STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, MO 63021

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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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

35394

37681

45083

Based on observation, interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity when one resident continued to have a certain staff assigned to them despite their request for a different staff member (Resident #84). In addition, staff used their personal cell phones in resident care areas and while providing care to the residents. The sample was 23. The census was 115.

Review of the facility's Resident Rights policy, dated 11/22/24, showed:

-Policy: The facility recognizes and respects that each resident has the right to exercise his or her rights as a resident of the facility and as citizen or resident of the United States. Exercising right means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. The facility will ensure that facility operations and systems are implemented in a manner that facilitates the resident/resident representative can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The facility will implement and maintain systems to ensure all facility staff understand and foster the rights of every nursing home resident.

Review of the facility's Employee Handbook, dated 7/1/24, showed:

-Telephone Calls and Messages:

-The Facility is dedicated to the care of the elderly and disabled. The care of these residents cannot be adequately accomplished when the employees are interrupted by outside personal phone calls or text messages. Unless you are authorized to use a cell phone as part of your job duties, cell phones are to be used only during the employee's rest or meal breaks and must be turned off in resident care or work areas. Please note, cell phones which are only muted, or silenced, are not turned off.

1. Review of Resident #84's annual Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 9/30/24, 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 - Few	-Cognitively intact; -Diagnoses included coronary artery disease, heart failure, high blood pressure, cirrhosis (chronic liver damage), diabetes, and depression. Review of the resident's progress notes, showed no documentation of the resident reporting unprofessional behavior from staff. During an interview on 11/21/24 at 10:42 A.M., the resident said there was a Certified Nurse Aide (CNA) who had yelled at him/her. The CNA entered the room and started to complain about how the resident should not be in bed and be in the wheelchair. It was as if he/she yelled at the resident, but at the same time complained about what staff did or was not supposed to do. The resident reported to staff and asked that the CNA not be assign him/her anymore, but yesterday, the CNA was assigned to him/her. During an interview on 11/25/24 at 11:43 A.M., the resident said the CNA worked again. He/She knew they are not supposed to be in here. The resident said that to the CNA. The resident said the CNA is meaner than hell. The resident got his/her daughter on the phone. The resident's daughter said there was a nurse aide who came into the room that was rough and nasty to the resident. The aide took the resident's water bottles that were purchased by family, without permission and told the resident to buy more. This happened approximately one month ago, and it was reported to the nurse manager, either the Director of Nursing (DON) or Licensed Practical Nurse (LPN) M. She was told it was not acceptable and they would look into it. The aide was not his/her favorite person. During an interview on 11/25/24 at 1:31 P.M., the Director of Nursing (DON) said she remembered an incident about the water, but it ended up being another issue and the water was not taken. The resident did not believe the aide was nice. The aide spoke in a loud voice, and the resident did not like it. She remembered something about the aide not being assigned to the resident. If a resident requested not to have a certain staff assigned to them, they would talk to the nurse manager and staffing. Staffing would be able to put them on a different floor. During an interview on 11/25/24 at 1:48 P.M., Licensed Practical Nurse (LPN) M said the resident reported staff did not bring him/her water and staff allegedly said, you don't need water. LPN M also remembered it was reported that the aide stood at the door and screamed at the resident. LPN M added they did not know a name at that time and the description changed from tall and thin to average. LPN M was told the name of the aide and said there are more than one aide with the same name, but the one he/she was familiar with speaks quietly. LPN M said if they found out who it was, they would tell them not to go in the room. They would not be assigned to the resident. During an interview on 11/25/24 at 2:20 P.M., the DON confirmed the identity of the aide and checked the schedule. The resident had the correct name of the aide and that aide worked on the unit during the night shift. The DON started the investigation and interviewed residents. The aide has been suspended. During an interview on 11/25/24 at 3:08 P.M., Hospice Registered Nurse (RN) N said the resident had strong complaints in the past two months, but not specific. They had an interaction that was upsetting to the resident. You could still tell he/she was upset. RN N said he/she reported to RN B and he/she talked to the DON. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a group interview on 11/21/23 at 1:27 P.M., seven residents, whom the facility identified as alert and oriented, attended the group meeting. All residents said the staff used their cell phones while providing care to the residents. One of the residents said he/she was told by a staff person to keep quiet because the staff was listening to music on their phone while assisting the resident with care. Another resident said he/she was told that he/she being too loud and that the staff could not hear his/her cell phone. The residents were unable to identify the staff by their names. Observation on 11/22/24 at 10:14 A.M., showed a staff person walked down Hall 300 looking down at his/her cell phone, then entered a resident's room. The staff person left the room after approximately one minute. At 10:18 A.M., the staff person returned with linens in his/her left hand and a cell phone in the right hand. He/She walked slowly while looking down at his/her phone. During an interview on 11/26/24 at 11:17 A.M., LPN H said personal phones or cell phones should not be used in the resident care areas. During an interview on 11/26/24 at 11:35 A.M., CNA C said staff were not supposed to use their cell phones while providing care to the resident. If important or emergency calls were expected, staff will let the residents know and step out of the resident areas to answer the call. 3. During an interview on 11/26/24 at 12:06 P.M., the Administrator said residents should be treated with dignity and respect. If a resident was uncomfortable with certain staff, the staff member will not take care of the resident. He expected staff to interview the resident and investigate the concerns. It should be documented. He expected staff to ensure the aide was not assigned to the resident. The aide is expected to be taken off the schedule until further notice. In addition, the Administrator expected staff to refrain from using their cell phones while providing resident care. The staff can have their cell phones but should not be actively using them in the resident care areas. MO00243731 MO00241905

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to ensure residents or the resident's responsible party (RP) were invited to participate in all aspects of person-centered care planning for one resident who was not notified after his/her insurance was changed by the facility (Resident #67). The sample was 23. The census was 115. Review of the facility's Resident Rights policy, dated 11/22/24, showed: -The facility recognizes and respects that each resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. Exercising rights mean that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. The facility will ensure that facility operations and systems are implemented in a manner that the resident/resident representative can exercise his or his rights without interference, coercion, discrimination, or reprisal from the facility. The facility will implement and maintain systems to ensure all facility staff understand and foster the rights of every nursing home resident; -Resident Rights include: The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meeting and the right to request revisions to the person-centered plan of care; -The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care; -The right to be informed, in advance, of changes to the plan of care; -The right to see the care plan, including the right to sign after significant changes to the plan of care; -The right to request, refuses, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Review of Resident #67's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/5/24, showed: -Cognitively intact; -Diagnosis included diabetes. Review of the resident's medical record, showed: (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted on [DATE]; -Diagnosis of type 2 diabetes with foot ulcer. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has little, or no activity involvement related to resident wishes not to participate; -Intervention: Resident is able to tell you his/her preferences about attendance/activities. During an interview on 11/25/24 at 9:03 A.M., the resident's family member said the facility, without permission or discussion with the resident or family, changed him/her from a Medicare Advantage plan to classic plan. Review of the resident's progress notes, dated 11/10/24 at 2:46 P.M., showed the resident's Trulicity (medication used for type 2 diabetes) out of stock. Pharmacy said medication is not covered by insurance. I spoke to resident and said if he/she would like to try Ozempic (medication used for type 2 diabetes) or another medication covered. Resident became upset, no, I would like to know who the hell changed insurance. Said he/she would call family and have family follow up with Endo (Endocrinology, specializes in diagnosing and treating conditions related to hormones) and insurance. Review of the resident's Physician's Orders Sheet (POS), dated November 2024, showed: -An order, dated 6/21/24, for Dulaglutide (Trulicity) subcutaneous (applied under the skin) solution pen-injector 3 milligram (mg)/0.5 milliliters (ml). Inject 4.5 mg subcutaneously one time a day, every Friday for hyperglycemia (blood sugar level too high). During an interview on 11/25/24 at 4:45 P.M., the Business Office Manager (BOM) said the resident's payor source is Medicaid. There was a mess up on the facility part. The BOM was informed there were two insurances. Some residents with dual plans and those two insurances were no longer able to see their medical provider, so he/she switched those residents to traditional Medicare with Part D so they would be able to see the house doctor. He/She assumed someone spoke to the residents and/or responsible party. The BOM later found out he/she had the incorrect information regarding Resident #67's insurance and medical provider after he/she switched the resident to classic Medicare. He/She explained to Resident #67's family that it was an error. The resident's family called the facility because he/she was concerned about the resident's medications, briefs, and extra money used to buy the resident snacks. The previous insurance provided money for the resident's family to purchase those items even though it is usually community-based supplies, and the facility has those items. They reached out to the resident's insurance and ensured there was a contract between the insurance and new ownership. The BOM said 14 residents were accidentally switched during that time. The BOM has since contacted the residents and responsible party, but Resident #67's family was the only one that wanted him/her to switch back. During an interview on 11/25/24 at 4:50 P.M., Licensed Practical Nurse (LPN) Manager L said there was never an issue with the resident's medication, Trulicity. The pharmacy delivered the medication, but it went missing. The facility paid for the replacement. There must have been a miscommunication because the medication is covered. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 9:30 A.M., the resident said no one notified him/her or his/her family about the insurance switch. He/She would have wanted someone to tell him/her. He/She confirmed there had been no change in his/her care or medications. Someone must have talked to corporate because LPN Manager L found a way to get him/her the Trulicity. During an interview on 11/12/24 at 12:06 P.M., the Administrator said he expected residents and their responsible party/power of attorney (POA) to have been notified regarding possible changes to providers and insurance. Typically, the social worker would have been responsible for notifying them. The residents have the right to be informed in advance of changes to the plan of care. MO00245661

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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. 37681 Based on interview and record review, the facility failed to notify hospice services after a resident fell and was transferred to the emergency room . The facility also failed to notify the resident's responsible party prior to transferring the resident to the emergency room (Resident #222). The sample size was 23. The census was 115. Review of the facility's undated Hospice Services Policy and Procedure, showed: -Definitions: Hospice Care means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care; -Terminally Ill means the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course; -Policy: The facility contracts for hospice services for residents who wish to participate in such programs; -Specific Procedures/Requirements; -The facility has entered into a contractual arrangement for hospice services to ensure that residents who wish to participate in a hospice program may do so; -The hospice agency retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions, which includes: -Designation of a hospice registered nurse to coordinate the implementation of the plan of care; -Provision of substantially all core services that must be routinely provided directly by the hospice employees, and cannot be delegated to the facility; -Communication between the hospice and facility when any changes are indicated or made to the plan of care. Review of Resident #222's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/15/24, showed: -Severe cognitive impairment; -Rejection of care occurred one to three out of seven days; -Dependent on staff for self-care and mobility; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included end stage renal disease and fractures; -Hospice services not indicated. Review of the resident's October 2024 physician's orders, showed: -An order dated 10/1/24 for hospice evaluation for severe malnutrition; -An order dated 10/3/24 to admit to hospice services. Review of the resident's Hospice Election Statement, showed the resident and hospice company signed the agreement on 10/2/24. Review of the resident's undated care plan, last revised 10/7/24, showed no information regarding hospice services. Review of the resident's progress notes, showed: -On 10/12/24 at 4:32 A.M., during rounds resident observed laying with legs in bed and head resting on floor mat next to bed. Resident appeared to have emesis (vomit), brown coffee grounds and was yelling out. 911 called related to being unable to move resident. Resident sent to the hospital for further evaluation and treatment. The resident's emergency contact notified of transfer. Message left for physician notifying him of the same; -On 10/12/24 at 8:30 A.M., resident received from hospital via medical transport. Resident had no changes when he/she arrived. Power of Attorney (POA) into visit and hospice nurse arrived. The hospice nurse visited with resident and stated he/she is actively dying. Nurse was upset with staff regarding resident going to hospital via 911 related to coffee ground emesis and fall with injury. During an interview on 11/26/24 at 11:05 A.M., Licensed Practical Nurse (LPN) I said he/she was the nurse on duty. When he/she assessed the resident, he/she was moaning and had coffee ground emesis all over and also had a back fracture. Whenever they touched the resident, he/she would moan in pain. LPN I did not contact the Hospice Nurse prior to sending the resident out. LPN I said he/she contacted the family and told them the resident would be sent out. He/She was not sure of the policy regarding contacting hospice before sending a resident out. During an interview on 11/26/24 at 11:00 A.M., the resident's responsible party said the facility called him/her after the resident was sent to the hospital. If the facility had called prior to sending the resident to the hospital, he/she would have informed the facility to not send the resident out. During an interview on 11/26/24 at 10:01 A.M., the Hospice Manager said when a resident had a change in condition at the facility, the facility staff were educated to contact hospice before calling 911 or sending a resident to the hospital. The facility staff notified hospice after they had already sent the resident to the hospital. The Hospice Nurse expected facility staff to contact hospice prior to sending the resident out. (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 11/25/24 at 11:22 A.M., the Director of Nursing (DON) said the night the resident had a fall, two nurses said they called the family and the family agreed to send the resident out to the hospital. However, when she spoke with the family, the family said they did not agree to send the resident to the hospital. The resident received hospice services and the facility staff should have called the hospice nurse prior to sending the resident to the hospital. MO00243731

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 12724 Based on interview and record review, the facility failed to ensure one resident (Resident #507) was free from verbal abuse and treated with respect and dignity, when a Certified Nurse Aide (CNA) used profanity at the resident and to not identity him/herself after being asked. In addition, the CNA continued to worked at the facility and was assigned to the resident. The sample was 30. The census was 114. Review of the facility's Resident's Rights policy, dated 11/22/24, showed the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the resident. The resident has the right to exercise his or her rights as a resident of the facility and as citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights. Review of Resident #507's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/16/25, showed: -Diagnoses included coronary artery disease (heart disease), high blood pressure, hyperlipidemia, anxiety, depression, and asthma; -Cognitively intact; -No physical or verbal behaviors. Review of the resident's care plan, in use during survey, showed: -Focus: The resident has a behavior problem related to repetitive vocal complaints regarding other patients care and embellishing the specifics of what actually happened; -Goal: Resident will have fewer episodes; -Interventions: Anticipate and meet the resident's needs; -Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by; -If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; -Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed; -Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Offer alternate placement and/or room change. Review of the resident's progress notes, February 2025, showed no documentation of the resident's interaction with staff or behaviors. During an interview on 4/16/25 at 9:15 A.M., the resident said he/she was on the phone with Ombudsman CC when an aide entered the room to assist the roommate. The resident told staff the roommate was hard to understand. The CNA told the resident to shut the fuck up. He/She said Ombudsman CC was on the phone, and the CNA said Fuck him/her too. During an interview on 4/16/25 at 10:00 A.M., Administrator MM said he/she was aware of the incident. The resident often interferes with other residents' care. He/She received an email from Ombudsman CC. The incident occurred on 2/18/25. Administrator MM read the email that he/she received and his/her response to the email. Ombudsman CC overheard CNA BB tell the resident to Mind your fucking business. Administrator MM spoke to CNA BB. He/She reported that he/she did not use profanity. He/She told the resident to Mind your own business. Administrator MM told CNA BB to leave the room whenever he/she feels frustrated. Administrator MM confirmed that CNA BB continued to work shifts at the facility. Review of the email correspondence from Ombudsman CC to Administrator MM, dated 2/18/25 at 4:50 P.M., showed We received a call from the resident regarding some of his/her concerns. While on the phone with the resident, a staff member was overheard telling the resident to Mind his/her own f***ing business when he/she asked the staff member's name. He/She refused to give the resident his/her name. He/She was caring for the resident at 4:45 P.M. on 2/18/25. The resident said this individual was also working last night. Can someone please follow up with the resident regarding these concerns. Review of the email correspondence from Administrator MM to Ombudsman CC, dated 2/18/25 at 6:04 P.M., showed I spoke to him/her (CNA BB), and he/she denies cussing, but did admit to telling him/her to mind his/her business and refusing to give his/her name. I also told him/her this was heard by someone on the phone, but he/she still denied it. We discussed the expectation moving forward is for him/her to leave the room when the resident starts to be disrespectful to him/her, and not to respond to the resident regarding the care for other residents as it is not his/her concern. He/She does not need to make any comment in regard to the resident being in anyone else's business. He/She can get someone else to provide the resident's care if he/she needs to. The resident can be very disrespectful and after a long day, it is best for them to walk away rather than engage. During an interview on 4/16/25 at 2:30 P.M., the resident said CNA BB was standing on the roommate's side of the room. He/She told CNA BB the roommate had trouble speaking. CNA BB told the resident to Mind his/her fucking business. He/She told the CNA that Ombudsman CC wanted to speak to him/her, and the CNA said, Fuck him/her too. The resident said he/he feared for his/her roommate's life and his/her own life, but especially for the roommate, because CNA BB was working with him/her. CNA BB tried to give the resident a shower in the past, and he/she refused. He/She told the CNA, No, not from you. He/She had witnessed disrespectful behavior to other residents from CNA BB. Sometimes the resident feels he/she has to speak for his/her roommate because he/she cannot communicate well. Review of the resident's shower sheet, dated 3/15/25, showed: -Refused; (continued on next page)

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	265766	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, MO 63021

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documented by CNA BB. During an interview on 4/16/25 at 3:06 P.M., Ombudsman CC said he/she remembered the incident. He/She was in the middle of a phone conversation with the resident. He/She heard the resident ask the aide a question. Ombudsman CC did not make out what the aide said, but could tell he/she had answered the question with an attitude towards the resident. The resident asked the aide what his/her name was, and the aide told the resident to Mind his/her fucking business. The resident made a point to tell the aide he/she was on the phone. He/She tried to further the conversation, but the aide left the room. Ombudsman CC clearly heard the aide say Mind your fucking business. He/She asked the resident if the aide knew he/she was on the phone. Ombudsman CC added he/she did not hear the CNA say Fuck him/her too. The resident's voice started to become louder, continuing to engage in a conversation, but the aide could not be heard as well. It was if the aide was leaving the room or left the room because his/her voice was fading. He/she did not hear what was said by the aide. At first he/she was concerned the aide responded that way and emailed Administrator MM. Administrator MM immediately went upstairs and started the investigation. The CNA was agency staff and Administrator MM was handling it. Ombudsman CC was unaware of the outcome. He/She did not know if the aide was suspended or terminated. The resident told her the aide was still working at the facility. The resident did not seem concerned, but he/she wanted an apology. The resident said the Administrator told the agency aide to apologize to the resident. The resident was never fearful, and Ombudsman CC felt confident the resident was able to confront staff. The resident said he/she saw the aide in the hall, but he/she never went to apologize to the resident. The resident was more concerned with the apology. Ombudsman CC said the CNA continuing to work with the resident would be an issue. The resident mentioned he/she saw the aide, but not that he/she was assigned to him/her. During an interview on 4/21/25 at 12:00 P.M., CNA BB said he/she remembered the incident. He/She confirmed he/she worked for agency and was offered a job at the facility, but never finished on-boarding. The roommate was at an activity, so when Resident #507 turned on the call light, he/she was surprised because the resident does not turn their call light on often. When CNA BB entered the room, he/she was not aware the roommate returned from the activity because he/she did not bring the roommate back. Resident #507 started telling CNA BB that agency staff do not know how to take care of his/her roommate. They did not understand the roommate. The resident continued to talk about the roommate and how to take care of him/her. CNA BB told the resident that he/she could take care of the roommate, and he/she was not talking to him/her about the roommate. CNA BB said he/she understood privacy laws and was not discussing anything about the roommate. CNA BB was aware the resident was on the phone with someone, an advocate or Ombudsman. CNA BB got on the phone with the advocate and said the same thing. CNA BB said he/she got on the phone and said he/she was not discussing the roommate with the resident. CNA BB did not know what was said on the phone because he/she gave the phone back and left the room. The resident told the Administrator. CNA BB was not sent home, and did not give a written statement. CNA BB never told the resident to Mind his/her business or Mind his/her fucking business. He/She was never asked what his/her name was from the resident. He/She had worked with the resident since the incident. He/She will do rounds and ask if he/she needed anything, and that is it. Review of CNA BB's employee punch report, showed he/she worked at the facility on 2/18, 2/19, 2/20, 2/21, 2/26, 2/28, 3/1, 3/2, 3/3, 3/4, 3/5, 3/6, 3/12, 3/14, 3/15, 3/16, 3/18, 3/19, 3/20, 4/2, and 4/6/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 322 Old State Road Ellisville, MO 63021	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/25 at 2:50 P.M., the Social Service Coordinator said she started working at the facility one month ago. If there was an incident that resulted in a resident alleging unprofessional or disrespectful behavior from staff, she would contact their immediate supervisor, the Social Worker, and conduct a safe survey. A safe survey is when they ask residents if they had any issues and if they felt safe. She would talk to the Director of Nursing (DON) and ask that they do not put that staff on the resident's assignment anymore. She was not aware of the incident that occurred with the resident and staff. During an interview on 4/21/25 at 3:00 P.M., the Social Worker said she had worked for the facility for ten years. The resident did report there was an incident that occurred when he/she was cussed at. The Social Worker heard about it during report by the Nurse Manager and the DON. It was reported and addressed by upper management. The resident wanted to talk about it. He/She said the staff cursed at him/her. The Social Worker did not remember if the resident said anything about the aide working with him/her again. It would not be appropriate for the aide to return after a resident reported they were cursed by them. It would not be appropriate for the aide to be assigned to that resident. They would have that person leave the building and determine if it happened. Even if they still worked in the facility, they would try not to assign the aide to the resident. Residents are also interviewed to see if they had problems with that aide. During an interview on 4/17/25 at 2:00 P.M., Administrator MM said there were interventions taken. CNA BB was told when providing care to the roommate, he/she did not have to explain anything when the resident is cussing or yelling. The aide should leave, step away, and get another aide to cover. Administrator MM spoke to the resident. Per the resident, he/she was asking questions about the roommate, and CNA BB said he/she would not answer questions about the roommate's care. Per CNA BB, he/she denied saying, Mind your fucking business. He/She said Mind your business. However, in addition to the resident's statement there is an interview with the ombudsman where he/she said he/she clearly heard CNA BB use the f word. Administrator MM was asked if there were conversations regarding assignment changes to ensure the aide would not work with the resident. Administrator MM did not recall conversations or documentation to show assignments were changed or interventions to ensure the CNA did not work with the resident. It ended with the email that was sent to the ombudsman. Administrator MM was unaware if he/she spoke to the unit manager. He/She did not have a reason for not sending the CNA home. He/She would expect all residents to be treated with dignity and respect. It was not appropriate for a staff member to tell a resident to mind his/her business when a resident asked for their name. MO00252008 MO00252419 MO00252173 MO00251714 MO00248649

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 40865 Based on interview and record review, the facility staff failed to appropriately respond to a resident's (Resident #351) change of condition, failed to conduct a thorough, documented assessment, and failed to contact the resident's physician, regarding the resident's change of condition, which began on [DATE]. The resident expired in the facility on [DATE]. The sample was 23. The facility census was 134. The Administrator was notified on [DATE] at 11:45 A.M., of an immediate jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor on-site verification. Review of the facility's, undated Change of Condition Notification Policy and Procedure, showed: -Definitions: Significant change in the resident's condition: Is any physical, mental or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); -Policy: The facility will promptly notify the resident, his or her physician/practitioner and representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, resident rights, etc); -Specific procedures/requirements: -The nurse will notify the resident's attending physician/practitioner or physician on call when there has been a: --Significant change in the resident's physical, mental, or psychosocial status; --Need to transfer the resident to a hospital/treatment center; -Prior to notifying the physician/practitioner of changes in the resident's condition, the nurse will make detailed observations and gather relevant and pertinent information for the provider; -Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: --The resident is involved in any accident or incident that results in an injury of unknown source: --There is a significant change in the resident's physical, mental or psychosocial status; -The nurse/designee will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status, including documentation of who was notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #351's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Cognitively intact; -No behaviors or rejection of care; -Functional abilities and goals: --Functional limitations in range of motion -Lower extremity: Impairment on one side; --Mobility devices: Wheelchair, walker; -Mobility: Roll left to right: Supervision or touching assistance; -Sit to lying: Supervision or touching assistance; -Lying to sitting on side of bed: Supervision or touching assistance; -Sit to stand: Supervision or touching assistance; -Chair/bed to chair transfer: Supervision or touching assistance; -Toilet transfer: Supervision or touching assistance; -Pain management: -At any time has resident been on a scheduled pain medication regiment: No; -At any time has resident received as needed pain medications: No; -Should pain assessment interview be conducted: Yes; -Pain presence: Yes; -Pain frequency: Almost constantly; -Pain effect on sleep: Almost constantly; -Pain intensity: Numeric rating scale (,d+[DATE]): 8; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection), peripheral vascular disease (PVD - a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), acute embolism and thrombosis of right calf muscular vein (any clot involving the deep veins of the calf) and polyneuropathy (a condition in which multiple peripheral nerves throughout the body are damaged). Review of the resident's care plan dated [DATE], showed: -Focus: Resident requires assistance with self care and mobility related to polyneuropathy, PVD, gangrene and post-op surgery; -Interventions: Bilateral half rails as needed for mobility; -Focus: The resident is at risk for falls; -Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; -Focus: The resident has pain; -Interventions: Administer analgesia (medications that relieve pain) (specify medication) as per orders. Monitor/document for side effects of pain medication. Observe for new onset or increased agitation, restlessness, confusion, nausea and falls. Report occurrences to the physician. Monitor/record pain characteristics (specify frequency) and as needed. Review of the resident's electronic Medication Administration Record for [DATE], showed: -Norco Oral Tablet ,d+[DATE]. Give one tablet by mouth every four hours as needed for pain; -On [DATE] at 1:45 A.M., Norco administered, pain level a 5. At 6:29 A.M., Norco administered, pain level a 7. At 12:06 P.M., Norco administered, pain level an 8. At 5:24 P.M., Norco administered, pain level a 4; -On [DATE] at 3:17 P.M., Norco administered, pain level a 6; -No documentation Norco administration after this time. Review of the resident's progress notes, showed: -On [DATE] at 3:17 P.M., staff administered Norco oral tab; -On [DATE] at 2:08 A.M., a note regarding the effectiveness of the pain medication administered at 3:17 P.M. , was unknown. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE] at 9:05 A.M., a note the nurse was informed by the tech at 8:30 A.M., the resident was Not how he/she was before. The nurse entered the room with the tech at 8:31 A.M. The tech said the resident was fine before and was talking to him/her while he/she was taking him/her to the bathroom. The resident was found next to bed in the wheelchair facing the television. The resident was drooling and leaning to one side. His/Her pupils were fixed (pupils that are unresponsive to light, remaining dilated or constricted). The resident was still breathing, airway was open and he/she had a thready pulse (a pulse that is so weak that it is not always palpable). Neurochecks (neurological checks) were performed and the resident was unable to do them. The nurse informed the Director of Nursing (DON) at 8:33 A.M. of the situation. While the DON called emergency medical services (EMS) at 8:34 A.M., the nurse obtained the vital signs machine at 8:35 A. M. The nurse took the blood pressure, pulse and oxygen. The resident's oxygen was at 80 (normal range is , d+[DATE]) and his/her blood pressure and pulse could not be obtained. His/Her manual pulse was thready. Neurochecks were performed again at 8:40 A.M., and the resident was guided to the floor from his/her wheelchair. Cardiopulmonary resuscitation (CPR, life sustaining measure) was started at 8:42 A.M. Help was called at 8:42 A.M., and at 8:45 A.M., an Automated External Defibrillator (AED, a medical device that can help save lives during sudden cardiac arrest) was applied. No shock was advised. EMS arrived at 8:44 A.M. Time of death was 9:17 A.M. Review of the EMS records, dated [DATE], showed: -Called for a patient in cardiac arrest; -Staff on scene were performing CPR and had an AED attached to patient; -EMS crew took over manual CPR at this time; -Staff stated to EMS the patient woke this morning and was acting normally. Staff stated the patient had no complaints. They said he/she never stated to them he/she had chest pain and never told them he/she had difficulty breathing; -Ten minutes prior to call, the patient became lethargic and lost consciousness; -The staff thought the resident was having a stroke; -After over 20 minutes of continuous resuscitation efforts the decision was made to call medical control and request terminating effort; -Complete report given to doctor and permission was given to stop resuscitation. Review of Resident #352's annual MDS dated [DATE], showed: -Adequate hearing and vision; -Able to understand others; -Able to make self understood. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 6:30 A.M., Resident #352, Resident #351's roommate, said the resident was in pretty bad shape when he/she was placed in their room, and he/she just got worse. On the morning of [DATE] around 2:00 A.M., he/she was watching television and heard his/her roommate choking. He/She asked his/her roommate, if he/she was okay, but the other resident did not respond. Resident #352 looked around the curtain and saw the Resident #351 gasping for breath. Resident #352 put on his/her shoes and rushed to the nurse's station and told the person there, his/her roommate was very sick and needed to see a nurse immediately. The person at the desk said the nurse was in another room helping another resident and he/she could not leave the desk to go get him/her, but would let the nurse know as soon as he/she returned. The resident went back to his/her room and waited, but no one came. He/She put on his/her call light and no one responded. After about 15 minutes he/she pushed Resident #351's call light, but no one responded. He/She finally fell asleep, and when he/she woke up Resident #351 was asleep in his/her bed. Then at breakfast ([DATE]), he/she heard Resident #351 had died . During interviews on [DATE] at 12:48 P.M. and on [DATE] at 2:00 P.M., Certified Nurse's Aide (CNA) Y said he/she worked with the resident from 3:00 P.M. to 11:00 P.M. on [DATE]. The resident was on his/her light all evening long. He/She was feeling sick and irritated. The resident told him/her, his/her head and chest were hurting. The CNA said he/she told the nurse several times. He/She thought the nurse went in to see the resident, but then he/she would hit the light again. The CNA saw the resident for the last time around 10:30 P. M. and he/she said he/she was fine. He/She passed the information along to the oncoming CNA that the resident was not feeling well. Between 11:00 P.M. and 11:15 P.M., as he/she was getting ready to leave, the resident's roommate came to the desk and told him/her, the resident was throwing up. He/She told the roommate the night CNA was aware the resident was not feeling good and would be in to see him/her soon. The CNA did not tell anyone the resident's roommate said he/she was throwing up. During an interview on [DATE] a 11:10 A.M., Registered Nurse (RN) W said he/she worked from 4:00 P.M. to 11:00 P.M. on [DATE]. He/She did not know the resident because this was his/her first time working on the floor. He/She did not remember anyone telling him/her there was a problem with the resident, and he/she thought there was another nurse working with him/her who would have passed medication to the resident. He/She did not call the physician or document anything, because he/she did not know there was a problem. During an interview on [DATE] at 10:40 A.M., Certified Medication Technician (CMT) S said he/she relieved the 3:00 P.M. to 11:00 P.M. nurse, who did not tell him/her the resident was having any problems on [DATE]. The 3:00 P.M. to 11:00 P.M. CNA told him/her the resident had an upset stomach shortly after shift change, and he/she gave the resident some Tums (antacid for upset stomach). The resident's roommate complained about the resident's television being too loud and asked if he/she could turn it off, but the CMT told the resident he/she could not do that because the other resident had the right to watch television. He/She did not see the resident again until around 6:30 A.M., and he/she was sleeping. They did not have a nurse on duty on the fourth floor that night. He/She would have called a nurse up from the other floor if there had been any problems. He/She did not administer any pain medication for the resident that night and the roommate did not say anything else to him/her about the resident being ill. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:45 A.M., CNA X said he/she worked overnight on [DATE] (into [DATE]). When he/she came in, the CNA who was leaving told him/her Resident #351 complained of not feeling well. He/She did not get to the resident's room until around 11:30 P.M., because they were trying to figure out where everyone would be assigned. The resident was in bed and said he/she needed something for his/her stomach, because he/she was nauseous. He/She told the CMT who took the resident some Tums, and the CNA got him/her a Coke. The resident's roommate told him/her, Resident #351 was not feeling good. The next time the CNA saw the resident was around 3:00 A.M. The resident was in the bathroom. He/She checked to see if he/she needed help, because he/she was not supposed to be getting up by him/herself. The resident did not look good. He/She was all clammy (sweaty). The CNA helped the resident back to his/her chair beside the bed and said he/she did not look well. The resident said he/she was alright so the CNA did not report this to the CMT or a nurse. Around 4:30 A.M. to 5:00 A.M., he/she checked on the resident again and he/she was asleep in bed. The CNA checked on the resident again around 7:00 A.M., and he/she was still sleeping. Between 8:00 A.M. and 8:30 A.M., the CNA took the resident his/her breakfast and he/she was in the bathroom again. The CNA went to wheel the resident out to his/her room for breakfast and the resident told him/her, he/she did not feel good. By the time they got to the bedside table, the resident slumped over in his/her wheelchair and stopped talking. He/She thought the resident was having a stroke. He/She immediately went and got the nurse. The nurse came into the room and said they needed to take vitals. The CNA thought they should send the resident to the hospital because it looked like a stroke. When they took the vitals, they could not be read. The nurse went and got oxygen and put it on 2 liters. Another nurse came in the room and put the oxygen on 10 liters. Another CNA came and told him/her other residents had their call lights on, so the nurse told him/her to go take care of the other residents. The CNA told the nurse he/she thought they should call 911, and the nurse told him/her it was done. When he/she was in the room with another resident, he/she heard the nurse calling for everyone to help, and when he/she got back in the room, the nurse was performing CPR. During an interview on [DATE] at 1:20 P.M., RN B said when he/she came in the morning of [DATE], no one told him/her anything about Resident #351. There was not a nurse working on the resident's floor the night before, so he/she did not get a verbal shift change. He/She only had the 24 hour shift report and there was nothing noted about the resident on it. He/She was passing medications when CNA X came and got him/her and said Resident #351 did not look like he/she had before. When the nurse got to the room, the resident was seated in his/her wheelchair by the bed. He/She was not responding, only grunting and had a pulse. The nurse told the CNA they needed to get vitals, and he/she ran down the hall to get the vitals machine. As he/she was getting the machine, he/she saw the DON on the other hall and told her to call 911. The nurse went back to the room and took the resident's vitals but could not get a reading for the resident's blood pressure or pulse. The resident's oxygen saturation level was 80, so he/she believed the resident needed oxygen. He/She left the CNA in the room with the resident and went to find oxygen. He/She found the oxygen tank but could not locate the tubing to apply the oxygen, so he/she went down to the second floor to get supplies. He/She told the nurse down on the second floor there was a resident in distress and ran back up to the fourth floor. RN B applied the oxygen but could not get the oxygen saturation level to go higher than 80. Licensed Practical Nurse (LPN) R came into the room and the resident was starting to get weaker, so they got him/her out of the wheelchair and onto the ground and started doing CPR. The DON came in then and helped them perform CPR. The EMS personnel arrived shortly after and took over CPR. CNA X told RN B the resident was responding to him/her prior to him/her coming to get the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 322 Old State Road Ellisville, MO 63021	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:50 A.M., LPN R said he/she was working on the second floor on [DATE] when RN B came down looking for oxygen supplies. He/She took the oxygen back up to the fourth floor and LPN R printed up the paperwork to send the resident to the hospital. When he/she got up to the fourth floor, the DON and another nurse were standing at the nurse's station. LPN R asked them if they needed to paperwork to give EMS and the DON told him/her they had not called 911. The DON thought RN B had called 911. LPN R went down to the resident's room to ask the nurse if he/she called 911. When he/she got to the room, the resident was up in his/her wheelchair and was breathing shallowly. RN B told LPN R, he/she had not called 911 because he/she told the DON to call. LPN R ran back to the nurse's station to tell the DON and nurse to call 911 and then went back to the resident's room to help. When he/she got back to the resident's room, the resident was unconscious. He/She told RN B they needed to get the resident out of the wheelchair, onto the floor and start CPR. They moved the resident onto the floor and then he/she ran to get the crash cart on the second floor. It took a few minutes to get back up to the fourth floor because the elevator stopped on each floor. When he/she got back to the room, the DON and RN B were performing CPR. EMS arrived shortly after to take over. He/She worked the night on [DATE] from 11:00 P.M. to 7:00 A. M. ([DATE]) and no one called down to report there were any problems with the resident. During interviews on [DATE] at 3:00 P.M. and on [DATE] at 11:30 A.M., the DON said she was passing medications on the other side of the 400 hall on [DATE] when RN B came over and said the resident was having trouble breathing and needed oxygen supplies. The RN did not tell him/her to call 911. The RN went down to the second floor to get the supplies. They usually keep oxygen supplies in the oxygen room or supply cabinet on each floor, so he/she did not know if they were out of supplies or the RN did not know where to locate them. The DON would have stayed with the resident and sent the CNA out to get the supplies. Staff should have called 911 immediately. She thought the RN had already called 911. When she got to the resident's room, RN B was performing CPR and they worked together to continue CPR until the EMS arrived. She did not know the resident complained of head and chest pain to the staff the night before. No one told her the resident did not look good during the night. This should have been documented. Staff should have notified the resident's physician and/or sent the resident to the hospital with these symptoms. He/She did not know the roommate alleged he/she tried to get help for the resident the night before and no one came to assess him/her. During an interview on [DATE] at 11:50 A.M., the Administrator said if the staff observed the resident not looking good and he/she complained of head and chest pain, the staff should have notified the nurse on duty to assess him/her. If the resident's roommate notified staff the resident needed help, they should have responded immediately. The staff should have notified the physician about these observations and complaints. All of this should have been documented. During an interview on [DATE] at 1:50 P.M., the nurse practitioner said he did not receive any calls at the office on [DATE] from the facility, and they have a 24 hour line that is always available. The facility staff told him the resident was found unresponsive and they performed CPR. No one told him the resident complained of head pain, chest pain or nausea the night before. If they would have told him, he would have told the staff to send the resident to the hospital because he was an extremely high risk for a Myocardial Infarction (MI, medical term for a heart attack) or a stroke. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:15 P.M., the resident's physician said no one called her office about the resident on [DATE]. If the resident was having head and chest pain, nauseous and sweaty, they definitely should have called, as these could be signs of a heart attack. The resident was at a higher risk for this with his/her diagnoses. Someone should have called when he/she first started having these symptoms. She would have had him/her immediately sent to the hospital. The hospital could have provided a higher level of care. She signed the death certificate, and stated the cause of death was acute coronary syndrome because she did not know all of this happened. She was just told the resident was found unresponsive and the facility performed CPR, and he/she died . It is possible if the resident went to the hospital and provided interventions, the outcome might have been different. Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the D level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s). MO00247802 MO00247822

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to provide services and/or treatment to increase or prevent reduction of range of motion. The facility failed to develop a measurable, goal oriented restorative nursing program, and/or exercise program, to ensure resident's requiring physical assistance were assisted by staff to maintain or improve their physical abilities, per facility policy. The facility provided a list of 16 current residents who had been discharged from skilled therapy services (Physical therapy (PT), Occupational Therapy (OT) or Speech Therapy (ST)) within the past 90 days. Of those 16, three were identified who would benefit from services to prevent reduction of range of motion (Residents #527, #525, and #526). The census was 114. Review of the facility's undated Restorative Nursing Services Policy and Procedure, showed: -Definitions: Restorative Nursing Program: refers to nursing interventions that promote the resident's ability to living as independently and safely as possible. This program focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning; -Policy: Residents will receive restorative nursing care as needed to help promote optimal safety and independence; -Specific Procedures/Requirements: -Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies); -Restorative nursing care will be provided by qualified and competent staff and in accordance with federal/state regulation and/or guidance. Restorative nursing interventions may be incorporated with the provision of ADL (activities of daily living) care or while carrying out other defined tasks; -Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care; -The resident or representative will be included in determining goals and the plan of care; -Restorative goals may include, but are not limited to supporting and assisting the resident in: adjusting or adapting to changing abilities. Developing, maintaining or strengthening his/her physiological and psychological resources. Maintaining his/her dignity, independence and self-esteem. Participating in the development and implementation of his/her plan of care; -The restorative nursing services restorative interventions will be implemented and documented in the medical record; -The MDS (Minimum Data Set, a federally mandated assessment instrument completed by facility staff) will only be coded as receiving restorative nursing for those interventions meeting the criteria defined in the RAI (resident assessment instrument) manual. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #527's quarterly MDS dated , 2/28/25, showed: -Upper/lower extremity impairment; -Dependent on staff for: toileting hygiene, shower/bathe, upper/lower body dressing, personal hygiene, and roll left/right; -Walk 10 feet ('): Not attempted due to medical condition or safety concerns; -Diagnoses of heart failure, high blood pressure, diabetes mellitus (low/high blood glucose level), hemiplegia (paralysis of one side of the body)/hemiparesis (weakness on one side of the body), seizure disorder and depression; -Received skilled speech therapy (ST), occupational therapy (OT) and physical therapy (PT) in the last 7 days; -Restorative Nursing Programs (range of motion (exercising the muscles that surround the joints), bed mobility, transfers, walking, dressing and/or grooming, eating and/or swallowing, and communications) for at least 15 minutes a day in the last 7 days: 0. Review of the resident's care plan, located in the electronic healthcare record (EHR), showed: -8/21/24: Focus: Chronic pain. Goal: Will verbalize adequate relief of pain or ability to cope with pain. Interventions/Tasks: Administer pain medications per physician orders; -8/22/24: Focus: At risk for falls with falls on 8/22/24, 8/25/24, 10/15/24, 10/26/24, 12/19/24, 12/20/24, 1/7/25 and 4/4/25. Goal: Will be free from falls and will not sustain serious injury from falls. Interventions/Tasks: Anticipate and meet the resident's needs. Be sure the call light is within the resident's reach and encourage the resident to use it for assistance as needed. Determine and address causative factors of the fall; -11/4/24: Focus: Impaired cognitive function or impaired thought processes related to stroke. Goal: Will be able to communicate basic needs on a daily basis. Interventions/Tasks: Ask yes/no questions in order to determine the resident's needs. Communicate with the resident/family/caregivers regarding resident's capabilities and needs; -The care plan did not show the resident was on a structured, goal oriented walking program to maintain or improve his/her walking ability. Review of the resident's physician's order sheet (POS) showed: -2/25/25: PT/OT/SP to evaluate and treat; -3/25/25: Extend ST five times a week for 30 days; -3/25/25: Extend OT five times for four weeks; -No order for a restorative nursing program or an exercise program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Training Sign-in Sheet dated 4/2/25, and signed by the Physical Therapy Assistant (PTA), showed: -Training Description: Ambulation and Transfers with wheeled walker and assist time one staff; -Bring wheelchair along for ambulation. Do not leave resident unattended on the toilet; -The training was signed by one Certified Nursing Assistant (CNA), three Certified Medication Technicians (CMTs), and one Licensed Practical Nurse (LPN); -The training did not show how often or how far the resident should walk. Review of the resident's PT discharge notes, showed: -Start of Care: February 25, 2025; -Date of Discharge: April 11, 2025; -Precautions: Fall risk; -Ambulation: Supervision or touching assistance to walk 10' and 50' with two turns; -Summary of Skilled Interventions: Therapeutic exercises to improve strength and endurance. Therapeutic activities to improve safety and independence with functional mobility. Gait (walking) training to improve safety and endurance with ambulation; -Barriers that impacted progress: Cognitive impairment; -Reason for Discharge: Resident has met goals. Review of the resident's OT discharge notes, showed: -Start of Care: February 25, 2025; -Date of Discharge: April 11, 2025; -Precautions: Fall risk; -Discharge Level: Sit - Stand: Supervision or touching assistance; -Discharge Level: Chair/Bed-to-Chair: Partial/moderate assistance; -Discharge Recommendations: Resident at maximum potential with self cares and mobility at this time. Have staff allow resident to do what he/she safely can do for himself/herself. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 4/17/25 at 10:07 A.M., showed the resident was in the dining room. Observation of the resident's room showed his/her wheeled walker was in his/her room with a sign taped to the walker. The sign was undated and showed the resident's name, room number, the device was a wheeled walker, level of assistance (contact guard (standing next to the resident)), walk in room and corridor. The sign did not show how many times a day the resident should walk or how far the resident should be walked. CNA T, who was assigned to the resident said he/she walked the resident a few feet in the resident's room to/from the resident's bathroom from his/her wheelchair or bed, about 10' with a gait belt (a belt applied the waist to provide stability during walking). He/She had never walked the resident in the corridor or to the dining room. He/She looked at the sign and confirmed it did not give instructions on how many times the resident should be walked or how far. CNA T had not been inserviced on any current walking program for the resident. The resident was already in the dining room this morning when he/she came to work. He/She did not walk the resident to the dining room. Review of the Training Sign-in Sheet dated 4/2/25, and completed by the PTA, showed CNA T did not attend the inservice. 2. Review of Resident #525's annual MDS dated [DATE], showed: -No impairment of the upper/lower extremities; -Dependent on staff for toilet hygiene, shower/bathe; -Partial/moderate assistance required for eating, upper/lower body dressing, personal hygiene, roll left/right, sit to lying, lying to sitting on side of the bed, sit to stand, and chair/bed-to-chair transfer; -Walk 10': Not attempted due to medical condition or safety concerns; -Diagnoses of high blood pressure, renal (kidney) insufficiency, diabetes mellitus, dementia and anxiety; -No skilled therapy in the last 7 days; -Restorative Nursing Programs: No. Review of the resident's care plan, located in the EHR, showed: -12/24/24: Focus: Communication problem. Goal: Will be able to make basic needs known. Interventions/Tasks: Monitor/document/report any changes in ability to communicate; -4/3/25: Focus: Impaired visual function. Goal: Will show no decline in visual function. Interventions/Tasks: Ensure proper visual aides are available. Remind resident to wear glasses; -4/3/25: Focus: Pain related to collapsed vertebra. Goal: Will not have an interruption in normal activities due to pain. Interventions/Tasks: Administer pain medication as ordered. Anticipate the resident's need for pain relief and respond immediately; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/3/25: Focus: Resident had a fall on 8/1/24 with minor injury. Resident is a moderate risk for falls related to gait/balance problems. Goal: Will resume activities without further incident. Will be free from falls. Will not sustain serious injury. Interventions/Tasks: Continue the interventions on the at-risk plan. Be sure the resident's call light is within reach and encourage resident to use it. Ensure resident is wearing appropriate footwear with good traction when ambulating; -The care plan did not show the resident was on a structured, goal oriented walking program to maintain or improve his/her walking ability. Review of the resident's POS, located in the EHR, showed no order for skilled therapy and no order for a restorative nursing program or an exercise program. Review of the resident's PT discharge notes, showed: -Start of Care: 12/10/24; -Date of Discharge: 2/13/25; -Discharge Level: Walk 10' with supervision or touching assistance; -Discharge Level: Walk 50' with supervision or touching assistance. 3. Review of Resident #526's quarterly MDS dated [DATE], showed: -Impairment of one upper extremity; -Dependent on staff for shower/bathe, personal hygiene, roll left/right, sit to stand and toilet transfer; -Partial/moderate assistance required for upper/lower body dressing; -Walk 10': Not attempted due to medical condition or safety concerns; -Diagnoses of anemia (the blood has a reduced ability to carry oxygen), coronary artery disease (heart disease caused by the build-up of plaque), high blood pressure, diabetes mellitus, hemiplegia/hemiparesis, seizures and depression; -No skilled therapy in the last 7 days; -Restorative Nursing Programs: No. Review of the resident's care plan, located in the EHR, showed: -10/2/24: Focus: Acute/chronic pain. Goal: Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions/Tasks: Administer pain medication as ordered. Anticipate resident's need for pain relief and respond immediately; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/8/24: Focus: Hemiplegia/hemiparesis related to stroke. Goal: Will remain free from complications or discomfort. Interventions/Tasks: Give medications as ordered. Pain management as needed; -12/20/24: Focus: At risk for falls related to hemiplegia/hemiparesis. goal: Will not sustain serious injury. Interventions/Tasks: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it. Help with transfers; -12/20/24: Focus: Had an actual fall 12/20/24 and 12/30/24. Goal: Will have no further falls; -The care plan did not show the resident was on a structured, goal oriented walking program to maintain or improve his/her walking ability. Review of the resident's POS, located in the EHR, showed: -3/25/25: PT presents at baseline functional level of stand-by assistance/minimal assistance for bed mobility and transfers. Physical therapy is not indicated at this time; -3/26/25: OT evaluation completed this date with no further treatment required as the resident is at baseline; -No order for a restorative nursing program or an exercise program. 4. During an interview on 4/26/25 at 7:07 A.M., LPN O said he/she worked at the facility part time. He/She was not sure if the facility had a list of residents who needed range of motion or walking. If there was a list, he/she had never seen it. Review of the Training Sign-in Sheet dated 4/2/25 and completed by the PTA, showed LPN O did not attend the inservice. During an interview on 4/26/25 at 7:12 A.M., CMT Q said he/she had worked at the facility for a couple of years. He/She worked on the second and third floor. He/She was not aware of any list of residents staff should be providing restorative services or routine exercises to. The facility used to have a restorative nursing program, but that was several months ago. There was no current restorative nursing program he/she was aware of. Review of the Training Sign-in Sheet dated 4/2/25 and completed by the PTA, showed CMT Q did not attend the inservice. During an interview on 4/16/25 at 7:15 A.M., CNA R said he/she was not aware of any residents who were on a restorative program. Review of the Training Sign-in Sheet dated 4/2/25 and completed by the PTA, showed CNA R did not attend the inservice. During an interview on 4/16/25 at 7:46 A.M., CNA N said this was his/her third week working at the facility. He/She did not know of any list of residents who required walking or range of motion exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Training Sign-in Sheet dated 4/2/25 and completed by the PTA, showed CNA N did not attend the inservice. During an interview on 4/16/25 at 7:51 A.M., MDS Coordinator M said he/she had been at the facility since 8/2024. The facility had not had a restorative nursing program since he/she had been there. He/She knew the managers had discussed it before in the daily meetings. The facility staff did try to walk some residents to the dining room, but there was no program and no documentation to show it was being done. Review of the Training Sign-in Sheet dated 4/2/25, and completed by the PTA, showed MDS Coordinator M did not attend the inservice. During an interview on 4/17/25 at 10:15 A.M., CMT X said there were no residents with orders to be walked or receive range of motion to his/her knowledge. Review of the Training Sign-in Sheet dated 4/2/25, and completed by the PTA, showed CMT X attended the inservice. During an interview on 4/17/25 at 10:15 A.M., LPN Y said there were no residents with orders to be walked or for range of motion he/she was aware of. Review of the Training Sign-in Sheet dated 4/2/25, and completed by the PTA, showed LPN Y did not attend the inservice. During an interview on 4/16/25 at 7:55 A.M., the Rehab Director said the last time the facility had a restorative nursing program with a restorative assistant to complete resident exercises was about two years ago. During an interview on 4/17/25 at 9:49 A.M., PT W said he/she had worked at the facility for 3 years, and OT V said he/she had worked at the facility for 5 years. PT W said a restorative program was a maintenance program to ensure residents did not lose their independence gained during skilled therapy. A restorative program was important to have. The facility had not had a restorative program for over a year. There had been discussions with management about starting a restorative program, but he/she did not know when it would happen. Both PT W and OT V looked at the list of 16 residents (completed by the Rehab Director) that had received skilled therapy and still resided at the facility. Both said if the facility had a restorative program, they would have referred Resident #525 for ambulation to/from the toilet, #526 for upper/lower body exercises and strengthening, and #527 for ambulation. Both the PT and OT said staff had been inserviced regarding ambulating Resident #527. They would look for the inservice sheet. All three residents were confused and unable to be interviewed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25 at 4:00 P.M., the Director of Nurses (DON) said she had been at the facility for about one year and there had not been a restorative program since she had been there. Administrator MM said they had not been able to dedicate a CNA to train as a restorative aide because all of their CNAs were needed on the floor to provide care. She thought that skilled therapy was inservicing the CNAs on who needed range of motion and ambulation assistance. They just don't currently have a program in place. Both Administrator MM and the DON acknowledged restorative nursing was important to ensure residents maintained their physical abilities. MO00252419

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37681 Based on interview and record review, the facility failed to assess and document findings for 72 hours, in accordance with the facility's policy after one sampled resident experienced an unwitnessed fall (Resident #99). In addition, the facility failed to update the resident's care plan. The sample size was 23. The census was 115. Review of the facility's Fall Protocols Policy, dated 10/22/23, showed: -Policy: The nursing staff, in conjunction with the interdisciplinary team will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The facility will maintain the environment in a manner to promote safety; -Actual Fall: If a resident experiences a fall, the resident will be assessed for potential injury and a change in condition; -The incident will be documented in the resident's medical record; -The resident will be monitored for change in condition every shift for 72 hours, unless otherwise ordered by the physician. Review of Resident #99's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/13/24, showed: -Cognitively impaired; -Wandering occurred one to three out of seven days; -Walked 10-50 feet with partial assistance; -Uses a manual wheelchair; -Diagnoses included diabetes, dementia and traumatic brain injury. Review of the resident's care plan, in use during the time of the investigation, revised 10/9/24, showed: -Focus: The resident is at risk for falls related to dementia, diabetes and high blood pressure medication; -Goal: The resident will be free of falls through the review date; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Bed in lowest position at all times. Review of the resident's progress notes, showed on 11/8/24 at 2:33 P.M., the Certified Medication Technician (CMT) called this nurse to look at resident for any injuries as resident told CMT he/she fell last evening. Upon entering the room, noted resident lying on his/her bed and spouse in chair next to the resident. The nurse obtained vital signs and looked at his/her back and knee; -No further documentation regarding the resident's fall. Review of the resident's neurological assessment flow sheet, received 12/2/24 at 2:51 P.M., showed neurological checks completed 11/8/24 and 11/9/24; -No further documentation of neurological checks. Review of the resident's care plan, showed no information regarding the fall on 11/8/24. During interviews on 12/2/24 at 10:36 A.M., and 12:12 P.M. and 12/3/24 at 7:22 A.M. with the Administrator and Director of Nursing, the resident's fall assessment was requested from the facility and not received. During an interview on 11/25/24 at 10:00 A.M., CMT O said the resident was at risk for falls. During an interview on 11/26/24 at 11:17 A.M., Licensed Practical Nurse (LPN) H said whenever there was an unwitnessed fall, or a witnessed fall with an injury, neurological checks should be completed for 72 hours after the resident's fall. During an interview on 11/25/24 at 4:37 P.M., the Director of Nursing (DON) said if a resident experienced an unwitnessed fall, staff should complete neurological checks for 72 hours and the checks should be documented in the resident's medical record. The resident did not have completed neurological checks documented in the medical record.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 35394 40865 JW Based on observation, interview and record review, the facility failed to provide pain management, for one resident (Resident #524) with a fractured hip who complained of pain when staff provided care upon waking, when assessed by therapy at breakfast and when put to bed after dinner. The resident was administered no pain medication for 19 hours until he/she was transferred to the hospital. The facility staff also failed to provide as needed (PRN) pain medication to one resident (Resident #516) who suffered from chronic pain for four hours. The facility also failed to ensure one resident's (Resident #507's) Lidocaine patch (a topical pain reliever) was ordered timely and administered as ordered. In addition, the facility failed to ensure timely referral to pain management and failed to implement alternative interventions after discontinuing the resident's Norco (an opioid pain reliever), placing the resident at higher risk for unnecessary pain and discomfort. The sample size was 30. The facility census was 114. The Administrator was notified on 4/17/25 at 4:45 P.M., of an immediate jeopardy (IJ) which began on 3/14/25. The IJ was removed on 4/18/25 as confirmed by surveyor on-site verification. Review of the facility's undated Pain Management policy, showed: -Definitions: Pain is an unpleasant sensory and emotional experience that can be acute, recurrent or persistent; -Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals; -Policy: The organization will ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. Pain management will be a collaborative effort between the resident, physician and representatives of the interdisciplinary team, including but not limited to pharmacy, nursing, mental health professionals, rehab therapy, social services, activities, etc; -Specific procedures/requirements: -Pain management is a multi-disciplinary care process that includes the following: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Assessing the potential for pain; -Effectively recognizing the presence of pain; -Identifying the characteristics of pain; -Addressing the underlying causes of pain; -Developing and implementing approaches to pain management; -Identifying and using specific strategies for different levels and sources of pain; -Monitoring for the effectiveness of interventions; -Modifying approaches as necessary; -It is important to recognize cognitive, cultural, familial, or gender specific influences on the resident's ability or willingness to verbalize pain; -Licensed nursing staff will conduct a comprehensive pain evaluation upon admission/readmission to the facility, at the quarterly review, whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain; -Licensed nursing staff will evaluate the resident's pain and consequences of pain at least each shift for the presence and/or absence of acute or breakthrough pain or significant changes in levels of chronic pain. Findings will be documented in the medical record; -If pain has not been adequately controlled, the (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	multidisciplinary team, including the physician may reconsider approaches and make adjustments as indicated; -If pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician may try to discontinue or taper analgesic medications to the extent possible; -The physician and staff in collaboration with the resident/resident's representative will establish a treatment regimen based on consideration of the following: --The resident's medical condition; --Current medication regimen; --Nature, severity and cause of the pain; --Course of the illness; --Treatment goals; -The resident's care plan will address pain based on the pain assessment and resident/resident representative choice. 1. Review of the Resident #524's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/23/25, showed: -Severely cognitively impaired; -Adequate hearing and vision; -Makes Self Understood: Understood; -Ability to Understand Others: Understands; (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Behaviors (physical and verbal) frequency: One to three days; -Rejection of care frequency: One to three days; -Diagnoses included weakness, cognitive communication deficit, unspecified dementia, age related osteoporosis (a condition where bones become weakened and brittle, increasing the risk of fractures, particularly in the hip, spine, and wrist), muscle weakness and heart failure; -Should a pain assessment be completed? Yes; -Pain management: -On scheduled pain regime? No; -Received as needed pain medications? No; -Pain Presence? No. Review of the resident's electronic Medication Administration Record (eMAR) dated March 2025, showed: -An order with a start date of 2/17/25 to obtain pain level via numeric pain scale every shift (pain is rated on a scale of 1-10, with 10 being the highest); -On 3/14/25, day shift, a 4 documented, on evening shift, a 4 documented and on night shift, a 6 recorded; -No order for pain medication. Review of the resident's speech therapy notes, dated 3/14/25 at 10:06 A.M., showed the resident verbalized pain in right hip area. The medication technician was notified. Review of the resident's physical therapy notes, dated 3/14/25 at 10:23 A.M., showed the resident seated in wheelchair at the dining table. The Certified Nurse's Aide (CNA) reported the resident complained of pain in the right hip. The resident stated My leg hurts and has pain with light touch at greater trochanter (the bony bump over the side of the hip) of right hip and has edema (swelling) in right lower extremity (RLE). Stop and watch form (staff communication form) filled out and given to the nurse. Per nurse practioner, X-ray ordered. Further treatment withheld until result of X-ray. Review of the resident's progress notes, showed: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/14/25 at 11:53 A.M., the nurse practioner (NP) saw the resident seated in his/her wheelchair down in the dining room and in no acute distress. Therapy asked the NP to see the resident. Resident was noted to be screaming out and would not let anyone move his/her RLE. When the NP saw the resident, he/she was much more calm and allowed him/her to palpate (examine a part of the body by touch) his/her RLE. It was significantly swollen and tender to palpation during the exam. The NP reviewed with nursing, an X-ray was ordered and pending arrival. Assessment plan: RLE pain, unable to ambulate, pending X-ray, continue to keep resident hydrated and continue with pain management. Allow resident to rest until X-ray is completed and continue to monitor; -At 7:15 P.M., the nurse reported the CNA informed him/her the resident was having increased right leg pain. Upon assessment, the resident was noted to have right hip pain radiating to his/her right knee. When staff assisted the resident to bed, the resident was noted to have right foot external rotation (the hip joint can have a limited range of internal rotation, leading to the foot turning out as a compensation) and was unable to tolerate bending his/her right knee. When attempted, the resident grabbed his/her right hip and yelled, Ouch! No discoloration noted to his/her right hip or knee. Bi-lateral lower extremity (BLE) edema noted. Staff stated the resident had increased swelling to his/her BLE. When assessing his/her right hip, the resident once again responded to any movement with Ouch! It was previously noted that morning on the nurse's station by the unit manager that a Stop and Watch was presented by the physical therapist. An order was noted in the electronic medical record by nurse practioner on this date for an X-ray of the right hip related to complaints of pain. The nurse called the unit manager to inform him/her of the resident's complaint of pain. The unit manager said he/she was aware and informed this nurse an X-ray order was to be placed per previous conversations in the day prior to his/her leaving for the day. The order was noted and the nurse would follow through with the X-ray company. The nurse placed the order with the X-ray company at that time. The X-ray company would be out as soon as possible; -At 9:40 P.M., the X-ray company was on-site at the facility to obtain rays of the right hip. Staff called the resident's family member to inform them of the resident's complaints of pain. The Director of Nursing (DON) called the facility to check on everyone due to the weather, and the nurse informed her of the X-ray obtained due to the resident's pain in right hip. Review of the resident's eMAR dated March 2025, showed: -No order for pain medication; -No medication for pain administered. Review of the resident's progress notes, showed: -On 3/15/25 at 2:35 A.M., the X-ray company informed the nurse of critical X-ray results. Findings: Acute intertrochanteric fracture (a broken hip that occurs between the greater and lesser trochanters of the femur- the thighbone.) noted. At 2:42 A.M., the nurse called the physician's office and left a message. At 2:59 A.M., the nurse called the physician's office and informed the NP of the X-ray results. The NP gave an order to send the resident to the emergency room (ER) for evaluation and treatment. At 3:30 A.M., staff placed a call to 911 for a non-emergent transfer to the hospital. At 4:00 A.M., emergency medical services (EMS) at facility to transport the resident to the hospital. At 11:03 A.M., the resident was admitted to the hospital with a closed fracture of the right femur; (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 4:46 P.M., the unit manager noted therapy brought the nurse a form he/she filled out for a change in condition from yesterday's therapy saying the resident's leg was warm, red and swollen. The nurse was actually walking out of his/her office for an appointment and passed this information on to the DON. X-ray orders were received by the 3-11 shift. They had not arrived so the nurse called and made the order STAT (immediate). Review of the resident's hospital admission records, dated 3/15/25, showed: -Resident presented to the emergency department with chief complaint of right hip pain after a fall. His/Her facility states he/she fell and hurt his/her right hip; -Primary pain intensity: 5 = moderate pain. Observation and interview on 4/15/25 at 5:30 A.M., showed the resident lay in bed yelling out Help me, Help me! The resident pointed to his/her right side and said it hurt. He/She did not remember how he/she hurt his/her hip. During interviews on 4/16/25 at 12:45 P.M. and on 4/17/25 at 9:15 A.M., CNA D said the resident was yelling out that morning (3/14/25), and he/she went into the room to check on him/her and get him/her up for the day. This was not unusual because the resident yelled out all of the time. The resident could stand on his/her own and would transfer to his/her wheelchair with assistance. When the CNA went to help the resident out of bed, he/she yelled out in pain. He/She could not stand on his/her own and the CNA put him/her back into the bed and changed him/her. The resident's leg looked swollen so he/she went to certified medication technician (CMT) E and told him/her the resident was complaining of pain and needed some pain medication. The CNA thought the CMT gave the resident the pain medication but did not know for sure because he/she waited for about an hour to go back so the medicine could kick in. The CNA got another staff member to assist him/her with getting the resident out of bed because the resident could not stand on his/her own or assist with the transfer. The CNA got the resident dressed and took him/her to the dining room. The resident received therapy in the morning, so CNA D asked the physical therapist (PT) to assess the resident to make sure he/she was able to do therapy. The PT assessed the resident and decided he/she could not do therapy and left. The PT did not say anything else to the CNA about the resident. The NP came down later and assessed the resident but did not say anything to him/her about what to do with the resident. The CNA thought a nurse came down but could not remember the nurse's name. No one told him/her to do anything differently with the resident. He/She did not know the resident's hip was broken because the resident always yelled out throughout the day, and he/she thought this was just his/her usual behavior. The resident ate his/her breakfast, lunch and dinner, so the CNA did not think the resident was in pain. CNA D changed the resident after lunch by having him/her hold onto the grab bar in the bathroom. The resident did not act any differently at that time. After dinner, the CNA decided to put the resident to bed first, before the other residents. CNA D got another aide to help him/her since the resident could not help with transferring that morning. When they went to transfer the resident into bed, he/she yelled out again in pain and needed more pain medication. The nurse immediately came and assessed the resident and ordered an x-ray. During an interview on 4/16/25 at 2:15 P.M., speech therapist (ST) EE said he/she was sitting with the resident that morning, and he/she was rubbing his/her leg and said it hurt. The ST told CMT E the resident was complaining of pain, left and did not see him/her again that day. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/16/25 at 9:30 A.M., PT DD said he/she thought the nurse manager had already looked at the resident when he/she got down there. He/She assessed the resident, wrote out a stop and watch note and told the nurse manager the leg was swollen. The resident was fine the day before and in fact walked further than ever before. During an interview on 4/16/25 at 1:15 P.M., LPN/Nurse Manager FF said he/she came in early that day and left early around 9:00 A.M. due to a medical appointment. Just as he/she was leaving, a PT person brought up a stop and watch note and handed it to the DON. A stop and watch note is anything out of the ordinary with a resident. He/She did not know there was anything wrong with the resident prior to this because the CNA did not say anything about the resident being in pain. He/She thought the DON was going to follow up on the resident. During an interview on 4/16/25 at 2:25 P.M., CMT E said he/she remembered the resident did not want to get up that day because he/she complained of pain. He/She could not remember who he/she notified, but someone came down to assess the resident. There was a concern about his/her pain but there was nothing for pain in the order book after the nurse and NP assessed him/her, so he/she did not request an order for anything or remember if he/she administered anything. During an interview on 4/17/24 at 9:45 A.M., CMT HH said they were short staffed that evening (3/14/25), and he/she had to go down to the resident's floor to administer medications. He/She remembered LPN GG going down with him/her to assess the resident. He/She did not administer any pain medication to the resident because the nurse assessed him/her and would have been responsible to get an order for the pain medication. During an interview on 4/16/25 at 2:00 P.M., LPN GG said he/she ended up coming down to assess the resident because the nurse scheduled left early that day. No one told him/her prior to coming down to assess the resident, that he/she complained of pain earlier that day or that he/she needed an X-ray. He/She did not realize it until later that evening after he/she assessed the resident when he/she was reviewing his/her electronic records and saw the NP notes for an order. He/She then notified the nurse manager and sent the order out for an X-ray. He/She did not remember giving the resident any pain medication that night. During interviews on 4/16/25 at 9:30 A.M. and on 3/17/25 at 3:30 P.M., the DON said she did not remember anyone telling her the resident was in pain that day. The information about the resident should have been passed to the oncoming nurse. If the resident complained about pain and did not have an order, the nurse should have called the physician to get an order. It would depend on if the resident was complaining about pain. It also depended on whether he/she complained of pain if he/she should have been left in his/her wheelchair all day. She did not remember seeing the stop and watch note on the resident or if the nurse told her about the X-ray. If someone did tell her a resident needed an X-ray, she would have a nurse order it and followed up with it. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 4/17/24 at 8:45 A.M. and at 12:45 P.M., the NP said he/she did not order an x-ray because he/she was told by staff the nurse had already called the physician to order an X-ray before he/she came down to assess the resident. He/She did not know the staff who gave him/her this information. If he/she had known the X-ray was not ordered, he/she would have ordered it immediately. He/She thought the staff called a private X-ray company and it just took awhile for them to get to the facility. He/She did not order pain medication for the resident because he/she thought the resident had an order for Tylenol and did not look like he/she was in pain when he/she assessed him/her. No one told him/her the resident continued to complain of pain. He/She did not find out about the delayed X-ray until the next day when staff called him/her to let him/her know the results of the X-ray. During an interview on 4/21/25 at 1:55 P.M., the resident's physician said he was not notified the day the resident fractured his/her hip and needed an X-ray. If an x-ray was ordered, staff should have followed up to ensure it was done in a timely manner. If the resident did not have pain medication on his/her orders, someone should have contacted him after he/she complained of pain the first time, so he could have ordered it. Staff should not have left the resident in his/her wheelchair all day because this could increase his/her pain. 2. Review of Resident #516's admission MDS dated [DATE], showed: -Adequate hearing; Vision: Adequate - sees fine detail, including regular print in newspaper/books; -Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; -Moderate cognitive impairment; -Diagnoses of anemia (the blood has a reduced ability to carry oxygen), coronary artery disease (heart disease due to plaque build-up in the arteries), high blood pressure, renal (kidney) insufficiency, respiratory failure and anxiety; -Pain Management: At any time in the past five days has the resident been on a scheduled pain medication regiment?: Yes. Received as necessary pain medication? No; -Pain Presence: Yes; -Pain Frequency: Frequently; -Pain Effect on Sleep: Almost constantly; -Pain Interference with Therapy Activities: Almost constantly; -Pain Interference with Day-to-Day Activities: Almost constantly; -Verbal Description Scale: Very severe, horrible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 322 Old State Road Ellisville, MO 63021	

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's care plan, located in the electronic health care record (EHR), showed: -Revised on 4/14/25: Focus: Impaired cognitive function and impaired thought processes related to impaired decision making. Goal: Will be able to communicate basic needs on a daily basis. Interventions/Tasks: Administer medications as ordered. Resident understands consistent, simple, directive sentences; -Revised on 4/14/25: Focus: Pain related to right hip fracture surgery. Goal: Resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions/Tasks: Administer pain medications per physician orders. Monitor/Document for side effects of pain medication. Review of the resident's physician's orders sheet (POS), located in the EHR, showed: -3/21/25: Acetaminophen (Tylenol) 325 mg every six hours PRN; -3/21/25: Oxycodone HCI (a narcotic pain medication) 10 milligrams (mg), 1 tablet every six hours PRN; -3/22/25: Gabapentin (used to treat neuropathic/nerve pain) 300 mg 3 times a day. During an interview on 4/15/25 at 5:38 A.M., the resident lay in bed and said he/she had constant pain on his/her right side. He/She turned on his/her call light around 4:00 A.M., because he/she needed an Oxycodone for the pain. CNA J answered his/her call light and told him/her there was no nurse on their floor (the fourth floor) to administer the pain medication. The resident rated the pain at a 6 at the time he/she asked. He/She has still not received the Oxycodone, and his/her pain is a 10 now. A clock was hanging on the wall across from the resident's bed. The resident was able to state the correct time. At 8:22 A.M., the resident lay in bed. He/She said he/she received his/her Oxycodone a few minutes ago. During an interview on 4/15/25 at 6:00 A.M., LPN LL said he/she was the only nurse for the third floor with 50 people and could not be responsible for another floor. No one called him/her to report anyone needed pain medication on the fourth floor. During an interview on 4/15/25 at 6:07 A.M., CNA J said the resident did ask for a pain pill a couple of hours ago, but there was no nurse scheduled to work this floor last night. He/She was waiting on a nurse from one of the other floors to make rounds on this floor so he/she could tell that nurse the resident needed a pain pill, but he/she had not seen another nurse making rounds. He/She should have called one of the other floors and told one of those nurses, but he/she did not. During an interview on 4/15/25 at 6:30 A.M., CMT II said CNA J told him/her a resident requested pain medication this morning, but he/she was not able to administer narcotics. He/She usually works on a floor where a nurse is assigned, and this was his/her first time working on this floor. The nurses always administered the pain medications when he/she was on the other floors. He/She did not know the protocol of who to call if a resident needed narcotics. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/15/25 at 6:45 A.M., LPN KK said he/she was responsible for the second floor and the medications on the first floor overnight. No one called him/her to let him/her know a resident needed pain medication on the fourth floor. During an interview on 4/16/25 at 7:07 A.M., LPN O said he/she would not go to another floor to give a medication if he/she is not the nurse scheduled for that floor. During an interview on 4/16/25 at 7:12 A.M., CMT Q said if a resident needed a narcotic and there was no CMT or nurse on the floor, the CNA should call the floor where a nurse or CMT was so they could come to the floor and administer the narcotic. During an interview on 4/16/25 at 7:15 A.M., CNA R said if he/she was working a floor with no nurse and a resident needed a pain medication he/she would call the floor where there was a nurse and tell them the resident needed a pain pill. During an interview on 4/16/25 at 7:46 A.M., CNA N said if a resident needed a pain medication and there was no nurse scheduled on that floor, he/she would call a nurse from one of the other floors and tell them what the resident needed. Review of the resident's MAR located in the EHR, dated 4/1/25 through 4/15/25, showed: -Acetaminophen 325 mg was administered on 4/1/25 for a pain level (pain is rated on a scale of 1-10, with 10 being the highest) of 5, 4/4/25 for a pain level of 6, and 4/5/25 for a pain level of 5; -Oxycodone HCl 10 mg was administered 26 times, on 14 of the 16 days. The last dose initialed as administered was on 5/14/25 was at 4:00 P.M. Only one dose was recorded administered on 4/15/25 and that was at 5:17 P.M. The MAR did not show the resident received an Oxycodone administered at approximately 8:00 A.M.; -Review of the resident's pain scale, showed out of a possible 45 times (three recordings a day for 15 days) a pain level of 0 recorded 36 times, a pain level of 2 recorded two times, a pain level of 5 recorded three times, a pain level of 7 recorded two times, and a pain level of 10 recorded one time. Review of the resident's Oxycodone Individual Narcotic Record (where staff initial a medication was administered and how many doses are left in the medication card) showed the resident received one dose of Oxycodone 10 mg on 4/14/25 AT 4:00 P.M. The resident did not receive another dose of Oxycodone until 4/15/25 at 8:00 A.M. (four hours after the resident said he/she had requested the medication at 4:00 A.M.). During a telephone interview on 4/21/25 at 3:10 P.M., Administrator NN said it should not take longer than 30 minutes for a resident to receive a medication after it's requested. Waiting four hours for medication is unacceptable. Administrator MM said the facility has a protocol identifying what floor a staff member should contact if a nurse is needed. Staff on the fourth floor where Resident #516 resided should have contacted a nurse on another floor as soon as the resident requested the pain medication. 3. Review of Resident #507's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Cognitively intact; -Has frequent pain; -Occasional pain during sleep; -Occasional pain interference with therapy activities; -Occasional pain with day to day activities; -Pain scale 7 out of 10; -Diagnoses included coronary artery disease, high blood pressure, anxiety, depression, and asthma. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has pain related to neck/back discomfort; -Goal: Resident will verbalize adequate relief of pain or ability to cope with incompletely relived pain; -Interventions: Administrator analgesia as per orders; -Resident prefers to wear back brace at times for comfort. He/She is able to apply and remove at will; -Monitor/Document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria (general distress), nausea, vomiting, dizziness, and falls. Report occurrences to the physician; -Monitor/Record/report to nurse any signs and symptoms of non-verbal pain. Changes in breathing, vocalizations, mood/behavior, eyes, face, and body; -Refer to pain clinic on 4/8/25. Review of the resident's POS, dated April 2025, showed: -An order, dated 7/15/24, Celebrex (to treat pain) oral capsule 200 mg. Give one capsule by mouth one time a day for pain; -An order, dated 7/15/24, Hydrocodone-Acetaminophen (Norco) oral tablet 10-325 mg. Give one tablet by mouth every six hours as needed for 4-10 out of 10, for moderate to severe pain; -An order, dated 7/20/24, screen and rate pain using pain scale 0-10 every shift; -An order, dated 7/15/24, Tylenol oral tablet 325 mg. Give two tablets by mouth every four hours as needed for fever; (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated 7/15/24, Tylenol oral tablet 325 mg. Give two tablets by mouth every six hours as needed for mild pain, 1-3 out of 10; -An order, dated 7/23/24, Lidocaine external patch, apply to left shoulder topically one time a day for pain and remove per schedule; -An order, dated 4/5/25, call pain clinic to schedule appointment. Update this order with appointment date and time. Advise resident appointment day for pain; -An order, dated 4/8/25, patient needs a referral for pain management. May contact pain clinic, one time only for pain management; -An order 4/15/25, Hydrocodone-Acetaminophen oral tablet 5-325 mg. Give one tablet by mouth every four as needed for pain scale 1-5. -An order, dated 4/8/25 to discontinue the Norco on 4/8/25. During an interview on 4/16/25 at 9:15 A.M., the resident said the physician discontinued his/her Norco, prior to 4/8/25. He/She has it written down. He/She was told by a nurse that he/she had to go to pain management and he/she could not receive anymore Norco. They did not wean him/her off the Norco, so he/she experienced nausea and diarrhea. During an interview on 4/16/25 at 12:20 P.M., the DON said the resident needed to go to pain management. He/She did not want to go, but ended up making an appointment with the physician of his/her choosing. The Medical Director discontinued the order. The DON did not know if there was anything documented about the medication being discontinued. The physicians put their order in the record at the time, and nursing confirms the order. The DON said she confirmed the order to discontinue the resident's Norco. The Medical Director would not re-fill the Norco. The resident was aware he/she cannot get a refill until he/she goes to pain management. The DON was not aware of any adverse effects or withdrawal symptoms from discontinuing the resident's Norco. Review of the resident's MAR, dated March 2025, showed: -An order, dated 7/15/24, Hydrocodone-Acetaminophen oral tablet 10-325 mg. Give one tablet by mouth every six hours as needed for 4-10 out of 10 for moderate to severe pain was administered on the following dates and times: -On 3/22/25, no documentation of Norco administered; -On 3/23/25, Norco was administered: -At 8:11 A.M., with a pain score of 5; -At 4:14 P.M., with a pain score of 8; -At 10:47 P.M., with a pain score of 8; -On 3/24/25, Norco was administered: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 8:22 A.M., with a pain score of 5; -At 4:10 P.M., with a pain score of 8; -On 3/25/25, Norco was administered: -At 10:19 A.M., with a pain score of 8; -At 6:06 P.M., with a pain score of 9; -On 3/26/25, Norco was administered: -At 3:44 A.M., with a pain score of 5; -At 11:37 A.M., with a pain score of 5; -On 3/27/25, Norco was administered: -At 8:57 A.M., with a pain score of 0; -At 4:03 P.M., with a pain score of 0; -An order, dated 7/15/24, Tylenol oral tablet 325 mg. Give two tablets by mouth every six hours as needed for mild pain 1-3 out of 10, was administered on the following dates and times: -On 3/28/25 at 8:45 P.M., with a pain score of 9; -On 3/29/25 at 1:57 P.M., with a pain score of 9. Review of the resident's MAR, dated April 2025, showed: -An order, dated 7/15/24, Hydrocodone-Acetaminophen oral tablet 10-325 mg. Give one tablet by mouth every six hours as needed for 4-10 out of 10, for moderate to severe pain, was not administered on 4/1 through 4/8/25; -Discontinued on 4/8/25; -An order, dated 7/23/24, Lidocaine external patch, apply to left shoulder topically one time a day for pain and remove per schedule, showed: -On 4/15/25 at 8:00 A.M., staff documented the administration of the Lidocaine patch; -At 8:00 P.M., staff documented medication not available for removal of Lidocaine patch; -On 4/16/25 at 8:00 A.M, staff documented medication not available; -At 8:00 A.M., staff documented other. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/16/25 at 2:30 P.M. and 3:42 P.M., the resident read off his/her personal notes. He/She said on 3/22/25 at 10:00 A.M., he/she was told by the nurse that the Hydrocodone has been canceled and you need to see pain management. He/She never received any information on where to go or who to see. They said the Medical Director discontinued the pain medicine. The resident did not meet the Medical Director until two days ago. The resident stated having diarrhea and pain by that Friday after the medication was discontinued (3/28/25). He/She notified staff of his/her symptoms. They told him/her that he/she could have two Tylenol every six hours. There were no assessments; the nurse did not give anything for his/her diarrhea. He/She had diarrhea as recent as two days ago. The last time he/she received Norco was on 3/22/25. The Tylenol helps a little at night, but he/she has pain and neuropathy (nerve damage that causes pain). He/She did not receive th [TRUNCATED]

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to ensure food was served at a safe and appetizing temperature for two of two observed meal services. This deficient practice affected all residents who ate meals at the facility, including members of the Resident Council who voiced complaints in the monthly resident council meetings and Residents #1 and #92. The census was 134. Review of the facility's Monitoring Food Temperatures for Meal Service policy, dated 2020, showed: -Guideline: Food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures; -Procedure: Proper procedures are followed to ensure that food temperatures are accurately and safely obtained according to safe handling practices. These procedures include the following steps; -If the serving/holding temperature of a hot food item is not at 135 degrees Fahrenheit (F) or higher when checked prior to meal service, the item will be reheated to at least 165 degrees (F) for a minimum of 15 seconds; -If the serving/holding temperature of a cold food item or beverage is not at 41 degrees (F) or below when checked prior to meal service, the item will be chilled on ice or in the freezer until it reaches 41 degrees (F) or less before service. 1. Review of the facility's October Resident Council Meeting minutes, dated 10/21/24, showed: -15 residents in attendance; -Dining Services: Residents agreed the food is still being served at room temperature to cold most of the time. Review of the facility's November Resident Council Meeting minutes, dated 11/18/24, showed: -20 residents in attendance; -Dining Services: Residents agreed that the food is still being served room temperature to cold most of the time, especially breakfast. Review of the facility's December Resident Council Meeting minutes, dated 12/16/24, showed: -18 residents in attendance; -Dining Services: A new kitchen manager has been hired. She is addressing food temperatures and all the processes/factors that go into receiving a hot meal. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the facility's lunch menu, dated 1/14/25, showed turkey crunch with buttered noodles, vegetables, pea soup, and orange slices. Observation of the meal service on 1/14/25 at 12:42 P.M., showed meal trays arrived in a nonheated and noninsulated carrier on the third floor. At 12:45 P.M., trays were passed out to the rooms. At 12:50 P.M., a resident tray was removed from the carrier. The meal was served on a plate that was heated while in the kitchen with a plastic dome covering the plate. The meal consisted of turkey on a bed of noodles, broccoli, orange slices and pea soup. Food temperatures were taken with a digital thermometer. The noodles and turkey showed a temperature of 102.6 degrees Fahrenheit (F), the broccoli was 110.0 degrees F, and the orange slices were 57.0 degrees F. 3. Review of the facility's lunch menu, dated 1/15/25, showed ham with brown sugar glaze, stuffing, cauliflower and bean soup. Observation on 1/15/25 at 12:55 P.M., showed staff brought the food trays to the third floor in a metal cart that was nonheated and noninsulated. Staff on the floor immediately went to the cart and removed one tray at a time and delivered it to residents who sat in the dining room. Then, staff pushed the cart down the hall and delivered trays to the residents who were eating in their room. At 1:10 P.M. the last tray was removed from the cart. At that time, the following food temperatures were obtained from a test tray off the cart. The meal was served on a plate that was heated while in the kitchen with a plastic dome covering the plate. The baked ham with brown sugar glaze was 109.8 degrees F; the stuffing was 117.5 degrees F; the cauliflower was 111.6 degrees F; and the bean soup was 114.6 degrees F. 4. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/5/24, showed the resident was cognitively intact. During an interview on 1/14/25 at 9:45 A.M., the resident said food was always served cold. He/She expressed concerns regarding this, and nothing had been done. The food had been served cold since August. Review of Resident #92's quarterly MDS, dated [DATE], showed, the resident was cognitively intact. During an interview on 1/14/24 at 10:27 A.M., the resident said the food was always served cold. 5. During an interview on 1/15/25 at 1:15 P.M., Certified Nursing Assistant (CNA) C said residents constantly complained of cold food. The food arrived to the floors late for staff to pass the trays. There were microwaves available on each floor if residents requested to have their food warmed up. During an interview on 1/15/25 at 3:13 P.M., the Dietary Manager said she started at the facility on 11/11/24 and residents complained of cold food. When food was served to residents, hot foods should be served at a holding temperature of 135 degrees F. Cold foods should be under 40 degrees F. After the food was prepared, it was placed in a metal carrier with a lid and placed on a tray to take to the units. The carrier used was not heated. The goal was to have steam tables and take them to each individual floor and serve the food when the resident was ready to eat. She was aware of the cold food and had been trying to address the issue. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/15/25 at 4:32 P.M., the Administrator said he expected hot foods to be served at 120 degrees F and cold foods under 40 degrees F. The cup of orange slices would be considered a cold food. They were in the process of ordering steam tables. MO00246428 MO00247995 MO00247996 42247

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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** 37681 Based on observation, interview and record review, 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 targeted gown and glove use during high contact resident care activities) 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 wounds requiring treatments (Resident #10). In addition, the facility failed to ensure staff used good infection control practices for one resident when staff failed to perform hand hygiene and prepared medications with his/her bare hand (Resident #70) and when one resident's catheter bag (a urine drainage bag that attaches to a catheter, (a tube inserted into the bladder to drain urine) was observed on the floor. (Resident #13). The sample was 23. The census was 115. Review of the facility's Enhanced Barrier Precautions (EBP), undated, showed: -Policy: The facility will ensure staff are trained in EBP and will maintain sufficient supplies to support implementation of EBP. EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff's hand and clothing; -EBP are indicated for residents with any of the following: -Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; -Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin teras covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to pressure ulcers (Injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction); -For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: -Transfers; -Wound care: any skin opening requiring a dressing; -PPE for enhanced barrier precautions is only necessary when performing high-contact activities; -The resident's care plan will address the need for enhanced barrier precautions and will be communicated to caregivers. Review of the facility's Medication Administration Policy, dated 7/1/24 showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication will be administered by persons licensed or permitted by this state to prepare, administer, and document the administration of medications; -Staff will follow established facility infection control procedures (handwashing, aseptic technique (a procedure that healthcare providers use to prevent the spread of germs that cause infection), gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility's undated Urinary Catheter Care policy, showed: -Policy: The purpose of this procedure is to prevent catheter-associated urinary tract infections; -Infection Control: Be sure the catheter tubing and drainage bag are kept off the floor. 1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/23/24, showed: -Cognitively intact; -Diagnoses included heart failure, dementia, and Parkinson's disease (the central nervous system and causes movement problems) ; -Resident had one Stage four pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often included undermining and tunneling); -Resident was dependent (helper does all the effort. Resident does none of the effort to complete the activity) on staff for rolling left to right; -Resident was dependent on staff for chair/bed to chair transfers; Review of the care plan, in use at the time of survey, showed: -Focus: resident had impaired skin integrity related to coccyx (tailbone) pimple that evolved into pressure injury (a localized area of skin damage caused by prolonged or severe pressure, friction, shear, or a combination of these factors); -Goal: resident site of impaired skin integrity will be free of signs and symptoms of infection during the review period; -Interventions: apply treatment per medical doctor orders; -The care plan did not show resident required EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, MO 63021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/22/24 at 10:35 A.M., showed the resident lay in bed. Licensed Practical Nurse (LPN) H and Certified Nurse Aide (CNA) D entered the resident's room and performed hand hygiene and put gloves on. CNA D unfastened the resident's brief and assisted the resident to roll over towards the window. LPN H removed the dressing from the coccyx area and provided wound care. CNA D assisted the resident to roll onto his/her back and fastened the brief. Then, staff attached the mechanical lift cloth to the mechanical lift and transferred the resident from the bed into his/her chair. LPN D did not wear a gown while providing wound care and neither staff member wore a gown while transferring the resident. There was no EBP sign outside the resident's door. During an interview on 11/25/24 at 1:05 P.M., LPN G said residents who had wounds should be on EBP and staff should wear a gown and gloves while providing wound care and direct resident care. Staff would know which residents required EBP by the sign outside their door. During an interview on 11/25/24 at 1:10 P.M., CNA D said he/she knew which residents required EBP from charting, if the resident had a wound or if he/she saw a dressing on the resident, or if the resident was a new admission. He/She would wear a gown, gloves, and a mask anytime he/she encountered the resident. During an interview on 11/25/24 at 3:00 P.M., the Infection Control Preventionist (ICP) said EBP were used for residents who had a chronic wound that was hard to heal, or if the drainage is not contained within the dressing or if the resident had MDRO. Staff knew which residents required EBP because there would be a sign posted outside their door. The ICP was responsible for putting the signs outside the resident's door. Staff should wear gown and gloves when providing high contact care. The resident was not on EBP. Residents who have a Stage four pressure ulcer should be on EBP. During an interview on 11/26/24 at 12:07 P.M., the Director of Nursing (DON) said she expected staff to wear gown and gloves while providing wound care and performing high contact care and she expected staff to follow the facilities polices and procedure. The facility would place EBP signs out for all residents who had treatments regardless of the stage of the wound. 2. Review of Resident #70's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included heart disease, high cholesterol, aphasia (difficulty speaking), stroke, hemiplegia/hemiparesis (weakness of one side of the body), anxiety disorder and asthma. Review of the resident's Medication Administration Record (MAR), dated 11/2024, showed: -Aspirin EC (enteric coated) (used to prevent heart attack or stroke) tablet delayed release 81 milligrams (mg), give 1 tablet by mouth one time a day for deep vein thrombosis (DVT, blood clot in a deep vein, usually in the legs); -Bupropion HCl ER (anti-depressant) oral tablet extended release 12-hour 200 mg, give 1 tablet by mouth one time a day for depression; -Cephalexin (antibiotics) oral tablet 250 mg by mouth one time a day for preventive for urinary tract infection (UTI); (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 322 Old State Road Ellisville, MO 63021	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cholecalciferol (Vitamin D) oral tablet, give 50,000 unit by mouth one time a day every Monday for Vitamin D deficiency for 10 weeks; -Fluticasone Propionate Suspension 50 micrograms/actuation (mcg/act) (nose spray for allergies) 1 spray in each nostril one time a day for allergies; -Isosorbide Mononitrate ER (used to treat chest pain and high blood pressure) tablet extended release 24 hours 60 mg, give 1 tablet for hypertension; -Lamotrigine (anti-depressant) tablet 25 mg, give 1 tablet by mouth one time a day for depression; -Lidoderm External Patch 5% (Lidocaine, pain reliever), apply 1 patch one time a day for osteoarthritic discomfort, morning on to right knee, remove at 8:00 P.M.; -Melatonin (used to help sleep) tablet 3 mg, give 1 tablet by mouth at bedtime for insomnia; -Omega-3 Fatty Acids (healthy fat supplement) capsule 1000 mg, give 1 capsule by mouth one time a day for supplement; -Pantoprazole Sodium tablet delayed release 40 mg, give 1 tablet by mouth one time a day for GERD (gastroesophageal reflux disease, when acid from your stomach backs up into the esophagus); -Sertraline HCl (anti-depressant) tablet 50 mg, give 1 tablet by mouth one time a day for depression; -Umeclidinium-Vilanterol Inhalation Aerosol Powder Breath Activated 62.5-25 mcg/act, 1 puff inhale orally one time a day for chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe); -Divalproex Sodium (can treat seizures) capsule delayed release sprinkle 125 mg, give 4 capsules by mouth two times a day for epilepsy (seizures); -Gabapentin (can treat seizures and pain) capsule 300 mg, give 1 capsule by mouth two times a day for pain; -Levetiracetam (anti-seizures) tablet 250 mg, give 1 tablet by mouth two times a day for anticonvulsant; -Acetaminophen (pain reliever, fever reducer) tablet 500 mg, give 2 tablets by mouth three times a day for pain; -Baclofen (muscle relaxant) tablet 10 mg, give 1 tablet by mouth four times a day for muscle spasms; -ProAir HFA Inhalation Aerosol Solution 108 (90 Base) mcg/act (Albuterol Sulfate inhaler) 2 puff inhale orally every 6 hours as needed for shortness of breath (SOB) or wheezing related to COPD; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ellisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 322 Old State Road Ellisville, MO 63021	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sumatriptan Succinate (treats migraine headache) oral Tablet 50 mg, give 1 tablet by mouth every 2 hours as needed for migraine; -Tramadol HCl (can treat moderate to severe pain) oral tablet 50 mg, give 100 mg by mouth every 12 hours as needed for pain. Observation on 11/21/24 at 9:47 A.M., showed Registered Nurse (RN) J prepared medications for the resident. The RN pulled and popped the medications from the bubble cards and poured bottled stock medications into his/her right hand and placed them onto his/her bare left hand. RN J repeated this process with all seventeen pills. RN J did not perform hand hygiene prior to handling the medications. During an interview on 11/26/24 at 11:17 A.M., LPN H said hand hygiene should be done prior to handling medications and in between residents' medication administration. The medications should be popped directly to the cup prior to administering to residents. During an interview on 11/26/24 at 12:07 P.M., the DON said she expected staff to perform hand hygiene and not handle medications with bare hands prior to administering them to residents. 3. Review of Resident #13's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Required partial assistance for toileting hygiene; -Indwelling catheter (a thin, hollow tube that's inserted into the bladder through the urethra to drain urine); -Diagnoses included heart disease, end stage renal failure and neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems). Review of the resident's November 2024 physician's orders, showed an order, dated 11/15/24, Resident has a urinary catheter. Catheter care to be provided every shift and as needed. Review of the resident's care plan, initiated 11/16/24, in use during the time of the investigation, showed: -Focus: The resident has a catheter; -Goal: The resident will be/remain free from catheter-related trauma. The resident will show no signs of urinary infection; -Interventions: Change catheter per physician's order. Evaluate as needed for possible removal of catheter and bladder retraining or toileting plan. Observation and interview on 11/20/24 at approximately 11:33 A.M., showed the resident lay on his/her back in bed. The resident's catheter bag lay directly on the floor, to the right of the resident's bed. The resident said he/she did not know if the catheter bag was supposed to be directly on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265766	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellisville Rehabilitation and Nursing	322 Old State Road Ellisville, MO 63021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/21/24 at 9:51 A.M., showed the resident lay in bed with his/her eyes closed. The catheter bag lay directly on the floor, to the right of the resident's bed. During an interview on 11/26/24 at 11:35 A.M., CNA C said catheter bags should be kept off the floor to prevent contamination. If he/she noticed a catheter bag on the floor, he/she would notify the nurse immediately. During an interview on 11/26/24 at 11:17 A.M., LPN H said catheter bags should not lay directly on the floor due to contamination and infection control. During an interview on 11/26/24 at 12:07 P.M., the Administrator and DON said catheter bags should be kept off the floor to prevent contamination and for infection control. 42247 45083