STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265783	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living - St Charles, LLC	723 First Capitol Drive Saint Charles, MO 63301

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47246 Based on interview and record review, the facility failed to report an injury of unknown origin as required to the state survey agency for one resident (Resident #51), in a review of 18 sampled residents. The facility census was 73. Review of the facility policy, Abuse Prevention, date (last revised 09/10/23), showed the following: -The facility is committed to protecting the residents from abuse by anyone including, but not limited to facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual; -Identification: -Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation; -The administrator and director of nurses (DON) must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and DON must be called at home or must be paged and informed of such incident; -Investigation: -The administrator, or designee, shall report any allegations of abuse, neglect or misappropriation of resident property as well as report any reasonable suspicion of crime in accordance with Section 1150B of the Social Security Act to the Department of Health as required; -Reporting: -Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident. 1. Review of Resident #51's face sheet, undated, showed the resident had a legal guardian. Review of the resident's medical diagnoses profile, undated, showed the resident had a diagnosis of unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) not due to a substance or known physiological condition. Review of the resident's clinical order sheet, undated, showed aspirin (blood thinner) oral tablet, chewable, 81 milligrams (mg) by mouth daily (08/31/23), open-ended (no stop date). Review of the resident's nursing progress notes on 03/21/24 at 11:09 P.M. showed licensed practical nurse (LPN) A documented the following: -While the aide was providing peri care (washing the genitals and anal areas) he/she notified this nurse that there was a bruise on the resident. When this nurse entered the room the resident was in bed, supine (lying flat on his/her back). Aide pulled back diaper and this nurse noticed a small bruise to the pubis of resident (one of the three main bones that make up the pelvis-the area between the trunk or main body-and the lower extremities; -No other bruising was noted. No pain. (Resident) says that there was not much feeling in his/her pubic, lower abdominal area and did not recall an incident that would have caused the bruise; -Assessed the bruise and areas around the bruise. Assessed other areas of the body for bruising. Skin was clear; -Called and spoke to resident's guardian to update on the findings. No further questions or concerns at this time. Called primary care provider (PCP) service and reported the findings to the PCP. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/28/24, showed the following: -Cognition severely impaired; -No behavioral symptoms; -No rejection of cares; -Dependent for toileting and mobility. Review of the resident's care plan, dated 05/19/24, showed the following: -The resident received a daily aspirin and had anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident will have not unknown bruising or profuse bleeding through his/her next review; -Check the resident's skin for bruising weekly. During an interview on 06/05/24 at 10:35 A.M., LPN A said the following: -He/She assessed the resident after a Certified Nurse Aide (CNA) told him/her there was a bruise on the resident; -The bruise was pale bluish gray in color and looked older, not necessarily new; -The bruise was about the size of a dime; -There was no other bruising on the resident, the resident had not had any falls or reported injuries; -He/She called the resident's next of kin and the primary care provider, but did not notify the Director of Nurses (DON) or administrator; -He/She did not consider the bruise might be from abuse because it did not look that concerning and it was small. If it had been larger, he/she would have reported it; -He/She now thought maybe he/she should have reported the bruise because of its location on the resident's body. During an interview on 06/05/24 at 1:10 P.M., the DON said the following: -She was not aware of the bruise that was found on the resident on 03/21/24 until the state agency brought it to her attention; -LPN A should have reported the injury of unknown origin (bruise) to administration when it was discovered; -Her expectation would be that all bruises, regardless of the presumed age or size, are reported, especially if it was a bruise of unknown origin; -Any bruise, regardless of presumed age or size, could be a potential sign of abuse and should be investigated immediately and reported to the state agency within the time frame defined by the regulation. During an interview on 6/14/24 at 9:30 A.M., the administrator said the following: -He was not aware of the bruise that was found on the resident until the state agency brought it to his attention; -LPN A should have reported the injury of unknown origin (bruise) to administration when it was discovered; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A bruise on a resident, regardless of the size or presumed age, should be reported immediately; -Upon finding an injury or bruise of unknown origin, the facility staff should contact the DON and administrator so an immediate investigation could be started, this would include interviews with all staff and residents, collection of statements by all involved to help identify the source of the injury or bruise and to identify if there were any concerns for intentional abuse; -Upon notification of an injury or bruise of unknown origin on a resident, following a thorough investigation, the administrator would report this incident immediately to the state agency, within two hours if concerns are related to possible abuse or neglect.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47246 Based on interview and record review, the facility failed to thoroughly investigate bruising of unknown origin that occurred for one resident (Resident #51), in a review of 18 sampled residents, to identify cause. The facility census was 73. Review of the facility policy, Abuse Prevention, date (last revised 09/10/23), showed the following: -The facility is committed to protecting the residents from abuse by anyone including, but not limited to facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual; -Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation; -The administrator and director of nurses (DON) must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and DON must be called at home or must be paged and informed of such incident; -The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation; -Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated, documented, and reported to the physician, families, and/or representative, and as required by state guidelines. 1. Review of Resident #51's face sheet, undated, showed the resident had a legal guardian. Review of the resident's medical diagnoses profile, undated, showed the resident had a diagnosis of unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) not due to a substance or known physiological condition. Review of the resident's clinical order sheet, undated, showed aspirin (blood thinner) oral tablet, chewable, 81 milligrams (mg) by mouth daily (08/31/23), open-ended (no stop date). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nursing progress notes on 03/21/24 at 11:09 P.M. showed licensed practical nurse (LPN) A documented the following: While aide was providing peri care (washing the genitals and anal area) he/she notified this nurse that there was a bruise on the resident. When this nurse entered the room the resident was in bed, supine (lying flat on his/her back). Aide pulled back diaper and this nurse noticed a small bruise to the pubis of resident (one of the three main bones that make up the pelvis-the area between the trunk or main body-and the lower extremities). No other bruising was noted. No pain. (Resident) says that there's not much feeling in pubic, lower abdominal area. Does not recall an incident that would have caused the bruise. Assessed bruise and areas around the bruise. Assessed other areas of the body for bruising. Skin was clear. Called and spoke to resident's guardian to update on the findings. No further questions or concerns at this time. Called primary care provider (PCP) service and reported the findings to the PCP. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/28/24, showed the following: -Cognition severely impaired; -No behavioral symptoms; -No rejection of cares; -Dependent for toileting and mobility. Review of the resident's care plan, dated 05/19/24, showed the following: -Problem: The resident received a daily aspirin and had anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body); -Goal: the resident will have not unknown bruising or profuse bleeding through his/her next review; -Approach: check the resident's skin for bruising weekly. During an interview on 06/05/24 at 10:35 A.M., LPN A said the following: -He/She assessed the resident after a certified nurse aid told him/her there was a bruise on the resident; -The bruise was pale bluish gray in color and looked older, not necessarily new; -The bruise was about the size of a dime; -There was no other bruising on the resident, the resident had not had any falls or reported injuries; -He/She called the resident's next of kin and the primary care provider, but did not notify the director of nurses (DON) or administrator; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not consider that the bruise might be from any abuse because it did not look that concerning and it was small, if it had been larger, he/she would have reported it; -He/She now thought maybe he/she should have reported the bruise because of its location on the resident's body; -He/She had abuse and neglect training when he/she was hired by the facility and on a yearly basis, the last in-service on abuse and neglect was in the past couple of months. During an interview on 06/05/24 at 1:10 P.M., the DON said the following: -She was not aware of the bruise that was found on the resident until the state agency brought it to her attention; -LPN A should have reported the injury of unknown origin (bruise) to administration when it was discovered; -Her expectation would be that all bruises, regardless of the presumed age or size, are reported, especially if it was a bruise of unknown origin; -Any bruise, regardless of presumed age or size, could be a potential sign of abuse and should be investigated immediately. During an interview on 6/14/24 at 9:30 A.M., the administrator said the following: -He was not aware of the bruise that was found on the resident until the state agency brought it to his attention; -LPN A should have reported the injury of unknown origin (bruise) to administration when it was discovered; -A bruise on a resident, regardless of the size or presumed age, should be reported immediately; -Upon finding an injury or bruise of unknown origin, the facility staff should contact the DON and administrator so an immediate investigation could be started, this would include interviews with all staff and residents, collection of statements by all involved to help identify the source of the injury or bruise and to identify if there were any concerns for intentional abuse; -Upon notification of an injury or bruise of unknown origin on a resident, following a thorough investigation, the administrator would report this incident immediately to the state agency, within two hours if concerns are related to possible abuse or neglect.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to ensure medication was administered per policy and as ordered, for one resident, Resident #55. The resident had a feeding tube (a tube inserted through the skin and the stomach wall to access for liquid nutrition and medications). Staff administered the resident's medications and did not flush appropriately between medications, and did not follow facility policy when preparing medications for dissolved medications or flushing with administration. This resulted in a medication error rate of 23.3% with 43 opportunities observed with ten errors. The facility census was 79. Review of the facility's General Guidelines for Administering Medications via Enteral Tube (Enteral feeding tubes allow liquid food to enter your stomach or intestine through a soft, flexible tube which enters a surgically created opening in the abdominal wall) Policy, revised January 2018, showed the following: -The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist; -Procedures: -In service training on bacteriological (related to the study of bacteria, especially those that cause disease) safety, administration, and monitoring of enteral solutions and medications via the enteral tube is provided by the facility to nursing personnel; -Enteral tubes are flushed with at least 15 milliliters (A measure of volume in the metric system) mL of purified or sterile water before administering medications, between each medication, and after all medications have been administered; -Each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with at least 15 mLs of water between each medication to avoid physical interaction of the medications. Tablets, powders, and beads (never crushed) from opened capsules, are mixed with 15-30 mLs of water prior to administration via the tube. Review of Lippincott's Clinical Do's and Don'ts (a manual of nursing practice), Administering Medication Through a Gastrostomy Tube (GT), dated, December 2002, showed the following: -If a medication is available only in tablet form, check with the pharmacist before crushing it. Also ask about compatibility of the medication with the feeding formula; -If a tablet can be safely crushed, use a pill crusher to grind it to a fine powder and mix it with 30 to 50 mL of warm water; -Remove the GT plug and attach a 30 to 60 mL piston syringe. (Interrupt continuous tube feedings, if necessary); (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Release the GT clamp. To verify tube placement and patency, aspirate for gastric contents, not the residual volume, and follow our facility's policy for reinstilling it. Clamp the GT, remove the syringe, and take out the plunger; -Reattach the syringe and unclamp the GT. Pinch the tubing to seal it and add 30 ml of water to the syringe. Release the tubing, let the water flow by gravity to flush it. Clamp the GT, remove the syringe, and take out the plunger; -Reattach the syringe and unclamp the GT. Pinch the tubing to seal it and add 30 mL of water to the syringe. Release the tubing, let the water flow by gravity to flush it, and pinch it again before the syringe empties; -Pour the diluted medication into the syringe and release the tubing to administer it. If you are giving more than one drug, flush between each dose with 15 to 30 mL of water, clap the GT, and replace the plug; -Document all liquids administered, including the flushes, on the patient's intake and output record; -Do not reclamp the tubing after administering a medication without flushing it. 1. Review of Resident #55's care plan, revised on 1/15/24, showed the following: -He/She was dependent on his/her gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid nutrition to the resident); -Check his/her g-tube placement via air auscultation or aspiration of stomach contents prior to giving medications or when reconnecting the tube; -The head of bed (HOB) should be elevated 30-45 degree at all times when nutrition is infusing, the tube is being flushed, meds are being given; essentially when GT is in use; -Flush the g-tube as ordered. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/02/24, showed the following: -He/She had severe cognitive impairment; -His/Her diagnoses included anemia Parkinson's disease, malnutrition, depression, and psychotic disorder; -He/She was taking high risk drug classes which included antipsychotic, antianxiety, antidepressant, antibiotic, and opioid medications; -He/She had a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Order Summary, dated June 2024, showed the following: -Diagnoses included severe protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of key nutrients, such as vitamins and minerals, that are needed for health), iron deficiency anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), psychotic disorder with hallucinations due to known physiological condition (mental illnesses that are characterized by psychotic symptoms, which can generally be described as a loss of contact with reality); major depressive disorder(a common mental disorder which involves a depressed mood or loss of pleasure or interest in activities for long periods of time), age related osteoporosis (deterioration in bone mass with increasing risk to fragility fractures) with current pathological fracture, vitamin d deficiency, thyrotoxicosis (a clinical state of inappropriately high levels of circulating thyroid hormones in the body), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dysphagia (difficulty swallowing foods or liquids), gastrostomy status (an artificial entrance to your stomach) , enterocolitis (inflammation of both the small intestine and the colon) due to clostridium difficile (bacterium that causes an infection of the colon) and , fistula (an abnormal opening or passage between two organs or between an organ and the surface of the body) of stomach and duodenum (the first part of the small intestine); -Crush meds and give through g-tube every shift for dysphagia, order start date 8/20/23; -Flush with 20 cc of water (H2O) before and after every pill, every shift for fluid replacement, order started 8/20/23; -Multivitamin liquid, give 5 ml via g-tube one time a day for vitamin deficiency, order started 11/17/23; -Ferrous sulfate (iron) oral tablet 325 mg, give one tablet via g-tube in the morning for anemia, order started 11/17/23; -Florastor (probiotic) oral capsule 250 mg, give 1 capsule via g-tube one time a day for C-diff, order started 12/09/23; -Ropinirole HCl (restless legs syndrome) oral tablet 0.25 mg, give 1 tablet via g-tube two times a day for Parkinson's give 0.25 mg two times a day and 0.50 mg at bedtime, order started 12/15/23; -Methimazole oral tablet, give 2.5 mg via g-tube two times a day for hyperthyroidism, order started 1/12/24. -Vancomycin (antibiotic) HCl oral suspension 250 mg, give 250 milligrams via g-tube one time a day for colitis, order started 1/19/24; -Nuplazid oral capsule 34 mg, give 1 capsule via g-tube in the morning for hallucinations related to Parkinson's disease, order started 2/16/24; -Celecoxib oral capsule 100 mg, give 1 capsule via g-tube two times a day for pain/discomfort, order started 2/16/24; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Escitalopram oxalate 5 mg oral tablet, give 5 mg via g-tube in the morning for depression, order started 2/20/24; -Enteral feed order every shift Osmolite 1.5 run at 50 milliliters per hour (mL/hr) per pump with 150 mL flush every 6 hours, order started 4/22/24; -Hydrocodone-acetaminophen oral tablet 5-325 mg, give 1 tablet via g-tube one time a day for pain, order started 5/09/24. Review of the resident's Medication Administration Record (MAR), dated 6-05-24, showed the following: -Crush meds and give through g-tube every shift for dysphagia; -Flush with 20 cc H2O before and after every pill, every shift for fluid replacement; -The administration box showed LPN B documented he/she administered the following A.M. medications: -Ferrous sulfate oral tablet 325 mg, give one tablet via g-tube in the morning for anemia; -Florastor oral capsule 250 mg, give 1 capsule via g-tube one time a day for C-diff; -Hydrocodone-acetaminophen oral tablet 5-325 mg, give 1 tablet via g-tube one time a day for pain; -Lexapro 5 mg oral tablet, give 5 mg via g-tube in the morning for depression; -Multivitamin liquid, give 5 ml via g-tube one time a day for vitamin deficiency; -Methimazole oral tablet, give 2.5 mg via g-tube two times a day for hyperthyroidism, order started 1/12/24. -Nuplazid oral capsule 34 mg, give 1 capsule via g-tube in the morning for hallucinations related to Parkinson's disease; -Vancomycin HCl oral suspension, give 250 milligrams via g-tube one time a day for colitis; -Celebrex oral capsule 100 mg, give 1 capsule via g-tube two times a day for pain/discomfort; -[NAME] oral tablet, give 2.5 mg via g-tube two times a day for hyperthyroidism; -Ropinirole HCl oral tablet 0.25 mg, give 1 tablet via g-tube two times a day for Parkinson's give 0.25 mg two times a day and 0.50 mg at bedtime. Observation on 6/05/24 at 8:48 A.M., 9:11 A.M., 9:50 A.M., and 9:54 A.M. showed Licensed Practical Nurse (LPN) B prepared the residents' medications as follows: -He/She sat out ten empty medication cups on top of the medication cart; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She took an empty medication cup to the medication storage room and filled it with 250 ml of the resident's bottle of vancomycin located in the refrigerator; -He/She went back to the medication cart and pulled the following medications out of the cart: -1. Ferrous sulfate oral tablet 325 mg; -2. Florastor oral capsule 250 mg; -3. Hydrocodone-Acetaminophen oral tablet 5-325 mg; -4. Escitalopram oxalate 5 mg oral tablet; -5. Multivitamin liquid 5 ml; -6. Nuplazid oral capsule 34 mg; -7. Ropinirole HCl oral tablet 0.25 mg; -8. Celecoxib oral capsule 100 mg; -9. Methimazole oral tablet 2.5 mg; -He/She placed each medication in a separate medication administration cup; -He/She emptied the contents of each capsule in a separate medication administration cup; -He/She added 5 ml of water to each medication cup to dissolve each pill/capsule; -He/She unhooked the feeding tube from the G-tube and checked residual (250 ml); -He/She attached a syringe to the g-tube and put 20 mL of water in the tube; -He/She administered two unidentified medications into the tube without flushing in between the medications; -The tube became clogged and LPN B called the alternate physician for the resident who came into the facility to evaluate the resident; -The alternate physician assessed the resident and then asked LPN B to push 20 mL of water through the tube. LPN B was able to push the water through and then flushed with another 20 mL of water; -He/She then proceeded to finish the medication pass. He/She emptied seven unidentified medications into the tube and flushed with 20 mL of water. LPN B forgot to give the resident his/her hydrocodone-acetaminophen oral tablet 5-325 mg pain medication. He/She then administered the hydrocodone-acetaminophen oral tablet 5-325 mg through the resident's tube and hooked the feeding tube back up to the pump; (continued on next page)

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	265783	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living - St Charles, LLC	723 First Capitol Drive Saint Charles, MO 63301

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not flush with 20 mL of water between each medication; -He/She did not flush with 20 mL of water after the last medication was given before he/she attached the feeding tube back up to the g-tube. During an interview on 6/05/24 at 10:03 A.M., LPN B said when he/she administers medications via g-tube, he/she will put each medication in a separate medication cup and add 5 mL of water and let all the medications dissolve completely. If medications are a capsule, he/she will empty the capsule in an empty administration cup. He/She will disconnect the feeding tubing from the g-tube and check the residual volume. He/She will flush the g-tube with 20 mL of water before administering any medication and again when all of the medications have been given, before hooking the feeding tube and pump back up. During an interview on 6/05/24 at 10:17 A.M., the resident's alternate care physician said he/she would expect physician orders to be followed when administering medications through a feeding tube. During an interview on 6/05/24 at 12:34 P.M., the Director of Nursing (DON) said she expected facility policies and physician orders to be followed. Staff should get clarification on physician orders if there is a question about medications being administered through a gastrostomy tube.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34536 Based on observation, interview and record review, the facility failed to serve the proper size entree to residents on a regular diet and mechanical soft diets, and failed to served pureed food items according to the spreadsheet menu to all residents on a pureed diet. The facility census was 73. Review of the undated facility policy, Portion Control, showed the following: -Individuals will receive the appropriate portions of food as defined by the state regulations and as planned on the menu. Control at the point of service is necessary to assure that the appropriate portion is served; -Use standardized recipes to avoid waste caused by overproduction. Recipes should be adjusted as needed and the yield and serving size specified on each recipe. The menu should list the specific portion size for each food item. Menus should be posted at the tray line so that the proper portion can be referenced for each special diet; -Serve the food with ladles, scoops, spoodles and spoons of standard sizes which match the menus. Scales should be used as needed to weigh meat portions. Scoops should be leveled off (not overflowing) for the most accurate portion size. Portions that are too small result in the individual not receiving the nutrients needed. Portions that are too large increase costs as well as providing the individual more food than needed or allowed (in the case of special diets); -Dining services staff will be in serviced by the dining services manager on proper portion sizes at regular intervals. Meal observations for quality control of portion sizes should be conducted by the dining services manager, registered dietitian (RD) or dietetic technician (DTR) on a routine basis. Review of the undated facility policy, Diet Orders and Food Preferences, showed the following: -Diet orders and food preferences will be kept on record in the kitchen and used to assure that each individual's needs and desires for food are met; -Procedure: The dining services manager obtains the correct diet order from the medical record and documents it in the dining services records; -The diet order and food preference records are used during meal service to ensure the correct diet is served and food preferences are honored; -Dining services staff are trained to carefully prepare an individual's meal using the diet order and food preference records and to serve that meal to the correct individual. 1. Review of the facility's Diet Type Report, dated 6/3/24, showed 69 residents had a physician-ordered regular diet and three residents had a physician-ordered mechanical soft diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 6/3/24 of the dietary spreadsheet menu, dated Spring/Summer 2023, Week 2, Day 9 showed staff were to prepare and serve the following menu items for the evening meal: -6 ounces (2/3 cup) of turkey tetrazzini to residents with a regular diet order; -6 ounces (2/3 cup) of tetrazzini with ground turkey to residents with a mechanical soft diet order; -4 ounces (1/2 cup) of diced carrots to residents with a mechanical soft diet order. Observation on 6/3/24 at 4:31 P.M. showed Dietary Staff C prepared mechanical soft turkey tetrazzini and added an unmeasured amount of turkey tetrazzini to a food processor and blended the mixture. The item was ground into small pieces and chunks. He/She covered the pan of ground turkey tetrazzini with plastic wrap. Observation on 6/3/24 at 4:44 P.M. showed Dietary Staff C placed pans of prepared food items into the steam table. Dietary Staff D placed utensils in pans of food. He/She did not refer to the dietary spreadsheet when selecting utensils for the pans of food. Observation on 6/3/24 at 4:51 P.M. showed the steam table pans of food and the utensils in each pan: -A 4-ounce (1/2 cup) utensil was in the regular turkey tetrazzini; -A 4-ounce utensil was in the carrots; -A 4-ounce utensil was in the mechanical soft turkey tetrazzini; -No diced carrots were on the steamtable. Observation on 6/3/24 at 4:52 P.M. showed Dietary Staff C started meal service in the main dining room. Observation on 6/3/24 at 5:12 P.M., showed Dietary Staff D began plating hall trays. Observation on 6/3/24 at 5:49 P.M. showed staff plated the last resident tray. (Staff served all residents on a regular and mechanical soft diet a 4-ounce portion of turkey tetrazzini instead of a 6-ounce portion. Staff did not serve the prepared ground turkey tetrazzini to the residents on a mechanical soft diet. Staff served these residents from the same pan as the residents with a regular diet. Staff served the residents on a mechanical soft diet a 4-ounce portion of regular carrots that were not diced.) Observation on 6/3/24 at 5:50 P.M., showed Dietary Staff D plated a sample regular diet test tray. He/She said staff choose the serving scoops/utensil according to the consistency of the food item. Vegetables got a spoon with holes to drain the liquid. He/She did not refer to anything when choosing sizes. All the serving sizes of the utensils used for lunch were 4-ounce sized utensils. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 6/3/24 at 5:52 P.M., of a requested sample test tray for a regular diet, showed the pieces of carrots were large in size and were long slices cut on the diagonal. 2. Review of the facility's Diet Type Report, dated 6/3/24, showed one resident had a physician-ordered pureed diet. Review on 6/3/24 of the dietary spreadsheet menu, dated Spring/Summer 2023, Week 2, Day 9 showed staff were to prepare and serve the following menu items to residents on a pureed diet at the evening meal: -6 ounces (2/3 cup) of pureed turkey tetrazzini; -#12 scoop (1/3 cup) of pureed carrots; -#16 (1/4 cup) of pureed bread; -#12 (1/3 cup) of pureed dessert. During interview on 6/3/24 at 5:09 P.M., Dietary Staff C said the resident on pureed diet typically did not come to the dining room and was usually sent hall trays. The resident on a pureed diet was going to receive pureed pork sausage, pureed green beans and mashed potatoes/gravy for the evening meal instead of turkey tetrazzini, carrots, bread and dessert. The sausage was leftover and needed to be used. Observation on 6/3/24 at 5:30 P.M. showed Dietary Staff C could not find the pureed sausage. He/She had placed it in the microwave to reheat the item. When he/she returned to retrieve the sausage, the item was not in the microwave. Observation on 6/3/24 5:40 P.M. showed Dietary Staff C and Dietary Staff D prepared the evening meal hall tray for the resident on a pureed diet. Staff plated pureed chicken with gravy, pureed green beans and mashed potatoes/gravy. The meal tray did not contain pureed bread or pureed dessert. The resident on a pureed diet should have received 6-ounces (2/3 cup) of pureed Turkey Tetrazzini and instead received pureed chicken. The resident on a pureed diet should have also received #12 scoop (1/3 cup) of pureed carrots, but instead staff served green beans. The resident should have been served #16 scoop (1/4 cup) of pureed bread but was not served any bread. The resident should have received #12 scoop (1/3 cup) of pureed dessert, but instead did not get any pureed dessert. During interview on 6/4/24 at 12:35 P.M., Resident #64 (who had a physician-ordered pureed diet) said he/she sometimes got to choose what he/she received to eat. He/She would like to have what everyone else was eating or what was on the menu for that meal. During interview on 6/4/24 at 2:24 P.M., the Dietary Director said the following: -Staff should use the spreadsheet menu to know what scoops to use. The cooks and serving area both have a copy of the spreadsheet menu to refer to at meal time; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Residents on a pureed diet should receive the same food items as the regular menu. The facility also used some frozen pre-made purees that need to be steamed or heated. If the facility used the pre-made frozen items, they should be the same items that were on the menu or close to it. During interview on 6/5/24 at 9:36 A.M., the Consultant Dietitian said the following: -Staff should use the spreadsheet menu to ensure proper serving utensils were chosen to serve food items; -Staff should prepare and serve all items on the menu for all therapeutic diets according to the spreadsheet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34536 Based on observation, interview, and record review, the facility failed to maintain the ice machine to be free of an accumulation of debris, failed to ensure food and beverage items were labeled, dated, properly stored and discarded when expired, failed to ensure open cans of foods were properly maintained during food preparation; failed to ensure a scoops was not stored inside a bulk food container, and failed to ensure staff used safe food handling techniques during meal service in the dining room. The facility census was 73. 1. Review of the undated facility policy, Cleaning Instructions: Ice Machine and Equipment, showed the ice machine and equipment (scoops) will be cleaned on a regular basis to maintain a clean, sanitary condition. Observation on [DATE] at 12:20 P.M. and on [DATE] at 9:11 A.M. showed the ice machine in the main kitchen had a buildup of pink and black debris on the white plastic interior portion of the unit. A small amount of white crusty debris was in the corners near the hinges. During interview on [DATE] at 2:24 P.M., the Dietary Director said an outside vendor fully cleaned the ice machine once or twice a month. The machine was completely emptied, cleaned and allowed to refill. Dietary staff cleaned and areas of buildup in the ice machine every week or so. During interview on [DATE] at 9:36 A.M. the Consultant Dietitian said the ice machine should be clean and could harbor bacteria if not maintained properly. 2. Review of the undated facility policy, Food Storage, showed the following: -Food is stored, prepared and transported at appropriate temperatures and by methods designed to prevent contamination; -All containers must be legibly and accurately labeled; -Food should be dated as it is placed on the shelves; -Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk food. Observation on [DATE] at 12:23 P.M. of the reach-in refrigerator in the kitchen showed a clear plastic pitcher contained red liquid. The pitcher was not labeled or dated. An additional clear pitcher of orange liquid was not labeled or dated. Observation on [DATE] at 12:24 P.M. showed a 24-ounce bottle of chocolate syrup was mostly empty and sat on a tile ledge in the corner of the kitchen next to a metal storage rack and the four-way reach in refrigerator. The label on the syrup showed to refrigerate after opening. A 32-ounce container of lemon juice sat in the same location. The lemon juice bottle was open and mostly full. The label directed to refrigerate after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on [DATE] at 12:26 P.M. and on [DATE] at 9:11 A.M. showed in another reach-in refrigerator, an entire pork loin, still in the packaging, was completely thawed, and dated ,d+[DATE]. Four large rolls of thawed hamburger dated ,d+[DATE] and two large, thawed roasts were dated ,d+[DATE] and ,d+[DATE]. Observation on [DATE] at 12:35 P.M. and on [DATE] at 9:11 A.M., of an upright home-type freezer showed an open 12-ounce box of chocolate muffins dated [DATE]. In addition, a cup containing a frozen ice cream treat was covered and stored in the freezer door. The item was not labeled or dated. Observation on [DATE] at 12:38 P.M., on the opposite side of the range hood, showed another opened 32-ounce bottle of lemon juice sat below a smaller flat-top griddle on a metal shelf. The label directed to refrigerate after opening. Observation on [DATE] at 12:45 P.M., showed a one-quart container of buttermilk sat inside the small reach-in refrigerator below the sandwich/salad preparation area. The container was bulging and did not have a use by date printed on it, nor did the container have any date written on it. Observation on [DATE] at 3:40 P.M. and on [DATE] at 9:23 A.M., in the basement level inside the dining room area, a small refrigerator held a plastic container with a strawberry poppy chicken salad labeled with a resident's name. The salad was not dated and appeared watery and slimy inside the container. Observation on [DATE] at 9:11 A.M., in the reach-in refrigerator showed the following: -Red liquid was pooled on the bottom of the unit; -The bottle of lemon juice sat on the tile ledge in the corner and was not refrigerated; -The reach-in beverage refrigerator had three clear drink pitchers with no labels or dates and contained orange, yellow and purple liquids. During interview on [DATE] at 2:24 P.M., the Dietary Director said the following: -Prepared food/leftovers were good for three days. Items such as dressing and fruit were good for seven days. Dietary staff was responsible for cleaning out the refrigerators every other day. Staff should go by the use by date on boxes of meat to know when meat should be discarded. The date on the raw meat in the refrigerator was the date it was received in the facility. The pork loin needed to be discarded. The cooks were responsible for cleaning out the meat refrigerator every Thursday; -The spill/blood in the bottom of the meat refrigerator should have been cleaned up when discovered. The liquid was from chicken that was thawing; -Drink pitchers should be labeled and dated; -The lemon juice under the stove was used for cleaning and not for consumption. The other lemon juice in the baking area should be refrigerated according to the label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 9:36 A.M. the Consultant Dietitian said all leftovers needed to be labeled and dated. Staff should follow manufacturer's use by dates when available. Leftovers were good for seven days. The date written on the label was the date it was prepared and then placed in the refrigerator. No label would be needed if an item was clearly identifiable. Meat should be used by the best by date. All meat came into the building frozen. The date should be written on the label when meat was placed in the refrigerator to thaw. All meat should be cooked as soon as it was thawed. The pork loin should have been cooked and it had not been done, so the pork should be discarded. 3. Observation on [DATE] at 12:36 P.M., showed four 6-lb cans of sliced carrots sat on the preparation counter next to the food processor. The lids had been removed but had been left inside the can. The lids had sunk down into the cans and were submerged approximately 0.50 inches to 1.0-inch down inside the carrot juice. Dates had been written on the can lids with black marker. The black writing had begun to smear and become illegible inside the liquid. Observation on [DATE] at 12:46 P.M. showed Dietary Staff C emptied all four cans of carrots into steam table pans and covered the pans with plastic wrap (to prepare them for the evening meal). During interview on [DATE] at 2:24 P.M., the Dietary Director said staff write the date canned items were received on the can lid with a black sharpie marker. Staff should open cans and use them right away and not let the lids sink down into the liquid. During interview on [DATE] at 9:36 A.M. the Consultant Dietitian said lids on the cans of carrots should have been removed after being opened. 4. Review of the undated facility policy, Food Storage, showed scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. Scoops are to be washed and sanitized on a regular basis as needed. Observation on [DATE] at 1:43 P.M. and on [DATE] at 9:11 A.M. showed a clear bulk container under the spice storage shelf, was not labeled and appeared to contain cornmeal. A large clear scoop was stored inside the container. During interview on [DATE] at 2:24 P.M., the Dietary Director said scoops should not be stored inside food items. During interview on [DATE] at 9:36 A.M. the Consultant Dietitian said scoops should not be stored inside containers of stored food items. 5. Review of the undated policy, Hand Washing, showed the following: -Staff will wash hands frequently as needed throughout the day following proper hand washing procedure; -Clean hands and exposed portions of the arms immediately before engaging in food preparation including working with exposed food; -Wash hands after handling soiled equipment or utensils and during food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated policy, Use of Plastic Gloves, showed the following: -Plastic gloves will be worn when handling food directly to ensure that bacteria are not transferred from the food handlers' hands to the food product being served; -If used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation; -Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed. Observation on [DATE] at 4:53 P.M., showed Dietary staff C bent over the dining room steam table pan of carrots. His/Her nametag on a lanyard fell into and dipped into the pan of carrots. Dietary Staff C appeared unaware that the nametag made direct contact with a food item. Observation on [DATE] at 4:56 P.M. showed Dietary Staff C touched the serving utensils in pans of food with his/her gloved-hands. Without changing his/her gloves, he/she handled ready to eat slices of bread by removing slices from the bread bag and placing a slice on the resident's meal plate. He/She repeated this process approximately 15 or more times during the dining room meal service. He/She did not change his/her gloves or wash hands at any point during the dining room meal service. During interview on [DATE] at 2:24 P.M., the Dietary Director said staff should use tongs when handling ready to eat food. Staff name tags should not be worn where they can come in contact with food. During interview on [DATE] at 9:36 A.M. the Consultant Dietitian said staff should serve ready to eat food with a clean gloved hand, a deli sheet or a utensil. Staff should not handle bread slices with a dirty hand. Staff name tags should not come in contact with food items. 47246

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on interview and record review, the facility failed to provide updated pneumococcal vaccine (a vaccine that can protect against pneumococcal disease) education as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines and failed to provide the option to receive the updated vaccination for four residents (Resident #318, #271, #54, and #275), who were admitted after new guidance was released, in a review of 18 sampled residents. The facility census was 73. Review of the facility policy Pneumococcal Policy dated 7/2016 showed: -All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections; -Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated; -Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission; -Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. (See current vaccine information statements at hnp:www.cdc.gov.vaccines1hcp.vis1inde:-html for educational materials.) Provision of such education shall be documented in the resident's medical record; -Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol; -Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination; -For residents who receive the vaccines the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record; -Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 9/22/23, showed the following: -Adults 19 through [AGE] years old with any of these conditions or risk factors: 1. Alcoholism or cigarette smoking; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Cerebrospinal fluid leak; 3. Chronic heart disease, including congestive heart failure and cardiomyopathies, excluding hypertension; 4. Chronic liver disease; 5. Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma; 6. Cochlear implant; 7. Diabetes mellitus 8. Decreased immune function from disease or drugs (i.e., immunocompromising conditions); 9. Immunocompromising conditions include: a. Chronic renal failure or nephrotic syndrome; b. Congenital or acquired asplenia, or splenic dysfunction; c. Congenital or acquired immunodeficiency; d. Diseases or conditions treated with immunosuppressive drugs or radiation therapy; e. HIV infection; f. Sickle cell disease or other hemoglobinopathies; -Adults 19 through [AGE] years old who never received any Pneumococcal Vaccine, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (8 weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; -Adults 19 through [AGE] years old who only Received PPSV23, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination; 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living - St Charles, LLC	723 First Capitol Drive Saint Charles, MO 63301

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adults 19 through [AGE] years old who only received PCV13, who have a risk condition (see above) other than an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13 for those with a cochlear implant or cerebrospinal fluid leak. The PPSV23 dose should be given at least 1 year after PCV13 for any of the other chronic health conditions. When PPSV23 is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13. When PPSV23 is used, they need another pneumococcal vaccine at least 5 years later. At that time, give either 1 dose of PCV20 or a second dose of PPSV23. When PCV20 is used, their vaccines will then be complete. When a second PPSV23 dose is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have received PCV13 and 1 Dose of PPSV23 and who have an immunocompromising condition: 1. Give 1 dose of PCV20 or a second PPSV23 dose; 2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine. Their vaccines are then complete; 3. The second dose of PPSV23 should be given at least 8 weeks after PCV13 and 5 years after PPSV23. No additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults [AGE] years or older who don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; (continued on next page)

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	265783	A. Building B. Wing	06/06/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Adults [AGE] years or older who have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least 8 weeks later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete. 1. Review of Resident #271's electronic health record showed a signed written consent from the resident's responsible party, dated January 2024, giving the authorization for the resident to receive the immunization. Review of the resident's face sheet showed the resident was over [AGE] years of age and admitted to the facility on [DATE] with acute on chronic systolic (congestive) heart failure (a type of heart failure that occurs when damage to the heart develops over time) and dementia. Review of the resident's physician order sheet (POS), dated 5/25/24, showed the resident may have pneumococcal vaccines. Review of the resident's immunization record on 6/4/24 showed no documentation the resident received the pneumococcal immunization. During an interview on 6/4/24 at 11:15 A.M., the resident's representative said that he/she thought the resident's vaccines were all up to date. 2. Review of Resident #54's face sheet showed the resident was over [AGE] years of age and admitted to the facility on [DATE] with intestinal obstruction (a gastrointestinal condition in which digested material is prevented from passing normally through the bowel). Review of the resident's physician order sheet (POS), dated 5/15/24, showed the resident may have pneumococcal vaccines. Review of the resident's Admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 5/22/24, showed the pneumococcal immunizations were up to date. Review of the resident's immunization record on 6/3/24 showed the following: -PCV13 received on 10/5/15; -PPSV23 received on 3/31/22. Review of the resident's electronic health record on 6/3/24 showed no documentation that the resident had been offered the PCV20. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #275's face sheet showed the resident was over [AGE] years of age and admitted to the facility on [DATE] with infection following a procedure (surgical site) and emphysema (chronic lung condition that damages the alveoli, or air sacs, in the lungs). Review of the resident's physician order sheet, dated 5/31/24, showed the resident may have pneumococcal vaccines. Review of the resident's immunization record on 6/3/24 showed no documentation that the resident had received or had been offered or declined the pneumococcal immunizations. 4. Review of Resident #318's clinical census showed the resident was over [AGE] years of age and admitted to the facility on [DATE]. Review of the resident's POS, dated June 2024, showed the following: -The resident's diagnoses included fracture of the left tibia and fracture of shaft of left fibula (bone in the leg); -The resident may have pneumococcal vaccines. Review of the resident's admission assessment MDS, completed by facility staff, dated 3/12/24, showed the pneumococcal immunizations were up to date. Review of the resident's immunization record on 6/4/24 showed the following: -Pneumovax 23 received on 2/04/14; -Prevnar 13 received on 6/14/16. Review of the resident's electronic health record on 6/4/24 showed no documentation that the resident had been offered the PCV20. During an interview on 6/3/24 at 3:30 P.M., the resident said he/she did not recall ever being offered the pneumonia vaccine. During an interview on 6/6/24 at 10:20 A.M., the Director of Nursing (DON) said the following: -She would expect staff to educate and offer vaccines based on CDC guidelines; -She would expect staff to follow physician orders. During an interview on 6/10/24, at 4:30 P.M., the Medical Director (MD) said the following: -He would expect physician orders to be followed; -He would expect staff to at least talk to the residents and educate them on vaccines based on CDC guidelines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45563

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34536 Based on observation and interview, the facility failed to maintain and repair essential food preparation equipment in the main facility kitchen. The facility census was 73. 1. Observation on 6/3/24 at 1:51 P.M., showed the meat slicer sat on a metal tray on top of the metal preparation counter and was covered with a vinyl/plastic cover. A layer of yellowish grease or liquid sat in the bottom of the tray and the base of the meat slicer sat in the liquid. During interview on 6/3/24 at 1:56 P.M. and on 6/4/24 at 2:24 P.M., the Dietary Director said the following: -She had worked at the facility for [AGE] years in dietary and had been the dietary director since September 2023; -The meat slicer was broken and had been broken for a couple of years. The grease in the bottom is from the meat slicer possibly leaking oil. The machine has not been in use. 2. During interview on 6/5/24 at 9:36 A.M., the Consultant Dietitian said the meat slicer had not worked since the COVID-19 pandemic and had not been used much in the last 2-3 years. During interview on 6/5/24 at 9:50 A.M. and at 1:00 P.M., the Dietary Director said the meat slicer did not work properly and was unsafe to use because the blade did not safely attach to the unit. The slicer was not being used by the dietary department. The meat slicer would be used on a daily basis if the unit was functional. The meat slicer was from the 1960's. She had tried to look for parts in the past but was unable to find replacement parts. The facility owners and administrator were aware that the meat slicer did not work properly. During interview on 6/5/24 at 2:24 P.M., the Administrator said he thought the dietary staff had used the meat slicer over the Winter. He was unaware that the slicer was not safe to use. He would like to buy the kitchen a new slicer but there had been budget restraints.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattresses, bed rails/ assist bars as part of a regular maintenance program to identify areas of possible entrapment for four residents, (Resident #1, #24, #32, and #271) in a review of 18 sampled residents who used bed rails. The facility census was 73. Review of the facility's Side Rail Assessment and Consent Policy, dated (last reviewed/revised) 11/16/2023, showed the following: -It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The safety of the residents, staff, and visitors are a primary concern. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. However, some residents desire to use bed rails as assistive and/or transfer devices and are not considered restraints. Because side rails have been implicated in injury up to and including death from entrapment and strangulation, a thorough assessment and consent will be obtained prior to the routine use of side rails to be used as assistive and/or transfer devices and not as a restraint; -Procedure: -Consent will be obtained for residents desirous of using side rails as assistive devices and/or transfer devices prior to use; -The resident or resident representative may provide consent; -A side rail assessment will be completed for residents who desire to use side rails as an assistive or transfer device; -Side rails will be applied according to manufacturer's recommendations; -In the event a gap between the mattress/bed and the side rail is greater than 2.5 inches, then gap stops are required to be in place; -Side rail assessment showing the decision for use is complete, done on admission, on initial use and reviewed quarterly; -Complete a new assessment yearly and at times of a significant change; -If a decision indicates freedom of movement is restricted, a physical restraint assessment must be completed; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All potential risk problems from side rail use such as strangulation and entrapment must be care planned regardless of reason for use. Review of the Food and Drug Administration (FDA) document titled, Guide to Bed Safety Rails in Hospitals, Nursing Homes, and Home Health Care: The Facts, revised April 2010, shows the potential risk of bed rails may include: -Strangling, suffocating, bodily injury, or death when patients or part of their body are caught between rails or between the bed rails and mattress; -More serious injuries from falls when patient climb over rails; -Skin bruising, cuts, and scrapes; -Inducing agitated behavior when bed rails are used as a restraint; -Feeling isolated or unnecessarily restricted; -And preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. During an interview on 06/06/24 at 10:20 A.M., the director of nurses (DON) said the the facility did not have a bed entrapment policy and procedure. 1. Review of Resident #1's face sheet, undated, showed he/she had a legal guardian. Review of the resident's medical diagnoses sheet, undated, showed the resident's diagnoses included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with diabetic neuropathy (a type of nerve damage that can occur with diabetes) and primary generalized osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time, causing joint pain and stiffness). Review of the resident's clinical physician orders sheet, dated 11/10/23, showed may use assist rail/U bars x2 to enhance self-participation in bed mobility and transfers. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 05/05/24, showed the following: -Cognitively impaired; -Lower extremity impairment on both sides; -Dependent for mobility/transfers; -Bed rails not used. Review of the resident's care plan, dated 05/07/24, showed the following: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident needs assist with activities of daily living (ADLs); -Goal: Staff will provide ADLs for the resident; -Approaches: May use assist rails x2 to enhance self-participation in bed mobility and transfers. Review of the resident's medical record showed no evidence of measurements or an evaluation for entrapment zones on the resident's bed. Observation on 06/04/24 at 10:05 A.M. showed the resident lay in his/her bed with mobility bars (inverted, U-shaped bars attached to the bed and fixed to a raised position, to aid mobility) on both sides of the resident's bed. During an interview on 06/04/24 at 10:05 A.M., the resident said he/she used the mobility bars to help him/her turn over in bed. Observation on 06/05/24 at 05:25 A.M. showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed, both rails were slightly loose and could be moved side-to-side and back and forth, with approximately a 3-inch gap between the rail and the mattress. 2. Review of Resident #32's face sheet, undated, showed he/she was his/her own person. Review of the resident's medical diagnoses sheet showed the resident had a diagnosis of acute on chronic diastolic (congestive) heart failure (a decreased function of the heart's ability to pump that may have resulted from damage to the heart, a blockage, or an infection. Acute symptoms such as shortness of breath can occur suddenly, whereas chronic symptoms usually persist on a day-by-day basis). Review of the resident's clinical physician orders sheet, dated 11/10/23, showed may use assist rail/U bars x2 to enhance self-participation in bed mobility and transfers. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Partial to moderate assistance for chair/bed-to-chair transfers; -Bed rails not used. Review of the resident's care plan, dated 04/23/24, showed the following: -The resident needs assist with activities of daily living (ADLs); -Staff will provide ADLs for the resident; -May use assist rails x2 to enhance self-participation in bed mobility and transfers. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no evidence of measurements or an evaluation for entrapment zones on the resident's bed. During an interview on 06/04/24 at 8:45 A.M., the resident said the following: -He/She used the mobility bars on his/her bed to help him/her get out of and move up in bed; -His/Her rails have been loose, especially the one on the side of the bed that he/she gets out of; -He/She told staff about one month ago that the rail was loose, and he/she was told there was nothing that could be done except to take it off; -He/She had stuffed sheets or towels between the rail and the mattress to keep the rail from being so loose. Observation on 06/04/24 at 8:45 A.M. showed mobility bars (inverted, U-shaped bars attached to the bed and fixed to a raised position, to aid mobility) on both sides of the resident's bed, both rails were loose and freely movable side to side and back and forth, with approximately 5-6 inches of room between the mobility bar and the mattress. 3. Review of Resident #24's face sheet showed the following: -The resident had a power of attorney; -Diagnoses included morbid obesity, rheumatoid arthritis (an autoimmune and inflammatory disease, which means that your immune system attacks healthy cells in your body by mistake, causing inflammation (painful swelling) in the affected parts of the body, mainly attacks the joints), weakness, chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), chronic kidney disease stage three (mild to moderate loss of kidney function), major depressive disorder and bipolar disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Highly impaired vision; -Required supervision by staff for all mobility areas except rolling from left to right in bed, sit to lying and lying to sitting on side of bed; -No restraints used including bed rails. Review of the resident's care plan, dated 5/7/24, showed the following: -The resident was at risk for falls related to need for assist with toileting, walking, transfers and psychotropic medication therapy; -Walks with assist of one and a walker; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Needs assist with transfers; -Keep bed in its lowest position when occupied. The resident's care plan did not address the use of bed rails on the resident's bed. There was no documentation to show his/her bed had been assessed for entrapment risk. Observations on 6/3/24 at 1:25 P.M. and 4:41 P.M., 6/4/24 at 8:55 A.M., and 6/5/24 at 5:27 A.M. showed the resident had a 1/8 bed rail on the left hand and right hand sides of his/her bed in the raised position. Record review showed no documentation the resident's care plan addressed the use of bed rails on the resident's bed. There was no documentation to show his/her bed had been assessed for entrapment risk. 4. Review of Resident #271's face sheet, undated, showed he/she had a responsible party. Review of the resident's medical diagnoses sheet, undated, showed the resident's diagnoses included acute on chronic systolic (congestive) heart failure (a condition in which the heart doesn't pump blood as well as it should), type 2 diabetes mellitus, dementia, and repeated falls. Review of the resident's clinical physician orders sheet, dated 5/25/24, showed no order for assist rail for bed mobility and transfers. Review of the resident's care plan, dated 5/25/24, showed the following: -The resident required staff assistance for transfers; -The resident required staff assistance with activities of daily living (ADLs'). Observation on 06/03/24 at 2:10 P.M. showed the resident lay in his/her bed with mobility bar attached to the bed and fixed to a raised position, on the left side of the resident's bed. During an interview on 6/3/24 at 2:10 P.M., the resident's representative said the resident required assistance from staff for ADLs and transfers. Observation on 06/05/24 at 05:35 A.M. showed the resident lay in his/her bed with mobility bar on the left side of the resident's bed in a raised position. Review of the resident's medical record showed no evidence of measurements or an evaluation for entrapment zones on the resident's bed. During an interview on 06/06/24 at 9:30 A.M., the director of maintenance said the following: -He completes a weekly safety check of all residents' rooms to make sure mattresses fit the bed frame and the side rails are not loose, but he does not do routine assessments or measurements for entrapment zones on beds with mobility bars. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/06/24 at 10:20 A.M., the DON said the following: -She would expect that entrapment zones should be measured on all beds that use mobility bars; -She was not familiar with the regulation that relates to how entrapment zones should be checked or the frequency of such assessments. 45563 47246