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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(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)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 42247 Based on observation, interview, and record review the facility failed to ensure staff adequately supervised residents during medication administration and/or assessed residents to self-administer medications and/or keep medications at their bedside (Residents #54, #61, #17, #81, #29, #88 and #92). The sample was 23. The census was 115. Review of the facility's undated Medication Administration Policy, showed: -Policy: the facility is committed to establishing and maintaining processes that promote safe medication administration; -Medications will be administered by the person licensed or permitted by the state to prepare, administer, and document the administration of medications; -The Director of Nursing (DON) services will supervise and direct all nursing personnel who administer medications and/or have related functions; -Medications will be administered in accordance with the orders, including any required time frames; -Residents may self-administer their own medications only if the attending practitioner, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Review of the facility's undated Self-Administration of Medications and Treatments Policy, showed: -Policy: residents have the right to self-administer medications / treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; -As part of the overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments is clinically appropriate for the resident; -If the team determines that a resident cannot safely self-administer medications/treatments, the nursing staff will administer the resident's medications; -The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications/treatments; -Self-administered medications and/or treatment supplies will be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff shall identify and give to the licensed nurse any medications/treatment supplies found at the bedside that are not authorized for self-administration, for return to the family or responsible party. 1. Review of Resident #54's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/24, showed: -Cognitively intact; -Diagnoses included anemia, hypertension (high blood pressure), renal failure, diabetes, hyperlipidemia (high level of lipids in the blood), hyperkalemia (high potassium), other fracture, hemiplegia (partial or complete paralysis on one side of the body), anxiety and depression; -Currently taking hypnotic, antidepressant and antiplatelet medications. Review of the resident's care plan, in use during survey, showed: -Focus: Resident is at risk for falls related to fracture of left femur with weight bearing restrictions, history of stroke, history of falls, end stage renal disease (ESRD) with dialysis; -Interventions: Monitor for side effects of narcotic pain medications which may increase risk for falls; -Focus: Resident has anemia related to ESRD; -Interventions: Give medications as ordered. Monitor for side effects, effectiveness; -Focus: Resident has arthritis of the bilateral knees; -Intervention: Give analgesics (pain reliever) as ordered by the physician. Monitor and document for side effects; -Focus: Resident has an alteration in Musculoskeletal status related to fracture of the lumbar transverse process (a type of spinal fracture), left tibia (shin bone) non-displaced fracture; -Interventions: Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness; -Focus: Resident is on antiplatelet therapy; -Interventions: Administer antiplatelet (prevent blood clots) medications as ordered by physician. Monitor for side effects and effectiveness every shift; -Focus: Resident is on pain medication therapy related to headaches and recent fracture; -Interventions: Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident uses antidepressant medication related to depression; -Intervention: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift; -Focus: Resident has potential for pressure injury development related to immobility due to recent fracture, weight bearing limitations, knee brace; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; -No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the resident's Physician's Orders Sheet (POS), dated November 2024, showed: -An order, dated 10/5/24, Lexapro (treat depression and anxiety) oral tablet 20 milligram (mg). Give one tablet by mouth one time a day for depression; -An order, dated 10/5/24, Minoxidil (treat high blood pressure) oral tablet. Give 2.5 mg by mouth two times a day for hypertension; -An order, dated 10/5/24, Plavix (prevents stroke and heart attacks) oral tablet 75 mg. Give 75 mg by mouth one time a day for stroke; -An order, dated 10/5/24, Protonix (treat acid reflux) oral tablet delayed release 40 mg. Give one tablet by mouth one time a day for gastroesophageal reflux disease (GERD, acid reflux); -An order, dated 10/5/24, Rocaltrol (treat low calcium and psoriasis) oral capsule 0.5 microgram (mcg). Give two capsules by mouth one time a day every Monday, Wednesday, and Friday; -An order, dated 10/5/24, Cozaar oral tablet (treat high blood pressure) 100 milligram (mg). Give one tablet by mouth one time a day for hypertension; -An order, dated 10/21/24, Doxazosin Mesylate tablet (treat urinary problems and high blood pressure) 8 mg. Give one tablet by mouth two times a day for hypertension; -An order, dated 10/21/24, Hydralazine (treat high blood pressure) HCl oral tablet 100 mg. Give one tablet by mouth three times a day for hypertension; -An order, dated 10/21/24, Labetalol (treat high blood pressure) HCL oral tablet 200 mg. Give two tablets by mouth, three times a day for hypertension; -An order, dated 10/21/24, Nifedipine (treat high blood pressure and chest pain) extended release (ER) oral tablet extended release 24-hour 90 mg. Give one tablet by mouth two times a day for hypertension; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 10/21/24, Tums (antacid) oral tablet chewable 500 mg. Give 2.5 tablet by mouth one time a day; -No physician's order to self-administer medications or leave medications at bedside. Review of the resident's Medication Administration Record (MAR), dated 11/21/24, showed: -An order, dated 10/5/24, Lexapro oral tablet 20 mg. Give one tablet by mouth one time a day for depression was administered as ordered; -An order, dated 10/5/24, Minoxidil oral tablet. Give 2.5 mg by mouth two times a day for hypertension was administered as ordered; -An order, dated 10/5/24, Plavix oral tablet 75 mg. Give 75 mg by mouth one time a day for stroke was administered as ordered; -An order, dated 10/5/24, Protonix oral tablet delayed release 40 mg. Give one tablet by mouth one time a day for gastroesophageal reflux disease was administered as ordered; -An order, dated 10/5/24, Cozaar Oral tablet 100 mg. Give one tablet by mouth one time a day for hypertension was administered as ordered; -An order, dated 10/21/24, Doxazosin Mesylate tablet 8 mg. Give one tablet by mouth two times a day for hypertension was administered as ordered; -An order, dated 10/21/24, Hydralazine HCl oral tablet 100 mg. Give one tablet by mouth three times a day for hypertension was administered as ordered; -An order, dated 10/21/24, Labetalol HCL oral tablet 200 mg. Give two tablets by mouth, three times a day for hypertension was administered as ordered; -An order, dated 10/21/24, Nifedipine ER oral tablet extended release 24-hour 90 mg. Give one tablet by mouth two times a day for hypertension was administered as ordered; -An order, dated 10/21/24, Tums oral tablet chewable 500 mg. Give 2.5 tablet by mouth one time a day was administered as ordered. Observation on 11/21/24 at 10:13 A.M., showed the resident in the wheelchair in his/her room. The resident's head was down, and eyes were closed. There was a small medication cup on the night table that contained approximately ten pills inside. Observation on 11/21/24 at 11:57 A.M., showed the resident in wheelchair in his/her room. The resident was awake but did not speak. The resident looked up and put his/her head back down. There was a small medication cup on the night table that contained two pink pills and one blue. One of the pink pills appeared to be broken in half. At 1:22 P.M., the medication cup with two pink pills and one blue pill was on the night table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24 at 12:21 P.M., Registered Nurse (RN) B said the resident is able to administer his/her own medications. RN B gives the resident the medication and he/she takes it. RN B leaves them in the room sometimes but will check on him/her later to ensure he/she took them. RN B said they watch the residents take the medications, so it is an indication they are able to self-administer. During an interview on 11/26/24 at 12:06 P.M., the Director of Nursing (DON) said the resident would not be appropriate to self-administer medications and should not have medications left at bedside. 2. Review of Resident #61's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included chronic obstructive pulmonary disease (COPD, chronic lung disease). Review of the care plan, in use at the time of survey, showed: -Focus: resident has shortness of breath (SOB) related to COPD; -Interventions: did not show use of inhaler; -No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/21/24, showed: -An order for Trelegy Ellipta Inhalation Aerosol powder 100-62.5-25 micrograms (mcg)/asthma control test (ACT, inhaler used to treat asthma and COPD) inhale one puff once daily for SOB; -An order for: Ventolin hydrofluoroalkane (HFA, type of propellant used in some inhalers)/inhalation aerosol solution 108 mcg/act (rescue inhaler that works quickly to relieve breathing problems), inhale two puffs every six hours as needed for SOB/wheezing related to COPD; -No physician's order to self-administer medications or leave medications at bedside. Observation on 11/21/24 at 10:08 A.M., showed RN B went into the resident's room with the Trelegy inhaler in his/her hand. The resident said he/she had his/her Trelegy inhaler in his/her room and got the inhaler. The nurse told the resident he/she was going to take the inhaler and put it on the cart. The resident said he/she also had a rescue inhaler in his/her room and he/she was not going to give it up. I want my inhalers in my hand, I am not going to be gasping for air while waiting for someone to come. They are short staffed or busy. I want my inhalers in my hand. The resident said he/she has had the inhalers in his/her room for 6 months and he/she used the rescue inhaler a couple times a day depending on how active he/she was. RN B said he/she would talk with the nurse manager about it and removed both Trelegy inhalers from the room. Observation on 11/22/24 at 9:00 A.M., showed the resident was in his/her room and there was a rescue inhaler was on the overbed table next to the bed. The resident said he/she used the inhaler during the night and again said he/she was not going to give up the inhaler. (continued on next page)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #17's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included dementia and depression. Review of the resident's care plan, in use at the time of survey, showed: -Focus: resident used psychotropic medications related to major depressive disorder; -Interventions: administer psychotropic medication as ordered by physician. Monitor for side effects and effectiveness every shift; -No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/22/24, showed: -An order for Aripiprazole (medication used to treat certain mental/mood disorders such as bipolar disorder and schizophrenia) 10 mg, give one tablet daily for major depression; -No physician's order to self-administer medications or leave medications at bedside. Review of the MAR, dated 11/20/24, showed: -An order for Aripiprazole 10 milligrams, give one tablet daily for major depression, showed the medication was administered. Observation on 11/20/24 at approximately 12:15 P.M., showed the resident lying in bed with the overbed table next to the bed. On the over bed table was half of a white pill in a clear medication cup and a cup with approximately one inch of water in it. The resident said he/she did not know what the pill was and maybe it did not come out of the cup. Observation and interview on 11/20/24 at 12:20 P.M. RN E said he/she did not know what the half pill was. RN E took the pill to the medication cart and checked the pill with the pills on the medication cards. RN E identified the medication as Aripiprazole 10 mg. RN E said when he/she punched the pill out this morning, it must have broken in half and when he/she administered the medication this morning, half of pill must have been left in the cup. The nurse went into the resident's room and administered the half of pill. RN E said the resident cannot self-administer his/her own medications. 4. Review of Resident #81's medical record, showed: -Severe cognitive impairment; -Diagnosis included Covid. Review of the resident's care plan, in use at the time of survey, showed: (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/25/24, showed: -An order for: guaifenesin 100 mg/5 milliliters (ml), give 10 ml every six hours for cough; -No physician's order to self-administer medications or leave medications at bedside. Review of the MAR, dated 11/1/24 through 11/26/24, showed: -An order for: guaifenesin 100 mg/5 mL, give 10 mL every six hours for cough. One dose of guaifenesin was administered on 11/18/24 at 5:30 P.M. Observation on 11/25/24 at 12:58 P.M., showed a bottle of diabetic guaifenesin on the nightstand, in the resident's room. During an interview on 11/25/24 at 1:15 P.M., the resident said he/she was taking the cough syrup a couple times a day. The staff brings a little cup into the room and poured the medication in and he/she would take it. During an interview on 11/25/24 at 1:25 P.M., Licensed Practical Nurse (LPN) G said the resident cannot have guaifenesin at his/her bedside and he/she would remove it from the room. The resident's family probably brought the medication in and left it at the beside. 5. Review of Resident #29's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included high blood pressure and heart failure. Review of the resident's care plan, in use at the time of survey, showed: -Focus: resident is on diuretic therapy (water pill) related to fluid overload; -Interventions: administer diuretic medication as ordered by the physician. Monitor for side effects and effectiveness every shift; -No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/25/24, showed: -An order for: Lasix (diuretic) 20 mg, give one tablet twice daily for congestive heart failure (CHF); -No physician's order to self-administer medications or leave medications at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR, dated 11/20/24, showed: -An order for Lasix 20 mg, give one tablet twice daily for CHF, showed the medication was administered. Observation and interview on 11/20/24 at approximately 1:00 P.M., showed a white pill on the nightstand next to the resident's bed. The resident said the pill was Lasix and it was given to him/her to take before going to a function this afternoon so he/she would not be interrupted. 6. Review of Resident #88's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnosis included COPD. Review of the care plan, in use at the time of survey, showed: -Focus: resident has SOB related to COPD; -Interventions: Administer puffers (inhalers) and nebulizers (a small machine that turns liquid medicine into a mist that can be inhaled through a mouthpiece or mask) as ordered; -No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/25/24, showed: -An order for: Budesonide Formoterol Fumarate Inhalation Aerosol 80-4.5 mcg/ACT (inhaler used to treat asthma and COPD), inhale two puffs twice daily for COPD, rinse mouth with water and spit back into cup after use; -No physician's order to self-administer medications or leave medications at bedside. Observation and interview on 11/20/24 at approximately 1:00 P.M., showed a Breyna (budesonide and formoterol fumarate) box with an inhaler in it. The resident said he/she used the inhaler. Review of the MAR, dated 11/21/24 through 11/25/24, showed: -An order for: Budesonide Formoterol Fumarate Inhalation Aerosol 80-4.5 mcg/act, inhale two puffs twice daily for COPD, rinse mouth with water and spit back into cup after use; showed the medication was administered twice daily. Observation on 11/21/24 at 11:40 A.M., 11/22/24 at 4:25 A.M., and 11/25/24 at 12:10 P.M., showed the Breyna box with the inhaler in it, remained on the overbed table. 7. Review of Resident #92's quarterly MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis included COPD. Review of the care plan in use at the time of survey, showed: -Focus: resident has altered respiratory status/difficulty breathing related to COPD; -Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects; - No documentation of self-administration of medications, assessed to self-administer medications, or allowed to keep medications at bedside. Review of the order summary report, dated 11/25/24, showed: -An order for: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 mcg/act, inhale two puffs every four hours as needed for treat or prevent bronchospasm related to COPD; -No physician's order to self-administer medications or leave medications at bedside. Review of the MAR, dated 11/20/24, showed: -An order for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 mcg/act, inhale two puffs every four hours as needed for treat or prevent bronchospasm related to COPD, showed the medication was not administered. Observation and interview on 11/20/24 at 2:20 P.M., showed an albuterol inhaler on the overbed table next to the resident's bed. The resident said he/she used the inhaler when he/she needed it. 8. During an interview on 11/25/24 at 1:00 P.M., Certified Medication Technician (CMT) F said when he/she administered medication, he/she would check the medication with the physician order, prepare the medication and administer the medication to the resident. He/She would stay with the resident to be sure the resident took the medication. No residents on the third floor were able to self-administer their medications. 9. During an interview on 11/25/24 at 1:25 P.M., LPN G said no residents on the floor could self-administer their medications and staff should not leave medications with the residents. 10. During an interview on 11/25/24 at 12:23 P.M., LPN K said residents who want to self-administer their own medications would need to be alert and oriented times four (person, place, time and situation), and they would need a physician order. The nurse did not know where the documentation would be for residents who wanted to self-administer their own medications. Resident #61 could self-administer his/her own rescue inhaler. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During an interview on 11/25/24 at 12:35 P.M., RN B said when he/she administered medications he/she would stay with the resident to ensure they took their medications. If a resident wanted to self-administer their medications, RN B would need to talk to the nurse manager about it. The nurse would assess the resident to be sure they were alert and oriented times four and they were capable of doing their own medications/inhalers safely. Resident #61 can self-administer his/her inhalers and Resident #88 should be able to. 12. During an interview on 11/25/24 at 3:00 P.M., the DON said she expected staff to stay with the resident while they take their medications. No residents in the facility can self-administer their own medications and there should be no medications left at the bedside. Rescue inhalers should be kept on the medication cart. 13. During an interview on 11/26/24 at 12:07 P.M., the Administrator said there was no residents who self-administer their medications. He expected staff to stay with the residents until their medications were consumed and he expected staff to follow the facility's policies and procedures.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 35394 Based on interview and record review, the facility failed to maintain documentation of a system that assured complete accounting of resident personal funds, and the facility failed to ensure access to resident personal funds was transferred to the facility's new management company upon a change in ownership. The facility also failed to ensure that monies held in the resident trust fund account was reconciled each month. The facility also failed to ensure quarterly statements were distributed to residents and/or their responsible party. This deficient practice affected all residents whose funds were handled by the facility. The census was 115. Review of the facility's undated Resident Personal Funds - Accounting and Management policy, showed: -Hold, safeguard, manage, and account for: Means that the facility must act as fiduciary of the resident's funds and report at least quarterly on the status of these funds in a clear and understandable manner. Managing the resident's financial affairs includes money that an individual gives to the facility for the sake of providing a resident with a non-covered service. In these instances, the facility will provide a receipt to the gift giver and retain a copy; -Procedures/Requirements: The resident may manage his or his own personal funds; -The resident may designate a representative to manage his or her personal funds; -The resident may have the facility hold, safeguard, and manage his or her personal funds; -Should the resident elect to have the facility manage his or her personal funds, it must be authorized in writing by the resident or the resident's representative, and a copy of such authorization will be documented in the resident's medical record; -Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard, manage and account for the personal funds of the resident. No service charge will be levied against the resident for the management of personal funds; -Should the facility manage the resident's funds, there will be a designation of duties of multiple staff members to ensure that the process is not managed solely by one individual; -Should the facility be appointed the resident's representative payee, and directly receive monthly benefits to which the resident is entitled, such funds will be managed in accordance with established policies related to financial management; -The resident will be informed in advance of any changes imposed to his or her personal funds; -A copy of all financial transactions will be filed in the resident's permanent records; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The resident may withdraw his or her request for the facility to manage his or her personal funds at any time by submitting a written notice to the Administrator; -Inquiries concerning the facility's management of resident funds should be referred to the Administrator or to the business office. Review of the facility's Resident Fund Account and Change in Management/Ownership, dated 11/22/23, showed: -Policy: The facility will provide new management or ownership with a full accounting of resident funds on deposit with the facility; -Procedure/Requirements: Should a change of management or ownership occur, the following transactions concerning our resident trust fund and/or our resident petty cash fund with be implemented; -Duties to new owner and/or Administrator: Upon the change of Administrator, sale of the facility or other transfer of ownership, the current Administrator/designee will provide the new Administrator/Owner with a written accounting of all resident funds deposited with the facility; -The report will be prepared by a Certified Public Accountant (CPA) in accordance with generally accepted accounting principals; -A new Administrator/Owner will sign for receipt for such funds; -Duties to residents: The current Administrator/Designee will provide to each resident, or representative (sponsor), a written accounting of the resident's personal funds held by the facility; -Such accounting will be presented to the resident, or representative (sponsor), prior to the change in management or transfer of ownership; -Rights of residents: In the event that a resident disagrees with the accounting of his or her funds, the current Administrator/Designee will attempt to resolve the issue before new management/ownership assumes responsibility for such funds. Should the disagreement not be resolved, the resident retains all rights and remedies provided under state law; -It is the responsibility of the resident, or representative (sponsor), to report all discrepancies as soon as possible after they are discovered. Review of the facility's resident trust account, showed: -November 2023 to July 2024, showed no documentation of ending balances, bank statements, and/or receipts; -August 2024 showed an ending balance of $118,068.63 and was not reconciled; -September 2024 showed an ending balance of $55,189.34 and was not reconciled; -October 2024 showed an ending balance of $50,722.70 and was not reconciled. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of previous trust account records, received on 11/24/24 at 8:59 A.M., showed a large stack of paper which contained copies of resident receipts from November 2023 through June 2024. There were no reconciliations, bank statements, quarterly statements from November 2024 through June 2024. During an interview on 11/25/24 at 9:50 A.M., the Business Office Manager (BOM) said he/she started on 9/4/24. The facility had new ownership and the initial deposit in the new account was on 8/27/24. He/She did not have access to the resident trust accounts and statements that were maintained by the previous owners until it was requested by the surveyor. He/She was responsible for reconciliating the resident trust, but had not done it. Moving forward, he/she would reconcile the trust monthly, but he/she was still trying to get it together. He/She was not sure who reconciled the resident trust prior to him/her. He/She was responsible for sending the quarterly statements, but had not sent them since he/she started as BOM. The first statements would come out in January. The residents knew they could come to the business office if they needed to know their balance. During an interview on 11/26/24 at 12:06 P.M., the Administrator said he expected the resident trust to be reconciled every month. He expected the bank statements to be a part of the reconciliation and for the residents to have detailed accounting or quarterly statements. He expected the facility to have all previous reconciliation and bank statements from the previous ownership.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to notify third party (TPL) within 30 days when a resident expired. This affected two residents who expired (Residents #171 and #172). The census was 115. Review of the facility's undated Resident Personal Funds - Accounting and Management policy, showed: -Hold, safeguard, manage, and account for: Means that the facility must act as fiduciary of the resident's funds and report at least quarterly on the status of these funds in a clear and understandable manner. Managing the resident's financial affairs includes money that an individual gives to the facility for the sake of providing a resident with a non-covered service. In these instances, the facility will provide a receipt to the gift giver and retain a copy; -Procedures/Requirements: The resident may manage his or his own personal funds; -The resident may designate a representative to manage his or her personal funds; -The resident may have the facility hold, safeguard, and manage his or her personal funds; -Should the resident elect to have the facility manage his or her personal funds, it must be authorized in writing by the resident or the resident's representative, and a copy of such authorization will be documented in the resident's medical record; -Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard, manage and account for the personal funds of the resident. No service charge will be levied against the resident for the management of personal funds; -Should the facility manage the resident's funds, there will be a designation of duties of multiple staff members to ensure that the process is not managed solely by one individual; -Should the facility be appointed the resident's representative payee, and directly receive monthly benefits to which the resident is entitled, such funds will be managed in accordance with established policies related to financial management; -The resident will be informed in advance of any changes imposed to his or her personal funds; -A copy of all financial transactions will be filed in the resident's permanent records; -The resident may withdraw his or her request for the facility to manage his or her personal funds at any time by submitting a written notice to the Administrator; -Inquiries concerning the facility's management of resident funds should be referred to the Administrator or to the business office. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Fund Account and Change in Management/Ownership, dated [DATE], showed: -Policy: The facility will provide new management or ownership with a full accounting of resident funds on deposit with facility; -Procedure/Requirements: Should a change of management or ownership occur, the following transactions concerning our resident trust fund and/or our resident petty cash fund with be implemented; -Duties to new owner and/or Administrator: Upon the change of Administrator, sale of the facility or other transfer of ownership, the current Administrator/ designee will provide the new Administrator/Owner with a written accounting of all resident funds deposited with the facility; -The report will be prepared by a Certified Public Accountant (CPA) in accordance with generally accepted accounting principals; -A new Administrator/Owner will sign for receipt for such funds; -Duties to residents: The current Administrator/Designee will provide to each resident, or representative (sponsor), a written accounting of the resident's personal funds held by the facility; -Such accounting will be presented to the resident, or representative (sponsor), prior to the change in management or transfer of ownership; -Rights of residents: An the event that a resident disagrees with the accounting of his or her funds, the current Administrator/Designee will attempt to resolve the issue before new management/ownership assumes responsibility for such funds. Should the disagreement not be resolved, the resident retains all rights and remedies provided under state law; -It is the responsibility of the resident, or representative (sponsor), the report all discrepancies as soon as possible after they are discovered. 1. Review of #171's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -admitted on [DATE]; -Death in facility: [DATE]. Review of the facility's trust account statement, dated [DATE], showed: -Expired on [DATE]; -Current balance of $5,693.01. 2. Review of Resident #172's medical record, showed: -admitted on [DATE]; (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Expired on [DATE]. Review of the facility's resident trust account statement, dated [DATE], showed: -Expired on [DATE]; -Current balance of $1,077.66. 3. During an interview on [DATE] at 9:50 A.M., the Business Office Manager (BOM) said he/she had been the BOM since [DATE]. He/She had to get the TPL letters ready for Resident #171, but he/she was getting ready to send it to the state. Resident #172 was his/her own responsible party, private pay, and did not have an estate. The BOM was looking into how to send it off since the resident was private pay. 4. During an interview on [DATE] at 12:06 P.M., the Administrator said he expected staff to ensure a final accounting for all residents who had expired or discharged from the facility within 30 days. He expected a letter to be sent to the appropriate parties timely. It was not appropriate for a resident who expired on [DATE] to still hold a trust account with over $1000 in it.

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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 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 45083 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans to address the specific needs of the residents (Residents #87 and #99). The sample was 23. The census was 115. Review of the facility's Resident Centered Care Plan Policy, dated 7/17/23, showed: -Policy: A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. To the extent practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process. -A comprehensive care plan for each resident will be developed within seven (7) days of completion of the resident's comprehensive Minimum Data Set (MDS) assessment; -The comprehensive care plan will be developed by a Care Planning/interdisciplinary Team (IDT) which includes at a minimum: -The resident's attending physician; -A registered nurse responsible for caring for the resident; -A nursing assistant responsible for the resident's care; -A member of food and nutrition services staff; -And may include as the resident's condition dictates: -A social services worker or designee; -An activities worker or designee; -Rehabilitative therapists as applicable; including but not limited to physical therapy, speech therapy, occupational therapy, and rehabilitative services for mental disorders or intellectual-disability; -Consultants (as appropriate, e.g., hospice representative, mental health professional, special services professional, pharmacist); -Others as appropriate or necessary to meet the needs or request of the resident.; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All reasonable efforts will be made to incorporate the resident's personal and cultural preferences and life choices in developing goals of care; -The resident/resident representative is encouraged to participate in the development of and revisions to the resident's care plan; -An explanation will be included in the resident's medical record if the participation of the resident/resident representative is determined not practicable for the development of the resident's care plan; -All reasonable efforts will be made for the resident/resident representative will be informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; -The resident/resident representative will be encouraged to exercise his or her 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; -Participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. iii) See the care plan; -To sign after significant changes to the plan of care; -The resident/resident representative will be informed, in advance, of changes to the plan of care; -The resident will receive the services and/or items included in the plan of care; -Every effort will be made to schedule care plan discussions at the best time of the day for the resident/resident representative; -The mechanics of how the IDT meets (e.g., face-to-face, teleconference, written communication, etc.) for care planning is at the discretion of the resident/resident representative and care planning team. 8) Each resident's comprehensive care plan will describe the following: -Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Any services that would otherwise be required but are not provided due to the resided s exercise of right to refuse treatment; Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of Preadmission Screening and Resident Review (PASARR) recommendations. Or, if the IDT disagrees with the findings of PASARR, rationale will be documented in the resident's medical record; -In consultation with the resident/resident representative, the comprehensive care plan will include: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident's goals and desired outcomes ii) Resident's preference and potential for future discharge iii) The resident's discharge plan and any referrals to the local contact agency 10) The comprehensive care plan will: -Incorporate identified problem areas; -Incorporate risk factors associated with identified problems; -Build on the residents' strengths; -Be culturally competent and trauma informed as applicable; -Reflect treatment goals, timetables, and objectives in measurable outcomes; -Identify the professional services that are responsible for each element of care; -Aid in preventing or reducing declines in the resident's functional status and/or functional levels; -Promote resident safety; -Enhance the optimal functioning of the resident by focusing on a rehabilitative program; -Reflect currently recognized standards of practice for problem areas and conditions; -Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan; -The Care Planning/interdisciplinary Team is responsible for the review and updating of care plans: -When requested by the resident / resident representative; -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; -At least quarterly and after each OBRA (Omnibus Budget Reconciliation Act) MDS assessment. 1. Review of Resident #87's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/25/24, showed: -Cognitively impaired; -No impairment to both upper and lower extremities; -Independent in mobility; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Walk up to 150 feet independently; -Wandering occurred one to three out of seven days; -Diagnoses included low blood pressure, high cholesterol, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), malnutrition and depression. Review of the resident's Elopement Evaluation, dated 10/22/24, showed: -Resident is ambulatory or self-mobile in wheelchair; -Cognitively impaired with poor decision-making and/or pertinent; -Wandering history: resident has history of wandering, opening doors to the outside and/or elopement, making statements that they are leaving or seeking to find someone/something, displaying behavior, body language, etc. indicating an elopement may be forthcoming; -Resident at risk of elopement; -Rationale: Always makes statement about leaving. Review of the resident's care plan, revised 10/23/24, showed: -Focus: The resident has impaired cognitive function or impaired thought processes related to Alzheimer's dementia; -Goal: Will be able to communicate basic needs on a daily basis through the review date; -Interventions: Administer medications as ordered, monitor/document for side effects and effectiveness. Identify self at each interaction, face the resident when speaking and make eye contact, reduce any distractions. Provide the resident with necessary cues, stop and return if agitated; -The care plan did not reflect the resident's risk of elopement. Observation on 11/20/24 at 11:37 A.M., showed the resident ambulated independently in the common area of Hall 100r memory care unit. The resident was pleasantly confused, had a coat on and pointed outside through the window and said his/her car was outside waiting for him/her. During an interview on 11/25/24 at 1:34 P.M., Certified Medication Technician (CMT) O said the resident had multiple attempts of exiting, standing by the doors and/or attempts of pushing the doors. The resident did not need a wanderguard (electronic monitoring device) because all the doors in Hall 100 were equipped with an alarm system, and the main entrance to the unit required codes to access. 2. Review of Resident #99's admission MDS, dated [DATE], showed: -Cognitively impaired; -Wandering occurred one to three out of seven days; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Walked 10-50 feet with partial assistance; -Used a manual wheelchair; -Diagnoses included diabetes, dementia and traumatic brain injury. Review of the resident's care plan, 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; -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, dated 11/8/24 at 2:33 P.M., the CMT called this nurse to look at resident for any injuries as resident told CMT he/she fell last evening. Upon entering 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 care plan, showed no information regarding the fall on 11/8/24. 3. During an interview on 11/26/24 at 11:17 A.M., Licensed Practical Nurse (LPN) H said the nurses have access to the residents' care plan. The care plan should be reflective of the residents' needs and care. 4. During an interview on 11/26/24 at 12:07 P.M., the Administrator and Director of Nursing (DON) said care plans should be specific to residents. Falls and elopement risk should be included in the resident's care plan.

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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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Ellisville Rehabilitation and Nursing	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 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)

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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 0689 Level of Harm - Minimal harm or potential for 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 - Minimal harm or potential for 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 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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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	-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:	(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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(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)

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

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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)

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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