STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265736	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U-City Forest Manor	1301 Partridge Avenue Saint Louis, MO 63130

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on interview and record review, the facility failed to ensure code statuses were accurate, signed and updated in medical records for three of 18 sampled residents (Residents #52, #48 and #19). The census was 73. Review of the facility's Advance Directives policy, dated February 2012, showed: -Policy; -Advance directives will be respected in accordance with state and facility policy; -Procedure; -Prior to or upon admission of a resident to the facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives; -Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directive; -Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record; -The interdisciplinary team will review annually with the resident his/her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident's assessment instrument. 1. Review of Resident #52's code status form, dated [DATE], showed a code status of Do Not Resuscitate (if heart stops beating or breathing stops, there will be no measures taken to restart the heart and breathing). Review of the resident's care plan, updated [DATE], showed: -Problem: The resident has a full code status; (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: The resident will continue to have advance directive full code status known and respected through next review date; -Approach: Initiate cardiopulmonary resuscitation (CPR) per policy. Review of the resident's physician's order sheet, dated [DATE], showed an order, dated [DATE] for a full code (full resuscitation). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Cognitively intact; -No behaviors; -Diagnoses included high blood pressure, renal disease, dementia and anxiety. During an interview on [DATE] at 12:24 P.M., the resident said he wanted to be a DNR. He/She could not recall discussing this with the Social Worker. During an interview on [DATE] at 12:04 P.M., Licensed Practical Nurse (LPN) E said the resident was a full code, according to the electronic medical record (EMR). LPN E looked in the paper chart and said the resident had a signed DNR sheet as well. The Social Worker was responsible for updating code statuses and should have done so in [DATE]. The resident's code status was confusing. However, if the resident was to code, he/she would treat the resident as if he/she were a full code. 2. Review of Resident #48's code status form, dated [DATE], showed Full Code. Review of the resident's care plan, edited [DATE], showed: -Problem: The resident has a full code status; -Goal: The resident will continue to have advance directive full code status known and respected through next review date; -Approach: Complete or update Advance Directives document on admission, readmission, annually, and as needed. Review of the resident's physician's order sheet, dated [DATE], showed full code. Review of the resident's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Rarely or never understood; -No speech; (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included anemia (low levels of healthy red blood cells to carry oxygen throughout the body), high blood pressure and cerebral palsy (congenital disorder of movement, muscle tone, or posture). During an interview on [DATE] at 12:04 P.M., LPN E said the resident's code status was full code according to paper and electronic charts and were dated more than a year ago. He/She said they should be updated yearly and signed by the residents or responsible parties. 3. Review of Resident #19's code status form, dated [DATE], showed Full Code. Review of the resident's care plan, edited [DATE], showed: -Problem: The resident has a full code status; -Goal: The resident will continue to have advance directive full code status honored and followed appropriately through next review date; -Approach: Complete or update Advance Directives document on admission, readmission, annually, and as needed. Review of the resident's annual MDS, dated [DATE], showed: -admitted [DATE]; -Adequate hearing and clear speech; -Moderately impaired cognition; -Diagnoses included high blood pressure, diabetes, high cholesterol, thyroid disease and arthritis. During an interview on [DATE] at 12:04 P.M., LPN E said the resident's code status was full code according to paper and electronic charts and were dated more than a year ago. He/She said they should be updated yearly and signed by the residents or responsible parties. 4. During an interview on [DATE] at 11:27 A.M., the Social Worker said she thought the Nursing Manager was responsible for updating code statuses for residents. At 2:52 P.M., she clarified she was the one responsible for updating code statuses and they should be clear and indicate if a resident was a full code or DNR, and should be reviewed at least annually, and if there was a change. 5. During an interview on [DATE] at 1:47 P.M., the Administrator, Assistant Director of Nursing (ADON) and Director of Nursing (DON) said the Social Worker was responsible for updating code statuses and they should be clear, accurate and updated yearly, and as needed. 45083

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42247 Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN-form CMS-10055) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for two of two sampled residents who remained in the facility upon discharge from Medicare Part A services (Residents #44 and #34). The sample size was 18. The census was 73. Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 1/9/09, showed the following: -If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled using either the SNFABN (form CMS-10055) or one of the five uniform denial letters; -The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have; and -If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. 1. Review of Resident #44's medical record, showed: -Medicare Part A skilled services start date of 11/1/23 and end date of 11/17/23; -No SNFABN form issued. 2. Review of Resident #34's medical record, showed: -Medicare Part A skilled services start date of 4/3/24 and end date of 4/25/24; -No SNFABN form issued. 3. During an interview on 5/3/23 at 10:06 A.M., the Regional Business Office Manager (BOM) said the facility provided residents with a SNFABN when they discharged off Medicare part B, not Medicare Part A. 4. During an interview on 5/7/24 at 1:47 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Regional Operational Director said they would expect for the beneficiary SNFABN to be completed after a resident discharge from Medicare Part A.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42247 Based on interview and record review, the facility failed to follow their policy by not retaining three years of grievance logs. The sample was 18. The census was 73. Review of the facility's Resident and Family Grievances policy, undated, showed: -Evidence demonstrating the results of all grievances will be maintained for a period of no less than three years from the issuance of the grievance decision. Review on 5/6/24 at approximately 2:00 P.M., showed the grievance binder with grievance logs from January 2024 to current. There were no grievance logs for 2022 or 2023. During an interview on 5/7/24 at 10:25 A.M., the Assistant Director of Nursing (ADON) said the facility had recently changed the process of how the grievances were logged. The facility had grievance logs from January 2024 to current. The ADON was unable to locate any other grievance binders. Grievance logs should be kept for a couple of years. During an interview on 5/7/24 at 1:47 P.M., the Administrator, the Director of Nursing, ADON and Regional Operational Director said they expected the facility to retain grievance logs for three years. MO00213088

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 42247 Based on interview and record review, the facility failed to ensure residents with a mental disorder had a DA-124 Level I screen (Pre-Admission Screening and Resident Review (PASARR) used to evaluate for the presence of psychiatric conditions to determine if a PASARR Level II screen is required) as required, for three of eight residents sampled for the PASARR requirement (Residents #8, #41 and #3). The census was 73. 1. Review of Resident #8's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/25/24, showed: -Date of admission on 9/18/20; -Moderate cognitive impairment; -Diagnoses included seizures disorder, depression, dementia (a group of thinking and social symptoms that interferes with daily functioning) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's medical record, showed no PASARR Level I on file. During an interview on 5/6/24 at 1:50 P.M., the Corporate Nurse said the resident had a PASRR. The old owners used a different computer system, and the facility did not have access to the old computer system. 2. Review of Resident #41's quarterly MDS, dated [DATE], showed: -Date of admission on 4/1/22; -Cognitively impaired; -Exhibited verbal behaviors, such as screaming and cursing one to three days per week; -Exhibited behaviors such as rejection of care four to six days per week; -Diagnoses included dementia and schizophrenia. Review of the resident's medical record, showed no PASARR Level I on file. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed: -Date of admission on 3/6/2013; -Cognitively intact; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included dementia, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and schizophrenia. Review of the resident's medical record showed, no PASARR Level I on file. 4. During an interview on 5/7/24 at 9:42 A.M., Social Services said she was aware the residents should have a PASARR completed within 30 days of admission. She was unable to locate the residents' PASARRs. 5. During an interview on 5/7/24 at 1:47 P.M., the Administrator, Assistant Director of Nursing (ADON) and Director of Nursing (DON) said the DA-124s should have been requested within 30 days of admission to the facility. 45083

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on interview and record review, the facility failed to ensure a discharge summary was completed, including a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge, for one of three residents investigated for discharge (Resident #74). The census was 73. Review of Resident #74's medical record, showed: -admitted [DATE]; -Diagnoses included high blood pressure, depression and stroke; -discharged on [DATE]. Review of the resident's progress notes, showed: -On 2/2/24 at 1:26 P.M., the nurse was informed by the Social Worker of resident needing a discharge order. The physician was at the facility today and given report on resident. Resident given order to discharge home and will be receiving services from Home Health. Appointment information given to resident's emergency contact. Assistant Director of Nursing (ADON) and Social Worker informed. Resident scheduled to discharge 2/5/24; -On 2/5/24 at 12:38 P.M., the resident discharged home with his/her significant other in stable condition. Medications with a copy of face sheet and medication orders sent. Resident has his/her clothing and items he/she took upon departure from the facility. ADON and Director of Nursing (DON) informed. Review of the resident's medical record, showed no discharge summary including a recapitulation of the resident's stay, was completed. During an interview on 5/6/24 at 3:01 P.M., the Regional Clinical Director said the discharge summaries were not done on the resident and should have been done prior to the resident's discharge from the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on observation, interview and record review, the facility failed to provide Activities of Daily Living (ADL) care for two of 18 sampled residents who were dependent on staff for personal care (Residents #27 and #67). The census was 73. Review of the facility Activities of Daily Living (ADL) Policy, dated 1/2024, showed: -The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. This includes the resident's ability to; -Bathe, dress, and groom; -Policy Explanation and Compliance Guidelines: -Conditions which may demonstrate unavoidable decline in ADLs include natural progression of the resident's disease state; - Deterioration of the resident's physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities; -Refusal of care and treatment by the resident or his/her surrogate to maintain functional abilities; -A resident who-is-unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; -The facility will identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline or lack of improvement; -The facility will maintain individual objectives of the care plan and periodic review and evaluation. 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/10/24, showed; -Cognitively impaired; -Dependent on staff with for all ADLs, except setup for eating; -Wheelchair for mobility; -Diagnoses included dementia, heart disease, kidney failure and diabetes. Review of the resident's care plan, dated 2/28/24, showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Category: ADLs Functional Status/Rehabilitation Potential, receives restorative therapy 2-3 times a week; -Goal: Will accomplish goals as specified on his/her restorative therapy treatment plan next review date; -Approach: Monitor progress, restorative and nursing to collaborate care and services to maximize accomplishments. Observation on 5/1/24 at 10:03 A.M. through 5/7/24 at 11:28 A.M., showed his/her fingernails were extremely long, extending past his/her fingertips approximately 1/4 inch to 1/2 inch, with a dark substance under his/her nails. During an interview on 5/7/24 at 11:29 A.M., the resident said he/she wanted his/her nails cut. He/she gets his/her showers okay, but his/her nails are long and dirty. During an interview on 5/7/24 at 11:30 A.M., Certified Nursing Assistant (CNA) L said CNAs can't cut residents nails if they are diabetic. CNAs should tell the nurse and find out if is it okay to trim the resident's nails or let them know they need to trim their nails if they are diabetic. During an interview on 5/7/24 at 11:34 A.M., CNA M said they have to tell the nurse the resident needs their nails trimmed if the resident is diabetic. 2. Review of Resident #67's admission MDS, dated [DATE], showed; -Cognitively impaired; -Independent with all ADLs; -Ambulatory; -Diagnoses included dementia, malnutrition and depression. Review of the resident's care plan, dated 2/21/24, showed: -Problem: ADLs Functional, at risk for poor hygiene due to unspecified dementia; -Goal: Will be clean, odor free and dressed appropriately daily through next review date; -Approach: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary, discreetly remind of personal hygiene needs if needed and assist as needed. Observation on 5/1/24 at 10:10 A.M. through 5/7/24 at 11:20 A.M., showed the resident's fingernails to be extremely long, extending approximately 1/4 inch past his/her fingertips. During an interview on 5/7/24 at 11:21 A.M., the resident held up his/her hand and said he/she needed these fingernails cut. They are too long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24 at 11:28 A.M., Licensed Practical Nurse (LPN) G said activities staff or a CNA normally trims the resident's nails. He/She said the resident does not refuse care. 3. During an interview on 5/7/24 at 12:10 A.M., Activities Aide N said trimming the resident's nails is part of ADL care. Activities will trim the resident's nails and/or add polish if the resident requests their nails done. The CNA is supposed to check to make sure their nails are okay, cleaned and trimmed. The nurse trims the nails on the diabetic residents. 4. During an interview on 5/7/24 at 2:27 P.M., the Assistant Director of Nursing (ADON) said ultimately it is the nurse's responsibility to ensure the residents' nails are trimmed as part of ADL care. She expected staff to ensure residents were clean and groomed. 5. During an interview on 5/7/24 at 1:50 P.M., the Administrator said he expected the residents to be clean and ADL care provided. MO00235205

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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** 36151 Based on observation, interview and record review, facility staff failed to provide 24 hour protective oversight for two residents (Residents #42 and #53) with a history of elopements/wandering. The residents resided on a secured behavior unit and staff did not follow physician's orders to monitor the resident's wanderguard (electronic monitoring) devices as ordered, checking and documenting functionality of the wanderguards, when Resident #42 was discovered not wearing his/her wanderguard and Resident #53's wanderguard was not functioning. The facility also failed to ensure smoking assessments were completed for two residents (Residents #41 and #39) who smoked. The sample size was 18. The census was 73. Review of the facility Elopement Policy and Procedure, undated, showed: -Monitoring of the Wander-guard System; -Each time a resident is assigned a wanderguard bracelet the resident's name, identification number of the bracelet, and the date activated will be documented on a log kept at the nurse's station. When the log is full, it will be kept in a file in the Director of Nursing Services office; -When the alarm goes off, everyone in the vicinity should be checking to see who set the alarm off. Once it is determined who set the alarm off, it should be turned off and re-armed. To re-arm an alarm, punch in the reset code 4731 star (*). You should see a green light to indicate that the alarm has been set. A yellow/orange light indicates that the system is not functioning. It should never be left in this mode, and anyone found leaving it in this mode will be terminated immediately. If you are unsure the alarm is reset appropriately, you should notify your charge nurse immediately; -If the alarm is found un-armed, the staff must call a Code Yellow immediately and begin a head count throughout the facility. Visual verification of each resident must be marked on the daily census sheet. The reason for the check must be recorded on the census sheet along with the time the check was done; -When the alarm goes off and there is apparently no one around, the staff must check to see who set the alarm off last. The staff will begin a search for the resident. Upon visual verification that the resident is safe, the staff will notify the charge nurse and the search will be stopped; -Each bracelet will be checked for function every shift by a staff member; -A record will be maintained on the Treatment Administration Record (TAR) of these per-shift checks and kept at the nurse's station. The Charge Nurse will be responsible for assigning a staff member to check bracelet functioning; -A handheld testing device will check the resident's bracelet. 1. Review of Resident #42's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/7/24, showed; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively impaired; -Wandering/behavior not exhibited; -Independent with most activities of daily living (ADLs), except supervision/verbal cues when bathing; -Lower extremity, impairment on both sides; -Wheelchair for mobility; -Diagnoses included heart failure, stroke, seizure disorder, and schizophrenia (delusions (false beliefs), hallucinations (seeing or hearing things that don't exist), unusual physical behavior, and disorganized thinking and speech). Review of the resident's physician's orders, showed; -An order dated 8/31/23, for Wanderguard, check every shift for placement/function and check skin every shift. Days 7:00 A.M.-3:00 P.M., Evenings 3:00 P.M. -11:00 P.M., Nights 11:00 P.M.-7:00 A. M. Review of the resident's care plan, dated 4/24/24 showed: -Problem: Cognitive Loss/Dementia, has impaired daily decision making as evidenced by constant redirection to use wheelchair versus walking or pushing wheelchair like a walker; -Goal: Will have positive experiences in daily routine without overly demanding tasks and without becoming overly stressed through next review date; -Approach: Calm if signs of distress develop during the decision-making process (feeling overwhelmed, fatigue, agitation, restlessness, withdrawal). Educate on the importance of using the wheelchair for locomotion. Encourage to verbalize feelings, concerns and fears. Clarify misconceptions; -Problem: Behavioral, is an elopement risk/wanderer and resides on the secured unit; -Goal: Will remain safe and not leave building via elopement through next review date; -Approach: Will remain and reside on secured/alarmed unit for safety. Immediately inform Charge Nurse of any attempts to leave the unit or facility unsupervised. Monitor whereabouts every 2 hours and as needed. Increase monitoring as needed. -No documentation regarding the use of a wanderguard. Review of the resident's TAR, showed no documentation regarding testing of the wanderguard for functionality. Review of the resident's nurse's progress notes, showed; -On 4/30/24 at 11:12 P.M., wanderguard intact and functional to left wrist; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U-City Forest Manor	1301 Partridge Avenue Saint Louis, MO 63130

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 5/1/24 at 3:20 P.M., wanderguard intact and functional to left wrist; -On 5/2/24 at 3:14 P.M., wanderguard intact and functional to left wrist; -On 5/3/24 at 1:35 A.M., wanderguard to left wrist intact, no documentation regarding functionality. During an interview on 5/3/24 at 12:25 P.M., Certified Nursing Assistant CNA J said he/she was Resident #42's caregiver and he/she was already up and dressed this morning when he/she arrived. He/She was unaware where the wanderguard was located on his/her body or how to check to see if they work. He/She said the previous aide was already gone when he/she arrived, and he/she did not get report. None of the residents try to go out the door. The ones who wander have wanderguards on them. During observation and interview on 5/3/24 at 12:13 P.M., Licensed Practical Nurse (LPN) G said they do not have a device to check the functionality of the wanderguards. Nursing checks the function of the wanderguards by taking them to the doorway and see if it alarms. He/She walked over to the resident to demonstrate how the wanderguard worked and found the resident had taken his/her wanderguard off. The resident said his/her wanderguard gets caught on his/her clothing and he/she took it off. 2. Review of Resident #53's quarterly MDS, dated [DATE], showed; -Cognitively impaired; -Wandering/behavior not exhibited; -Staff provide substantial/maximal assistance with all activities of daily living (ADLs); -Lower extremity, impairment on both sides; -Wheelchair for mobility; -Diagnoses included traumatic brain injury (TBI), seizure disorder and depression. Review of the resident's physician's orders, showed. -An order dated 8/31/23, May have wanderguard, check daily per shift for function and skin issues every shift. Days, Evenings and Nights. Days 7:00 A.M.-3:00 P.M., Evenings 3:00 P.M.-11:00 P.M., Nights 11:00 P.M.-7:00 A.M. Review of the resident's care plan, dated 3/6/24, showed; -Problem: Behavioral Symptoms, resides on the secured unit, wanders into other resident's room, history of elopement and elopement attempts; -Goal: Resident resides on the secured unit and wanders into other residents' rooms and claims that it's his/her room; history of elopement and elopement attempts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Approach: Will remain safe and will not leave this facility via elopement through next review date. Wander guard to left ankle at all times. Check skin every shift. Monitor whereabouts at all times throughout the day. Offer tasks/activities such as walking with staff to occupy [NAME] during the day to reduce wandering/elopement chances; -Problem: At risk for epileptic seizures due to history of TBI; -Goal: Will maintain baseline neurological status through next review date; -Approach: Soft helmet on at all times. May be removed for ADLs and as needed. SEIZURE PRECAUTIONS: Do not leave alone during a seizure, protect from injury, if out of bed, help to the floor to prevent injury. Remove or loosen tight clothing, don't attempt to restrain resident during a seizure as this could make the convulsions more severe, protect from onlookers, draw curtain etc.; -Problem: Requires constant monitoring when out of bed due to unsteady gait; needs reminders to sit in wheelchair versus pushing it; has poor insight and history of falls due TBI; -Goal: Will not sustain serious injuries due to falls through next review date; -Approach: Encourage to stay seated in the wheelchair for safety. Keep in the line of sight of when out of bed. Make sure he/she is wearing soft helmet and hip protectors at all times. May be removed for ADLs. Review of the resident's TAR, showed no documentation regarding testing of the wanderguard for functionality. Review of the resident's nurse's progress notes, showed; -On 4/30/24 at 11:11 P.M., wanderguard intact and functional to left ankle; -On 5/1/24 at 3:19 P.M., wanderguard intact and functional to left ankle; -On 5/2/24 at 3:13 P.M., wanderguard intact and functional to left ankle; -On 5/3/24 at 1:36 A.M., wanderguard intact to his/her left ankle, no documentation regarding functionality; Observation and interview on 5/3/24 at 12:13 P.M., Licensed Practical Nurse (LPN) G walked over to the resident and pushed his/her wheelchair over to the doorway. The alarm did not sound when the resident was in close proximity of the door. LPN G said normally, the wanderguard will sound when they are this close, it will actually sound on the other side of the wall. He/She said nursing documents in the location and functionality of the wanderguard devices in the electronic medical record. During an interview on 5/3/24 at 12:30 P.M., CNA K said he/she was the Resident #3's caregiver. The resident was already dressed when he/she arrived and did not know where the wanderguard was located. Residents are not able to take the wanderguards off. They are hard to take off unless you cut the band. He/She was unaware how to check to ensure the wanderguards worked, other than they will sound when the resident wearing them went by the doors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview on 5/3/24 at 1:00 P.M., the Assistant Director of Nurses (ADON) said staff should check the wanderguards every shift to make sure they are working. The device itself will sound when they go close to the door. The ADON attempted to demonstrate the wanderguard, but was not able to locate the wanderguard on Resident #42. The ADON then wheeled Resident #53, whose wanderguard was secured to his/her left ankle, to the doorway and the alarm did not sound. The ADON said she was not made aware of the wanderguards not working or missing until state surveyors made him/her aware. The ADON expected staff to notify him/her immediately. At 1:10 P.M., the ADON said she had located a device to check the functionality of the wanderguards. The device was in the original box the wanderguards arrived in. She then checked Resident #53's wanderguard. It illuminated, then did not. She was not familiar with how the monitoring device functioned. She said the nurses should have the wanderguard monitoring device on their care unit to check functionality. She said they would be placing the residents on 15 minute checks until the new wanderguards arrive. If there is an order for a wanderguard, it should be documented in the medical record as ordered. She expected staff to know how to check functionality on those wanderguards, and they should follow the physicians orders and check for the wanderguards and ensure they are operational. 4. Review of Resident #41's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -Exhibited verbal behaviors such as screaming, threatening and cursing others one to three days per week; -Exhibited behaviors such as rejection of care four to six days per week; -Independent with manual wheelchair; -Diagnoses included heart failure, renal disease, stroke and schizophrenia; -Current tobacco use not indicated. Review of the resident's care plan, undated 4/18/24, showed: -Problem: The resident chooses to smoke cigarettes; -Goal: The resident will continue to smoke as desired in designated area through next review date; -Approach: Monitor during smoke times for safety. Make sure smoke apron is in place at all times during smoking. Conduct smoking safety evaluation on admission, annually and as needed. Review of the resident's May 2024 physician's order, showed an order, dated 11/2/22 for smoke apron on during smoke breaks. Review of the resident's medical record, showed no smoking assessment. Observation on 05/03/24 at 9:27 A.M., showed the resident in the smoking area with a smoking apron on, smoking a cigarette. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #39's annual MDS, dated [DATE], showed: -Cognitive impairment; -No behaviors; -Independent with mobility; -Diagnoses included renal disease, hepatitis, stroke and TBI; -Current tobacco use indicated. Review of the resident's care plan, updated 4/18/24, showed: -Problem: The resident chooses to smoke cigarettes; -Goal: The resident will continue to smoke as desired independently in designated area through next review date; -Approach: Allow the resident to smoke in designated area. Check skin and clothes for cigarette burns. All cigarette supplies will be housed at the front desk receptionist area and given out at designated smoke times only. Review of the resident's medical record, showed no smoking assessment. Observation on 05/03/24 at 9:27 A.M., showed the resident in the smoking area smoking a cigarette. 6. During an interview on 5/6/24 at 10:23 A.M., LPN A said smoking assessments had not been completed on the residents. They should be done periodically and upon admission. He/She was not sure who was responsible for completing smoking assessments but thought the Social Worker was responsible. 7. During an interview on 5/6/24 at 11:27 A.M., the Social Worker said she was responsible for completing smoking assessments quarterly, annually and as needed. She had been in the position as the Social Worker for a year and had not completed smoking assessments. 8. During an interview on 5/7/24 at 1:47 P.M., the Administrator, ADON and the Director of Nursing said wanderguards should be monitored and documented as ordered. Smoking assessments should have been completed by the Social Worker and should have been done annually and as needed. 37681

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37681 Based on observation, interview and record review, the facility failed to ensure a resident who received routine dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys are not able to) treatment had accurate physician's orders in place, consistent communication and a dialysis contract with the dialysis provider. This affected one of one resident sampled for dialysis review (Resident #41). The sample size was 18. The census was 73. Review of the facility's Care of a Resident with end-stage renal disease (ESRD) policy, updated November 2017, showed: -Policy Statement; -Residents with ESRD will be cared for according to currently recognized standards of care; -Policy Interpretation and Implementation; -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents; -Education and training of staff includes, specifically; -The nature and clinical management of ESRD; -The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; -Timing and administration of medications, particularly those before and after dialysis; -Education and training of staff in the care of dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care; -Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including; -How the care plan will be developed and implemented; -How information will be exchanged between the facilities; -Responsibility for waste handling, sterilization and disinfection of equipment Review of Resident #41's Dialysis Communication Form, dated 7/17/23, showed a form with no information filled out. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record, showed no dialysis contract, no further dialysis communication forms since July 2023 and no information regarding the monitoring of the resident's arteriovenous fistula (AVF, a connection between an artery and a vein) dialysis site. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/14/24, showed: -Cognitively impaired; -Exhibited behaviors such as rejection of care four to six days per week; -Diagnoses included heart failure, ESRD and dementia. Review of the resident's care plan, updated 4/18/24, showed: -Problem: The resident has end stage renal disease and received hemodialysis via right AVF every Monday, Wednesday and Friday at 12:00 P.M., chair time; -Goal: The resident will have immediate interventions should any signs and symptoms of complications from dialysis occur through next review date; -Approach: Obtain and document vital signs per orders/per protocol. Monitor/document signs and symptoms of bleeding, hemorrhage and septic shock. Monitor/document signs and symptoms of infection to right AVF. Encourage resident to go for the scheduled dialysis appointments. Obtain and document weights per orders. Monitor significant changes. Document and notify the provider for changes, as needed. Monitor right AVF dialysis site every shift and as needed. Review of the resident's Treatment Administration Record (TAR), for the months of February 2024, March 2024 and April 2024, showed no order to check for vital signs, weight or AVF prior to, or after receiving dialysis. Review of the resident's May 2024 physician's orders, showed an order, dated 12/14/22, for transportation to transport the resident to dialysis on Tuesday, Thursday and Saturdays; -No order to check the dialysis site. During an interview on 5/6/24 at 10:23 A.M., Licensed Practical Nurse (LPN) A said the last dialysis communication from the provider was done 7/17/23. The communication forms were supposed to be completed each time the resident returned from dialysis. They were often lost so they were not done. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 1:31 P.M., the Assistant Director of Nursing (ADON) said there should have been a dialysis communication form with the resident's vitals and status that went with the resident to the dialysis center. The resident's weight is also entered onto the form and should have been done every time the resident attended dialysis. The nurse should have been checking the resident's dialysis site every shift. The information should have been documented in the progress notes and on the TAR. She also expected the information to be accurate on the physician's orders and reflect the days the resident attended dialysis. There should have been an order to check the resident's dialysis site. There should have been a dialysis contract but they were unable to obtain it from the dialysis provider. During an interview on 5/7/24 at 1:47 P.M., the ADON, Director of Nursing (DON) and Administrator said the dialysis communication forms should have been done each time the resident attended dialysis. There should have been a dialysis contract available at the facility. There should have been an order to check the resident's site. The information should have been documented in the resident's medical record.

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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. 42247 Based on interview and record review, the facility failed to provide eight hours of Registered Nurse (RN) coverage for 16 out of 92 days. This had the potential to cause unmet health needs for all residents. The census was 73. Review of the facility's Staffing policy, dated: 7/19, showed: Policy Statement: Our facility provides adequate staffing to meet needed care and services for our resident population; -Our facility maintains adequate staffing on each shift to ensure that our residents' needs and services are met. Licensed Registered Nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Review of the facility's [NAME] Payroll Based Journal (PBJ) Staffing Data Report (data collected by Center for Medicare and Medicare Services (CMS), dated fiscal quarter one, 2023, showed: -On 10/14, 10/15, 10/28, 10/29, 11/4, 11/5, 11/11, 11/12, 11/25, 11/26, 12/1, 12/3, 12/9, 12/10, 12/16 and 12/17/23, there was no RN coverage. During an interview on 5/6/24 at approximately 1:30 P.M., the Assistant Director of Nursing (ADON) said the facility was usually staffed with one RN on the day shift, and two to three Licensed Practical Nurses (LPN) on day and evening shift and two LPNs on the night shift. On 10/14, 10/15, 10/28, 10/29, 11/4, 11/5, 11/11, 11/12, 11/25, 11/26, 12/1, 12/3, 12/9, 12/10, 12/16 and 12/17/23 the facility did not have RN coverage. During an interview on 5/7/24 at 1:47 P.M., the Administrator, Director of Nursing, ADON and Regional Operational Director said they expected the facility to have eight hours of RN coverage daily.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 27 opportunities observed, two errors occurred, resulting in a 7.41% error rate (Residents #44 and #20). The census was 73. Review of the Novolog FlexPen U-100 Insulin (rapid-acting insulin that helps lower mealtime blood sugar spikes in adults and children with diabetes) insulin pen injection; 100 unit per milliliters (unit/mL) (3 mL), manufacturer's instructions for use, revised 2/2023, showed: -Pull off the pen cap. Wipe the rubber stopper with an alcohol swab; -Remove the protective tab from a disposable needle. Screw the needle tightly onto the insulin pen. It is important that the needle is put on straight. Never place a disposable needle on the pen until ready for injection; -Pull off the big outer cap; -Pull off the inner needle cap and throw it away; -Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing, turn the dose selector to select 2 units; -Hold the Novolog FlexPen with the needle pointing up. Tap the cartridge gently with the finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Review of the Humalog Kwikpen Insulin (fast-acting insulins used to control high blood sugar in adults and children with diabetes), injection, 3 mL single-patient-use pen (100 units per mL), manufacturer's instructions for use, revised 8/2023, showed: -Pull the per cap straight off; -Wipe the rubber seal with an alcohol swab; -Check the liquid in the pen (should look clear); -Select a new needle, pull off the paper tab from the outer needle shield; -Push the capped needle straight onto the pen and twist the needle on until it is tight; -Pull off the outer needle shield, do not throw it away, pull off the inner needle shield and throw it away; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Priming the insulin pen: Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If not priming before each injection, may get too much or too little insulin; -To prime the pen, turn the dose knob to select 2 units; -Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top; -Continue holding the pen with needle pointing up. Push the dose knob in until stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly; -You should see insulin at the tip of the needle. If not, repeat the priming steps, no more than 4 times. If still do not see insulin, change the needle and repeat the priming steps. 1. Review of Resident #44's Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/18/24, showed: -Makes self-understood and understands others; -Moderate cognitive impairment; -Diagnoses included high blood pressure, kidney disease, diabetes and high cholesterol. Review of the resident's Medication Administration Record (MAR), dated May 2024, showed: -Novolog FlexPen U-100 insulin pen; 100 unit/mL (3 mL); -Amount to administer: 20 units; subcutaneous (applied under the skin and fatty tissue); -Blood sugar checks at 8:00 A.M., 12:00 P.M. and 5:00 P.M.; -Lantus Solostar U-100 Insulin (long-acting insulin) insulin pen; 100 unit/mL (3 mL); -Amount to administer: 50 units; subcutaneous. Observation on 5/2/24 at 12:04 P.M., showed Licensed Practical Nurse (LPN) G checked the resident's blood sugar level using a multi-use glucometer. LPN G obtained the Novolog insulin pen for the resident, applied a disposable needle and dialed the 20-units dose and administered it to the resident. He/She did not wipe the insulin pen's rubber seal with alcohol and did not prime the insulin pen prior to administering the medication to the resident. 2. Review of Resident #20's quarterly MDS, dated [DATE], showed: -Makes self-understood and understands others; -Cognitively intact; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included heart disease, high blood pressure, kidney disease, diabetes, high cholesterol and stroke. Review of the resident's MAR, dated May 2024, showed: -Humalog (fast-acting insulins used to control high blood sugar in adults and children with diabetes) injection, 6 units three times a day (TID) with meals at 8:00 A.M.,12:00 P.M., 5:00 P.M.; -Humalog sliding scale: 201-250=1 unit, 251-300=2 units, 301-350= 3 units, greater than 351=4 units. If over 400 call the doctor. Observation on 5/2/24 at 12:12 P.M., showed LPN G checked the resident's blood sugar level using a multi-use glucometer. The resident's blood sugar level was 349. LPN G obtained the Humalog insulin pen for the resident, applied a disposable needle and dialed the 9 units total and administered it to the resident. He/She did not wipe the insulin pen's rubber seal with alcohol and did not prime the insulin pen prior to administering the medication to the resident. 3. During an interview on 5/6/24 at 10:05 A.M., LPN E said the insulin pen's rubber tip should be wiped with alcohol prior to applying the disposable needle. LPN E did not know the priming steps of an insulin pen. 4. During an interview on 5/6/24 at 3:05 P.M., the Director of Nursing (DON) said he expected staff to wipe the rubber tip of the insulin pen with alcohol. He said he was not sure about the pen priming prior to insulin administration. At 3:46 P.M., the DON said the facility has no policy for insulin pen priming, and they would follow the manufacturer's instructions. 5. During an interview on 5/7/24 at 1:47 P.M., the Administrator, DON, Assistant Director of Nursing and Regional Operational Director said they expected staff to be free of medication errors.

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	265736	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U-City Forest Manor	1301 Partridge Avenue Saint Louis, MO 63130

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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. 45083 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with acceptable standards of practice. The facility identified six medication/treatment carts and two medication rooms. Four of the six carts and one medication room were checked for medication storage. Issues were found in the three of four medication carts. Insulin pens were opened and dated more than 28 days. Multiple bottles of over the counter (OTC) medications were undated and expired. The census was 73. Review of the facility's Medication Storage Policy, dated June 2020, showed: -Policy: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists. 1. Observation of the nurse's medication cart for Halls 100, 200, 400 on 5/2/24 at 11:25 A.M., showed: -2 pens of Basaglar Kwikpen 3 ml (milliliters) insulin glargine pen (used to treat high blood sugar), opened 3/25/24; -Caldyphen Lotion Clear (used to relieve itching and pain caused by minor skin irritation), opened, undated, expired 3/8/24. 2. Observation of the Certified Medical Assistant's (CMT) medication cart for Halls 100 and odd rooms in 400, on 5/2/24 at 11:35 A.M., showed the following opened OTC medication bottles: -Mucus Relief (cough and cold medicine) 400 mg (milligrams), undated, expired 3/24; -Vitamin-D (used for levels of vitamin D) 10 mcg (micrograms), undated, expired 11/23; -One Daily multivitamin with Iron, undated, expired 2/24; -Allergy Relief 10 mg, dated 2/8/24, expired date not visible or readable; -Allergy Relief 4 mg, dated 2/7/24, expired 1/24; -Several more opened OTC medication bottles were undated, expiration dates were within current date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation of the CMT's medication for Halls 200 and even rooms in 400, on 5/2/24 at 11:47 A.M., showed the following opened OTC medication bottles: -One Daily multivitamin, undated, expired 10/23; -Vitamin B12 100 mg, undated, expired 10/23; -Major Heartburn Relief, dated 4/23, expired 3/24; -Allergy Relief 10 mg, undated, expired 1/24; 4. During an interview on 5/2/24 at approximately 11:55 A.M., CMT I said the medications should be dated upon opening. If medications were not dated and expired, he/she would not administer them to the residents. Licensed Practical Nurse A told CMT I to throw away expired medications. 5. During an interview on 5/6/24 at 3:05 P.M., the Director of Nursing (DON) said he expected the staff to date OTC medications once opened and should only be good for 30 days. Insulin pens were also to be dated and should only be used for 28 days. He expected the staff to check expiration dates prior to administering medications to the residents and destroy or discard expired medications properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection prevention and control when the facility failed to clean shared medical equipment between resident use with an approved Environmental Protection Agency (EPA)-registered disinfectant for two sampled residents (Residents #44 and #20). In addition, staff failed to remove all gloves and perform hand hygiene when providing wound care for two of two residents sampled for wound care (Residents #14 and #69). The sample was 18. The census was 73. Review of the facility's glucometer's (a device for measuring the concentration of glucose in the blood) manufacturer's instruction, showed: -Cleaning and disinfecting procedures for the meter: The meter should be cleaned and disinfected between each patient; -Cleaning Instructions: Cleaning is the removal of visible dirt and debris. Whenever your glucose meter is dirty, clean the outside of the meter with a new CaviWipes towelette (disposable germicidal cleaner and healthcare disinfecting wipe) or an EPA-registered disinfecting wipe. The cleaning process does not reduce the risk for transmission of infectious diseases; -Disinfection Instructions: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting; -The Disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Review of the facility's Infection Prevention and Control Program Policies and Program, revision date August 2018, showed: -Hand hygiene general statement: good hand hygiene is a requirement of standard precautions. Wash or sanitize hands before and after each care contact for which hand hygiene is indicated by acceptable professional practice, utilizing designated time frames and products. Hands should be washed with soap and water when they are visibly soiled, or if they have come in contact with blood or other body fluids, before or after eating or handling food, and times specified by other applicable regulations; -The policy did not address glove use. Review of the facility's Handwashing policy, dated April 2015, showed: -Hands should be thoroughly washed before and after providing resident care; -Hand antiseptic/hand sanitizer is a supplement or alternative to the use of soap and water when hands are not visible soiled; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The policy did not address glove use. 1. Review of Resident #44's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/18/24, showed: -Makes self-understood and understands others; -Moderate cognitive impairment; -Diagnoses included high blood pressure, kidney disease, diabetes and high cholesterol. Review of the resident's Medication Administration Record (MAR), dated May 2024, showed: -Novolog FlexPen U-100 Insulin (rapid-acting insulin that helps lower mealtime blood sugar spikes in adults and children with diabetes) insulin pen; 100 unit per milliliters(unit/mL) (3 mL); -Amount to administer: 20 units; subcutaneous (applied under the skin and fatty tissue); -Blood sugar checks at 8:00 A.M., 12:00 P.M. and 5:00 P.M.; -Lantus Solostar U-100 Insulin (long-acting insulin) insulin pen; 100 unit/mL (3 mL); -Amount to administer: 50 units; subcutaneous. Review of Resident #20's quarterly MDS, dated [DATE], showed: -Makes self-understood and understands others; -Cognitively intact; -Diagnoses included heart disease, high blood pressure, kidney disease, diabetes, high cholesterol and stroke. Review of the resident's MAR, dated May 2024, showed: -Humalog (fast-acting insulins used to control high blood sugar in adults and children with diabetes) 6 units three times a day (TID) with meals at 8:00 A.M.,12:00 P.M., 5:00 P.M.; -Humalog sliding scale: 201-250=1 unit, 251-300=2 units, 301-350= 3 units, greater than 351=4 units. If over 400 call the doctor. During observation and interview on 5/2/24 at 12:04 P.M., Licensed Practical Nurse (LPN) G checked Resident #44's blood sugar level using a multi-use glucometer. The LPN wiped the glucometer with an alcohol pad. He/She said he/she used the same glucometer for all the residents in the hall. After checking the resident's blood sugar, the LPN wiped the glucometer using an alcohol pad, let it dry and moved on to check Resident #20's blood sugar. At 12:12 P.M., LPN G wiped the glucometer with alcohol pads, applied the test strips and proceeded to check Resident #20's blood sugar. He/She then wiped the glucometer with alcohol pads and placed it in the top drawer of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 5/2/24 at 2:55 P.M., Licensed Practical Nurse (LPN) A said the facility had multiuse glucometers. There are two glucometers on the medication cart. LPN A placed a barrier on top of the medication cart, removed the glucometer from the drawer of the cart, wiped the glucometer with a bleach germicidal wipe, then he/she placed the glucometer on top of the barrier on the medication cart. He/She said the glucometer stays on the barrier until it has air dried. If he/she ran out of bleach wipes he/she would notify the Nurse Supervisor. During an interview on 5/2/24 at 3:05 P.M., Registered Nurse (RN) B said staff should clean the glucometer with a Sani wipe/bleach wipe after each use. If the bleach wipes are not available, the nurse should notify someone. The facility should have Sani wipes available. If they are locked up, staff should ask someone to get them. Staff cannot use alcohol to clean the glucometers. If they used alcohol, the glucometer probably was not clean. RN B was not aware of staff using alcohol to clean the glucometer. During an interview on 5/6/24 at 2:59 P.M., the Nurse Practitioner (NP) said the glucometer should be wiped down between each patient. The NP did not know the facility's policy, but she expected the facility to use a microbacterial product based on the facility's policy. During an interview on 5/6/24 at 3:05 P.M., the Director of Nursing (DON) said the facility used multi-use glucometers. Staff should disinfect the glucometer before and after use with a Clorox wipe. Staff should not use alcohol to clean/disinfect the glucometer. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included: Alzheimer's disease, dementia, anxiety, depression and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of the care plan, in use at the time of survey, showed: -Problem: On 4/27/2024 a coccyx (tailbone) wound was discovered; -Interventions: provide wound care to the affected are(s) per orders. Review of the physician order, in use at the time of survey, showed: -Cleanse coccyx wound with dermal wound cleanser, pat dry, apply Medi-honey (used for removing necrotic (dead) tissue and aides in healing) gel to wound bed, cover with border foam dressing. Change every 72 hours. Observation on 5/6/24 at 9:15 A.M., showed the resident lay in bed. LPN E performed hand hygiene and put on gloves. LPN E set up the needed supplies for the resident's treatment. LPN E removed his/her gloves and performed hand hygiene. Then, he/she put on two pair of gloves. The resident was rolled onto his/her side. LPN E removed the old coccyx dressing, and one pair of gloves. With one pair of gloves still on, LPN E cleaned the wound with wound cleanser, and removed the second pair of gloves. LPN E put on new gloves, applied the dressing, then he/she removed his/her gloves and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's admission MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included: high blood pressure and dementia; -Number of stage two pressure ulcers (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister): one. Review of the physician order sheet, in use at the time of survey, showed: -Clean coccyx wound with wound cleanser, pat dry, apply collagen plus alginate (highly absorbent dressing that promotes healing), cover with border foam dressing, change every 72 hours. Observation on 5/6/24 at 10:40 A.M., showed the resident lay in bed. LPN E washed his/her hands and put two pair of gloves on. LPN E set the needed supplies for the resident's wound care on the over the bed table and removed both pair of gloves. Then, LPN E put three gloves on the right hand and two gloves on the left hand. LPN E prepared the wound supplies and removed one glove from the right hand. LPN E removed the dressing off the resident's buttocks and one pair of gloves, with one pair of gloves still on, LPN E cleaned the area on buttocks with wound cleanser and removed the last pair of gloves. LPN E put new gloves on and dried the wound with gauze and applied the dressing. LPN E removed his/her gloves and performed hand hygiene. During an interview on 5/7/24 at 11:20 A.M., Certified Medication Technician (CMT) F said hand hygiene should be done before and after care. Gloves should be worn while providing personal care and changed when going from a dirty area to a clean area. Staff should not double glove. During an interview on 5/7/24 at 11:35 A.M., LPN G said gloves should be worn when staff provide treatments. Staff should do hand hygiene prior to starting wound care, put gloves on, remove the old dressing, remove their gloves and perform hand hygiene, put new gloves on, apply the medications and dressings, remove their gloves and do hand hygiene. Staff should not double glove because you don't know what could have got down between the gloves and there would be a risk for cross contamination. During an interview on 5/7/24 at 11:50 A.M., LPN H said staff should not double glove when providing care. During an interview on 5/7/24 at 11:30 A.M. the Assistant Director of Nursing (ADON) said staff should not double or triple glove while providing care. If staff put on more than one pair of gloves, they would need to remove all the gloves and perform hand hygiene between dirty and clean. During an interview on 5/7/24 at 1:47 P.M., the Administrator, DON, ADON and Regional Operational Director said they expected staff to follow acceptable infection control standards of practice. 45083