STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265776	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Spanish Lake, The	610 Prigge Road Saint Louis, MO 63138

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41061 Based on interview and record review, the facility failed to ensure pain medications were given as ordered for one of three sampled residents (Resident #14). The census was 127. Review of the facility's Administering Medication Policy, reviewed on 1/24/24, showed: -Policy: Medications will be administered in a safe and timely manner, and as prescribed; -Medications must be administered in accordance with the orders, including any required time frame; -If a medication is unavailable, the Certified Medication Technician (CMT)/Nurse will look in the First Dose Cabinet and/or central supply for over-the-counter medications, and administer the medication. If the medication is still unavailable, the CMT/Nurse will reorder the medication by either faxing or calling the request into the pharmacy; -If a medication is missing, and the pharmacy has not sent the requested medication the following day, the Director of Nursing or designee is to be notified to assist in removing barriers and obtaining the medication in a timely manner, whether the issue lies within the pharmacy or a new prescription needs to be updated. Review of Resident #14's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/26/24, showed: -Cognitively intact; -Continually in an altered level of consciousness; -Scheduled pain medication regime present; -Pain was present occasionally; -Pain interfered with day-to-day activities occasionally; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included anxiety, depression, schizophrenia (breakdown in relation between thought, emotion and behavior leading to faulty perception, inappropriate actions, and feelings), post-traumatic stress disorder (PTSD), Parkinson's disease (disorder of central nervous system that affects movement) and chronic pain due to trauma. Review of the resident's care plan, undated, showed: -Problem: The resident fixates on pain medications/narcotics (used to treat severe pain); -Interventions included give medications as ordered. Review of the resident's Medication Administration Record (MAR), dated August 2024, showed: -An order, dated 7/2/24, for Lidocaine patch, no strength noted, (prevents pain by blocking the signals at the nerve endings in the skin), apply to neck and back topically, give one time a day for pain; -Documentation showed the Lidocaine patch was not given on the following days due to not available: 8/3, 8/6, 8/8, 8/12, 8/18, 8/20 and 8/22/24. Review of the resident's progress notes, showed no documentation the facility ordered the Lidocaine patches or informed the Primary Care Physician (PCP) of the missing medication. Review of the facility's emergency (e) kit medication list, undated, showed: -Lidocaine 4% patch, five per box, were kept in stock. During an interview on 8/24/24 at 7:56 P.M., the resident said he/she was told by nursing staff that his/her medications were misplaced when the resident went to get them. The resident did not know what happened to his/her medications. During an interview on 8/23/24 at 1:13 P.M., Licensed Practical Nurse (LPN) G said: -The CMTs were responsible for re-ordering medications; -He/She expected CMTs to inform their nurse immediately if a medication was missing; -He/She would look in the medication room for a missing medication or see if the facility had the missing medication in the e-kit; -Nurses had access to the e-kit; -He/She expected CMTs to tell their nurse if they were not able to get a medication for the resident, so the nurse could call the pharmacy to determine the hold-up and/or call the PCP to see if they wanted an alternative medication ordered; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses were expected to document in the progress notes when a resident was missing a medication, what they did to try to resolve the issue, who they notified and how they followed up to resolve the issue. During an interview on 9/11/24 at 2:02 P.M., the Administrator said: -She expected staff to have knowledge of and follow policies; -She expected nurses to follow physician orders; -When a resident was missing a medication, she expected staff to see if there was medication in the medication room, call pharmacy in regards to re-ordering medication, call the PCP to see if the medication was correct, if needed a script to re-order to pharmacy, or if the medication needed changed, then document all they did in the resident's progress notes and update the resident on the status of their medication; -Lidocaine patches were in the facility's e-kit; -She expected CMTs to notify the nurse when they found the resident was missing Lidocaine patches; -She expected the nurses to get the Lidocaine patches out of the e-kit to use for the resident; -Nursing staff not following physician orders was adverse to quality of care; -The resident was at risk of increased pain due to missing medication. MO00241056 MO00240725

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on observation, interview and record review, the facility failed to ensure nurses completed weekly skin assessments, weekly wound assessments and to ensure treatments were applied as ordered to pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), for one resident (Resident #5) out of three sampled residents. The facility also failed to ensure facility wound reports were accurate. This had the potential to affect all residents at risk for skin breakdown. The census was 127. Review of the National Pressure Ulcer Advisory Panel (NPUAP), prevention and treatment of pressure ulcers: Quick Reference Guide, Washington DC: National Pressure Ulcer Advisory Panel 2014 showed the following: -Assess the pressure ulcer initially and re-assess it at least weekly; -With each dressing change, observe the pressure ulcer for signs that indicate a change in treatments as required (e.g., wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications); -Address the signs of deterioration immediately. Review of the Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Chapter 3, Section M, showed the definitions of different stages of pressure ulcers as follows: -Stage II: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (necrotic (dead)/avascular tissue in the process of separating from the viable portion of the body, usually light colored, soft, moist and stringy). May also present as an intact or open/ruptured blister; -Unstageable pressure ulcers (known but unstageable due to coverage the wound bed by slough and or eschar (thick leathery, frequently black or brown in color, necrotic tissue). Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Review of the NPUAP, Prevention and Treatment of Pressure Ulcers; Quick Reference Guide, Washington DC: National Pressure Ulcer Advisory Panel: 2009, showed ongoing assessment of the skin is necessary to detect early signs of pressure. Review of the facility's Pressure Ulcer Prevention and Management policy, reviewed date of 1/24/24, showed: -Policy: This facility is committed to the prevention of avoidable pressure ulcers and the promotion of healing of existing pressure ulcer(s); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach for pressure ulcer prevention and management, starting with prompt assessment and treatment, including efforts to identify risk, stabilize, reduce or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate; -Licensed nurses will conduct a full body skin assessment on all residents upon admission, readmission and weekly; -Assessments of pressure ulcers will be performed by a licensed nurse or physician and documented daily with treatments and weekly wound report; -Evidence-based treatments, in accordance with current standards of practice will be provided for all residents who have a pressure ulcer present; -The Director of Nursing (DON), the Assistant Director of Nursing (ADON), Wound Nurse or designee will review all relevant documentation regarding skin assessment, pressure ulcer risks progression towards healing and compliance at least weekly and discussed at the weekly Interdisciplinary Team (IDT) meeting; -The attending physician will be notified of the presence, progressions toward healing or lack of healing of any pressure ulcers upon identification of the ulcers. Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/14/24, showed: -admitted on [DATE]; -Cognitively intact; -Impairment on one side of upper and lower body; -Always incontinent of bladder; -Frequently incontinent of bowel; -Dependent on staff for toileting and transfers from the bed/chair; -Required moderate assistance for rolling left and right in the bed; -Required maximal assistance to transfer from a lying to sitting position and from a sitting to lying position; -At risk for pressure ulcers; -No unhealed pressure ulcers; -Diagnoses included heart failure, stroke, diabetes, respiratory failure, kidney disease, muscle weakness and seizure disorder. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's wound report, dated 6/2/24 through 6/29/24, showed no documentation found for the resident. Review of the resident's progress notes, showed: -On 7/5/24 at 4:52 P.M., the resident was evaluated to be at high risk for pressure ulcers; -On 7/12/24 at 1:23 P.M., the resident refused to allow the primary care physician (PCP) to assess his/her wound. Review of the facility's wound reports, showed: -On the 7/7/24 through 7/13/24 wound report, the resident was admitted on [DATE] with a pressure ulcer (stage not noted) on his/her buttock, no stage noted, no measurement noted, no wound assessment noted. The resident refused the physician visit; -On the 7/21/24 through 7/27/24 wound report, the resident was noted as admitted on [DATE] with a Stage II pressure ulcer on his/her buttock, measured on 7/24/24, with slough tissue present. There was no documentation found of the resident's wound measurement. Review of the facility's wound report, dated 7/28/24 through 8/3/24, showed the resident had a pressure ulcer to his/her buttock, stage not noted, no measurement noted, resident refused to be seen by PCP. Review of the resident's progress notes, showed: -On 7/31/24 at 3:57 P.M., the resident was sent out to the hospital due to chest pains; -On 8/6/24 at 3:15 P.M., the resident returned from the hospital. Review of the resident's care plan, undated, showed: -Problem: The resident had actual impairment to his/her skin integrity related to a Stage II pressure ulcer (PU) to his/her buttocks and unstageable PU to his/her left heel noted on 8/6/24; Interventions included: On 8/6/24, apply barrier cream to buttocks as ordered and apply skin prep to left heel as ordered. Review of the resident's assessments found in the electronic medical record (EMR), showed: -No documentation found of a skin evaluation completed upon admission on 8/6/24; -No documentation found showing any wound assessments. Review of a dietary note in the resident's progress notes, dated 8/8/24 at 1:06 P.M., showed the resident had no skin concerns. Review of the facility's wound reports, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On the 8/4/24 through 8/10/24 wound report, the resident had a Stage II pressure ulcer on his/her left buttock, measuring 0.5 centimeters (cm) by 0.5 cm on 8/8/24, with granulation tissue (healthy, red tissue) present, treat with barrier cream twice a day and as needed; the resident had a Stage II pressure ulcer on his/her left heel, measuring 4.0 cm by 3.5 cm on 8/8/24, with granulation tissue present, treat with skin prep daily; -On the 8/12/24 wound report, the resident had a Stage II pressure ulcer on his/her left buttock measuring 0. 5 cm by 0.5 cm, the tissue type was scab, treat with barrier cream twice a day and as needed. The resident had a pressure ulcer, not staged, measuring 4.0 cm by 3.5 cm, the tissue type was scab, treat with skin prep daily. Review of the resident's skin evaluations, showed: -A skin evaluation, dated 8/15/24, showed the resident did not have any current skin issues; -There were no other skin evaluations found. Review of the resident's Treatment Administration Record (TAR), dated August 2024, showed: -An order, dated 7/25/24, for a weekly skin assessment every Thursday day shift. Documentation showed left blank on 8/8 and 8/22; -An order, dated 8/21/24, to cleanse left buttock with soap and water, apply barrier cream twice a day and as needed until healed. Documentation showed on 8/21/24 during day shift, the entry was left blank; -An order, dated 8/22/24, to cleanse the resident's left heel with soap and water, then apply skin prep daily until healed. Documentation showed the order was followed; -There was no documentation found for treatment to the resident's buttock prior to 8/21/24; -There was no documentation found for treatment to the resident's left heel prior to 8/22/24. Review of the facility's wound reports, dated 8/18/24 through 8/23/24, showed no documentation found for the resident. Review of the resident's progress notes, showed: -On 8/23/24, at 1:21 P.M., a dietary note : The resident's care plan showed the resident had a Stage II Pressure Ulcer on his/her buttocks and an unstageable pressure ulcer on his/her left heel. -No documentation found showing when the wounds were found on the resident's buttocks or left heel, who was notified, if new orders were obtained and how the facility was following up on the resident's care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/23/24 at 9:47 A.M., showed the resident received perineal care (peri-care, washing the front and back of the hips, genitals, anal area and buttocks) from a Certified Nurse Assistant (CNA). The resident's brief and paper chuck were soaked with urine and fecal matter. The CNA cleaned the resident. The CNA did not apply barrier cream to the resident's left buttock. There was no pressure ulcer observed. During an interview on 8/23/24 at 10:19 A.M., the resident said: -The nursing staff did not put any type of cream on his/her buttocks; -He/She was in pain related to his/her buttocks; -The nursing staff did not apply anything to his/her left heel. During an interview on 8/23/24 at 1:13 P.M., Licensed Practical Nurse (LPN) G said: -He/She was the nurse assigned to the resident; -The resident did not have any treatments ordered for wounds; -Nurses were responsible for completing treatments listed on the TAR during their shift; -Nurses were responsible for completing skin assessments listed on the TAR during their shift; -If there were any skin issues, nurses were expected to document the location of the wound, what was done, when they contacted the PCP and what orders were put in place. Review of the PCP's wound report, dated 8/26/24, showed: -The resident had a Stage II pressure ulcer on his/her left buttock, measuring 0.8 cm by 0.5 cm, tissue present scab, stable, treat with barrier cream twice a day and as needed; -The resident had a pressure ulcer (unstaged) on his/her left heel, measuring 1.0 cm by 1.0 cm, tissue present scab, improving, treat with skin prep daily. During an interview on 8/23/24 at 3:13 P.M., the DON said: -She expected nurses to complete weekly skin assessments; -She expected nurses to assess any new skin issues, describe the wound, plus the location, contact the PCP, get new orders and document all in a progress note; -She was responsible for completing weekly wound assessments for each resident and entering the information into their individual EMR; -She was responsible for completing the facility wound reports. She used the information from her own wound assessment and from the wound assessments she received from the PCP, who did rounds on each resident, completing weekly wound assessments; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The wound assessments from the PCP did not have complete assessments of the wounds, did not show drainage, peri-wound (skin around wound) status, tissue type in wound bed or the percentage of different tissue types; -The facility wound reports were not accurate; -She expected accurate wound assessments both in the residents' EMR and on the facility wound report, so the IDT could adequately monitor if residents' wounds were healing or declining; -Inaccurate or lack of assessment increased the risk of residents' wounds not healing and could affect the plan of care. During interviews on on 8/23/24 at 2:26 P.M. and on 9/11/24 at 2:02 P.M., the Administrator said: -She expected staff to have knowledge of and follow policies; -The DON was responsible for completing the facility wound report; -The DON was responsible for completing residents' weekly wound assessments with the PCP or by herself; -She expected the DON to update residents' weekly wound assessment in their EMR, documented in either a wound assessment or in the progress notes; -Nurses were responsible for completing physician orders; -The DON was responsible for checking TARs for completeness on a daily basis; -Wound reports were not accurate if the information was repeated from week to week, using the same measurements from the week before; -Inaccurate wound reports increased the risk of delayed wound healing, of infection, and prohibited the facility from determining if a wound was healing or declining and ultimately affected residents' plans of care; -Lack of weekly wound assessments in a resident's EMR would affect their plan of care since clinicians could not see the progression of the wound, would not be able to determine if the treatment was appropriate or if changes were needed. It would also make the EMR incomplete; -The DON was responsible for putting orders in as soon as she got them from the PCP; -Wounds were at increased risk of deterioration and increased risk of infection if orders were not put in when given by the PCP; -She expected nurses to report any new skin issues to the DON and the PCP, get a treatment order and document a full assessment on the wound in the skin evaluation and progress note; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses were expected to complete skin assessments on admission, readmission, weekly and at discharge and were documented on skin evaluation forms; -She expected the DON and the ADON to audit residents' charts for skin assessment completions on a weekly basis. If they were not done, she expected the DON and ADON to tell the nurse who would then complete the skin assessment; -Residents were at risk of having undetected skin issues with increased risk of infection and wound healing delayed if skin assessments were not completed. MO00238790

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41061 Based on observation, interview and record review, the facility failed to ensure residents who required colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall) services received such care consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for one resident (Resident #7) out of three sampled residents. The census was 127. Review of the facility's Administering Medication Policy, reviewed on 1/24/24, showed: -Policy: Medications will be administered in a safe and timely manner, and as prescribed; -Only persons licensed or permitted by the state of Missouri to prepare, administer and document the administration of medications and/or have related functions can administer medications; -Medications must be administered in accordance with the orders, including any required time frame; -Topical medications used in treatments will be documented on the Treatment Administration Record (TAR); -Residents may self-administer their own medications only if the attending physician and nursing personnel has determined they have the decision-making capacity to do so safely. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/19/24, showed: -admitted on [DATE]; -readmitted on [DATE] from an inpatient psychiatric facility; -Cognitively intact; -No behaviors noted; -Moderately impaired eyesight; -No corrective lenses; -Supervision or touching assistance needed for all activities of daily living (ADLs); -Colostomy present; -Diagnoses included anxiety, depression, bipolar disease (psychiatric illness characterized by both manic and depressive episodes, or manic ones only), psychotic disorder (mental disorder characterized by a disconnection from reality) and post-traumatic stress disorder (PTSD). (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plan, undated, showed: -Problem: The resident had impaired cognitive function/dementia or impaired thought process. Interventions included administer medications as ordered. Monitor/document for side effects and effectiveness; -No documentation found for a plan of care for colostomy status. Review of the resident's skin evaluation, dated 7/30/24 at 5:41 P.M., showed no current skin issues. Review of the resident's progress notes, showed: -On 8/6/24 at 3:23 P.M., a skin evaluation note showed irritation and redness was noted to the colostomy peri-skin (skin surrounding the stoma); -There was no documentation found showing when the resident went out to the emergency department (ED); -On 8/6/24 at 8:45 P.M., the resident returned from the ED for colostomy site irritation. Review of the resident's hospital discharge documents, dated 8/6/24, showed: -Diagnosis: Colostomy complication, unspecified; -There were no medications prescribed. Review of the resident's progress notes, showed: -On 8/11/24 at 4:51 P.M., the resident called 911 to escort him/her to the ED for colostomy complications; -On 8/11/24 at 11:59 P.M., the resident returned from the ED with a discharge diagnosis of ostomy care. The Primary Care Provider (PCP) was notified and there were no new orders. Review of the resident's hospital discharge documents, dated 8/11/24, showed: -Chief complaint: the resident has a colostomy, complains the facility was out of bags and he/she was in severe pain at the site; site was red and inflamed; -Skin surrounding ostomy has mild erythema (redness), no drainage noted, mild tenderness, nontoxic appearance -Wound care was provided by the Registered Nurse (RN) and ostomy bag was replaced. Resident sent back with ostomy supplies. Review of the resident's PCP progress note, dated 8/13/24, showed: (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident complained of irritation around the colostomy stoma (an opening in the body). The resident had previously been to the ED and was provided some zinc (barrier cream) protection; -The resident was not wearing a colostomy bag when examined; -The resident complained the colostomy bags fell off because they were not the right size; -The Director of Nursing (DON) and staff said the resident was exhibiting a behavior and intentionally removing the colostomy bags. The bags should last three days but the resident's bag did not last one day; -Assessment plan for colostomy complication showed the resident was stable, colostomy supplies were ordered, hopefully the resident was not removing them. Continue barrier cream. Review of the resident's skin evaluation, dated 8/12/24 at 7:20 P.M., showed the resident had redness and irritation around the colostomy area. Review of the resident's Treatment Administration Record (TAR), dated August 2024, showed: -An order dated 8/14/24, to apply a barrier ring (used to fill uneven skin contours near stoma) to affected area, one time a day every other day, for colostomy care. Documentation showed the nursing staff left 8/14, 8/16 and 8/20 blank. -An order dated 8/14/24, to apply stoma adhesive (protective skin barrier) paste to affected area one time a day, every other day related to colostomy status. Documentation showed the nursing staff left 8/14, 8/16 and 8/20 blank; -An order dated 8/14/24, to apply skin prep barrier wipes, once a day every other day, related to colostomy status. Documentation showed the nursing staff left 8/14, 8/16 and 8/20 blank; -An order dated 8/14/24, to change the [NAME]-plus 2 border barrier opening (stoma site flange, adhesive plate to secure an ostomy pouch to the body) every other day, one time a day for colostomy status. Documentation showed the nursing staff left 8/14, 8/16 and 8/20 blank; -An order, dated 8/14/24, for a two-piece drainable pouch to get changed every other day, one time a day, for colostomy status. Documentation showed the nursing staff left 8/14, 8/16 and 8/20 blank. Review of the resident's progress notes, showed: -On 8/19/24 at 11:31 A.M., a skin evaluation note showed irritation was noted to ostomy site. Review of the resident's Physician Order Sheet, active as of 8/23/24, showed: -There was no order found for the resident to complete his/her own colostomy care. Observation on 8/23/24 at 11:41 A.M., showed the resident in his/her room, laying on his/her bed fully clothed. The resident lifted his/her shirt to show his/her colostomy bag. The colostomy bag was intact. The skin under the colostomy flange was not visible. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Spanish Lake, The	610 Prigge Road Saint Louis, MO 63138

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/23/24 at 11:42 A.M., the resident said: -He/She had to ask nursing staff for colostomy supplies to change his/her flange and bag; -He/She changed his/her entire colostomy apparatus, including the flange and bag when needed; -He/She was told by the Director of Nursing (DON) the nurses were expected to change and care for his/her ostomy site; -The nurses did not change or care for his/her ostomy site; -Nursing staff did not put any ointments on the skin surrounding his/her stoma; -The skin surrounding his/her stoma was red and painful. During an interview on 8/23/24 at 1:35 P.M., Licensed Practical Nurse (LPN) A said: -The resident changed his/her own colostomy apparatus and bag; -Nurses were expected to apply the stoma adhesive, skin prep and flange to the resident's colostomy site as ordered; -He/She was not sure if he/she had ever followed the orders; -The resident had to get the colostomy supplies to change the stoma site flange and bag from nursing staff as they were stored in the nurses' treatment cart; -Nurses were expected to document when they followed physician orders on the MAR/TAR. During an interview on 9/11/24 at 2:02 P.M., the Administrator said: -She expected staff to have knowledge of and follow policies; -The facility did not have a policy on ostomy care; -Nurses were responsible for ostomy care to residents, include changing ostomy apparatus and topical treatments; -She expected nurses to assess the site during treatments to note any changes, irritation, make sure skin was still intact; -She expected nurses to document any skin changes to ostomy site, inform DON, call PCP and get any new orders; -The nurses were responsible for providing ostomy care to the resident, including changing ostomy apparatus, due to the resident changing his/her ostomy apparatus too often and causing irritation to the ostomy site. Prior to 8/13/24, the resident was allowed to do it on his/her own; (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses were responsible for completing all orders on the TAR; -Blanks in a TAR/MAR meant the nurses failed to document or the resident was out of the building; -She could not confirm if an order was followed if there was a blank in the MAR/TAR; -She expected the resident's care plan and order to reflect if the resident was able to change his/her own ostomy site; -The MDS care plan team was responsible for updating care plans; -Nurses were responsible for putting in orders; -She expected nurses to chart honestly and accurately to maintain accurate medical records; -The resident was at risk of delayed healing of the ostomy site and increased risk of skin irritation if the resident was changing his/her own ostomy site and the nurses were not applying the topical cream per the physician order. MO00239083 MO00240867

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46888 Based on observation, interview and record review, the facility failed to ensure call lights were accessible to residents while in their rooms for five out of five sampled residents (Resident #5, #11, #12, #13 and #15). This had a potential to affect all residents. The census was 127. 1. Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/14/24, showed: -Cognitively intact; -Had impaired vision; -Impairment on one side of upper and lower body; -Always incontinent of bladder; -Frequently incontinent of bowel; -Dependent on staff for toileting and transfers from the bed/chair; -Required moderate assistance for rolling left and right in the bed; -Required maximal assistance to transfer from a lying to sitting position and from a sitting to lying position; -Used a wheelchair for mobility; -Diagnoses included heart failure, stroke, diabetes, respiratory failure, muscle weakness, cognitive communication deficit and seizure disorder. Observation on 8/23/24 at 9:46 A.M., showed the resident lay in his/her bed. A short call light string hung off the wall, out of reach of the resident. During an interview on 8/23/24 at 10:14 A.M., the resident said he/she could never use the call light because it was not in reach. The resident would scream for help from his/her bed if he/she needed something from staff, in hopes they would hear him/her. It did not make him/her feel safe. 2. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Moderately impaired cognitive skills; -Occasionally incontinent of bladder; -Required moderate assistance with hygiene; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Used a cane/crutch for mobility; -Wore corrective lenses for impaired vision; -Had incidents of hallucinations and delusions; -Diagnoses included stroke, end stage renal disease (where the kidneys permanently stop functioning and require dialysis or a kidney transplant to stay alive) and schizophrenia (breakdown in relation between thought, emotion and behavior leading to faulty perception, inappropriate actions and feelings). During an observation and interview on 8/23/24 at 10:11 A.M., the resident lay supine in bed. His/Her call light was a single piece of string hanging down at the wall and out of reach of the resident. He/She would have to lean out over the side of the bed and reach for the call light if needed. He/She said he/she could not reach the call light. Staff rarely made sure the call light was in reach. He/She would get up and take himself/herself to the bathroom during the day and at night. He/She has had falls going to the bathroom. During an interview on 8/23/24 at 4:30 P.M., Certified Nurse Assistant (CNA) E said that call lights should be in reach of all residents, at all times. It is dangerous for the resident; anything can happen, if they do not have a call light in reach. The resident cannot get to the call light in the dark at night and has an increased risk of falling. 3. Review of Resident #12's admission MDS, dated [DATE], showed: -Rarely/never understood others; -Long term memory problem; -Severely impaired eyesight; -No corrective lenses; -Could not recall current season, location of own room, or staff names and faces; -Moderately impaired cognitive skills for daily decision making; -Required moderate assistance for rolling left and right in the bed, to transfer from a lying to sitting position and from a sitting to lying position; -Required maximal assistance for toileting, from sit to stand position and chair/bed-to-chair transfers; -Dependent on staff to pick up objects; -Used a wheelchair for mobility; -Frequently incontinent of bowel; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included diabetes, schizophrenia and dementia. Observation on 8/23/24 at 4:07 P.M., showed the resident sat in a wheelchair, in the middle of his/her private room, watching television. The call light string was on the resident's bed, out of reach of the resident. The Director of Nursing (DON) walked into the room, picked up the call light string off of the resident's bed and tried to secure it to the resident's wheelchair. The call light string did not extend far enough to reach the resident. During an interview on 8/23/24 at 4:08 P.M., the DON said the resident could not reach the call light from where he/she was sitting in the room. The resident could not walk. The resident could call out for help if needed. During an interview on 8/23/24 at 4:30 P.M., CNA E said the resident could not propel him/herself in the wheelchair to get to the call light. 4. Review of Resident #13's annual MDS, dated [DATE], showed: -Cognitively intact; -Required maximal assistance with dressing, personal hygiene, rolling to left or right in bed, going from a sitting to lying position, going from a lying to sitting position, going from sitting to standing position, bed to chair and chair to chair transfers, transfers on and off the toilet and in/out of the shower; -Used a manual wheelchair for mobility; -Had occasional bladder incontinence; -Had frequent bowel incontinence; -Diagnoses included debility (physical weakness), gastroesophageal reflux disease (GERD, a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), arthritis, schizophrenia and anxiety. During an observation and interview on 8/23/24 at 11:18 A.M., the resident sat in his/her wheelchair in front of the television in his/her room. His/Her call light was a single piece of string hanging down at the wall and out of reach of the resident. He/She said he/she could not reach the call light. Staff do not make sure the call light is in reach most of the time. He/She has had to yell out for help on several occasions. 5. Review of Resident #15's quarterly MDS, dated [DATE], showed the following: -Diagnoses of schizophrenia, major depressive disorder and seizures; -Cognitively intact. Observation on 9/17/24 at 8:07 A.M., showed the call light box in the resident's room had only one pull cord. The pull cord was positioned towards the resident's roommate. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/17/24 at 2:14 P.M., the resident said if he/she needed staff assistance in his/her room, he/she had to ask his/her roommate to pull the cord for him/her. During an interview on 9/17/24 at 2:11 P.M., Licensed Practical Nurse (LPN) A said he/she was aware the resident's room does not have two pull cords for the call light. The resident does not need a call light, so staff kept the one pull cord positioned for the resident's roommate. 6. Review of an email, sent on 9/10/24 at 12:54 P.M., showed the Administrator said the facility did not have a call light policy. 7. During an interview on 8/23/24 at 10:02 A.M., CNA B said: -Residents would use call lights when they needed help from staff; -Nursing staff were alerted when call lights were activated by an audible bell sound and a light would come on over the resident's room. During an interview on 8/23/24 at 4:30 P.M., CNA E said: -Each resident should have a call light available at all times; -The call light should be in reach of all residents at all times; -Each time staff enters a room, they should verify that the call light was in reach of the resident; -The call lights in the facility were a single string; -Not all strings had a clip on them to clip it to the resident or bedding; -It was dangerous, anything can happen, for the resident if they did not have a call light in reach; -The resident could fall trying to get to the call light; -If the resident was in a wheelchair and could not propel themselves to the call light, they could yell out, but that was dependent on people hearing them yell. During an interview on 8/23/24 at 4:16 P.M., the DON said: -She expected staff to ensure call lights were in reach of residents before they left the room; -She expected nursing staff to round on residents at least every two hours to ensure residents had their needs met and call lights were in reach; -She was not sure why the call lights were made out of a thin string; there was risk of the call light string breaking when pulled for use; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents were at risk of serious injury and/or danger if they could not access their call lights to use when they needed help; -Some residents were not able to yell loud enough for staff to hear them if they were in need of assistance; -Residents were at a higher risk of falling if they tried to get up out of their chair/wheelchair to get to a call light; -Residents were at higher risk of falling out of bed if they tried to lean over to retrieve a call light that was out of reach or stuck behind them. During an interview on 9/17/24 at 2:47 P.M., the Maintenance Associate said he was not employed at this facility, but he worked at a sister facility and was at the facility helping out. He expected for a room with two residents to have a call light box with two pull cords. He expected staff to let him know if a resident's room was missing a call light pull cord. During interviews on 9/11/24 at 2:02 P.M. and on 9/17/24 at 2:49 P.M., the Administrator said: -Nursing staff were expected to make sure call lights were in reach and working properly. -She expected nursing staff to notify maintenance if call lights were too short or not working. -There was a risk to residents if call lights were not in reach, as they couldn't notify staff of an emergency and would not get their basic needs met. -She expected each room to have a call light box with two pull cords. -She expected each resident to have their own pull cord. MO00241652