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

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 just needed to smoke. During an interview on 8/7/25 at 12:56 P.M., the Social Worker Assistant said the admitting nurse was responsible for the initial smoking assessment. The social services will follow-up and make sure the assessments were completed correctly and timely. He/She said Resident #4 was a smoker but was not observed to have his/her smoking materials in the room. All the residents' smoking materials were kept in the nurses' stations. The resident was admitted prior to his/her employment and was not aware of the inaccurate initial assessment. 4. Review of Resident #16's medical record, showed:-Cognitively intact;-Diagnoses included: end stage renal failure (a condition where the kidneys lose their ability to adequately filter waste and excess fluids from the blood, and maintain proper chemical balance), anxiety, and depression;-A Safe Smoking Eval, dated 5/6/25, showed, does the resident smoke: no. Review of the care plan, in use at the time of survey, showed:-Focus: Resident smokes. They have been advised of the facility smoking policy. The resident requires supervision with smoking. Date Initiated: 12/11/2024;-Goal: will be compliant with facility smoking policy through review date;-Interventions: observe resident during smoking for unsafe smoking (dropping cigarette, hold to close to body, etc.) and report to nurse; offer and encourage use of safety devices (smoking apron, holder) when smoking; provide assistance as needed to assist resident to and from smoking area; reassess resident smoking ability quarterly and reports of unsafe practice. During an observation and interview on 8/5/25 at 1:45 P.M., showed the resident lay in bed and watched TV. The resident said he/she was a smoker. On 8/6/25 at 6:00 P.M., the resident sat in his/her wheelchair propelled him/herself in the hall and said he/she was going outside to smoke. On 8/7/25 at approximately 10:49 A.M., the resident sat outside in the smoking area with a cigarette in his/her right hand. Review of the safe smoking evaluation provided by facility on 8/7/25 showed a smoking assessment dated [DATE], showed:-Does the resident smoke: Yes;-Summary: This resident is safe to smoke with minimal supervision. During an interview on 8/8/25 at 7:45 A.M., Assistant Director of Nursing (ADON) L said the hospitality aide takes the residents outside to smoke. Smoking assessments are completed every quarter or if the residents' condition changed. The smoking assessment and the care plan should match. ADON L said she did not have a list of residents who smoked, and she has not seen the resident smoke. 5. During an interview on 8/7/25 at 8:26 A.M., the Director of Nursing (DON) said if the smoking assessment says no, that means they do not smoke. Smoking assessments should be accurate. She was not sure who is responsible to complete the smoking assessments. Smoking assessments should be done on admission and quarterly. She believes maintenance staff are responsible for maintaining the smoking area. There should be no trash in the ash cans. Cigarettes should be in ash cans and not on the ground. If staff notice this is an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	issue this should be reported so it can be addressed. Residents assessed safe to smoke independently should be occasional observed to ensure they are properly disposing of their cigarettes and to ensure they are following safe smoking practices. If staff notice cigarette butts scattered on the grounds, this should prompt staff to evaluate who is not properly disposing their cigarette butts.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored appropriately. The facility identified seven medication/treatment carts and two medication rooms. Four of the seven carts and both medication rooms were checked for medication storage. Issues were found in all four medication carts. Staff failed to discard expired bottles of over the counter (OTC) medications, and a bottle of Pro-Stat protein drink (increases wound healing). In addition, the staff failed to refrigerate a bottle of Latanoprost eye drops (treats glaucoma, an eye condition that causes blindness), a bottle of Lorazepam (used to treat anxiety), and a vial of tuberculin purified protein derivative (PPD, used to diagnose silent (latent) tuberculosis (TB) infection) solution. Furthermore, the staff failed to label one insulin pen with a resident's name. The census was 165.Review of the Facility's Storage of Medication, dated 9/2018, showed:-Policy: Medications and biologicals are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications;-General Guidelines: all medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label;-Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 Fahrenheit (F) and 46 F with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Controlled substances that require refrigeration are stored within a locked box within the refrigerator that is attached to the inside of the refrigerator or in accordance with state regulations and facility policy;-The nurse will check the expiration date of each medication before administering it;-All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. 1. Observation and interview on 8/5/25 at 11:00 A.M., of the Certified Medication Technician (CMT) cart on the south hall showed, in the top drawer of the medication cart was:-One bottle of Lactobacillus tablets (probiotic) was open with an expiration date of 1/25;-One bottle of fish oil (supplement) 500 mg was open with an expiration date of 8/24;-One bottle of calcium citrate (supplement) 200 mg was open with an expiration date of 7/25;-One bottle of niacin (vitamin B3 supplement) 250 mg was open with an expiration date of 3/25;-One bottle of zinc (supplement) 50 mg was open with a best by date of 4/25;-One bottle of Latanoprost 0.005% eye drop with a refrigerate sticker on the bottle;-CMT R said both the nurses and the CMTs were responsible for checking the expiration dates. The eye drops should be stored in the refrigerator. 2. Observation and interview on 8/5/25 at 11:15 A.M., of the nurse one med cart on the South Hall, in the drawer, showed:-One bottle of vitamin C 250 mg, opened with an expiration date of 1/25;-One box of oral pain relief gel, opened with an expiration date of 2/25;-One bottle of Pro-Stat, opened and dated 7/14/25 with an expiration date of 2/15/25;-One out of eight insulin pens were not labeled with a resident's name on it;-CMT S said both the nurses and CMTs are responsible for checking the expiration dates. He/She did not know who the insulin pen belonged to. 3. Observation and interview on 8/5/25 at 11:35 A.M., of the CMT cart on the memory care hall in the top drawer of the cart showed:-One bottle of oyster shell calcium (supplement) 500 mg open with an expiration date of 10/24;-In the narcotic box was one bottle of lorazepam concentrate 2 mg/ml with a refrigerate sticker on the box. Assistant Director of Nurses (ADON) A removed the lorazepam from the cart and said they would reorder the medication because the name on the label was hard to read and Lorazepam should be stored in the refrigerator. The CMTs are responsible for checking the expirations. Review of Lorazepam Oral Concentrate, 2 milligram (mg) per milliliter (mL) package insert, showed store at 2 to 8 Celsius (C) (36 to 46 F). 4. Observation and interview on 8/5/25 at 11:53 A.M., of the nurse cart on the rehab hall, showed a vial of opened PPD in the top drawer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse (RN) U said PPDs should be stored in the refrigerator. 5. During an interview on 8/8/25 at 11:00 A.M., the Director of Nursing (DON) said all medications should be labeled with the resident's name on it. PPD, liquid lorazepam and latanoprost eye drops should be stored in the refrigerator. Medications should be checked daily for expiration dates by whomever is on the cart. Expired medications should be disposed.

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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. **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 (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 give the resident's full Social Security payment. The DPOA finally made credit card payments after not paying for a long time. He/She never paid full payments. The DPOA had not contacted the facility about the resident's Social Security or payments. The credit card payments were all he/she made. The DPOA said that was all the resident had and that was not true. The BOM doubted any billing was mailed to the resident's DPOA because there was no address on file. The BOM confirmed the resident signed the authorization and agreement for a resident trust account. The DPOA was not contacted. The invoices were sent off by a third party. The BOM would also call residents and/or a responsible party if there were concerns. The resident wanted his/her money to come to the facility because his/her DPOA was not giving him/her money. The resident saw everyone else get their money, so he/she asked if he/she could have money. The BOM was asked if he/she was aware the resident had a DPOA. He/She said it would not take effect until the resident's death. Review of the resident's trust statement, showed:-On 8/21/24, an open transfer;-On 10/2/24, a Social Security deposit in the amount of $2,976.00;-Monthly care costs were debited from the account from 10/2/24 through 7/11/25;-Monthly Social Security deposits were credited to the account from 10/2/24 through 7/11/25. Review of the resident's progress notes, dated 7/7/25, showed staff had a meeting with resident's DPOA and resident. The DPOA now states that he/she knows nothing about the resident's pension and has no idea where it is going. The DPOA said that he/she has lots of concerns about the facility and the way that some things are handled. He/She stated that he/she will be taking the resident home with him/her on Friday, 7/11/25. He/She states that he/she has home health (HH) set up and a room just for the resident. During an interview on 7/11/25 at 5:48 P.M., the DPOA said he/she was presented with a check for money the resident had saved. The check was only for $260.00, and should have been for $490.04. During the care meeting held on 7/7/25, he/she was informed the resident would receive $490.04. He/She saw this figure on the computer. He/She was told the money was for insurance. Review of the resident's July 2025 resident trust statement, showed:-On 7/1/25, a balance of $490.02;-On 7/11/25, $20.00 was debited from the account for personal needs. The remaining balance was $470.02;-On 7/11/25, $260.00 was debited from the account for care cost payment. The remaining balance was $210.02;-Account was closed on 7/11/25. During an interview on 8/7/25 at 9:30 A.M., the BOM confirmed the money debited from the trust account on 7/11/25 was a care cost. The resident was being discharged from the facility and the care cost was debited from the resident trust. The DPOA was not contacted or informed about the care cost. During an interview on 8/8/25 at 8:57 A.M., the Administrator said she was aware the DPOA was upset about the resident's trust. She would expect staff to know if a resident had a DPOA for financial if it had been provided. The billing statements were mailed from the corporate office. She would expect documentation if a bill was sent or if there were call attempts regarding the resident's liability. She would expect the resident and/or responsible party to be notified if funds were debited from the trust account. 256072316764101676426

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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 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** Based on observation, interview, and record review, the facility failed to provide services per professional standards for one resident who had an order for daily wound care and the treatment was not completed over the weekend (Resident #26). Staff failed to ensure one resident's treatment was applied as needed for a cancer lesion with drainage that was not covered and exposed (Resident #130). In addition, staff failed to obtain weights on one resident per their policy. When the weight was obtained, the resident had experienced a weight loss (Resident #1). The census was 165. The sample was 33.Review of the facility's Wound Management policy dated June 2020, showed:-Purpose: To provide a system for the treatment and management of residents with wounds including pressure and non-pressure injuries;-A resident who has a wound will receive necessary treatment and services to promote healing, prevent infections, and prevent new pressure injuries from developing;-The attending physician will be notified to advise on appropriate treatment promptly;-Per attending physician order, the nursing staff will initiate treatment and utilize interventions for wound management. 1. Review of Resident #26's medical record, showed:-Diagnoses included laceration right ankle;-An order dated 7/22/25, right medial malleolus (ankle), cleanse with normal saline/wound cleanser, pat dry, apply xeroform (non-adhesive dressing) and dry dressing every day and as neededfor wound care. During an interview on 8/4/25 at 9:20 A.M., the resident sat in a reclined Broda chair (medical reclining chair) and said staff do not take care of him/her right. Observation of the resident's right inner ankle showed a dressing dated 8/1 with staff initials. The resident said staff do not change the dressing every day. It should be done daily but is not done daily. Observation on 8/5/25 at 7:51 A.M., showed Wound Nurse M entered the resident's room to provide wound care. The resident lay in bed on his/her back. Wound Nurse M completed the resident's wound care as ordered and said the resident's ankle wound is to be changed daily. Observation showed the wound bed pink, no inflammation, and no drainage noted. The wound approximately quarter size. During an interview on 8/5/25 at 1:07 P.M., Wound Nurse M said the weekend nursing staff should do resident treatments on the weekends. He/She only does them Monday through Friday when working. 2. Review of Resident #130's medical record, showed:-Diagnoses included personal history of malignant melanoma of skin (skin cancer), cerebrovascular disease, and dementia;-An order, dated 7/17/25, for wound care to left forehead. Cleanse with normal saline (NS)/ wound cleanser (WC), pat dry, apply petroleum gauze to wound bed. Cover with dry dressing daily and as needed (PRN) every dayshift for wound care. Review of the resident's electronic Medication Administration Record (eMAR), dated 8/1/25 through 8/7/25, showed:-An order, dated 7/17/25, wound care to left forehead. Cleanse with NS/WC, pat dry, apply petroleum gauze to wound bed. Cover with dry dressing daily and PRN: -On 8/1/25 and 8/4/25, treatment documented as administered;-On 8/2, 8/3, 8/5, 8/6, and 8/7/25, treatment blank; -On 8/1 through 8/7/25, no documentation of treatment administered PRN. Review of the resident's care plan, in use during survey, showed:-Problem: The resident has potential for impairment to skin integrity: -Goal: The resident will be free from injury through the review date; -Interventions: Follow facility protocols for treatment;-Problem: The resident has an Activity of Daily Living (ADL) self-care performance deficit: -Goal: The resident will maintain current level of function through the review date; -Interventions: Skin inspection: The resident requires skin inspection weekly. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Review of the resident's skin assessment, dated 8/1/25, showed:-Does the resident have any skin impairments: yes;-Description: Status post-surgical biopsy to right side of head. Treatment in progress. Review of the facility's wound report dated 8/5/25, showed the following for the resident:-Location: Left head;-Measurements: Length: 4.00 centimeters (cm), width: 3.00 cm, depth: 0.10 cm;-Etiology: Basal Cell Carcinoma (skin cancer);-Epithelial (the cells that line the internal and external surfaces of the body): 50%;-Granulation (new tissue growth): 50%;-Exudate (drainage) amount: Light. Review of the (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's progress notes, dated 8/5/25, showed Basal Cell Carcinoma of skin of scalp and neck. Recommendations: Educated nursing team and/or patient to assess and communicate any significant changes in wound status, noting evidence of wound infection/cellulitis, infection, foul odor, osteomyelitis (bone infection), or acute ischemic changes and notify wound provider or primary care provider accordingly. If no evidence of healing within 2-4 weeks, re-evaluate plan of care and patient adherence. Plan of care discussed with facility staff. Dressing/ordered/applied. Observation on 8/4/25 through 8/7/25, showed:-On 8/4/25 at 9:31 A.M., the resident's left side of head with an exposed wound, some dried blood, and healing scabs. The resident did not have a bandage on the wound;-On 8/5/25 at 9:47 A.M., the resident in the activity room. The wound on the left side of the forehead was visible from across the room, no dressing in place. At 12:37 P.M., the wound was exposed, not covered. At 2:24 P.M., the resident was observed with a bandage that was wrapped around the top of his/her head. No date applied documented on the bandage;-On 8/6/25 at 12:35 P.M., the resident in the dining room. A bandage was wrapped around the top of the resident's head, dated 8/5/25. A soiled, pinkish color spot on the bandage, on the back of the head, not where the wound was located. It appeared the dressing had spun around;-On 8/7/25 at 1:18 P.M. and 1:43 P.M., the resident in the dining room. The wound on the left forehead was exposed, without a bandage. At 1:43 P.M., the resident in a bathroom, looking into the mirror. No bandage wrapped around his/her head. The wound exposed. During an interview on 8/7/25 at 1:43 P.M., Certified Medication Technician (CMT) V said the resident was suspected of having cancer. The wound team completes the treatments when they are here. The nurse will do it if the wound team is not here. The resident does not refuse. He/She goes back and forth about having the dressing applied, but will allow staff to do it. The resident will also remove the bandage at times. CMT V had not noticed any changes in the wound in the past three months. The only time he/she had seen it bleed was when the wound nurse was messing with it. They know the resident will remove the bandage and they will come back and do the dressing again. During an interview on 8/8/25 at 8:26 A.M., Assistant Director of Nursing (ADON) A said the resident had a surgical biopsy and it is an aggressive cancer. He/She did not know what kind of cancer. The wound team treats it daily. ADON A will change the bandage if the wound team is not here, if the resident will allow them to. She would expect staff to document if the treatment cannot be completed or if resident refuses. During an interview on 8/8/25 at 8:57 A.M., the Administrator said the wound team is here Monday through Friday and sometimes on the weekend. She would expect staff to follow treatment orders and document if the resident refuses the treatment. If the bandage was taken off, she would expect staff to attempt to change the bandage unless the resident refuses. If the bandage appeared stained or soiled, she would expect staff to attempt to change the bandage. 3. During an interview on 8/7/25 at 8:26 A.M., the Director of Nursing (DON) said physician orders should be followed. The nursing staff are responsible for doing wound care if it is not done by the wound nurse. 4. Review of the facility's Assessment and Management of Resident Weights policy, dated 6/2020, showed:-Purpose: To ensure each resident maintains acceptable parameters of weight and nutrition status;-Weights are obtained upon admission and/or re-admission, then weekly fr four weeks, and monthly thereafter. Additional weights may be obtained at the discretion of the licensed nurse or interdisciplinary team;-Admissions and re-admissions will be weighted on the shift they arrive. Hospital weights will not serve as admission or re-admission weights. Review of Resident #1's care plan, in use during survey, showed:-Focus: The resident has nutritional problem. The resident has orders to meet nutritional needs;-Goal: The resident will comply with recommended diet daily;-Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Monitor/document/report to physician PRN for signs and symptoms of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing. Refusing to eat. Appears concerned during meals. Monitor/record/report to physician for signs and symptoms of malnutrition. Emaciation, muscle wasting, significant weight loss: 3 pounds in one week, greater than 5% in one month, greater than 7.5% in three months, greater than 10% in six months. (continued on next page)

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	265703	A. Building B. Wing	08/08/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record, showed:-Diagnoses included congestive heart failure, aphasia (loss of ability to speak), dysphasia (difficulty swallowing), and altered mental status.-A hospital progress note, dated 5/17/25: History of Present Illness: Patient states that his/her dry weight is 133 pounds. He/She is 123 pounds today;-admitted to the facility on [DATE];-A weight on 6/5/25, the resident weighed 152.6 lbs. Scale: Wheelchair;-No documentation of additional weights before or after 6/5/25;-No documentation of the resident's weight minus the weight of the wheelchair. Review of the resident's progress notes, showed on 6/24/25 and 6/26/25, resident has a trend of eating <51%. During an interview on 8/8/25 at 8:26 P.M., ADON A said it is the facility's policy to weigh the residents upon admission and then they are weighed weekly for four weeks. She would expect staff to obtain the residents' weight per policy or document the reason why the weight was not obtained. She would expect the weight to be accurate. If the resident was weighed in a wheelchair, the weight of the wheelchair chair should be subtracted. The ADONs are responsible for ensuring the weights are completed. Observation on 8/5/25 at 9:41 A.M., showed the resident was in his/her bed, eyes were open, but he/she did not verbally speak. The meal tray was positioned on the table with biscuits and gravy. The meat was a mechanical soft texture. The biscuits and gravy were untouched. During an observation and interview on 8/6/25 at 12:15 P.M., Registered Nurse (RN) Q reviewed the medical record and confirmed the resident was weighed on 6/5/25 and the weight documented as 152.6 pounds. Certified Nursing Assistant (CNA) T assisted RN Q to weigh the resident using the Hoyer lift (full body mechanical lift). The scale on the Hoyer lift showed the resident's weight measured 103.8 pounds. RN Q confirmed the resident's weight. During an interview on 8/6/25 at 12:30 P.M., CNA T said when the resident was first admitted , he/she ate small portions at first, then he/she ate all his/her food. He/She ate 50% of his/her meal for breakfast. CNA T was asked if the resident looked like he/she lost weight. He/she said the resident looks the same. During an interview on 8/6/25 at 12:30 P.M., RN Q said the residents are weighed once a month unless otherwise ordered by the physician. RN Q was unaware of the resident's weight loss. There were no reports of weight changes or changes with eating. The resident requires assistance with eating. There was no documentation if the dietician was made aware or if the resident was assessed. During an interview on 8/8/25 at 8:57 A.M., the Administrator said staff are expected to weigh the residents upon admission and weekly for four weeks unless the Registered Dietician or physician says differently. She would expect the weight to be accurate and if the weight was not able to be obtained, she would expect staff to document it in the medical record. If the resident was weighed in a wheelchair, she would expect staff to subtract the weight of the wheelchair from the total weight. The resident should have been weighed per policy at admission. The nursing department is responsible for ensuring the weights are completed. She would expect staff to report changes in residents' meal consumption to their ADON and communicate up the chain. They would have a meeting with the Registered Dietician and DON. She would expect staff to notify the dietician. Staff are expected to accurately document the percentage the residents are consuming in the chart.

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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. 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 (continued on next page)

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	265703	A. Building B. Wing	08/08/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 forehead and over both eyes. The bruising extended up to his/her hair line and down below his/her eyes to his/her cheek bones, on both sides of his/her face. The bruising was dark blackish blue in color. There was a slightly elevated lump on the right side of the resident's forehead. The resident appeared to be awake but did not open his/her eyes to verbal stimulation. His/Her eyelids appeared swollen. During an interview on 8/5/25 at 9:42 A.M., Licensed Practical Nurse (LPN) C said the aide noticed today that the resident's face was bruised. He/She was the resident's nurse yesterday and the resident's face was not bruised at that time. He/She first noticed it today. The night shift nurse did not report any fall to him/her at shift change. During an interview on 8/5/25 at 9:44 A.M., CNA D said the last time he/she took care of the resident was a long time ago, so he/she cannot speak as to when the bruising occurred, but he/she is the one who noticed it this morning and reported it to the nurse. He/She is not the resident's CNA, he/she only passed the breakfast tray and saw it. The resident does not speak English and night shift did not say anything about it to his/her knowledge. The resident would not be able to get him/herself up on his/her own if he/she were to fall. During an interview on 8/5/25 at 9:47 A.M., CNA E said he/she was off yesterday. He/She did work over the weekend but did not have the resident's assignment. He/She did not notice any bruising over the weekend, but the bruising is really bad, and he/she thinks that he/she would have noticed it if it had been there at that time. It is very noticeable. During an interview on 8/5/25 at 11:10 A.M., Assistant Director of Nursing (ADON) F said he/she was here yesterday and cannot say that he/she saw the resident. He/She did not work over the weekend. If the resident had a fall, he/she does not believe the resident could get him/herself back into bed on his/her own. Someone would have to help him/her up. The resident could not say what happened. He/She has no idea how the bruising happened. During an interview on 8/5/25 at 11:13 A.M., Certified Medication Technician (CMT) G said he/she speaks Bosnian and the resident speaks Polish. They are not the same language, but many words are similar, so he/she can communicate with the resident and can understand a lot of what he/she said. He/She talked to the resident today when he/she put him/her in bed this morning after breakfast. Yesterday, there was no bruising. This morning when he/she started to pass medications, he/she saw the resident's face and it looked horrible. The resident was more confused this morning as well. He/She asked the resident what happened, and he/she said he/she fell. At first, the resident said he/she fell from the chair and then he/she said from bed, so it is unclear exactly what happened. The resident pointed to his/her head and said pain. CMT G used a translator application on his/her phone to help better communicate with the resident and asked the resident how he/she fell, and he/she said he/she could not remember. He/She nodded when asked if he/she fell from the bed and said it was yesterday evening. The resident would not be able to get him/herself up on his/her own if he/she fell, so he/she is not sure if someone helped him/her up. If staff were to find a resident on the ground, staff are to find the charge nurse. He/She was shocked to see the resident's face and noticed the right side of the head had a bump on it. During an interview on 8/5/25 at 11:21 A.M., the resident's CNA, CNA H said he/she worked yesterday but the resident was not on his/her assignment. He/She did not remember seeing the resident the day prior so he/she cannot say if there was bruising at that time. No staff reported the resident had a fall, so he/she is not aware what happened. During an interview on 8/5/25 at 12:27 P.M., the resident's roommate said last night he/she was sleeping, and he/she woke up to go to the bathroom. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	curtain was pulled between the two beds. The bathroom is on Resident #22's side of the room. When he/she went to the door of the bathroom, he/she looked over and saw Resident #22 was on the floor, on his/her side, and wrapped in his/her blanket. The pillow had fallen off the bed too and Resident #22 was laying there awake. He/She asked Resident #22 what happened and turned the call light on to get staff. Staff came in and soon there were 3 or 4 staff in the room. Staff got the resident off the floor and into bed. He/She cannot remember any of the staff names. He/She knows exactly what time it was because he/she looked. It was 12:30 A.M. Resident #22's bed was low when he/she fell. During an interview on 8/5/25 at 3:06 P.M., CMT I said he/she worked the evening shift on 8/4/25 and the resident did not have any falls on his/her shift. He/She arrived at work yesterday and gave the resident his/her medication around 4:30 P.M. At that time, there was no bruising. Review of the resident's medical record, showed: -A progress note dated 8/5/25 at 10:04 A.M., noted resident with facial bruising. No complaints of pain or discomfort. The resident reported that he/she had fallen out of his/her wheelchair. He/She was asked how he/she got to the floor, he/she said I forgot, I'm cuckoo;-A facial x-ray, dated 8/5/25 at 11:30 A.M., showed no fracture seen;-No documentation of the fall, a resident assessment, vital signs, neurological checks, or physician/family notification at or around 12:30 A.M. on 8/5/25. During an interview on 8/6/25 at 9:08 A.M., the Director of Nursing (DON) said the facility concluded their investigation into the bruising and was not able to determine which staff placed the resident back in bed after the fall. At 9:45 A.M., the DON said there is no documentation of the fall completed at the time of the fall, no assessment, and no neurological checks documented on night shift. According to the staff interviewed as part of the investigation, the resident was just put back to bed with no assessment. She is not sure if the doctor was notified prior to the morning shift when staff noticed the bruising. The resident should have been assessed at the time of the fall, neurological checks completed, and physician notified. Neurological checks were started in the morning; at the time the injuries were first noted by day shift. During an interview on 8/6/25 at 11:35 A.M., the Medical Director, who is also the resident's physician, said the facility notified him of the resident's facial bruising due to a fall. He ordered an x-ray. He received lots of calls and cannot recall if the facility called on Monday night or Tuesday morning, but they did notify him of the resident's fall. Staff is expected to follow their policies regarding falls and neurological checks. Observation of the resident on 8/6/25 at 2:41 P.M., showed the resident sat in a wheelchair near the North Hall nurse's station. The bruising extended down the right side of the resident's face, down to his/her neck, and to his/her collar bone. Bruising visible over the lower left outer arm. The resident's right eye appeared swollen, and the eye appeared to be squinting. The resident's entire forehead, both eyes, the right side of the face and cheek, and right side of the neck appeared black and blue. The resident's left eye was blood shot. 1676424

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	265703	A. Building B. Wing	08/08/2025

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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. 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, (continued on next page)

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	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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 on the Nurse Administration Record (NAR). She expected the dialysis pre/post assessments to be completed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy and procedure for the monthly drug regimen review by failing to ensure the physician or designee responded to the pharmacy recommendation timely for two of five residents sampled for medication review (Residents #3 and #145). The sample was 33. The census was 165.Review of the facility's Documentation and Communication of Consultant Pharmacist Recommendations Policy, dated 8/20, showed:-Policy: The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion;-Recommendations: A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, prescribers, and the care planning team;-Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible prescriber or physician's designee is contacted by the consultant pharmacist or the facility, and the prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record;-Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. If the prescriber that does not respond Is also the Medical Director, the Director of Nursing and the Administrator will address the requirements with the Medical Director and/or pursue more formal actions if necessary to facilitate compliance. 1. Review of Resident #3's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/21/25, showed:-Severe cognitive impairment;-Diagnoses included non-Alzheimer's dementia, depression and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). Review of the resident's care plan in use at the time of survey, showed:-Focus: resident requires psychotropic medications;-Goal: will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date;-Interventions: Consult with pharmacy, Medical Doctor (MD) to consider dosage reduction when clinically appropriate. Review of the Consultant Pharmacist Communication to Physician form, dated 1/29/25, showed: -Please note per Centers for Medicare and Medicaid Services (CMS) requirements the use of psychotropic medications is confined to limited duration of use without reassessment of a gradual dose reduction or discontinuation;-This resident has been receiving hydroxyzine (antihistamine, used to relieve itching and treat anxiety and tension) 50 milligrams (mg) three times a day (TID) since 7/24. An evaluation for gradual dose reduction should be documented at this time. If gradual dose reduction is contraindicated, please review the following and check If appropriate:-The resident's target symptoms returned or worsened after the most recent attempt at tapering dose;-Past reduction attempts have resulted in problematic behavior and/or staff Inability to provide care;-Past reduction attempts have resulted in psychiatric instability by exacerbating an underlying medical or psychiatric disorder;-Past reduction attempts have caused the resident to pose danger to self or others;-Physician response to recommendations/finding agree or other;-Physician/Practitioner signature;-The form was blank. Review of the progress notes, dated 1/29/25 through 2/28/29, showed no documentation the MD reviewed the recommendation. Review of the Consultant Pharmacist Communication to Physician, dated 4/24/25, showed: -Please note per CMS requirements the use of psychotropic medications is (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confined to limited duration of use without reassessment of a gradual dose reduction or discontinuation;-This resident has been receiving trazodone (antidepressant) 50 mg every (q) bedtime (hs) since 6/24. An evaluation for gradual dose reduction should be documented at this time. A second form showed this resident has been receiving quetiapine (antipsychotic) 25 mg twice a day (BID) since 6/24. An evaluation for gradual dose reduction should be documented at this time. If gradual dose reduction Is contraindicated, please review the following and check If appropriate:-The resident's target symptoms returned or worsened after the most recent attempt at tapering dose;-Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care;-Past reduction attempts have resulted in psychiatric instability by exacerbating an underlying medical or psychiatric disorder;-Past reduction attempts have caused the resident to pose danger to self or others;-Physician response to recommendations/finding agree or other;-Physician/Practitioner signature;-Both forms were blank. Review of the progress notes, dated 4/24/25 through 6/30/25, showed no documentation the physician reviewed these consults. 2. Review of Resident #145's annual MDS, dated [DATE], showed:-Short-term and long-term memory problem;-Worse current behavior or other symptoms, care rejection, or wandering compared to prior assessment;-Diagnoses included dementia and depression;-Takes antipsychotic and antidepressant medications. Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has a mood problem;-Goal: Resident will not experience any increase in signs and symptoms of mood disturbance;-Interventions: Administer medications as ordered, observe and document signs and symptoms of effectiveness and side effects;-Focus: Resident uses antidepressant medication;-Goals: Resident will have decreased episodes of depressed mood, through target date. Resident will be without complications of antidepressant medication's side effects;-Interventions: Observe for side effects of antidepressant medications. Provide the medications per medical provider's orders. Review of the resident's Medication Administration Record (MAR) for the month of August 2025, showed:-Prozac (antidepressant) oral capsule 20 mg, to give 1 capsule by mouth one time a day for depression;-Seroquel (Quetiapine) oral tablet 25 mg, to give 1 tablet by mouth at bedtime related to major depressive disorder. Review of the Consultant Pharmacist Communication to Physician form, dated 1/29/25, showed: -Please note per CMS requirements the use of psychotropic medications is confined to limited duration of use without reassessment of a gradual dose reduction or discontinuation;-The resident has been receiving quetiapine 25 mg twice a day (BID) since 10/24. An evaluation for gradual dose reduction should be documented at this time. If gradual dose reduction is contraindicated, please review the following and check if appropriate;-The resident's target symptoms returned or worsened after the most recent attempt at tapering dose;-Past reduction attempts have resulted in problematic behavior and/or staff Inability to provide care;-Past reduction attempts have resulted in psychiatric instability by exacerbating an underlying medical or psychiatric disorder;-Past reduction attempts have caused the resident to pose danger to self or others;-Physician response to recommendations/finding agree or other;-Physician/Practitioner signature;-The form was blank. Review of the progress notes, dated 1/30/25 through 4/30/25, showed no documentation the MD reviewed the recommendation. Review of the Consultant Pharmacist Communication to Physician form, dated 4/25/25, showed the same reviews and recommendations from 1/29/25. The form was blank. Review of Psychiatric Nurse Practitioner's (NP) assessment notes, dated 5/14/25, showed:-Patient denied any psychotic symptoms;-No staff reports of agitation or restlessness at this time;-We will reduce Seroquel to 25 mg at bedtime only;-If dose reduction is well tolerated, the plan is to discontinue Seroquel at next visit;-Continue Prozac for depression and anxiety. Review of the resident's assessment and progress notes, showed no follow-up documentation after the 5/14/25 NP's visit. No changes in the current dose of Seroquel. 3. During an interview on 8/8/25 at 7:45 A.M. Assistant Director of Nursing (ADON) L said the pharmacy consultant visited the facility. Any recommendations are given to the Director of Nursing (DON). The MD visited the facility twice a week. He will either sign the recommendations or have psych review (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the recommendation. Then, the DON distributes the recommendations to nursing staff. If there are any changes in the physician's order, the ADON will enter the orders into the computer and notify the resident/resident representative. 4. During an interview on 8/8/25 at 11:00 A.M., the DON said she expected the pharmacy consult recommendation to be reviewed within seven days. The DON said the pharmacy reviews should have been reviewed timely.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure reach resident relieves food choices that accommodate their preferences, for one resident (Resident #171) who preferred chocolate milk with all meals and was not provided with chocolate milk. The census was 165. The sample was 33.Review of the Know Your Rights, resident rights poster, located at the nurse stations, showed residents have the right to participate in their care. Review of Resident #171's medical record, showed:-Diagnoses included: Dysphagia (difficulty swallowing) after a stroke and diabetes;-A nutritional communication form, dated 7/29/25, showed meal location preference: In room. Moderately thick liquids. During an interview on 8/4/25 at 9:18 A.M., the resident said he/she has not had breakfast yet. When he/she gets his/her breakfast he/she wants chocolate milk. It is on his/her ticket for each meal, yet he/she is never given chocolate milk. The resident provided his/her dinner meal ticket, that remained on his/her bedside table from the day prior. Review of the resident's meal ticket dated for dinner 8/3/25, showed beverages: Chocolate milk, 1 cup, nectar thick. Observation and interview on 8/4/25 at 10:08 A.M., showed the resident sat up in bed with his/her breakfast tray. The only drink on the tray was orange juice. No chocolate milk. The resident said he/she did not get chocolate milk served with breakfast. He/She told the nurse, and they just said it was not on the tray. They never provided it. Review of the resident's meal ticket dated for breakfast 8/4/25, showed beverages: Chocolate milk, 1 cup, nectar thick. During an interview on 8/5/25 at 7:47 A.M., the resident said he/she did not get his/her chocolate milk for lunch on 8/4/25. He/She should get it 3 times a day with every meal, and he/she does not. When he/she asks about it, staff just say it is not on there and do not provide it. Observation on 8/5/25 at 8:59 A.M., showed the resident's room door closed as staff passed hall meal trays. At 9:03 A.M., staff brought the resident his/her breakfast. Observation showed the tray had orange juice and no chocolate milk. Staff set the tray down on the resident's bedside table and left the room. Staff did not check the meal ticket for accuracy. The resident said see no milk. I don't know why they don't give me my milk, it is on my ticket. Staff just set it down and leave. Review of the resident's meal ticket dated for breakfast 8/5/25, showed beverages: Chocolate milk, 1 cup, nectar thick. During an interview on 8/6/25 at 1:03 P.M., the resident said he/she did not get his/her chocolate milk for breakfast today. He/She is really hoping he/she gets it for lunch. Observation at 1:05 P.M., showed staff brought the resident's tray to his/her room with no chocolate milk. The resident requested chocolate milk. Another staff member on the hall overheard the request and said oh, yes, the resident loves his/her chocolate milk. The staff person who left the tray told dietary staff who was on the hall, that the resident wanted chocolate milk and then continued to pass trays. At 1:08 P.M., staff entered the resident's room with a cup of thickened chocolate milk. At 1:10 P.M., the resident said he/she should not have to ask for the chocolate milk because it is on his/her meal ticket. Review of the resident's meal ticket dated for lunch 8/6/25, showed beverages: Chocolate milk, 1 cup, nectar thick. During an interview on 8/6/25 at 1:11 P.M., the Dietary/Kitchen Director said dietary staff check the meal tickets on the line in dietary to ensure accuracy. Then nursing staff should be checking it as well when they pass out the trays. Nursing staff should identify if something is missing and bring the tray back. The resident should have been getting his/her chocolate milk with meals. She will tell the dietary staff to make sure he/she gets his/her chocolate milk from now on. The resident should not have to ask for the chocolate milk if it is on the meal ticket, it should already be on the tray.