at 8:00 A.M. and 5:00 P.M.;-On 06/03/26 at 5:00 P.M., the MAR blank;-On 06/04/26 at 5:00 P.M., the MAR blank;-On 06/05/26 at 8:00 A.M., a 3 documented (3 = resident away from facility) on the MAR;-On 06/05/26 at 5:00 P.M., the MAR blank;-On 06/06/26 at 8:00 A.M., a 9 documented (9 = other, see nurses notes) on the MAR;-On 06/06/26, at 5:00 P.M., the MAR blank;--Progress notes, dated 06/06/26 at 8:50 A.M. and 6:55 P.M., showed the resident refused meds;-On 06/07/26 at 8:00 A.M. and 5:00 P.M., a 7 documented (7 = not administered/see progress notes) on the MAR; --Progress notes, dated 06/07/26, showed no documentation why the medication not administered. At 5:36 P.M., doctor notified of need for signed script for Ativan 0.5 mg. Unable to administer;-On 06/08/26 at 8:00 A.M. and 5:00 P.M., showed a 7 documented on the MAR;--Progress notes, dated 06/08/26, showed at 10:50 A.M., waiting on arrival of medication. No documentation why medication not administered at 5:00 P.M.; -On 06/09/26 at 8:00 A.M. and 5:00 P.M., a 7 documented on the MAR;--Progress notes, dated 06/09/26, showed at 10:19 A.M., awaiting arrival of medication. No documentation why medication not administered at 5:00 P.M.;-On 06/10/26 at 8:00 A.M., a 9 documented on the MAR;--Progress notes, dated 06/10/26, showed at 10:19 A.M. awaiting pharmacy. At 3:20 P.M., waiting on script;-On 06/10/26 at 5:00 P.M., a 7 documented on the MAR;--No progress note on 06/10/26 about why medication not administered at 5:00 P.M.;-On 06/11/26 at 5:00 P.M., a 7 documented on the MAR;--A progress note, dated 06/11/26 at 5:29 P.M., showed waiting on script;-On 06/12/26 at 8:00 A.M., and 5:00 P.M., a 7 documented on the MAR;--No progress notes on 06/12/26 about why medication not administered;-On 06/13/26 at 8:00 A.M. and 5:00 P.M., a 7 documented on the MAR;--Progress notes, dated 06/13/26, showed at 11:16 A.M., awaiting pharmacy. At 7:26 P.M., script needed;-On 06/14/26 at 8:00 A.M. and 5:00 P.M., a 7 documented on the MAR; --Progress notes, dated 06/14/26, showed at 10:13 A.M., awaiting pharmacy. No documentation why medication not administered at 5:00 P.M.;-On 06/15/26 at 8:00 A.M. and 5:00 P.M., a 7 documented on the MAR;--Progress notes, dated 06/15/26, showed at 9:31 A.M., no script. At 5:26 P.M., awaiting script;-On 06/16/26 at 8:00 A.M. and 5:00 P.M., the MAR blank;-On 06/17/26 at 8:00 A.M. and 5:00 P.M., the MAR blank;-On 06/18/26 at 8:00 A.M. and 5:00 P.M., a 7 documented on the MAR;--Progress notes, dated 06/18/26, showed no documentation why medication not administered at 8:00 A.M. At 6:24 P.M., medication awaiting arrival;-On 06/19/26 at 8:00 A.M. and 5:00 P.M., the MAR blank;-On 06/20/26 at 8:00 A.M. and 5:00 P.M., a 9 documented on the MAR;--A progress note, dated 06/20/26 at 3:59 P.M., showed med not available;-On 06/21/26 at 8:00 A.M. and 5:00 P.M., a 9 documented on the MAAR:--A progress note, dated 06/21/26 at 7:34 P.M., showed med not available, not received from pharmacy;-On 06/22/26 at 8:00 A.M. and 5:00 P.M., the MAR blank;--A progress note, dated 06/22/26 at 9:29 A.M., showed med not available, not received from pharmacy;-On 06/23/26 at 8:00 A.M. and 5:00 P.M., the MAR blank;-On 06/24/26 at 5:00 P.M., the MAR blank;-On 06/25/26 at 8:00 A.M., the MAR blank. During an interview on 06/23/26, at 9:45 A.M., the resident said the facility's inability to get his/her medications had been going on for almost a month. He/She did not believe staff contacted his/her psychiatrist and/or primary care physician to get the prescription filled. He/She was used to taking an anti-anxiety medication daily and he/she was getting very anxious about not having his/her medications. He/She spoke to the charge nurses and they just blow him/her off. He/She felt like his/her mental status was going to decline due to not having his/her anti-anxiety medications. During an interview on 06/24/26 at 8:20 A.M., Licensed Practical Nurse (LPN) D said the resident did not have his/her Ativan 0.5 mg because the pharmacy would not fill his/her prescription. It had been almost three weeks. He/She did not know what the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	holdup was. He/She contacted the pharmacy on multiple occasions and they kept telling him/her the physician had not sent over the written prescription. LPN D did not call the resident's primary care physician, the Medical Director, and/or the Director of Nursing (DON). He/She did not know if anyone else attempted to contact the resident's primary care physician or Medical Director. During an interview on 06/24/26 at 12:45 P.M., Physician B, the resident's primary care physician, said he/she didn't usually order psychotropic medications. The psychiatrist that ordered the resident's medication should have sent the written script over to the pharmacy. If the resident had not received the medication in a couple of days because the pharmacy did not have a written script, Physician B expected the nursing staff to notify the psychiatrist, Physician B, or the DON. Physician B was not notified the resident went for 22 days without his/her ordered medication. He/She expected staff to follow physician's orders and to notify the primary care physician if they had difficulty getting medications. During an interview on 06/24/26 at 2:35 P.M., the DON said she expected staff to provide the resident's medication as ordered. The nurses were responsible for ordering medication. The resident's psychiatrist should have sent the pharmacy a written script so the medications could be filled. Residents should not have to go without their medication. If the staff could not get the medication from the pharmacy, they should have notified her so she could check with the pharmacy or contact the resident's physician. She was not aware the resident had gone three weeks without getting his/her prescribed medications. 304964730494943051491