STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265732	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview, and record review the facility failed to ensure the dignity of residents by failing to ensure staff members stayed off their cell phones during care (Residents #1, #22, #40 and #44), failing to ensure staff were seated next to the residents while feedings residents (Residents #9 and #20), and failing to ensure staff replaced silverware for a resident who dropped theirs (Resident #21). The sample was 12. The census was 47. Review of the facility's Quality of Life, Dignity policy, dated august 2009, showed: -Policy Statement: each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality; -Policy Implementation: residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self- esteem and self-worth. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Review of the facility's in-service for all nursing staff, dated 2/10/09, showed: -Cell phones cannot be on while you are on duty; -Using cell phones during working hours has become a problem. You may use your cell phone during break time or lunchtime. Anyone abusing this policy will receive a written reprimand. Continued abuse of this policy may result in termination. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/4/24, showed: -Severe cognitive impairment; -Diagnoses included dementia, anxiety, and major depressive disorder. Observation on 10/21/24, of the resident in the dining room, showed: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 1:03 P.M., the resident sat at a table in the dining room. Nurse Aide (NA) E seated next to the resident at the table. NA E had his/her phone in his/her lap, and appeared to be texting; -At 1:04 P.M., NA E set down his/her phone, picked up a grape with his/her hand from the resident's plate, and fed the grape to the resident; -At 1:06 P.M., NA E looked down at his/her phone in his/her lap; -At 1:07 P.M., NA E grabbed a grape with one hand and fed it to the resident while scrolling on his/her phone with his/her other hand. NA E did not watch the resident as he/she fed the resident the grape; -At 1:10 P.M., NA E stood up from the table with his/her phone in his/her hand and walked away from the table. 2. Review of Resident #22's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses include diabetes and depression. Observation on 10/21/24 at 9:47 A.M., showed NA E seated on the resident's bed. The resident in his/her wheelchair next to the bed. NA E had his/her phone in his/her hand, held it up to his/her face, and appeared to be texting. NA E not interacting with the resident. During an interview on 10/21/24 at 11:02 A.M., the resident said he/she did not know why NA E was in his/her room on his/her phone. NA E was not in the room to help him/her, NA E just walked into his/her room and sat down without saying anything. He/She said it made him/her feel uncomfortable. 3. Review of Resident #40's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses include diabetes and Alzheimer's disease. Observation on 10/22/24, of the resident in the dining room, showed: -At 12:43 P.M., the resident seated at a table to eat lunch with NA E seated next to him/her. NA E had his/her phone in his/her lap and appeared to be texting; -At 12:45 P.M., NA E lifted his/her phone off his/her lap and appeared to be sending a text; -At 12:46 P.M., NA E grabbed the resident's spoon and gave the resident a bite of food; -At 12:47 P.M., NA E placed his/her phone flat on the table and appeared to be texting; -At 12:48 P.M., NA E grabbed the resident's spoon and gave the resident a bite while he/she looked down at his/her phone; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:50 P.M., NA E grabbed his/her phone and appeared to be texting; -At 12:51 P.M., Certified Nursing Assistant (CNA) G walked over to the table and told NA E to get off his/her phone. As CNA G walked away NA E grabbed his/her phone from the table and placed it under the table and appeared to be texting. 4. Review of Resident #44's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included diabetes, anxiety, asthma and acute respiratory failure. During an interview on 10/22/24 at 9:26 A.M., the resident said that earlier in the morning, NA E had come into his/her room to provide care. NA E was on a phone call with his/her daughter the entire time he/she was being assisted and it made him/her feel uncomfortable. Licensed Practical Nurse (LPN) A came into his/her room and observed NA E on a phone call. LPN A told NA E to get off his/her phone. During an interview on 10/23/24 at 11:36 A.M., LPN A said he/she did walk into the resident's room on 10/22/24 and observe NA E on his/her phone, on a phone call while he/she provided care to the resident. He/She told NA E to get off his/her phone. 5. Review of Resident #9's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included dementia and major depressive disorder. Observation on 10/21/24 at 8:23 A.M., of the resident in the dining room, showed the resident seated in his/her wheelchair at a table. NA C walked up to the resident's table, stood over the resident, grabbed the resident's spoon, and gave the resident a bite of food. 6. Review of Resident #20's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included Alzheimer's disease and anxiety. Observation on 10/21/24, of the resident in the dining room, showed: -At 7:43 A.M., the resident seated at a table. NA C walked up to the resident, stood over the resident, and started to feed the resident; -At 7:43 A.M., NA C walked away from the resident; -At 7:44 A.M., NA C walked back to the resident, stood over the resident, and started to feed the resident; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:32 A.M., NA C stood over the resident and fed him/her. 7. Review of Resident #21's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included dementia, dystonia (involuntary muscle contractions that cause repetitive or twisting movements), and chronic obstructive pulmonary disease (COPD, lung disease). Observation on 10/21/24, of the resident in the dining room, showed: -At 8:19 A.M., the resident dropped his/her spoon on the ground. The resident started to eat his/her eggs with his/her hands; -At 8:24 A.M., the resident began struggled to eat his/her eggs with his/her hands; -At 8:26 A.M., the resident struggled to wipe his/her hands on his/her clothing protector; -At 8:44 A.M., the resident propelled him/herself out of the dining room in his/her wheelchair without ever receiving assistance from staff to get new utensils. 8. During a resident council meeting on 10/22/24 at 2:35 P.M., five residents, whom the facility identified as alert and oriented, said staff are always on their cell phones. 9. During an interview on 10/23/24 at 11:19 A.M., CNA H said the facilities policy on cellphone usage is that no staff are allowed to be on their phones while working. Staff are allowed to use their phones on break. He/She would expect staff to follow the cell phone policy. It is not appropriate for staff to use their cell phones when feeding residents, or while providing care to a resident. It is not appropriate to stand up while feedings residents. 10. During an interview on 10/23/24 at 11:34 A.M., LPN A said staff are not allowed to use their phones during work. Staff are only allowed to use their cell phones in the break room or outside. He/She would expect staff to follow the facility's cell phone policy. It is not appropriate for staff to use their cell phones when feeding residents or while providing care to a resident. It is not appropriate to stand while feedings residents and that staff should be seated. 11. During an interview on 10/23/24 at 11:43 A.M., the Assistant Director of Nursing (ADON) said staff are only to use their cell phones in the break room or outside. Staff are not to use their phones in resident areas. She would expect staff to follow the facility's cell phone policy. It is not appropriate for staff to use their cell phones when feeding residents or while providing care to a resident. It is not appropriate to stand up while feedings residents and staff should be seated. 12. During an interview on 10/23/24 at 11:51 A.M., the Assistant Administrator said there is a zero-tolerance policy for staff using their cell phones in resident areas. Staff are to use their phones in the break room. He would expect all staff to follow the cell phone policy. It is not appropriate for staff to use their cell phones when feeding residents or while providing care to a resident. Is not appropriate to stand while feedings residents and staff should be seated.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40290 Based on interview and record review, the facility failed to immediately notify the physician of abnormal lab results for one resident (Resident #11) and to notify the resident and the resident's representative of abnormal lab results and new orders for medications to treat a urinary tract infection (UTI). The sample was 12. The census was 47. Review of the facility's Change in a Resident's Condition or Status policy, revised December 2016, showed: -Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.); -Policy Interpretation and Implementation: -The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): --Need to alter the resident's medical treatment significantly; -Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: --There is a significant change in the resident's physical, mental, or psychosocial status; -Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status; -Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. Review of Resident #11's medical record, showed diagnoses included UTI. Review of the resident's physician progress note, dated 7/17/24, showed: -Reason for visit: I am itching down there; -Assessment overview: Urinalysis (UA)/culture and sensitivity test (C&S, diagnostic laboratory test used to identify types of bacteria and to determine types of antibiotic that can be used to treat the bacteria). Review of the resident's lab results report, showed: -Collection date: 7/22/24 at 4:15 P.M.; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received date: 7/23/24 at 11:25 A.M.; -Reported date: 7/26/24 at 5:24 P.M.; -The urinalysis showed: -Clarity: Hazy (reference range: range of results considered to be normal: Clear); -Nitrites: Positive (reference range: Negative); -Leukocytes: +3 (reference range: Negative); -White blood cells: Greater than 50 (reference range: Less than six); -White blood cell clumps: Present (reference range: Absent); -The culture showed: -Citrobacter farmeri (bacteria) present. Review of the resident's progress notes, showed: -No documentation on 7/26/24 or 7/27/24 of staff attempting to notify the physician of the resident's lab results, received 7/26/24; -A progress note, dated 7/28/24 at 3:53 P.M., in which staff documented UA/C&S results reported to physician, new orders received: Bactrim DS (sulfamethoxazole-trimethoprim, antibiotic medications) by mouth (PO) twice a day (BID) for five days. Probiotic Acidophilus, one PO BID for five days; -No documentation regarding the lab results and new orders reported to the resident and/or the resident's responsible party. Review of the resident's physician order sheet, showed: -An order, dated 7/29/24, for Bactrim DS oral tablet 800-160 milligrams (mg), one tablet PO BID related to UTI, for five days; -An order, dated 7/29/24, for Probiotic Acidophilus oral tablet chewable, one tablet PO BID related to UTI for five days. During an interview on 10/20/24 at 8:41 A.M., the resident said recently, he/she reported intense burning to his/her doctor and the next day, staff obtained a urine sample from him/her. The next thing he/she knew, he/she was told he/she had been taking an antibiotic for several days for a urinary tract infection. The facility never told him/her had a UTI until days after taking the antibiotic. The facility did not tell his/her POA about the UTI, either. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 10:11 A.M., Licensed Practical Nurse (LPN) A said when a physician issues orders for a UA, the urine should be collected within 24 hours, unless it is a STAT (immediate) order. Labs are collected on Tuesdays and Thursdays, so nurses try to align the collection of urine with the lab collection dates. During the interview, LPN A reviewed the resident's electronic medical record (EMR) and confirmed the orders for labs were received on Wednesday, 7/17/24, and the resident's urine should have been obtained so it could have gone out the next day, a scheduled lab day. The lab results were reported to the facility on Friday, 7/26/24. Ideally, the facility nurse should have reported the results to the physician within 24 hours. When lab results are received on Friday evenings or on the weekends, the nurse should still contact the physician and if they cannot get through, they should leave a message and chart the communication as a note in the resident's EMR. When new orders are received, including new orders for an antibiotic, the resident and resident's responsible party should be notified. This communication should also be charted in the resident's EMR. During an interview on 10/24/24 at 11:33 A.M., the Assistant Director of Nurses (ADON) said when the physician issues orders for a urinalysis, the resident's urine should be obtained right away, aligned with the facility's lab days on Tuesdays or Thursdays, unless the lab is a STAT order. When the lab results are reported to the facility, they should be reported to the physician right away. Labs results received on the weekends should still be reported to the physician the same as they would be during the week. Lab results are faxed to the front office fax, not the fax in the facility's medication room, so staff might not see lab results faxed on the weekends, unless they know to be looking out for them. When residents are started on new medications, it should be reported to the resident and their responsible party. She expects nurses to document their communication with the physician, resident, and responsible party in the resident's EMR. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administrator said he expects labs to be obtained in a timely manner, as ordered by the physician. He expects the results of labs and new orders for medications to be reported to the resident and/or their responsible party. He expects nursing staff to document their communication with physician, residents, and responsible parties in the resident's EMR.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to provide the resident and/or resident representative with emergency written notices of transfer/discharge for two residents transferred to the hospital for acute medical reasons (Residents #31 and #19). The sample was 12. The census was 47. Review of the facility's Transfer or Discharge Notice policy, revised December 2016, showed: -Policy Statement: Our facility shall provide a resident and/or the resident's representative (sponsor) with a 30-day written notice of an impending transfer or discharge; -Policy Interpretation and Implementation: -A resident and/or his or her representative (sponsor) will be given a 30-day advance notice of an impending transfer or discharge from our facility; -Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: --An immediate transfer or discharge is required by the resident's urgent medical needs; -The resident and/or representative will be notified in writing of the following: --The reason for the transfer or discharge; --The effective date of the transfer or discharge; --The location to which the resident is being transferred or discharged ; --A statement of the resident's rights to appeal the transfer or discharge; --The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman; --The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices; 1. Review of Resident #31's medical record, showed: -discharged to the hospital on 2/8/24; -readmitted to the facility on [DATE]; -discharged to the hospital on 3/26/24; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-readmitted to the facility 3/30/24; -No documentation the resident and/or their representative were provided a written notice of the resident's transfers to the hospital on 2/8/24 and 3/26/24. 2. Review of Resident #19's medical record, showed: -discharged to the hospital on 9/13/24; -readmitted to the facility on [DATE]; -No documentation the resident and/or their representative were provided a written notice of the resident's transfer to the hospital 9/13/24. 3. During an interview on 10/24/24 at 10:11 A.M., Licensed Practical Nurse (LPN) A said when a resident is sent out to the hospital for an acute medical issue, the nurse sends paperwork out with the resident, including the resident's face sheet, medication list, code status sheet, and any pertinent labs or imaging. They used to send out a notice of transfer/discharge as well, but they fell off doing this a while ago. 4. During an interview on 10/24/24 at 11:33 A.M., the Assistant Director of Nurses (ADON) said when a resident goes out to the hospital, a notice of transfer/discharge should be given to the resident. A copy of the document should also be given to the resident's family. She checked to see if Residents #31 and #19 received notices of transfer/discharge when they went out to the hospital, and could not find documentation to show this was done. She expects notices of transfer/discharge to be provided when residents go out to the hospital. 5. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administrator said he expects residents and/or their representatives to receive a notice of transfer/discharge when a resident is transferred to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to provide the resident and/or resident representative with written information on the facility's bed hold policy at the time of transfer for two residents transferred to the hospital for acute medical reasons (Residents #31 and #19). The sample was 12. The census was 47. Review of the facility's Bed Holds and Returns policy, revised March 2017, showed: -Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy; -Policy Interpretation and Implementation: -Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: --The rights and limitations of the resident regarding bed-holds; --The reserve bed payment policy as indicated by the state plan (Medicaid residents); --The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents). 1. Review of Resident #31's medical record, showed: -discharged to the hospital on 2/8/24; -readmitted to the facility on [DATE]; -discharged to the hospital on 3/26/24; -readmitted to the facility 3/30/24; -No documentation the resident and/or their representative were provided a written notice of the facility's bed hold policy at the time of the resident's transfers to the hospital on 2/8/24 and 3/26/24. 2. Review of Resident #19's medical record, showed: -discharged to the hospital on 9/13/24; -readmitted to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation the resident and/or their representative were provided a written notice of the facility's bed hold policy at the time of the resident's transfer to the hospital 9/13/24. 3. During an interview on 10/24/24 at 10:11 A.M., Licensed Practical Nurse (LPN) A said when a resident is sent out to the hospital for an acute medical issue, the nurse sends paperwork out with the resident, including the resident's face sheet, medication list, code status sheet, and any pertinent labs or imaging. They used to send out a bed hold notice as well, but they fell off doing this a while ago. 4. During an interview on 10/24/24 at 11:33 A.M., the Assistant Director of Nurses (ADON) said when a resident goes out to the hospital, a notice of bed hold should be given to the resident. A copy of the document should also be given to the resident's family. She checked to see if Residents #31 and #19 received bed hold notices when they went out to the hospital, and could not find documentation to show this was done. She expects bed hold notices to be provided when residents go out to the hospital. 5. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administrator said he expects residents and/or their representatives to receive a bed hold notice when a resident is transferred to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40290 Based on interview and record review, the facility failed to ensure one resident received an accurate assessment, reflective of the resident's status at the time of assessment, by failing to identify the resident's unplanned significant weight loss, unhealed pressure ulcers (injuries to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction), and other skin problems (Resident #31). The sample was 12. The census was 47. Review of Resident #31's medical record, showed diagnoses included bullous pemphigoid (an autoimmune skin disorder that causes blisters on the skin). Review of the resident's weights, showed: -On 2/19/24, weighed 147.2 pounds (lbs); -On 8/19/24, weighed 120.0 lbs; -Significant weight loss of -18.48% in six months. Review of the resident's nutrition quarterly review, dated 8/20/24, showed: -Greater than 10% weight change in 180 days; -Additional information: Significant weight loss of -25 pounds in six months. Continues with trend down. Poor appetite continues. Stability continues to be guarded with declining condition. Review of the resident's skin assessment, dated 8/22/24, showed: -Bullous pemphigoid wound to right upper extremity anterior (in front of) with serosanguineous (thin, watery, pale, red/pink drainage) exudate (fluid that has seeped out of the tissue); -Bullous pemphigoid wound to left lateral (to the side of) knee with serosanguineous exudate; -Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (dead tissue). May also present as an intact or open/ruptured blister.) pressure ulcer to left buttock; -Stage IV (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often includes undermining or tunneling.) pressure ulcer to sacrum (triangular bone at the base of the spine). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/24/24, showed: -Weight loss of 5% in the last month of loss of 10% in the last six months: Yes, on physician-prescribed weight-loss regimen; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unhealed pressure ulcers: None; -Other ulcers, wounds, and skin problems: None. During an interview on 10/23/24 at 4:40 P.M., the Assistant Director of Nurses (ADON) said she completes all MDS assessments for all residents in the facility. Resident #31's significant weight loss was not planned and was not physician-prescribed. The ADON misinterpreted the question on the MDS regarding physician-prescribed weight-loss regimen, and thought this question referred to interventions in place to address weight loss. At the time of the assessment, the resident had a Stage II pressure ulcer and a Stage IV pressure ulcer, but the ADON was focused on the resident's bullous pemphigoid areas and did not mark the correct areas on the skin section of the MDS. She expects the MDS to be completed accurately. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administrator said he expects resident assessments to be completed accurately.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to develop comprehensive care plans with resident-specific interventions to meet the resident's preferences and goals, and to address the resident's medical, physical, and psychosocial needs for five residents (Residents #31, #19, #20, #41, and #44). The sample was 12. The census was 47. Review of the facility's Care Plans - Comprehensive Person-Centered policy, revised [DATE], showed: -Policy Statement: A comprehensive, person-centered care plan that includes measurable outcomes and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -Policy Interpretation and Implementation: -The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -The comprehensive, person-centered care plan will: -Include measurable objectives and timeframes; -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; -Incorporate identified problem areas; -Incorporate risk factors associated with identified problems; -Build on the resident's strengths; -Reflect the resident's expressed wishes regarding care and treatment goals; -Reflect treatment goals, timetables and objectives in measurable outcomes; -Identify the professional services that are responsible for each element of care; -Aid in preventing or reducing decline in the resident's functional status and/or functional levels; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and -Reflect currently recognized standards of practice for problem areas and conditions; -Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan; -Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process; -Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change; -The IDT must review and update the care plan: -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -At least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) assessment. 1. Review of Resident #31's medical record, showed diagnoses included stroke, bullous pemphigoid (an autoimmune skin disorder that causes blisters on the skin), local infection of the skin, urinary tract infection (UTI), diabetes, and high blood pressure. Review of the resident's electronic physician order sheet (ePOS), showed: -An order, dated [DATE], for ProSource oral liquid (high protein and calorie nutritional supplement), 30 milliliters (mL) by mouth twice daily for wound healing; -An order, dated [DATE], for alternating pressure mattress; -An order, dated [DATE], for mirtazapine (anti-depressant) oral tablet 15 milligrams (mg), one tablet by mouth at bedtime for poor appetite, -An order, dated [DATE], for urinary catheter 16 French (size) with 10 mL balloon (used to hold the urinary catheter in place) for wound healing; -An order, dated [DATE], to send to wound clinic for consult and treatment of wounds; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated [DATE], for soft heel boots to bilateral (both sides) lower extremities as tolerated, every shift; -An order, dated [DATE], for Med Pass 2.0 (fortified nutritional shake), 120 mL, four times a day for weight loss; -An order, dated [DATE] for regular diet, pureed texture, super cereal (calorie dense cereal) at breakfast, ice cream at lunch/dinner. Review of the resident's nutrition quarterly review, dated [DATE], showed: -Current diet order: Mechanical soft diet; -Snack/supplement orders: Med Pass supplement 120 mL three times daily, liquid protein 30 mL twice daily, super cereal at breakfast, ice cream at lunch/dinner; -Additional information: Significant weight loss of -25 pounds in six months. Continues with trend down. Poor appetite continues. Multivitamins/minerals in place for skin integrity support. Mirtazapine (antidepressant that also increases the appetite) 15 mg ordered, which may help aid in appetite stimulation. Assisted at meals with encouragement. Continue to encourage intakes at meals/supplements, continue to offer snacks and alternatives at meals as indicated, assistance at meals. Review of the resident's skin assessment, dated [DATE], showed: -Bullous pemphigoid wound to right upper extremity anterior (in front of); -Bullous pemphigoid wound to left lateral (to the side of) knee; -Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (dead tissue). May also present as an intact or open/ruptured blister) to left buttock; -Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed) to sacrum (triangular bone at the base of the spine). Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Upper extremity impairment on one side and lower extremity impairment on both sides; -Indwelling catheter in use; -Weight loss of 5% in the last month, loss of 10% in the last six months; -Mechanically altered diet received; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At risk of developing pressure ulcers; -Unhealed pressure ulcers: None; -Other ulcers, wounds, and skin problems: None. Review of the resident's medical record, showed the resident seen routinely by a wound clinic. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has unplanned/unexpected weight loss related to poor food intake; -Interventions: Give the resident supplements as ordered. Alert nurse/dietician if not consuming on a routine basis; -Focus: Potential for impaired skin integrity as evidenced by Braden scale (used to determine pressure ulcer risk); -Interventions included: Educate resident/representative about the proper usage of pressure reducing devices and monitor nutritional status; -Focus: The resident has bladder incontinence; -The care plan failed to identify the resident's intake of a mechanically altered diet; -The care plan failed to identify the resident's significant weight loss and specific interventions to address weight loss, including super cereal and ice cream with meals, and nutritional supplements administered as treatments; -The care plan failed to identify the resident's use of an indwelling catheter and interventions specific to catheter use; -The care plan failed to identify the resident's active, unhealed bullous pemphigoid wounds and pressure ulcers, and specific interventions to address his/her impaired skin integrity, including the use of a low air-loss mattress, soft heel boots, nutritional supplements, as well as monitoring and treatments completed by a wound clinic. Observation on [DATE] at 8:53 A.M., showed the resident seated upright in bed on an alternating pressure mattress. A catheter bag hung at the foot of the bed. Certified Nurse Aide (CNA) D stood next to the resident's bed and assisted to feed the resident pureed food from a divided plate. During an interview on [DATE] at 9:11 A.M., CNA I said the resident has a catheter. He/She stopped eating and had unplanned weight loss. He/She gets health shakes. He/She has wounds and wears boots on his/her feet for them. During an interview on [DATE] at 9:32 A.M., CNA G said the resident has a catheter. He/She does not eat anything and has lost weight. He/She receives a pureed diet and likes some foods, like bananas. He/She has several wounds and wears pressure relieving boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:11 A.M., Licensed Practical Nurse (LPN) A said the resident has a catheter and has had unplanned significant weight loss. He/she receives a pureed diet and only consumes about ,d+[DATE]% at meals. He/She has a lot of bullous pemphigoid wounds and two pressure ulcers for which he/she has an alternating pressure mattress and pressure relieving boots. He/She received nutritional supplements. These things should be on his/her care plan. 2. Review of Resident #19's medical record, showed diagnoses included major depressive disorder (MDD) and anxiety disorder due to known physiological condition. Review of the resident's hospital transfer orders to the receiving facility, dated [DATE], showed discharge diagnoses of dementia and suicidal ideation. Review of the resident's progress notes, from [DATE] through [DATE], showed: -On [DATE], the resident slipped and fell while ambulating in the hallway; -On [DATE], the resident noted with a skin tear from his/her recent fall; -On [DATE], the resident was witnessed sliding off the couch. Review of the resident's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Delusions exhibited; -Verbal behavioral symptoms directed and other behavioral symptoms not directed toward other exhibited one to three days; -No falls during review period. Review of the resident's progress notes from [DATE] through [DATE], showed: -On [DATE], the resident found on the floor. Witnesses said the resident was walking and tripped over his/her feet and fell to the floor; -On [DATE], the resident was witnessed to trip over his/her foot, losing his/her balance, and fell to the floor. A laceration noted to the resident's left eyebrow; -On [DATE], the resident turned and lost his/her balance, falling on the floor by the nurse's station. He/She was admitted to the hospital from [DATE] through [DATE] for a fractured femur (large bone of the upper leg); -On [DATE], the resident returned to the facility from the hospital. The resident stated he/she was dying and was uncooperative during an exam; -On [DATE], the resident confused, repeating the words, My mom and dad are dead, you want me to die. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], the resident continues to fixate on scenarios concerning death and/or requesting his/her parents. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has potential of limited physical mobility related to decreased cognition and aging process: -Goal: The resident will maintain current level of mobility being able to walk independently through review date (OVERDUE); -Interventions: Ambulation - the resident is able to ambulate independently; -Focus: The resident has had an actual fall with (SPECIFY - no injury, minor injury, serious injury) poor balance; -Goal: The resident will resume usual activities without further incident through the review date (OVERDUE); -Interventions: Continue interventions on the at-risk plan; -Focus: The resident is at risk for falls related to gait/balance problems, unaware of safety needs; -Goal: The resident will not sustain serious injury through the review date (OVERDUE); -Interventions: Anticipate and meet the resident's needs. Follow facility protocol. Physical therapy evaluate and treat as ordered or as needed; -Focus: The resident has impaired cognitive function/dementia or impaired thought processes related to dementia; -Goal: The resident will maintain current level of cognitive function through the review date. The resident will remain oriented to person through the review date (OVERDUE); -Interventions included: Administer medications as ordered. Monitor/document for side effects; -Focus: The resident has a mood problem related to dementia; -Goal: The resident will have improved mood state evidenced by decreased signs/symptoms of anxiety through the review date (OVERDUE); -Focus: The resident has depression related to current health status; -Goal: The resident will exhibit indicators of depression, anxiety, or sad mood less than daily by review date. The resident will remain free of signs/symptoms of distress, symptoms of depression, anxiety or sad mood by/through review date (OVERDUE); (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan failed to be updated with measurable goals related to focus areas; -The care plan failed to identify the resident's falls on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], and the resident sustaining a hip fracture from the fall on [DATE], with interventions to decrease future falls. The care plan failed to identify the resident's decrease in mobility and use of wheelchair as a result of the hip fracture; -The care plan failed to identify the resident's history of suicidal ideation and current, ongoing thoughts regarding death and dying, and specific interventions that were found to be effective or ineffective in addressing his/her thoughts on dying. Observation on [DATE] at 9:28 A.M., showed the resident on his/her side in bed. During an attempted interview, the resident confused and repeatedly said he/she was dying. He/She said someone was trying to take his/her dress and repeatedly said he/she did not want to die. Observation on [DATE] at 8:37 A.M., showed the resident propelled into the dining room in his/her wheelchair. The resident said he/she was scared and someone died . He/She repeatedly said he/she was scared. During an interview, CNA I and Nurse Aide (NA) C said this is what the resident says all the time. Observation on [DATE] at 9:27 A.M., showed the resident propelled down the hallway talking to him/herself, saying he/she was dying. Observation on [DATE] at 12:23 P.M., showed the resident seated at a table in the dining room. He/She talked to him/herself and his/her tablemate, repeatedly saying he/she was dying. During an interview on [DATE] at 9:11 A.M., CNA I said the resident is very confused and obsessed with dying. He/She chants, Help me die, help me die, and says he/she is dying or his/her parent is dying. The resident has been doing this since CNA I began working with the resident in February 2024. Nothing helps the resident stop focusing on dying. The resident used to walk but a few months ago, the resident changed and started falling all the time. The resident broke his/her hip and now he/she is in a wheelchair. During an interview on [DATE] at 9:32 A.M., CNA G said the resident is totally confused. He/She constantly talks about dying, wanting to die to be with his/her parents, and asking to help him/her die. The resident has been this way since he/she came to the facility several years ago and nothing helps address this. The resident walked with a limp for years. A few months ago, he/she started falling more often and recently broke his/her hip. The resident is currently using a wheelchair. During an interview on [DATE] at 9:52 A.M., the Social Services Director said the resident perseverates on death. When the SSD started working with the facility three years ago, the resident did not talk about death as much, but this has progressively increased. The resident used to walk and was up for most of the day. A month or so ago, he/she fell and broke his/her hip and now he/she is in a wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:11 A.M., LPN A said the resident is alert and oriented to self. He/She is frequently anxious and talks about dying a lot. His/Her talk about dying has increased since his/her overall decline and progression of dementia. Sometimes having a conversation with the resident helps, and sometimes it does not. He/She likes to have reassurance from someone. During an interview on [DATE] at 11:33 A.M., the Assistant Director of Nursing (ADON) said the resident is alert and oriented to self. He/She is confused and talks about him/her dying, people dying, and wanting to die. The resident has always been this way since admission. His/Her medication was changed recently, but he/she still expresses thoughts about dying. The resident used to walk independently, but now uses a wheelchair due to falling and breaking his/her femur. 3. Review of Resident #20's medical record, showed diagnoses included underweight, abnormal weight loss, hypothyroidism (underactive thyroid), Alzheimer's disease, dementia, unspecified psychosis, and anxiety. Review of the resident's ePOS, showed: -An order, date [DATE] for regular texture diet, no pork, super cereal at breakfast, and ice cream or pudding at lunch and dinner; -An order, dated [DATE], for Med Pass 2.0 three times a day related to abnormal weight loss. Review of the resident's annual MDS, dated [DATE], showed: -Resident rarely/never understood; -Rejection of care behavior not exhibited; -Supervision or touching assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has nutritional problem or potential nutritional problem of abnormal weight loss related to poor cognition; -Goal: The resident will comply with recommended diet for weight reduction daily through review date (OVERDUE); -Interventions: Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition factors. Invite the resident to activities that promote additional intake. Monitor/report to physician as needed signs/symptoms of malnutrition. Provide and serve supplements as ordered: Med Pass 2.0. Provide, serve diet as ordered. Monitor intake and record every meal. Registered Dietician to evaluate and make diet change recommendations; -The care plan failed to identify the resident's significant weight loss, use of a divided plate and dietary supplements of super cereal and ice cream with meals, and the resident's preference to eat with his/her hands and refusal of assistance during meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nutrition/dietary notes, showed: -On [DATE], the resident noted with significant weight loss of -5.1% in one month. Weight trend likely related to recent COVID positive cases last month. Med Pass 120 ml three times a day in place. Super cereal at breakfast, ice cream or pudding at lunch and dinner. Appetite varied depending on mood. Per conversation with nursing, resident will not let staff help with feeding, but have been trying a divided plate at meals. Stability guarded related to dementia disease progression and advanced age. Multiple interventions in place for nutrition support; -On [DATE], the resident noted with significant weight loss of -10.9% in six months. Resident feeds self, will not let staff help with feeding. Observation on [DATE] at 7:43 A.M., showed the resident seated in the dining room. NA C stood next to the resident and fed him/her for one minute, then walked away. The resident did not refuse feeding assistance. After NA C walked away, the resident began feeding him/herself, using his/her hands to eat. Observation on [DATE] at 12:51 P.M., showed the resident seated at a table in the dining room. The resident ate his/her food using his/her hands, dropping food onto the table and his/her lap. Observation on [DATE] at 9:29 A.M., showed the resident used his/her hands to eat breakfast from a divided plate in the dining room. The resident dropped food onto the table and floor. Observation on [DATE] at 12:49 P.M., showed the resident used his/her hands to eat lunch from a divided plate in the dining room. A bowl of ice cream next to the resident's plate. The resident dropped food onto the table and floor. Observation on [DATE] at 5:39 P.M., showed the resident seated in the dining room. Staff placed a table, bowl of ice cream, and utensils on the table in front of the resident. The resident used his/her hands to eat dinner, dropping food onto the table. During an interview on [DATE] at 9:11 A.M., CNA I said the resident has lost a tremendous amount of weight. He/She is very confused. His/her appetite is good, but he/she gets confused while eating. He/She likes ice cream with meals. He/She will not allow staff to assist him/her with eating. During an interview on [DATE] at 9:32 A.M., CNA G said the resident is very confused. He/She had lost a lot of weight. He/She gets ice cream with meals and a divided plate. He/She eats with his/her hands but misses his/her mouth and gets food all over him/herself. He/She refuses to let staff provide feeding assistance and will push staff away when they try. During an interview on [DATE] at 10:11 A.M., LPN A said the resident has had a significant weight loss. He/She has a good appetite and eats with his/her hands. He/She will not let staff assist him/her with eating. 4. Review of Resident #41's medical record, showed diagnoses included dementia, depression, high blood pressure, high cholesterol, peripheral vascular disease (PVD, a lack of blood flow to the arms and legs), and overweight. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Clear speech; -Able to make self understood; -Able to understand others; -Severe cognitive impairment; -No impairment with hip, knee, ankle, foot; -No mobility devices needed; -Independent with toileting, showers, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, sit to lying, sit to stand, chair/bed to chair transfer, toilet transfer, and able to walk 150 feet once standing. Review of Physical Therapy Assistant Progress Note, dated [DATE], showed: -Current level of Function, max assistance of bed mobility, poor muscle strength, and maximum assistance of two with chair/bed to chair transfers; -Precautions: At risk for falls and mechanical lift for transfers. Review of the resident's care plan, in use at the time of the investigation, showed: -Focus: Current Functional Performance; -Goals: the resident's functional status will progress towards personal discharge goal during stay; -Interventions: the resident is independent with bed mobility, dressing, locomotion off/on the unit, personal hygiene, toilet use, transfers, walk in corridor, and walk in room. Observation on [DATE] at 8:37 A.M. and 11:22 A.M., staff propelled the resident in his/her wheelchair to the day room. At 12:11 P.M., staff propelled the resident in his/her wheelchair to the dining room. At 1:10 P.M., staff propelled the resident in his/her wheelchair to their room. Observation on [DATE] at 10:16 A.M., showed staff assisted the resident to stand in the shower room on the 100 hall, by Certified Medication Technician (CMT) F, CNA H and Physical Therapy Assistant (PTA) L. CNA H said the resident needs assist of two for transfers, and staff use a mechanical lift to assist the resident out of the bed to wheelchair. Staff have dress, provide hygiene, and toilet the resident. 5. Review of Resident #44's quarterly MDS, dated [DATE], showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnoses included asthma and acute respiratory failure. Review of the resident's ePOS, showed an order dated [DATE], for continuous oxygen at 2 liters via nasal canula (device used to deliver oxygen with into the nostrils). Review of the resident's care plan, dated [DATE], showed: -Problem: The resident has oxygen therapy; -Goal: The resident will have no symptoms of poor oxygen absorption through the review date; -Interventions: Give medications as ordered by physician. Monitor and document side effects and effectiveness of medications. Oxygen setting: oxygen via nasal cannula continuous at 2 liters; -The care plan did not include a concern or interventions of the resident removing his/her nasal canula. Observations on [DATE] at 8:53 A.M., [DATE] at 9:50 A.M., [DATE] at 9:23 A.M., [DATE] at 9:23 A.M., [DATE] at 2:56 P.M., and [DATE] at 9:15 A.M., showed the resident lay in bed with his/her nasal canula off. During an interview on [DATE] at 8:04 A.M., the resident said he/she uses oxygen whenever he/she needs it. During an interview on [DATE] at 10:40 A.M., LPN A said the resident has an order for continuous oxygen but does not always keep his/her nasal canula on. He/She would expect for the care plan to have interventions that reflect monitoring the resident to ensure he/she has his/her nasal canula in place. During an interview on [DATE] at 12:39 P.M., the ADON said the resident requires continuous oxygen and does not always keep his/her nasal canula on. She would expect interventions to be included on the resident's care plan for staff to follow when the resident does not want to wear his/her nasal canula. 7. During an interview on [DATE] at 11:33 A.M., the ADON said she is responsible for updating the care plans for all residents. She expects them to include services provided for the resident to attain their highest practicable physical, mental, and psychosocial well-being. She expects the care plans to include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward their goals. She expects care plans to identify specific areas of concern, including significant weight loss, wounds, and catheter use. Care plans should specify interventions in place to assist the resident, including diet orders and dietary supplements, the use of pressure relieving devices, and ADL needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview with the ADON and Assistant Administrator on [DATE] at 12:31 P.M., the Assistant Administrator said he expects care plans to include services provided for resident to attain resident's highest practicable physical, mental, and psychosocial well-being. He expects care plans to include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward goals. The ADON and Assistant Administrator said care plans should be updated with changes in conditions. Care plans should be a true reflection of the resident and their care needs. 46888 49992

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the resident's care needs for four residents (Residents #38, #46, #22, and #32) of 12 sampled residents. The facility census was 47. Review of facility's, undated, Care Plans, Comprehensive Person-Centered policy, showed: -Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implanted for each resident; -Policy Interpretation and Implementation: Areas of concern that identified during the resident assessment will be evaluated before intervention are added to the care plan. The comprehensive, person-centered care plan is developed with seven (7) days of the completion of the required comprehensive assessment. Assessments of resident are ongoing and care plans are revised as information about the residents and the residents' condition change. 1. Review of Resident #38's medical record showed: -Diagnosis of cerebral aneurysm (bleeding from a blood vessel that accumulates around the brain), diabetes, high blood pressure, depression, and seizures. Review of the resident's Admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/11/24, showed: -admitted [DATE]; -Care Area Assessment Summary: Care areas triggered and identified by the facility as care planned: Cognitive loss/dementia, communication, urinary continence/indwelling catheter, psychosocial well-being, activities, falls, nutrition status, pressure ulcers, psychotropic drug use, and physical restraints. Review of the resident's quarterly MDS, dated [DATE], showed: -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Usually understood; -Ability to Understand Others: Usually understands; -Severe Cognitive Impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic Medical Record (EMR) on 10/22/24 at 1:48 P.M., showed the resident did not have a comprehensive care plan. 2. Review of Resident #46's medical record showed diagnosis included depression, dementia, and anxiety. Review of the resident's admission MDS, dated [DATE], showed: -admitted [DATE]; -Adequate hearing and vision; -Speech Clarity: Unclear speech, slurred or mumbled; -Makes Self Understood: Rarely/never understood; -Ability to Understand Others: Rarely/never understands; -Care Area Assessment Summary: Care areas triggered and identified by the facility as care planned: Cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling catheter, psychosocial well-being, behavioral symptoms, activities, falls, nutritional status, pressure ulcers, and psychotropic drug use. Review of the resident's EMR on 10/20/24 at 11:11 A.M., showed the resident did not have a comprehensive care plan. 3. Review of Resident #22's admission MDS, dated [DATE], showed: -admitted [DATE]; -Care Area Assessment Summary: Care areas triggered and identified by the facility as care planned: Cognitive loss/dementia, communication, activities of daily living functional/rehabilitation potential, urinary continence/indwelling catheter, falls, nutritional status, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses include type two diabetes mellitus and depression. Review of the resident's EMR, on 10/23/24 at 12:56 P.M., showed the resident did not have a comprehensive care plan. During an interview on 10/24/24 at 10:39 A.M., Licensed Practical Nurse (LPN) A said he/she would expect each resident to have a care plan. He/She would expect for the resident's care plan to be completed in the appropriate time frame. He/She confirmed that the resident's care plan does not show up in the resident's EMR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #32's medical record showed diagnosis included depression, dementia, weakness, high blood pressure, and anemia. Review of the resident's admission MDS, dated [DATE], showed: -admitted [DATE]; -Care Area Assessment Summary: Care areas triggered and identified by the facility as care planned: ADL functional/rehabilitation potential, urinary continence/indwelling catheter, psychosocial well-being, activities, falls, nutrition status, pressure ulcers, and psychotropic drug use. -Clear speech; -Able to make self understood; -No cognitive impairment. Review of the resident's EMR on 10/24/24 at 10:30 A.M., showed the resident did not have a comprehensive care plan. 5. During an interview on 10/23/24 at 12:10 P.M., Nursing Assistant (NA) K said that he/she asks the nurses how to care for the resident. 6. During an interview on 10/23/24 at 12:37 P.M., LPN A said that the Certified Nursing Assistants (CNAs) and NAs have access to the EMR and are able to view the care plan. The care plan is created by the Assistant Director of Nursing (ADON) at the time of admission and updated with changes in the resident's care. 7. During an interview on 10/24/24 at 8:53 A.M., CNA G said the NAs and CNAs have access to the care plan in the EMR, and there is a resource binder at the nurse's station that contains step by step guidance on how to perform care tasks for any resident. If the resident does not have a care plan he/she will ask the charge nurse about the resident. He/She would expect all residents to have a care plan. 8. During an interview on 10/24/24 at 8:57 A.M., NA J said that he/she was in-serviced on how to use the EMR when first hired but he/she had not accessed the EMR since. He/She will ask the charge nurse or another staff member for information on how to care for a resident. 9. During an interview on 10/24/24 at 9:05 A.M., CNA I said that he/she did have access to the EMR but never used the access. He/she will ask the charge nurse on how to care for a resident. 10. During an interview on 10/24/24 at 12:33 P.M., the ADON said that each NA and CNA have access to the EMR and can view the care plan. The ADON creates the care plan at the time of admission. The NA and CNA can get information from the charge nurse on how to care for the resident. She would expect for care plans to be completed in the appropriate time frame as indicated in the facility's policy. She would expect all nursing staff to have access to the resident's care plan. The residents' care plan is not in the EMR due to an error while creating the care plan. A comprehensive care plan should be done with 14 days of admission and updated with changes in the resident's condition. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 49992

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure all staff certified in cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) received their CPR certification through a provider whose training includes hands-on practice and in-person skills assessment. The facility identified 10 CPR-certified staff and problems were found with three. The sample was 12. The census was 47. Review of the facility's Advance Directives policy, revised [DATE], showed no guidance for ensuring staff received CPR certification through a provide whose training includes hands-on practice and in-person skills assessment. Review of the facility's resident code status report, reviewed [DATE], showed 22 residents with full code status. Review of the CPR certification for CPR-certified facility staff, showed Licensed Practical Nurse (LPN) A, Registered Nurse (RN) Q, and the Assistant Director of Nurses (ADON) through a provider that offers online CPR certification. Review of the nurse staffing sheets, dated [DATE] through [DATE], showed: -On [DATE] from 7:00 A.M. to 3:00 P.M., ADON and LPN A the only CPR-certified staff scheduled; -On [DATE] from 7:00 A.M. to 3:00 P.M., ADON and LPN A the only CPR-certified staff scheduled; -On [DATE] from 3:00 P.M. to 11:00 P.M., RN Q the only CPR-certified staff scheduled; -On [DATE] from 7:00 A.M. to 3:00 P.M., ADON and LPN A the only CPR-certified staff scheduled; -On [DATE] from 3:00 P.M. to 11:00 P.M., RN Q the only CPR-certified staff scheduled; -On [DATE] from 7:00 A.M. to 3:00 P.M., ADON and LPN A the only CPR-certified staff scheduled; -On [DATE] from 3:00 P.M. to 11:00 P.M., RN Q the only CPR-certified staff scheduled; -On [DATE] from 3:00 P.M. to 11:00 P.M., RN Q the only CPR-certified staff scheduled; -On [DATE] from 7:00 A.M. to 11:00 P.M., LPN A the only CPR-certified staff scheduled. During an interview on [DATE] at 10:44 A.M., the ADON said the provider used for her CPR certification is an online CPR certification provider. In the past, the ADON and LPN A looked up the regulations about CPR certification and did not find anything about the CPR certification requiring a hands-on practice component. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:31 P.M., the ADON and Assistant Administrator said they expect CPR-certified staff to have received training that includes a hands-on practice and in-person skills assessment, in accordance with regulatory requirements.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992 Based on observation, interview, and record review, the facility failed to provide services consistent with acceptable standards of practice for one resident when staff failed to accurately assess the appropriate wheelchair size, resulting in skin irritation and indentations to the resident's legs, and failed to reposition the resident for six hours (Resident #41). In addition, the facility failed to date when a dressing was completed for one resident (Resident #16). The sample size was 12. The census was 47. Review of the facility's undated Admission Assessment and Follow Up: Role of the Nurse, showed: -Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purpose of managing the resident, initiating the care plan, and completing required assessment instruments, including the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff). 1. Review of Resident #41's medical record, showed diagnosis of dementia, depression, high blood pressure, high cholesterol, peripheral vascular disease (PVD, a lack of blood flow to the arms and legs) and overweight. Review of the resident's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Clear speech; -Able to make self understood; -Able to understand others; -Severe cognitive impairment. Review of the resident's care plan, in use at the time of the investigation, showed: -Focus: the resident has PVD related to disease process; -Goals: the resident's extremities will be free from pain, pallor, coldness, edema (swelling), and skin lesions through next review; -Interventions: Encourage resident to change position frequently, not sitting in one position for long periods of time. Monitor the extremities for signs or symptoms of injury, infection, or ulcers. Review of the resident's shower sheet, dated 10/22/24 showed no open areas. Review of the resident's skin assessment, dated 10/21/24 at 10:14 A.M., showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin warm and dry, skin color within normal limits, mucous membranes moist, turgor normal; -Does resident have current skin issues? No. Observations of the resident, on 10/24/24, showed: -Approximately 8:00 A.M., the resident sat in his/her wheelchair in the dining room and ate breakfast; -At 8:37 A.M., staff propelled the resident in his/her wheelchair from his/her into the day room; -At 9:45 A.M., the resident sat in the dining room and participated in activities; -At 11:22 A.M., staff propelled the resident in his/her wheelchair to the dayroom; -At 11:42 A.M., the resident sat in the day room, in his/her wheelchair. During interview with the resident, he/she complained that his/her bottom, back and legs hurt. The wheelchair that he/she sat in was not his/her property, and he/she had been using the wheelchair since he/she came back to the facility a few weeks ago. Observation at this time showed the resident kept attempting to reposition in the wheelchair, and was unsuccessful; -At 12:08 P.M., the resident remained in the day room in a wheelchair. The resident attempted to reposition and said his/her bottom really hurts. The resident said that they make him/her stay up to long. The resident asked a passing person to push his/her wheelchair to their room and they told the resident he/she would get someone to help; -At 12:11 P.M., the resident asked Certified Nursing Assistant (CNA) D to push him/her to their room. CNA D said that it was time for lunch and propelled the resident in the wheelchair to the dining room; -At 1:10 P.M., CNA F propelled the resident in his/her wheelchair to their room; -At 1:20 P.M., the resident sat in the wheelchair, in his/her room. CNA D passed by the room, and the resident said that he/she was ready for bed. CNA D responded that he/she needed to get help; -At 1:35 P.M., CNA J, entered the resident's room, pulled back the covers on the bed, and place two bed protector pads on top of the bed, then told the resident he/she would be back. During the interview with the resident, he/she said there is pain behind his/her knees and his/her bottom hurts; -At 2:28 P.M., CNA J entered the doorway of the resident's room and asked if the resident wanted to play Bingo. The resident replied that he/she was ready for bed. CNA J said that he/she would get some help; -At 2:31 P.M., CNA J was approached by another staff member to assist with a different resident, CNA J took the mechanical lift and supplies to another resident's room; -At 2:35 P.M., the resident sat in a wheelchair, in his/her room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/24 at 10:16 A.M., showed CMT F, CNA H and Physical Therapy Assistant (PTA) L assisted the resident to stand in the shower room on 100 hall. Indentations and reddened areas visible to the back of both the resident's calves near the knees and circle imprints to the back of both thighs near the knees. Both CMT F and CNA H, noted the reddened area to the back of the resident's legs and said that they would make the nurse aware. CNA H said the resident needs assist of two for transfers, and staff use a mechanical lift to assist the resident out of the bed to the wheelchair. During an observation on 10/22/24 at 10:27 A.M., Licensed Practical Nurse (LPN) A assessed the resident's legs, noting the purplish area the size of a quarter to the outer aspect of the resident's left calf near the knee and the reddened areas to the back of the resident's legs. LPN A said that the bracket on the wheelchair for the foot pedals was applying pressure to the back of the resident's legs, on the calves near the knees. The residents legs rested on the brackets on both sides of the wheelchair, causing the redness and indentations to the back of the thighs, near the knees. During an interview on 10/22/24 at 10:16 A.M., CNA H said that if the resident is incontinent of bowel and bladder, they should be assisted to the bathroom several times. PTA L said that he/she does not evaluate the residents for the wheelchair. Nursing supplies the wheelchairs to the residents. During an interview on 10/23/24 at 8:53 A.M., CNA G said that residents who are incontinent of bowel and bladder should be checked more often. During the interview on 10/24/24 at 12:33 A.M., the Assistant Director of Nursing (ADON) said that she would expect staff to provide incontinence care and reposition the residents more frequently. She would not expect residents to sit in the same position in a wheelchair for six hours. Staff should be documenting red areas and open skin areas on shower sheets and during skin assessments. She would expect staff to report to the charge nurse if a wheelchair is not appropriate for a resident. 2. Review of Resident #16's medical record, showed diagnosis of diabetes, high blood pressure, high cholesterol, kidney disease, amputation (removal of a limb), and dementia. Review of the resident's 5-day MDS, dated [DATE], showed: -admitted [DATE]; -Clear speech; -Able to make self understood; -Able to understand others; -Severe cognitive impairment. Review of the resident's care plan, in use at the time of the investigation, showed no focus for skin integrity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/20/24 at 9:15 A.M., showed the resident sat at the nurse's station in his/her wheelchair. There was a dressing to the right lower leg, near the ankle, that was not dated. The resident was unable to recall what had happened. Observation on 10/21/24 at 11:53 A.M., showed the resident resting in bed, a dressing to his/her right lower extremity, not dated. Observation on 10/22/24 at 9:23 A.M., showed staff assisted the resident to his/her room for an incontinent episode. While in bed, a dressing to the right lower extremity visible, not dated. CNA H was not able to identify a date on the dressing. At 9:48 A.M., LPN A entered the room and said that the abrasion on the right lower extremity occurred on Sunday, October 20, 2024. During an interview on 10/23/24 at 12:37 P.M., LPN A said that nurses should date the dressing when the dressing is changed. During an interview on 10/24/24 at 12:33 P.M., the ADON said that she would expect the nursing staff to date the dressing when the treatment is performed.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview, and record review, the facility failed to ensure foot care was maintained for two of 12 sampled residents (Resident #44 and Resident #21) resulting in long nails and dry feet. The census was 47. Review of the facility's activities of daily living (ADL) Policy, dated march 2018, showed: -Policy statement: residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; -Policy Implementation: appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks); and communication (speech, language, and any functional communication systems); - If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. 1. Review of Resident #44's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/13/24, showed: -Cognitively intact; -Diagnoses included diabetes, anxiety, asthma, and acute respiratory failure. Review of the resident's care plan, in use at the time of the investigation, showed: -Focus: the resident has diabetes; -Goal: the resident will have no complications related to diabetes through the review date; -Interventions: don't use over the counter remedies for calluses, refer to podiatrist to treat. Review of the resident's most recent skin evaluation, dated 10/18/24, showed no indication that the resident had dry skin. During an interview on 10/20/24 at 8:54 A.M., the resident said his/her feet are very dry a flaking. His/Her toe nails are way too long. He/She has been at the facility for around eight months and has not seen the podiatrist yet. His/Her feet hurt. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/21/24 at 9:50 A.M., of the resident's feet, showed: -The left foot had dry skin. The big toenail was approximately 1 inch long; -The right foot had dry, flaky skin. The toenails were long and jagged. The big toenail was approximately 1 inch long. During an interview on 10/23/24 at 9:17 A.M., the resident said his/her nails often get stuck on the bed covers and hurts. He/She would like to be able to wear his/her shoes but does not want to get holes in the shoes from his/her nails. 2. Review of Resident #21's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included dementia, dystonia (involuntary muscle contractions that cause repetitive or twisting movements), and chronic obstructive pulmonary disease (COPD, lung disease). Review of the resident's care plan, dated 9/30/24, showed: -Focus: the resident has an ADL self-care performance deficit; -Goal: the resident will maintain current level of function in ADLs, transfers, mobility, and toileting through the review date; -Interventions: bathing/showering: check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of the resident's most recent shower sheets, showed: -On 10/2/24, no skin or nail concerns documented; -On 10/4/24, no skin or nail concerns documented; -On 10/9/24, no skin or nail concerns documented; -On 10/11/24, no skin or nail concerns documented. Review of the resident's most recent skin evaluation, dated 10/19/24, showed no indication that the resident had any dry skin concerns. Review of the resident's most recent podiatry visit notes, dated 9/27/24, showed the resident refused care. During an interview on 10/21/24 at 2:00 P.M., Family Member M said the resident's nails are long and need to be trimmed. Observation on 10/22/24 at 11:35 A.M., of the resident's feet, showed: (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The left foot had dry, flaky skin. His/Her toenails were long and jagged; -The right foot had dry, flaky skin. His/Her toenails were long and jagged. 3. During an interview on 10/24/24 at 9:49 A.M., Certified Nursing Assistant (CNA) G said CNAs and nurses are both responsible for resident foot care. If the resident is diabetic then the nurse is responsible for trimming the resident's nails. Foot care should be documented on the resident's shower sheets or on the skin assessment. Dry skin and long nails should be documented and reported to the charge nurse. 4. During an interview on 10/24/24 at 10:43 A.M., Licensed Practical Nurse (LPN) A said if a resident is observed to have dry skin or long nails, documentation should be made on the shower sheet by CNAs or on the skin assessment completed by the charge nurse. Skin assessments should be completed for each resident weekly. All residents are referred to the podiatrist upon admission and are seen by the podiatrist every three months. 5. During an interview on 10/24/24 at 12:42 P.M., the Assistant Director of Nursing (ADON) said Resident #21 refused to let the podiatrist trim his/her nails at his/her last appointment. Resident #44 is on the list to see the podiatrist but for some reason was not seen when the podiatrist was last at the facility. She would expect staff to be observing resident's feet while providing care to ensure residents do not have dry skin or long nails. CNAs write any skin or nail observations on the resident's shower sheet. She would expect the weekly skin assessments to be complete and accurate. The charge nurse can trim residents nails if they are diabetic.

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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** 40290 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents when staff failed to prevent residents' feet from dragging on the floor during staff-assisted propelling for two residents (Residents #41 and #32). Facility staff failed to use gait belts during assisted transfers for three residents (Residents #40, #20, and #41) and failed to ensure one resident with a history of falling from his/her wheelchair was appropriately repositioned in his/her chair (Resident #21). The sample was 12. The census was 47. The facility did not have a written policy regarding transfer protocols. 1. Review of Resident #41's medical record, showed diagnoses of dementia, depression, high blood pressure, high cholesterol, and overweight. Review of the resident's quarterly Minimum Data Set (MDS,) a federally mandated assessment instrument completed by the facility staff, dated 7/18/24, showed: -admitted [DATE]; -Clear speech; -Able to make self understood; -Able to understand others; -Severe cognitive impairment. Observation on 10/20/24 at 9:10 A.M., showed the resident propelled down the hall in a wheelchair toward the dining room by Certified Nursing Assistant (CNA) H. No leg rests were on the resident's wheelchair and the resident had difficulty keeping his/her legs elevated. The resident lowered his/her legs three times while being propelled, and his/her shoe touched the floor causing resistance. CNA H stopped the wheelchair and the resident lifted his/her legs to allow the staff to continue to propelling the wheelchair. During an interview on 10/21/24 at 11:42 A.M., the resident said he/she is not able to keep his/her legs up all the time when the staff propel him/her in the wheelchair. His/Her feet drop to the floor and it hurts sometimes. 2. Review of Resident's #32 medical record, showed diagnoses included depression, dementia, weakness, high blood pressure, and anemia. Review of the resident's admission MDS, dated [DATE], showed: -admitted [DATE]; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clear speech; -Able to make self understood; -No cognitive impairment. Observation on 10/24/24 at 8:51 A.M., showed the resident being propelled in his/her wheelchair out of the dining room, toward his/her room by Nursing Assistant (NA) J. No leg rests were on the wheelchair and the resident had difficulty keeping his/her legs elevated. The resident lowered his/her legs two times while being propelled and his/her shoe touched the floor, causing resistance. CNA J stopped the wheelchair and the resident lifted his/her legs to allow the staff to continue to propelling the wheelchair. During an interview, the resident said his/her foot gets caught sometimes. 3. During an interview on 10/24/24 at 8:53 A.M., CNA G said that if a resident is unable to elevate their legs up while being propelled to the dining room, the staff should stop, get leg pedals, and tell the nurse. During an interview on 10/24/24 at 9:05 A.M., CNA I said that if a resident is unable to elevate their legs, he/she would propel the resident backwards in their wheelchair. During an interview on 10/24/24 at 12:33 P.M., the Assistant Director of Nursing (ADON) said that she would expect staff to use wheelchair leg pedals for those residents who are unable to elevate their legs and would expect the staff not to pull the residents backwards. 4. Review of Resident #40's medical record, showed diagnoses included diabetes, dementia and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed: -admitted [DATE]; - Unclear speech; -Rarely/never understood. -Dependent on staff for care needs. During an observation on 10/21/2024 at 8:23 A.M., Licensed Practical Nurse (LPN) B entered the day room to assist the resident back in the chair. LPN B folded the resident's right arm, positioned it near the stomach, and used his/her left hand to grab the resident's right arm, then placed his/her right forearm under the resident's left arm, and lifted the resident. 5. Review of Resident #20's medical record, showed diagnoses included Alzheimer's disease, dementia, anxiety, and psychotic disorder. Review of the resident's fall risk evaluation, dated 8/14/24, showed the resident at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident the resident's annual MDS, dated [DATE], showed: -Resident rarely/never understood; -Independent with mobility of sitting to standing. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is high risk for falls related to confusion; unaware of safety needs; -Interventions included follow facility fall protocol; -No documentation regarding the resident's transfer status. Observation on 10/21/24 at 8:38 A.M., showed the resident seated at a table in the dining room. CNA I stood on one side of the resident and CNA D stood on the other side of the resident. CNA D wore a gait belt around his/her torso. The CNAs attempted to lift the resident by grasping the resident's biceps and lifting up. The resident swung his/her arms away. Both CNAs used one hand to grasp each of the resident's biceps and their other hand to grasp the waistband of the resident's pants, then lifted the resident by his/her arms and pants to a standing position. A gait belt was not positioned around the resident during the transfer. 6. Observation on 10/22/24 at 10:16 A.M., showed Resident #41 seated in the shower room. Certified Medication Technician (CMT) F and CNA H placed the gait belt around the resident, under the arms, and using the gait belt and the residents' shorts, assisted the resident to stand. CNA H said that the resident requires assistance of two staff with standing, and a mechanical lift for getting the residents in and out of the wheelchair and in the bed. During an interview on 10/24/24 at 9:11 A.M., CNA I said the resident can transfer on his/her own. If staff have to assist the resident during a transfer, it is because the resident is being stubborn. When staff assist the resident with transfers, they should use a gait belt. During an interview on 10/24/24 at 9:32 A.M., CNA G said the resident is able to sit and stand on his/her own. Sometimes the resident might need a boost. During an interview on 10/24/24 at 10:11 A.M., LPN A said generally, the resident is independent with transfers. Sometimes, he/she requires minimal assistance from staff. 7. During an interview on 10/24/24 at 9:32 A.M., CNA G said when staff assist the resident with transfers, a gait belt should be used. It would not be appropriate to lift a resident by their arms due to potential for injury. During an interview on 10/24/24 at 10:11 A.M., LPN A said when staff assist residents with transfers, they must use a gait belt. It is not appropriate to transfer residents by pulling the resident by their arms or clothing due to potential injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON and Assistant Administrator on 10/24/24 at 12:33 P.M., the ADON said any transfer assisted by staff requiring them to put hands on them, would require staff to use a gait belt. The gait belt should be around the resident's waist. 8. Review of Resident #21's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included dementia, dystonia(involuntary muscle contractions that cause repetitive or twisting movements) and chronic obstructive pulmonary disease (lung disease). Review of the resident's care plan, dated 9/30/24, showed: -Focus: The resident is at high risk for falls; -Goals: The resident will be free of falls through the review date. The resident's falls will be minimized/eliminated by the review date; -Interventions: Anticipate and meet the resident's needs. Ensure that the resident is wearing appropriate footwear (non-skid socks or shoes) when ambulating or mobilizing in wheelchair. Purposeful staff rounding. Staff will educate resident on fall prevention and give safety cues and reminders to ask for help when needed to prevent falls. Review of the resident's most recent fall risk assessment, dated 9/30/24, showed: -The resident had not had any falls in the past three months at the time of this assessment; -Score of five, which indicated the resident was not a high risk for falls. Review of the resident's progress notes on 10/21/24 at 9:21 A.M., showed: -The resident has had falls on the following dates: 5/16/24, 6/28/24, 7/2/24, 7/7/24, and 10/20/24. Observation on 10/21/24 at 7:18 A.M., showed the resident in the dining room at a table. The resident was leaning to the right side of his/her wheelchair. The resident was slouched down in his/her wheelchair. Observation on 10/21/24 at 11:19 A.M., showed the resident in his/her room sitting in his/her wheelchair. The resident was leaning over with his/her chest touching his/her legs. The resident's bedroom door was cracked. Observation on 10/22/24 at 10:38 A.M., showed the resident sitting in his/her wheelchair at the end of the 100 hallway. The resident was leaning over with his/her chest touching his/her legs. No staff were observed on the hallway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/24 at 9:55 A.M., CNA G said the resident has a history of falls. He/She would expect staff to be conducting frequent rounds on the resident to ensure the resident was safe. He/She would expect for staff to reposition the resident in his/her wheelchair if he/she is observed leaning. During an interview on 10/24/24 at 10:38 A.M., LPN A said the resident has a history of falling. Some of the resident's falls have been from the wheelchair. The resident normally leans to the right when in his/her wheelchair. He/She would expect for staff to reposition the resident in his/her wheelchair if the resident is observed to be leaning. He/She would expect staff to be performing frequent checks on the resident to ensure the resident is safe. During an interview on 10/24/24 at 12:33 P.M., the ADON said the resident has a history of falls. She said the resident normally leans to his/her right side when in his/her wheelchair. She would not always expect staff to reposition the resident due to the resident's leaning to be normal for the resident. She would expect for staff to conduct frequent rounds on the resident to ensure the resident was safe from falling. 46888 49992

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview, and record review the facility failed to ensure physician orders were followed for a resident with an order for continuous oxygen usage (Resident #44). In addition, the facility failed to ensure oxygen masks were properly stored while not in use and the facility had a process to ensure routine changing of the oxygen tubing for infection control purposes, for two sampled residents (Resident #44 and Resident #14). The sample was 12. The Census was 47. Review of the facility's Oxygen Administration policy, revised October 2010, showed: -The purpose of this procedure is to provide guidelines for safe oxygen administration; -Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration; -The policy failed to address storage of oxygen supplies to prevent contamination, or frequency and process to change out oxygen tubing. 1. Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/13/24, showed: -Cognitively intact; -Diagnoses included anxiety, asthma, and acute respiratory failure. Review of the resident's Physician Order Summary (POS), in use at the time of the survey, showed: -An order, dated 3/4/24, for continuous oxygen at 2 liters via nasal canula (device used to deliver oxygen with two small tubes that fit into the nostrils); -An order, dated 3/4/24, for Ipratropium-Albuterol Inhalation Solution (used to open lung airway) 0.5-2.5 milligram (MG)/3 milliliter (ML) 1 vial inhale orally every 4 hours as needed for shortness of breath. Review of the resident's care plan, dated 9/30/24, showed: -Focus: the resident has oxygen therapy; -Goal: The resident will have no symptoms of poor oxygen absorption through the review date; -Interventions: give medication as ordered by the physician. Monitor and document side effects and effectiveness. Oxygen setting: oxygen via nasal canula at two liters continuous. During an interview on 10/20/24 at 8:04 A.M., the resident said he/she uses oxygen whenever he/she feels like he/she needs it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/20/24 at 8:04 A.M., 10/21/24 at 9:50 A.M., 10/22/24 at 9:23 A.M., and 10/23/24 at 9:17 A. M., showed the resident in his/her bed awake. The resident's concentrator on and set to two liters. The resident did not wear his/her oxygen per nasal canula. During an interview on 10/24/24 at 9:57 A.M., Certified Nursing Assistant (CNA) G said the resident is on continuous oxygen. The resident does not always wear his/her nasal canula and has a behavior of taking it off. He/She would expect frequent monitoring of the resident to ensure the resident has his/her nasal canula on. During an interview on 10/24/24 at 10:40 A.M., Licensed Practical Nurse (LPN) A said the resident has an order for continuous oxygen. The resident frequently removes his/her nasal canula. He/She would expect the resident's frequent removal of oxygen to be on his/her care plan. He/She would expect staff to perform frequent rounds on the resident to ensure he/she has his/her nasal canula on. During an interview on 10/24/24 at 12:39 P.M., the Assistant Director of Nursing (ADON) said the resident has an order for continuous oxygen. She would expect for staff to ensure the resident has his/her nasal canula on. She would expect the resident to be care planned for his/her removal of his/her nasal canula. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included wheezing, shortness of breath, and dementia. Review of the resident's POS, in use at the time of the survey, showed: -An order, dated 8/22/23, for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG/3ML 1 vial, inhale orally three times a day related to wheezing. Review of the resident's care plan, in use at the time of the survey, showed the care plan did not include the resident's nebulizer (machine used for breathing treatments) use. Observation on 10/20/24 at 9:32 A.M., 10/21/24 at 11:12 A.M., 10/22/24 at 2:55 P.M., and 10/24/24 at 9:27 A. M., showed an oxygen concentrator and nebulizer in the resident's room. Tubing connected to the nebulizer. The nebulizer mask sat on the side table next to the nebulizer, uncovered. During an interview on 10/24/24 at 9:57 A.M., CNA G said the resident is currently receiving nebulizer treatments. He/She would expect for the resident's nebulizer mask to be stored in a plastic bag when not in use. During an interview on 10/24/24 at 10:40 A.M., LPN A said the resident is currently receiving nebulizer treatments three times a day. He/She would expect the resident's nebulizer mask to be stored in a plastic bag when not in use. During an interview on 10/24/24 at 12:39 P.M., the ADON said the resident receives nebulizer treatments. She would expect for the resident's nebulizer mask to be properly stored when not in use.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42795 Based on interview and record review, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. The census was 47. Review of the facility's Staffing policy, revised, April, 2007, showed: -The facility provides adequate staffing to meet needed care and services of the resident population; -The facility maintains adequate staffing on each shift to ensure that the residents' needs and services are met; -Licensed RN and licensed nursing staff are available to provide and monitor the delivery of resident care services. Review of the facility's staffing sheets dated 10/1 through 10/21/24 showed no RN coverage for: 10/1, 10/2, 10/3, 10/4, 10/6, 10/8, 10/10, 10/11, 10/13, 10/14, and 10/19/24. During an interview on 10/23/24 at 9:05 A.M., the Assistant Director of Nursing (ADON) said she was aware that an RN is required eight hours a day, seven days a week. She is responsible for staffing. It was difficult to get RNs to work. She puts the request for an RN on the agency website, and no one picks up the shift. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administer said he would expect staffing to be covered with an RN eight hours a day, seven days a week.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 42795 Based on interview and record review, the facility failed to ensure Nursing Assistants (NAs) that were employed by the facility were certified within 4 months of hire for five out of five NA's, who worked in the facility for more than 4 months. The census was 47. Review of the Facility Assessment, reviewed 7/21/23, showed: -Staff training and education that are necessary to provide level and types of support and care needed for the resident population included certification and licensure requirements, yearly in-services, and additional education provided when needs are trends are identified. Record review the hire dates for of all NAs, reviewed on 10/23/24, showed: -The facility hired NA R on 5/5/21; -The facility hired NA J on 8/2/23; -The facility hired NA S on 4/3/24; -The facility hired NA C on 4/26/24; -The facility hired NA T on 5/20/24; -The five NAs were not certified within the required 4 month period. During an interview on 10/21/24 at 8:07 and 8:55 A.M., NA C said he/she has worked at the facility since April, 2024 and was waiting to test out. He/She has completed the training online but was waiting for the Assistant Director of Nursing (ADON) to sign off on the completion of his/her training so that he/she could take the test. During an interview on 10/23/24 at 12:17 P.M., NA J said he/she is waiting for the ADON to send the link that approves for him/her to re-take the test. During an interview on 10/23/24 at 9:05 A.M., the ADON said all of the NA's are enrolled in the 16 hour online course. The NA are responsible to complete the program and the test. Some of the NAs have failed their test and need to take the course over. The NAs are responsible for the completion of the course and test taking. The ADON said she cannot see the progress of the NAs online training and is not aware of signing off on anything. Some of the NAs are finding it challenging to find a testing site and there usually is a long period of time between finishing the course and taking the test.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42795 Based on interview and record review, the facility failed to establish a system of record for all controlled drugs with sufficient detail to enable an accurate reconciliation for two out of three medication carts reviewed. This had the potential to affect all residents with controlled substance orders. The census was 47. Review of the facility's Controlled Substances policy, revised December, 2012, showed: -The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II (a drug classification) narcotics and other controlled substances; -Nursing staff must count controlled medications at the end of each shift; The nurse coming on duty and the nurse going off duty must make the count together. Review of the Narcotic Count Sheets dated 10/1 through 10/19/24 on the 400 and 500 medication cart showed: -22 out of 57 shifts had no nurse initial on the shift change count; -28 out of 57 shifts only had one nurse initial on the shift change count. Review of the Narcotic Count Sheets dated 10/1 through 10/19/24 on the 100, 300, and 600 medication cart showed: -23 out of 57 shifts had no nurse initial on the shift change count; -28 out of 57 shifts only had one nurse initial on the shift change count. During an interview on 10/20/24 at 9:05 A.M., Certified Medicine Technician (CMT) F said he/ she is the main nursing staff member that signs the narcotic sheets. There should be two nursing staff members when counting narcotics, one off going staff member and one oncoming staff member, every shift, every day. He/She will count with another nursing staff member, but he/she cannot make someone sign the narcotic count when they have completed counting. During an interview on 10/20/24 at 9:10 A.M., Licensed Practical Nurse (LPN) A said there should be two staff members signing the narcotic book and completing the count, one off going and one oncoming staff member. This should be done every shift, every day. During an interview on 10/23/24 at 9:05 A.M., the Assistant Director of Nursing (ADON) said she expected the narcotics to be counted and documented by two different staff members, every shift, every day.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications when one resident (Resident #19) was prescribed Haldol (haloperidol, antipsychotic medication) without appropriate documentation in the resident's medical record to support the clinical need for the medication. The facility failed to appropriately monitor for adverse consequences and medication effectiveness when the resident had an increase in falls after the adjustment to his/her psychotropic medications, and no improvement with his/her psychiatric symptoms. The sample was 12. The census was 47. Review of the facility's Antipsychotic Medication Use policy, revised [DATE], showed: -Policy Statement: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed; -Policy Interpretation and Implementation: -Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; -The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; -The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications; -Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: -The behavioral symptoms present a danger to the resident or others; AND: -The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia, or grandiosity); or -Behavioral interventions have been attempted and included in the plan of care, except in an emergency; -Antipsychotic medications will not be used if the only symptoms are one or more of the following: -Wandering; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Poor self-care; -Restlessness; -Impaired memory; -Mild anxiety; -Insomnia; -Inattention or indifference to surroundings; -Sadness or crying alone that is not related to depression or other psychiatric disorders; -Fidgeting; -Nervousness; or -Uncooperativeness; -The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications Review of Resident #19's medical record, showed diagnoses included major depressive disorder (MDD) and anxiety disorder due to known physiological condition. Review of the resident's hospital transfer orders to the receiving facility, dated [DATE], showed: -Hospital stay [DATE] through [DATE]; -Discharge diagnoses: Dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) and suicidal ideation. Review of the resident's medical record, from [DATE] through [DATE], showed: -A progress note, dated [DATE], in which staff documented the resident fell while walking; -No documentation of other falls; -No documentation of behaviors exhibited; -No documentation of increased symptoms related to depression, anxiety, or other psychiatric or neurological conditions. Review of the resident's physician order summary (POS) as of [DATE], showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated [DATE], for Ativan (a benzodiazepine medication used to treat anxiety) 1 milligram (mg), one tablet by mouth (PO) three times daily (TID) related to anxiety; -An order, dated [DATE], for donepezil (brand name Aricept, a medication used to treat dementia) 10 mg, one tablet PO at bedtime related to dementia; -An order, dated [DATE], for Lamictal (an anticonvulsant medication used to treat seizures and mood disorders) oral tablet 100 mg, one tablet PO twice daily (BID) related to MDD. Review of the resident's psychiatric visit progress note, dated [DATE], showed: -Chief complaint: Agitated, anxious; -Appetite, sleep, and energy: Normal/unchanged; -Aggression: No; -Medication side effects: None; -Examination: Appearance within normal limits. Gait: Unsteady. Level of consciousness: Alert; -Mental status: Oriented to person. Manner: Irritable. Activity: Agitated. Poor fund of knowledge. Mood: Anxious. Affect: Angry. Disorganized thought process. Thought contents: Hopelessness, confused. Normal perception. Poor attention/concentration. Impaired and limited cognition and short term memory; -Medical history: Unchanged from history documented in initial psychiatric evaluation and subsequent notes; -Medications: Lamictal 100 mg, Ativan 1 mg TID, Aricept 10 mg at night; -Assessment: Worsening: -Diagnoses: MDD, anxiety; -Treatment recommendation/follow up: -Increase Lamictal to 150 mg for one week, then go to 150 mg BID; -Decrease Ativan to 0.5 mg TID; -Add Haldol 0.25 mg BID. Review of the National Institute of Health, National Library of Medicine document on haloperidol, updated [DATE], showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Older patients: haloperidol is classified as a high-risk medication according to the American Geriatrics Society Beers Criteria, underscoring the importance of using the lowest effective dose for the shortest feasible duration; -Common adverse effects include sedation; -Contraindications: -As numerous drugs, including barbiturates, benzodiazepines, and opioids can induce central nervous system depression, the concurrent use if haloperidol should be either avoided or approached with extreme caution; -Box Warning: Older patients with dementia-related psychosis have an elevated mortality risk of approximately 1.6 to 1.7 times higher than other patients; -Warnings and Precautions: Haloperidol should not be used as a chemical restraint to address patient behavior or restrict patient mobility, as it is not a conventional or accepted treatment. This approach should be reserved for situations where the need to address potential violence is crucial to ensure the safety of both staff and patients; -Falls: Antipsychotics, including haloperidol, have been associated with somnolence (excess sleepiness), motor instability, and orthostatic hypotension (sudden drop in blood pressure when standing from a seated position), all of which can contribute to falls, fractures, and other fall-related injuries. For older adults with conditions or medications that could exacerbate these effects, the risk of falls must be assessed at the initiation of antipsychotic treatment and throughout the treatment duration. Review of the MedlinePlus document on haloperidol, revised [DATE], showed: -Important warning: Studies have shown that older adults with dementia who take antipsychotics such as haloperidol have an increased chance of death during treatment; -Haloperidol is not approved by the FDA for the treatment of behavior problems in older adults with dementia; -What side effects can this medication cause, included: -Unusual, slowed, or uncontrollable movements of any part of the body; -Restlessness; -Agitation; -Nervousness; -Mood changes; -Dizziness, feeling unsteady, or having trouble keeping balance. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes from [DATE] through [DATE], showed: -On [DATE], the resident fell ; -On [DATE], the resident fell . Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Severe cognitive impairment; -Delusions exhibited; -Verbal behavioral symptoms and other behavioral symptoms occurred one to three days; -No falls since last assessment; -The MDS did not include the resident's diagnosis of dementia. Review of the resident's progress notes from [DATE] through [DATE], showed: -On [DATE], the resident refused a shower and became combative with staff; -On [DATE], the resident fell ; -On [DATE], the resident fell ; -On [DATE], the resident fell and was admitted to the hospital from [DATE] through [DATE] for a fractured femur (the large bone of the upper leg); -On [DATE], the resident returned to the facility from the hospital. The resident stated he/she was dying and was uncooperative during an exam; -On [DATE], the resident confused, repeating the words, My mom and dad are dead, you want me to die. -On [DATE], the resident refused a shower; -On [DATE], the resident continues to fixate on scenarios concerning death and/or requesting his/her parents. Review of the resident's medical record, showed no documentation of follow-up visits with the psychiatrist after [DATE]. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has impaired cognitive function/dementia or impaired thought process related to dementia; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: -Monitor/document/report as needed (PRN) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status; -Review medications and record possible causes of cognitive deficit: new medications or dosage increases, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity; -Focus: The resident has a mood problem related to dementia; -Interventions included: -Administer mediations as ordered. Monitor/document for side effects and effectiveness; -Monitor/record/report to physician PRN acute episodes, feelings, or sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits, change in sleep patterns, diminished ability to concentrate, change in psychomotor skills; -Monitor/record/report to physician PRN mood patterns, signs/symptoms of depression, anxiety, sad mood; -Focus: The resident has depression related to current health status: -Interventions included: -Monitor/document/report PRN any signs/symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness; -Monitor/record/report to physician PRN risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons; -No documentation related to the resident expressing thoughts or anxiety related to dying or death. Observation on [DATE] at 9:28 A.M., showed the resident on his/her side in bed. During an attempted interview, the resident confused and repeatedly said he/she was dying. He/She said someone was trying to take his/her dress and repeatedly said he/she did not want to die. Observation on [DATE] at 8:37 A.M., showed the resident propelled into the dining room in his/her wheelchair. The resident said he/she was scared and someone died . He/She repeatedly said he/she was scared. During an interview, Certified Nurse Aide (CNA) I and Nurse Aide (NA) C said this is what the resident says all the time. Observation on [DATE] at 9:27 A.M., showed the resident propelled down the hallway talking to him/herself, saying he/she was dying. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 12:23 P.M., showed the resident seated at a table in the dining room. He/She talked to him/herself and his/her tablemate, repeatedly saying he/she was dying. During an interview on [DATE] at 9:11 A.M., CNA I said the resident is very confused and obsessed with dying. He/She chants, Help me die, help me die, and says he/she is dying or his/her parent is dying. The resident has been doing this since CNA I began working with the resident in February 2024. Nothing helps the resident stop focusing on dying. The resident used to walk and enjoyed walking with other residents and helping them out. A few months ago, the resident changed and started falling all the time. He/She started taking naps and that is no like the resident. During an interview on [DATE] at 9:32 A.M., CNA G said the resident is totally confused. He/She constantly talks about dying, wanting to die to be with his/her parents, and asking to help him/her die. The resident has been this way since he/she came to the facility several years ago. The resident walked with a limp for years. A few months ago, he/she started falling more often and recently broke his/her hip. Recently, the resident has not been out of bed as much, maybe due to his/her hip, but he/she used to be up more. During an interview on [DATE] at 9:52 A.M., the Social Services Director said the resident perseverates on death. When the SSD started working with the facility three years ago, the resident did not talk about death as much, but this has progressively increased. The resident used to walk and was up for most of the day. A month or so ago, he/she fell and broke his/her hip and now he/she is in a wheelchair. The SSD is unsure what medications the resident is taking. A psychiatrist comes to the facility to see residents and they meet with and give their reports to nursing. During an interview on [DATE] at 10:11 A.M., Licensed Practical Nurse (LPN) A said the resident is alert and oriented to self. He/She is frequently anxious and talks about dying a lot. His/Her talk about dying has increased since his/her overall decline and progression of dementia. He/She was recently prescribed Haldol to try to help with these behaviors. The facility does not do behavior charting. The resident did have behaviors before being prescribed Haldol and the behaviors should have been charted by nurses. The psychiatrist has not been to the facility in a while. When the psychiatrist visits, he/she meets with the Assistant Director of Nurses (ADON). During an interview on [DATE] at 11:33 A.M., the ADON said the resident is alert and oriented to self. He/She is confused and talks about him/her dying, people dying, and wanting to die. The resident has always been this way, since admission. The psychiatrist prescribed the resident Haldol because the resident was yelling and due to his/her expression of dying. These behaviors should have been charted. The facility does not use behavior charting, but they should. The resident's ongoing behaviors should be on his/her care plan. The resident still exhibits behavior of talking about dying, even on the Haldol. The psychiatrist has not seen the resident since [DATE]. The resident had an increase in falls, starting in [DATE]. The ADON can understand how it would seem Haldol may have contributed to the increase in falls, based on the documentation in the resident's record. She will contact the psychiatrist to make an appointment for the resident to be seen.

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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. 42795 Based on observation, interview and record review, the facility failed to have a system in place to ensure drugs and biologicals stored in the medication room refrigerator were being stored at a proper temperature for one out of one medication rooms observed. The medication room refrigerator also had food and nutritional supplements stored with the medications. The census was 47. Review of the facility's Storage of Medications policy, revised, April, 2007, showed: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; -The nursing staff shall be responsible for maintaining medication storage and preparation area in a clean, safe, and sanitary manner; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secure location; -Medication must be stored separately from food and must be labeled accordingly. During an interview and observation on 10/20/24 at 9:05 A.M., the medication room had a small refrigerator that contained a thermometer hanging on the inside of the door, two boxes of insulin vials (treats diabetes), one box of tuberculin testing serum, a locked container that contained a box of Ativan (medication used to treat anxiety), several cartons of Nepro (a nutritional supplement), several cartons of Boost (a nutritional supplement), one carton of Med Pass (a nutritional supplement) and an undated, clear plastic bowl of applesauce covered with clear plastic wrap. Certified Medication Technician (CMT) F said he/she was not aware of any system in place or temperature log for the medication refrigerator. He/She was not aware food items for residents were not to be stored with the medications because it was always stored that way. During an interview on 10/20/24 at 9:10 A.M., Licensed Practical Nurse (LPN) A said there was no refrigerator log and he/he was not sure who was responsible to check the refrigerator. During an interview on 10/24/24 at 12:31 P.M., the Assistant Administrator and The Assistant Director of Nursing (ADON) said they did not have a system in place to check the refrigerator temperature in the medication room. They were not aware that medications should not be stored with food items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40290 46888 Based on observation, interview, and record review, the facility failed to ensure facility staff performed appropriate hand hygiene during meal service which effected 15 residents (Residents #21, #36, #11, #39, #20, #1, #13, #14, #35, #37, #9, #43, #19, #41, and #17). The sample was 12. The census was 79. Review of the facility's handwashing/hand hygiene policy, dated August 2015, Showed: -Policy statement: this facility considers hand hygiene the primary means to prevent the spread of infections; -Policy implementation: all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; -Use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap and water for the following situations: before and after direct contact with residents, before and after eating or handling food, before and after assisting a resident with meals. 1. Review of Resident #21's medical record, showed diagnoses included dementia, dystonia (involuntary muscle contractions that cause repetitive or twisting movements), and chronic obstructive pulmonary disease (COPD, lung disease). 2. Review of Resident #36's medical record showed diagnoses included Alzheimer's disease and depression. 3. Review of Resident #11's medical record showed diagnoses included acute respiratory failure. 4. Review of Resident #39's medical record showed diagnoses included diabetes and major depressive disorder. 5. Review of Resident #20's medical record showed diagnoses included Alzheimer's disease and anxiety. 6. Review of Resident #1's medical record showed diagnoses included dementia, anxiety, and major depressive disorder. 7. Review of Resident #13's medical record showed diagnoses included diabetes and dementia. 8. Review of Resident #14's medical record showed diagnoses included wheezing, shortness of breath, and dementia. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of Resident #35's medical record showed diagnoses included diabetes and major depressive disorder. 10. Review of Resident #37's medical record showed diagnoses included Alzheimer's disease and dementia. 11. Review of Resident #9's medical record showed diagnoses included dementia and paranoid schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). 12. Review of Resident #43's medical record showed diagnosis of Parkinson's disease (brain disorder causing unintended or uncontrolled movements). 13. Review of Resident #19's medical record showed diagnoses included major depressive disorder and anxiety. 14. Review of Resident #41's medical record showed diagnoses included dementia and major depressive disorder. 15. Review of Resident #17's medical record showed diagnoses included Alzheimer's disease and anxiety. 16. Observation on 10/21/24, of breakfast in the main dining room, showed: -At 7:32 A.M., Licensed Practical Nurse (LPN) B and Nurse Aide (NA) C repositioned Resident #21 in his/her chair by holding onto the resident's arms and pants. No hand hygiene performed; -At 7:33 A.M., NA C walked up to Resident #36 and assists the resident with his/her clothing protector; -At 7:35 A.M., NA C walked up to Resident #21, took the resident's cup from his/her hand, and placed it on the table. NA C grabbed onto the resident's wheelchair handle for support as he/she stood near the resident; -At 7:37 A.M., NA C walked to Resident #21 and grabbed the resident's silverware, unraveling it from the napkin. He/She then started to cut the resident's food; -At 7:38 A.M., NA C grabbed Resident #21's clothing protector and put it on him/her. He/She grabbed the resident's wheelchair handle as he/she started to walk away; -At 7:39 A.M., NA C grabbed Resident #11's silverware and started to cut up the residents food; -At 7:39 A.M., NA C walked up behind Resident #21's wheelchair and positioned the resident's wheelchair closer to the table; -At 7:40 A.M., NA C grabbed Resident #21's drink from the table and assists the resident with a drink; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 7:42 A.M., NA C placed his/her hand on Resident #39's shoulder as he/she walked past the resident; -At 7:43 A.M., NA C grabbed Resident #20's spoon and gave the resident a bite of food; -At 7:44 A.M., NA C picked up Resident #1's silverware and started to cut the resident's food. NA C then went to Resident #20 and picked up his/her spoon and fed him/her a bite of food; -At 7:45 A.M., NA C grabbed Resident #13's wheelchair and propelled the resident to his/her spot at the table. NA C rubbed the resident's back as he/she walked away; -At 7:45 A.M., NA C grabbed and chair and pulled it up to the table next to Resident #14. He/She picked up the resident's drink to assist him/her with a drink; -At 8:12 A.M., NA C reached down and unlocked Resident #14's wheelchair with his/her hands, stood up, and propelled the resident out of the dining room door and walked back into the dining room; -At 8:17 A.M., NA C stood next to Resident #35. He/She picked up the resident's silverware and picked up the resident's piece of toast with his/her hand and spread jam on the toast. He/She then patted the resident's shoulder; -At 8:18 A.M., NA C walked back over to Resident #1 and placed his/her hand on the resident's wheelchair handle as he/she spoke to the resident; -At 8:20 A.M., NA C walked over to Resident #37 and gave the resident a hug; -At 8:23 A.M., NA C stood next to Resident #9 and grabbed the resident's wheelchair handle as he/she reached over the resident to grab the resident's drink; -At 8:23 A.M., NA C walked over to Resident #43 and picked up his/her silverware to assist the resident with cutting his/her food; -At 8:25 A.M., NA C walked over to Resident #9 and sat down next to him/her. He/She picked up the resident's drink and assisted the resident with a drink; -At 8:28 A.M., NA C stood up and propelled Resident #9 in his/her wheelchair out of the dining room; -At 8:29 A.M., NA C propelled Resident #9 into the sitting room, reached down, and locked the resident's wheelchair with his/her hands, then walked back into the dining room; -At 8:31 A.M., NA C placed his/her hands on the handles of Resident #1's wheelchair as he/she spoke with another staff member; -At 8:32 A.M., NA C grabbed Resident #20's spoon to give the resident a bite of food; -At 8:37 A.M., NA C wiped his/her nose with his/her hand; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:38 A.M., NA C grabbed Resident #19's silverware off the table and cuts up the resident's food; -At 8:41 A.M., NA C patted Resident #19's shoulder; -At 8:41 A.M., NA C walked over to Resident #21 and unlocked the resident's wheelchair with his/her hands; -At 8:43 A.M., NA C held onto Resident #21's wheelchair handle as he/she spoke with the resident. He/She rubbed the resident's shoulder and then rubbed his/her eye with his/her right hand; -At 8:45 A.M., NA C stood next to Resident #19 and fed the resident. He/she itched his/her head with his/her right hand; -At 8:52 A.M., NA C grabbed Resident #41's wheelchair handles and pushed the resident out of the dining room; -At no time during the observation did NA C complete hand hygiene. 17. Observation on 10/21/24, of lunch in the dining room, showed: -At 12:37 P.M., Certified Nursing Assistant (CNA) D propelled Resident #17, in his/her wheelchair to a spot at the table, and put a clothing protector on the resident; -At 12:38 P.M., CNA D walked over to Resident #19 and assisted the resident with his/her clothing protector; -At 12:39 P.M., CNA D walked over to Resident #21 and assisted the resident with his/her clothing protector; -At 12:40 P.M., CNA D grabbed Resident #21's coffee cup and gave it to the resident. He/She then grabbed the resident's silverware and placed it in front of the resident; -At 1:03 P.M., NA E sat in a chair next to Resident #1 to assist the resident with eating. At 1:04 P.M., NA E held his/her phone in both hands texting. He/She then put down his/her phone, picked up a grape from the resident's plate with his/her right hand, and then fed the grape to the resident. At 1:06 P.M., NA E grabbed a grape from the resident's plate with his/her right hand and fed it to the resident. At 1:07 P.M., NA E grabbed a grape from the resident's plate with her right hand and fed it to the resident. At 1:09 P.M., NA E grabbed a grape from the resident's plate with her right hand and fed it to the resident; -During the observation, neither CNA D nor NA E completed hand hygiene. 18. During an interview on 10/24/24 at 8:25 A.M., CNA G said staff should wash their hands before going into the dining room and after touching each plate. Staff should also wash their hands anytime they touch anything. He/She would expect staff to follow the hand washing policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. During an interview on 10/24/24 at 8:28 A.M., Certified Medication Technician (CMT) F said staff are expected to wash their hands or use hand sanitizer before coming into the dining room, before passing each plate, and every time they touch something. Hand hygiene is important to prevent cross contamination of germs. He/She would expect staff to be following the hand washing policy. 20. During an interview on 10/24/24 at 8:58 A.M., LPN A said staff are expected to wash their hands before they enter the dining room, after passing three plates, after feeding a resident, or if they touch something. Hand washing is important to prevent the spread of germs and contamination. He/She would expect staff to follow the hand washing policy. 21. During an interview on 10/24/24 at 12:37 P.M., the Assistant Director of Nursing (ADON) and Administrator said they would expect all staff to follow the hand hygiene policy and procedures. They would expect staff to wash or sanitize their hands before coming into the dining room, after each tray passed, and whenever they touch something.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42795 Based on interview and record review the facility failed to electronically submit to the Center of Medicaid and Medicare Services (CMS) complete and accurate direct care staffing information no less frequently than quarterly, for three quarters proceeding the annual survey. The census was 47. Review of the fiscal years Payroll Based Journal (PBJ) staffing report, showed the facility triggered for failing to submit data for: -Fiscal year quarter 1, 2024 (October 1 to December 31); -Fiscal year quarter 2, 2024 (January 1 to March 31); -Fiscal year quarter 3, 2024 (April 1 through June 30). During an interview on 10/24/24 at 12:31 P.M. the Assistant Administrator said it was his responsibility to submit the PBJ report to CMS. He was aware that the report needed to be sent and had not done so.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 Based on observation, interview and record review, the facility failed to ensure staff used good infection control practices for one resident when providing wound care (Residents #38). The facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs can spread that requires gown and glove use during high contact resident care activities for certain residents) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with urinary catheters (a tube that drains the bladder) and wounds requiring treatments (Residents #38 and #31). In addition, the facility failed to provide tuberculosis (TB) testing for five residents out of five residents reviewed for TB testing (Resident #38, #11, #12, #14, and #22). The sample was 12. The census was 47. An EBP policy was requested but not provided by the facility. Review of the facility's Wound Care policy, revised October, 2010, showed: -The purpose of this procedure is to provide guidelines for the care of wounds to promote healing; -Steps in the procedure: -Use disposable cloth (paper towel is adequate) to establish a clean field on resident's overbed table; -Place all items to be used during your procedure on the clean field; -Arrange the supplies so they can be easily reached; -Wash and dry hands thoroughly; -Position the resident and place disposable cloth next to the resident under the wound to serve as a barrier to protect the bed linens and other body sites; -Put on exam glove, loosen tape and remove the dressing; -Pull glove over dressing and discard into appropriate receptacle; -Wash and dry hands thoroughly; -Put on gloves: -Gowns will only be necessary if soiling of your skin or cloth with blood, urine, feces, or other body fluids is likely; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Masks and eyewear will only be necessary if splashing of blood or other body fluids into the eyes; -Use no touch technique by using sterile tongue blades and applicators to remove ointments and creams form their containers; -Pour liquids solutions directly on gauze sponges on their papers; -Wear exam gloves for holding gauze to catching irrigation solutions that are pored directly over the wound; -Wash tissue around the wound that is usually covered by the dressing, tape, or gauze with antiseptic or soap and water; -Apply treatments as indicated; -Dress the wound and mark with initials, time and date and apply to the dressing. 1. Review of Resident #38's medical record showed: -Diagnosis that included adult failure to thrive, pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body), diabetes, and stroke; -No care plan; -An order, dated 5/29/24, to cleanse coccyx (tailbone) wound with wound cleaner, pack with saline moistened Kerlix (a type of gauze dressing), cover with ABD pad (a large thick dressing) and secure. Change daily and as needed (PRN); -An order dated, 6/30/24, provide urinary catheter care every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/21/24 at 9:40 A.M., showed no EBP signage on the resident's door. The resident lay in bed, soiled with stool. Certified Nursing Assistant (CNA) G and Nursing Assistant (NA) J wore gloves and provided perineal care (care to the surface area between the thighs, extending from the pubic bone to tail bone) by turning the resident from side to side. Neither staff wore a gown. The resident had a urinary catheter that drained yellow urine. Licensed Practical Nurse (LPN) B entered the resident's room and said he/she was going to provide wound care. LPN B left the room and stood at the treatment cart. LPN B used hand sanitizer and began opening drawers on the treatment cart. LPN B placed sheet of parchment paper on top of the treatment cart. LPN B opened one drawer and removed an unpackaged Kerlix dressing that lay directly inside drawer, with his/her ungloved hands and placed it on the parchment paper. LPN B then opened another drawer and removed unpackaged 4x4 gauze with his/her ungloved hands and placed the 4x4 gauze on the parchment paper located on top of the treatment cart. LPN B then removed a pair of blue handled scissors from the top drawer of the treatment cart and began cutting the Kerlix dressing. LPN B did not clean the scissors prior to cutting the Kerlix dressing. LPN B removed the dressings with the parchment paper with ungloved hands and a box of gloves and entered the resident's room and placed the box of gloves and parchment paper with the dressings on the resident's bed. LPN B did not wear a gown. LPN B used hand sanitizer then applied gloves and removed the resident's coccyx dressing that was dated 10/20/24. LPN removed gloves and used hand sanitizer and applied clean gloves. LPN B cleansed the resident's coccyx wound with the 4x4's that were located on the parchment paper on the resident's bed. LPN B then removed the Kerlix dressing from the parchment paper and applied normal saline to the Kerlix and then packed the Kerlix into the resident's coccyx wound. LPN B removed his/her gloves and used hand sanitizer. LPN B then applied clean gloves and placed an ABD pad on top of the coccyx wound and secured with tape. LPN B did not label or date the resident's coccyx dressing. LPN B removed his/her gloves and left the room. CNA G and NA J finished getting the resident dressed and placed a Hoyer pad (a specialized transfer pad used for mechanical lifts) under the resident by turning him/her side to side. The resident was then transferred by CNA G and NA J with the use of a Hoyer lift and placed in a Broda chair (specialized reclining chair). CNA G, NA J, and LPN B did not wear a isolation gown while providing care. 2. Review of Resident #31's medical record, showed: -Diagnoses included stroke, bullous pemphigoid (an autoimmune skin disorder that causes blisters on the skin), local infection of the skin and subcutaneous tissue, and urinary tract infection; -A physician order, dated 5/29/24, for urinary catheter 16 French (size) with 10 milliliter (ml) balloon, for wound healing. Review of the resident's skin assessment, dated 10/18/24, showed: -Bullous pemphigoid wound to left lateral (to the side of) knee with serosanguineous (thin, watery, pale, red/pink drainage) exudate (drainage); -Bullous pemphigoid wound to left anterior (in front of) thigh with serosanguineous exudate; -Bullous pemphigoid wound to left medial (toward the middle or center) thigh with serosanguineous exudate; -Bullous pemphigoid wound to right upper extremity anterior with serosanguineous exudate; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (dead tissue). May also present as an intact or open/ruptured blister) to left buttock with sanguineous (bloody) exudate; -Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed) pressure ulcer to sacrum (triangular bone at the base of the spine). Review of the resident's care plan, in use at the time of survey, showed no documentation regarding the use of EBP. Observation on 10/20/24 at 9:24 A.M., showed no signage regarding EBP outside of the resident's room. The resident in bed with his/her catheter bag hung from the foot of the bed, and rested on the floor. Observation on 10/21/24 at 8:53 A.M., showed no signage regarding EBP outside of the resident's room. The resident seated upright in bed while CNA D fed him/her breakfast. CNA D did not wear a gown or gloves while providing feeding assistance. Observation on 10/22/24 at 10:20 A.M., showed no signage regarding EBP outside of the resident's room. The resident on his/her back in bed while NA K provided a bed bath. NA K wore gloves and no gown while providing bathing assistance. Observation on 10/23/24 at 10:39 A.M., showed no signage regarding EBP outside of the resident's room During an interview on 10/23/24 at 11:36 A.M., CNA G said he/she was not aware of EBP and never heard of it. 3. During an interview on 10/23/24 at 11:44 A.M., LPN A said he/she was not aware of EBP and it is not currently in place. The nurse should wash their hands and apply clean gloves prior to touching the sterile dressings. Scissors that are used off the treatment cart should be cleaned prior to cutting any dressing because staff would not know it the person before you cleaned them. The dressings should be labeled with the nurses' initials and dated. 4. During an interview on 10/23/24 at 12:15 P.M., Certified Medicine Technician (CMT) F said he/she was not aware of EBP and has not been in-serviced on it. 5. During an interview on 10/24/24 at 11:24 A.M., the Assistant Director of Nursing (ADON) said she was aware of the EBP precautions requirement but has not implemented it in the facility yet. Staff have not been in-serviced and Resident #38 and #31 would be residents that would require EBP due to their wounds and urinary catheters. She would expect staff to wash their hands and apply gloves prior to touching clean dressings. She would expect staff to clean scissors with a bleach wipe prior to cutting a dressing. She would expect staff to label the dressing with their initial and with the date completed. 6. Review of the facility's TB policy, revised July, 2013, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility shall screen all resident for TB infection and disease; -Individuals identified with active TB disease shall be isolated form other residents and ancillary staff, and transported to an appropriate care facility; -Screening new admissions or re-admissions: -The facility will screen referrals for admission or readmission for information regarding exposure to, or symptoms of TB and will check recent result (within 12 months) tuberculin skin test (TST), blood assay for Mycobacterium tuberculosis (organism that cause TB) (BAMT), or chest x-ray (CXR); -Any resident with documented negative TST, BAMT, or CXR with the previous 12 months will receive a baseline (two step) TST or (one step) BAMT on admission; -If the first step is negative a follow up TST will be administered one to three weeks after the initial test is read; -Asymptomatic (without symptoms) resident who have a known positive skin test or past history of TB, and have not had a CXR in the past six months, will receive a CXR before, or soon after admission; -The physician will screen each new admission for possible signs and symptoms of TB, including coughing, loss of appetite, fatigue, weight loss, night sweats, bloody sputum, hoarseness, fever, or chest pain. 7. Review of Resident #38's medical record showed: -An admitted [DATE]; -Diagnosis that included adult failure to thrive, pressure wound, diabetes, and stroke. -No documentation that resident was screened for TB or received a TST. 8. Review of Resident #11's medical record showed: -An admitted [DATE]; -Diagnosis that included sepsis (a systematic infection that affects the entire body) and acute (short duration) respiratory failure; -No documentation that resident was screened for TB or received a TST. 9. Review of Resident #12's medical record showed: -An admitted [DATE]; -Diagnosis that included, stroke, COVID-19, diabetes, and heart failure; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation that resident was screened for TB or received a TST. 10. Review of Resident #14's medical record showed: -A admitted [DATE]; -Diagnosis that included diabetes, urinary tract infections (UTI), sepsis, yeast infection and heart failure; -No documentation that resident was screened for TB or received a TST. 11. Review of Resident #22's medical record showed: -An admitted [DATE]; -Diagnosis that included sepsis, long term use of antibiotics, enterocolitis (inflammation of the colon), cystitis (inflammation of the urinary bladder), and diabetes; -No documentation that resident was screened for TB or received a TST. 12. During an interview on 10/23/24 at 9:05 A.M., the ADON said she is expected to ensure that the resident TB screening and TST is completed. The residents are to receive a two-step TST on admission and then a one-step TST once yearly. If the resident has a history of TB or a previous positive result, then a CXR is obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265732	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on interview and record review the facility failed to offer and vaccinate as desired, eligible residents for the pneumococcal (pneumonia) vaccine for 4 out of 5 residents sampled for immunizations (Resident #12, #11, #38, #22). The census was 47. Review of the facility's Pneumococcal Vaccine policy, revised August, 2016, showed; -All residents will be offered pneumococcal vaccines to aid in preventing pneumonia or pneumococcal infections; -Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated; -Assessments of pneumococcal vaccination status will be conducted within 5 working days of the resident's admission if not conducted prior to admission; -Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine; -Provisions of such education shall be documented in the resident's medical record; -Resident's and their representatives have the right to refuse vaccination; -If refused, appropriated entries will be documented in each resident's medical record indication the date of the refusals of the pneumococcal vaccination; -For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record; -Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 1. Review of Resident #12's medical record showed: -An admitted [DATE]; -Diagnosis that included, stroke, COVID-19, diabetes, and heart failure; -No documentation that resident was screened or received the pneumococcal vaccine. 2. Review of Resident #11's medical record showed: -An admitted [DATE]; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis that included sepsis (a systematic infection that affects the entire body) and acute (short duration) respiratory failure; -No documentation that resident was screened or received the pneumococcal vaccine; 3. Review of Resident #38's medical record showed: -An admitted [DATE]; -Diagnosis that included adult failure to thrive, diabetes, and stroke; -No documentation that resident was screened or received the pneumococcal vaccine. 4. Review of Resident #22's medical record showed: -An admitted [DATE]; -Diagnosis that included sepsis, long term use of antibiotics, enterocolitis (inflammation of the colon), cystitis (inflammation of the urinary bladder), and diabetes; -No documentation that resident was screened or received the pneumococcal vaccine. 5. During an interview on 10/23/24 at 9:05 A.M., the Assistant Director of Nursing (ADON) said she is responsible for screening and checking the vaccine status of the residents. It is expected that the residents should be offered the pneumococcal vaccine if they do not have any contraindications and are eligible. Refusals of the vaccine are to be documented in the medical record. Education is also expected to be provided to the resident or residents responsible party for each type of immunization.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on interview and record review, the facility failed to offer the COVID-19 vaccines for four out of five residents sampled for immunizations (Resident #11, #38, #22, and #14). The census was 47. Review of the facility's COVID -19 Vaccination of Residents policy, revised, May, 2023, showed: -Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated; -Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so; -The resident or the resident's representative has the opportunity to accept or refuse COVID-19 vaccine, and to change his/her decision; -COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his/her designee; -The individual who coordinates these responsibilities in the facility is the Assistant Director of Nursing (ADON); -The COVID-19 vaccine may be offered and provided directly by the facility or indirectly, such as through the arrangement with a pharmacy partner, local health department, or other appropriate health entity; -Before the COVID-19 vaccine is offered, the resident is provided education regarding the benefits, risks, and potential side effects associated with the vaccine; -Information is provide to the resident in a format and language that is understood by the resident or representative; -Residents are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine. 1. Review of Resident #11's medical record showed: -An admitted [DATE]; -Diagnoses that included sepsis (the body's response to an infection) and acute (short duration) respiratory failure; -No documentation that the resident was screened or received the COVID-19 vaccine. 2. Review of Resident #38's medical record showed: (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An admitted [DATE]; -Diagnoses that included adult failure to thrive, pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body), diabetes, and stroke; -No documentation that the resident was screened or received the COVID-19 vaccine. 3. Review of Resident #22's medical record showed: -An admitted [DATE]; -Diagnoses that included sepsis, long term use of antibiotics, enterocolitis (inflammation of the colon), and cystitis (inflammation of the urinary bladder), and diabetes; -No documentation that resident was screened or received the COVID-19 vaccine. 4. Review of Resident #14's medical record showed: -An admitted [DATE]; -Diagnoses that included diabetes, urinary tract infections (UTI), sepsis, yeast infection and heart failure; -Received COVID-19 vaccine, dose one on, 1/2/21 and received dose two on, 1/30/21; -No further documentation that resident was screened or received any additional COVID-19 vaccines. 5. During an interview on 10/23/24 at 9:05 A.M., the ADON said she was responsible for screening and checking the vaccine status of the residents. It was expected that the residents should be offered the COVID-19 vaccine if they do not have any contraindications. Refusals of the vaccine should be documented in the medical record. Education is also expected to be provided to the resident or the resident's responsible party for each type of immunization.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42795 Based on interview and record review the facility failed to ensure Certified Nursing Assistants (CNA) received a minimum of 12 hours on ongoing education annually for five out of five sampled CNAs. The census was 47. A policy related to CNA 12-hour training was requested and not provided by the facility. 1. Review of CNA M's employee file showed hire date: 1/15/20. No in-service training records provided upon request. 2. Review of CNA N's, employee filed showed hire date: 9/28/22. No in-service training records provided upon request. 3. Review of CNA O's employee file showed hire date: 9/10/21. No in-service training records provided upon request. 4. Review of Certified Medication Technician (CMT) F's employee file showed hire Date: 12/12/22. No in-service training records provided upon request. During an interview on 10/23/24 at 12:15 P.M., CMT F said he/she the facility provides in-services, but he/she is not aware of any formal tracking or training system. 5. Review of CMT P's employee file showed hire Date: 4/2/22. No in-service training records provided upon request. 6. During an interview on 10/22/24 at 11:12 A.M., the Assistant Director of Nursing (ADON) said she completes in-services with staff but does not keep track of the 12 hours. She could not provide any documentation of the in-services completed by the staff. It is her responsibility to keep a system but had not been doing so.