STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265824	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42594 Based on interview and record review, the facility failed to inform five residents (Residents #5, #13, #14, #15, and #16) or their representatives, in a review of 16 sampled residents, of respiratory therapy services they may be charged for which were not covered under Medicare/Medicaid or by the facility's per diem rate, prior to receiving those services, when the facility charged the residents for respiratory therapy services. The facility census was 115. The facility did not provide a policy for the respiratory therapy department or to outline the responsibilities of the respiratory therapist. 1. Review Resident #5's face sheet showed the resident's payer source was private pay and Medicare Part B. Review of the resident's Physician Orders, dated 6/19/24, showed an order for respiratory therapy/nursing to perform flutter valve-chest wall manipulation to facilitate lung function three times a day. (The ordered therapy ended on 8/19/24.) Review of the resident's billing statement from the facility, dated 8/31/24, showed the following: -Charges on the statement were from 7/1/24 to 7/31/24; -The resident was billed $1051.98 for non-covered respiratory therapy services (pulse oximetry and chest wall manipulation) for June 2024 and July 2024; -The facility credited the resident $290.59 for June 2024 and $761.39 for July 2024 that totaled $1051.98. The facility assumed the expense for respiratory services not covered by the resident's insurance. During an interview on 9/24/24 at 11:45 A.M., the resident's power of attorney said he/she did not receive any documentation regarding the charges that would be billed to the resident for respiratory therapy (RT) services not covered by Medicare prior to the resident starting respiratory therapy services in June 2024. After he/she received the bill (for July 2024), he/she spoke with the Business Office Manager and questioned the charges. The Business Office Manager said the charges would be credited to the resident. (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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no documentation the facility or the respiratory therapist notified the resident or the resident's representative of the respiratory therapy services the resident was to receive and no documentation staff notified the resident or his/her representative of the charge for these services. 2. Review of Resident #13's face sheet showed the following: -The resident's payer source was private pay and Medicare Part B; -The resident had diagnoses that included chronic obstructive pulmonary disease and acute respiratory failure. Review of the resident's Physician Order, dated 4/5/24, showed the resident admitted to hospice. Review of the resident's Physician Order, dated 6/6/24, showed an order for an incentive spirometer (a device that measures the volume of air inhaled into the lungs when breathing in and to help improve lung function) due to pulmonary dysfunction related to obstructive sleep apnea and chronic obstructive pulmonary disease four times a day. (The order ended 9/20/24.) Review of the resident's Physician Order, dated 6/19/24, showed an order for respiratory therapy/nursing to perform chest wall manipulation to facilitate lung function for acute respiratory failure, hypoxia (low levels of oxygen) and a non-productive cough three times a day. (The order ended on 10/22/24.) Review of the resident's billing by the facility for June, July, August and September 2024, provided by the Business Office Manger by email on 10/4/24, showed the following: -For June 2024, $9,462.84 was waiting to be billed to Medicare for respiratory services; -For July 2024, $9,125.00 was waiting to be billed to Medicare for respiratory services; -The amounts above were what would be billed to Medicare and then the facility billing system would assess what the 20% co-insurance would cover and the remainder would be billed to the resident. Review of the resident's Physician Order, dated 8/22/24, showed an order for an incentive spirometer due to pulmonary dysfunction related to obstructive sleep apnea and chronic obstructive pulmonary disease every 24 hours as needed. (The order ended on 10/18/24.) Review of the resident's billing by the facility for June, July, August and September 2024, provided by the Business Office Manger by email on 10/4/24, showed the following: -For August 2024, $10,500.00 was waiting to be billed to Medicare for respiratory services; -For September 2024, $7,900.00 was waiting to be billed to Medicare for respiratory services; -The amounts above were what would be billed to Medicare and then the facility billing system would assess what the 20% co-insurance would cover and the remainder would be billed to the resident. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/24 at 10:40 A.M., the resident's responsible party said the following: -He/She was unaware the resident received RT services for an incentive spirometer or a flutter valve since June 2024; -The resident was on hospice services and the responsible party thought all of the resident's care was provided by the hospice company. Review of the resident's medical record showed no documentation the facility or the respiratory therapist notified the resident or the resident's representative of the respiratory therapy services the resident was to receive and no documentation staff notified the resident or his/her representative of the charge for these services. 3. Review of Resident #14's face sheet showed the resident's payer source was private pay and Medicare Part B. Review of the resident's Physician Order, dated 4/12/24, showed the resident admitted to hospice. Review of the resident's Physician Order, dated 6/18/24, showed an order for respiratory therapy/nursing to perform chest wall manipulation to facilitate lung function for chronic respiratory failure, lung expansion and oxygenation four times a day. (The order ended on 10/22/24.) Review of the resident's billing statement from the facility, dated 8/31/24, showed the following: -Charges on the statement were from 7/1/24 to 7/31/24; -The resident was billed $857.37 for non-covered respiratory therapy services (pulse oximetry and chest wall manipulation); -The facility wrote off $857.37. During an interview on 10/3/24 at 10:13 A.M., the resident's power of attorney said the following: -He/She first became aware the resident received RT services when he/she received a bill from the facility with over $800 in respiratory charges not covered by Medicare; -Each time he/she visited the facility, the resident never had any signs of respiratory problems that he/she would have reported to the nurse; -He/She was confused as to why the resident needed respiratory services; -He/She spoke to the facility about the bill (for non-covered respiratory therapy services) and they wrote off the amount after he/she questioned the charges. Review of the resident's medical record showed no documentation the facility or the respiratory therapist notified the resident or the resident's representative of the respiratory therapy services the resident was to receive and no documentation staff notified the resident or his/her representative of the charge for these services. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #15's face sheet, dated 10/3/24, showed the resident's payer source was Medicare and Medicaid. Review of the resident's Physician Orders, dated 6/13/24, showed orders for respiratory therapy/nursing to perform to perform flutter valve-chest wall manipulation to facilitate lung function three times a day for chronic obstructive pulmonary disease and an unproductive cough. (The order ended on 10/18/24.) Review of the resident's billing by the facility for June, July, August and September 2024, provided by the Business Office Manager by email on 10/4/24, showed the following: -For June 2024, $5,947.46 was waiting to be billed to Medicare for respiratory services; -For July 2024, $11,510.00 was waiting to be billed to Medicare for respiratory services; -For August 2024, $8,900.00 was waiting to be billed to Medicare for respiratory services; -For September 2024, $7,650.00 was waiting to be billed to Medicare for respiratory services; -The amounts were what would be billed to Medicare and then the facility billing system would assess what the 20% co-insurance would cover and Medicaid would be billed. During an interview on 10/3/24 at 12:07 P.M., the resident's representative said the following: -He/She was not aware the resident was receiving respiratory services; -He/She asked an unknown staff member a while back about a device in the resident's room and was told it was to help the resident clear his/her lungs; -He/She never received any notice or documentation regarding the charges that would not be covered by Medicare. Review of the resident's medical record showed no documentation the facility or the respiratory therapist notified the resident or the resident's representative of the respiratory therapy services the resident was to receive and no documentation staff notified the resident or his/her representative of the charge for these services. 5. Review of Resident #16's face sheet, dated 10/3/24, showed the resident's payer source was Medicare, a private secondary insurance and Medicaid. Review of the resident's Physician Order, dated 6/24/24, showed an order for respiratory therapy/nursing to perform to perform flutter valve-chest wall manipulation to facilitate lung function three times a day to help with an unproductive cough. (The order ended on 10/22/24.) Review of the resident's billing by the facility for June, July, August and September 2024, provided by the Business Office Manager by email on 10/4/24, showed the following: -For July 2024, $7,775.00 was waiting to be billed to Medicare for respiratory services; (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For August 2024, $7,750.00 was waiting to be billed to Medicare for respiratory services; -For September 2024, $5,850.00 was waiting to be billed to Medicare for respiratory services; -The amounts were what would be billed to Medicare and then the facility billing system would assess the 20% co-insurance and the resident's secondary private insurance would be billed and then Medicaid would be billed the remaining amount. During an interview on 10/3/24 at 10:27 A.M., the resident's responsible party said the following: -He/She was not aware of the RT services being provided to the resident; -He/She did not receive any notice or documentation that told him/her the resident would be responsible for charges not covered by Medicare for the respiratory therapy services prior to the resident starting the RT services. Review of the resident's medical record showed no documentation the facility or the respiratory therapist notified the resident or the resident's representative of the respiratory therapy services the resident was to receive and no documentation staff notified the resident or his/her representative of the charge for these services. 6. During an interview on 9/24/24 at 2:15 P.M., the Respiratory Therapist said the following: -She did not have to get consent from the hospice company to treat Resident #13 and Resident #14 (who received hospice services) because they were already getting respiratory therapy services before she started at the facility at the end of May; -She did not think she had to contact hospice to start a new respiratory therapy service such as an incentive spirometer or a flutter valve; -She notified the residents and/or the residents' responsible parties of therapy services she would provide. (Review of the residents' medical records showed no documentation of this notification); -She did not notify the residents and/or the residents' responsible parties of costs not covered by the residents' insurance; -She assessed the residents and entered the information on the Physician Respiratory Assessment/Evaluation form in the electronic health record. She wrote a note in the physician communication book at the front desk and then the physician would look in the resident's electronic health record and sign the assessment/evaluation as an order to start the recommendations. During an interview on 9/24/24 at 1:43 P.M. and 10/3/24 at 1:57 P.M., the Business Office Manager said the following: -She did not get consent from the residents or their representatives for charges not covered by Medicare; (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She refused to bill Medicare for respiratory therapy services because families were not notified of the services that were provided, and the Respiratory Therapist did not notify hospice they were providing services to the residents. During an interview on 9/24/24 at 3:40 P.M., the Operations Manager said it was not clear when the facility started the in-house respiratory therapy services or who would notify residents or their representatives of Medicare non-covered charges. During an interview on 9/25/24 at 4:20 P.M., the Administrator said she expected the Respiratory Therapist to follow the policy for notifying residents of services and non-covered services. During an interview on 10/9/24 at 11:01 A.M., the Regional Director of Operations said the following: -He did not know if any of the facility staff informed the residents or the resident's representative of non-covered charges that could be incurred after billing Medicare; -The facility should only bill Medicare Part B for respiratory services deemed necessary by a physician and then the facility would assume the expense of the 20% co-insurance not covered by Medicare; -The residents who were billed was a mistake. They should not have been billed for their 20% co-insurance; -The facility bills Medicare Part B for respiratory therapy services. If the resident had a secondary insurance, it would be billed (if the service was authorized) and then the facility would bill Medicaid (if the resident had Medicaid). If the secondary insurance did not authorize the respiratory therapy service, the facility could not bill them or Medicaid and the facility would assume the expense for the services not covered. MO241453

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice for three resident (Resident #2, Resident #4 and Resident #10) of 13 sampled residents when staff failed to ensure medications were not left in resident rooms, and residents had an order to keep medications at bedside. The facility census was 113. The facility did not provide a policy for medications at the resident's bedside. 1. Review of resident #2 quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 2/22/24 showed: -Able to make self understood and able to understand others, difficulty with some decision making; -Requires staff assistance with Activities of Daily Living (ADL's); -Diagnoses of heart disease, hypertension, diabetes, stroke, dementia and depression. Review of the Physician Order Sheet (POS) for June 2024 showed an order for Nystatin External Powder, apply to abdominal folds every 12 hours as needed. Observation on 6/13/24 at 10:00 A.M. showed a container of Nystatin Powder in the resident's bathroom with another resident's name on the label. During an interview on 6/13/24 at 10:00 A.M. the resident said staff will occasionally put powder under his/her abdominal folds, but he/she has not had any powder put on for a while. 2. Observation of room [ROOM NUMBER] showed the following: -Two residents resided in the room; -An opened bottle of artificial tears were in the bathroom with no label or resident name on the bottle and with an expiration date of 6/2019 During an interview on 6/13/24 at 11:10 A.M. Assistant Director of Nursing (ADON) C said the following: -She did not know who the Nystatin Powder belonged to and did not recognize the name on the container; -She did not know who the artificial tears belonged to in room [ROOM NUMBER]; -The medication should not be kept in a resident's room unless they have an order to self administer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident # 4's quarterly MDS dated [DATE] showed the following: -Usually makes self understood and able to understand others, able to make appropriate decisions; -Requires extensive assistance with ADL's; -Diagnoses of cancer, anemia, heart disease, hypertension, diabetes and Alzheimer's disease. Observation on 6/13/24 at 1:00 P.M. in the resident's bathroom showed: -An opened bottle of Clear Eyes, eye drops with no name on the bottle with an expiration date of 10/2023; -A container of Mineral Cream dated 11/7/23 with another resident's name on the pharmacy label. Review of the resident's POS dated June 2023 showed no order for Clear Eyes or mineral cream. During an interview on 6/13/24 at 1:10 P.M. the resident said he/she did not know who the Clear Eyes or the mineral cream belonged to and did not know how it got in his/her room. 4. Review of Resident #10's quarterly MDS dated [DATE] showed: -Unable to understand others and unable to make self understood, unable to make decisions; -Dependent upon staff for ADL's; -Diagnoses of Alzheimer's disease and dementia. Observation on 6/14/24 at 8:15 A.M. showed a tube of triple antibiotic ointment in the window sill with another resident's name on the tube and dated 12/8/23. Review of the resident's June POS showed no order for triple antibiotic ointment. During an interview on 6/14/24 at 2:00 P.M. the Director of Nursing said: -Medications should not be left in a resident's room unless the resident has an order for self administration; -Staff should only use medication that has the correct resident name on the label; -The facility will need to educate family on not to bringing in medication and leaving it in resident rooms. MO236465 MO237380

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to ensure staff provided five residents (Residents #1, #2, #3, #4, and #7), who were unable to perform their own activities of daily living, in a review of 13 sampled residents, the necessary care and services to maintain good oral hygiene. The facility census was 113. Review of the facility policy for Activities of Daily Living (ADL) dated revised on 3/2018 showed: -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs); -Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). The facility did not provide a policy for oral hygiene. 1. Review of Resident #1 Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 3/8/24 showed: -Resided in room [ROOM NUMBER] A bed; -The resident was able to make self understood and able to understand others, unable to make appropriate decisions; -Required supervision with oral hygiene and set up of supplies; -The oral status section not marked; -Diagnoses of Alzheimer's disease and depression. Review of the resident's care plan dated 6/5/24 showed no care plan for oral hygiene. Observation of the resident on 6/13/24 at 10:00 A.M. showed food particles and a white substance built up along the gum line of the resident's teeth. During an interview on 6/13/24 at 10:00 A.M. the resident said he/she did not remember the last time he/she had assistance to brush his/her teeth. 2. Review of Resident #2's quarterly MDS, a federally mandated assessment instrument completed by staff, dated 2/24/24 showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resided in room [ROOM NUMBER] B; -Able to make self understood and able to understand others, some difficulty in making decisions; -Required extensive assistance with oral hygiene and the oral hygiene section blank; -Diagnosis of heart disease, diabetes, stroke, dementia and depression. Review of the residents care plan dated 5/20/24 showed no care plan for oral hygiene. Observation of the resident on 6/13/24 at 10:00 A.M. showed food particles in the resident's teeth. During an interview on 6/13/24 at 10:00 A.M. the resident said the following: -He/She had two electric toothbrushes and both of them were missing; -He/She has not had his/her teeth brushed in a long time; -He/She would like to be able to brush his/her teeth. Observation on 6/13/24 at 10:05 A.M. in the resident's bathroom showed: -Two regular toothbrushes in the cabinet with no name on either one of them, both had been used and were dry with caked white substance on the brush head; -One electric toothbrush with no name on it, dry and caked with a white substance. 3. Review of Resident #3's quarterly MDS dated [DATE] showed: -Usually able to understand others, and usually able to make self understood, some difficulty with making decisions; -Extensive assist with ADL's, set up with oral hygiene with the oral status section blank; -Diagnoses of diabetes, dementia, Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Review of the resident's care plan dated 4/30/24 showed no care plan for oral hygiene. During an interview on 6/13/24 at 10:40 A.M. the resident said the following: -He/She has his/her own teeth on the bottom and had dentures on the upper; -He/She needs help from the staff to brush his/her teeth and take care of his/her dentures and he/she does not get the help. Observation on 6/13/24 at 10:40 A.M. of the resident's bathroom showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A toothbrush holder labeled with the resident's name, in side of the holder was an unused new toothbrush; -Four tubes of toothpaste, two were open with only a small amount gone and two unopened tubes; -An empty denture cup that was dirty with a whitish substance on the inside and outside of the cup; -A dirty emesis basis with two used toothbrushes that were dry and caked with a substance. 4. Review of Resident #4's quarterly MDS dated [DATE] showed: -Usually makes self understood and usually understands others. Able to make appropriate decisions; -Dependent upon staff for ADL's, partial staff assistance with oral hygiene and oral status blank; -Diagnoses of heart failure, hypertension, stroke with paralysis on one side, anxiety. Review of the resident's care plan for ADL's dated 4/5/24 showed the following: -Resident has limited ability to perform self-care due to the aging process; -Assist with oral hygiene daily and as needed. Observation of the resident on 6/13/24 at 1:00 P.M. showed the resident's teeth slightly yellow/brown with a white substance noted between his/her teeth and the gum line. During an interview on 6/13/24 at 1:00 P.M. the resident said the following: -He/She does not often get out of bed; -He/She has an electric toothbrush and is able to brush his/her own teeth when staff give him/her the toothbrush. He/She could not remember the last time he/she brushed his/her teeth. Observation on 6/13/24 at 1:05 P.M. in the resident's bathroom showed an electric toothbrush that was dry in an emesis basin that was dirty and caked with a white substance. 5. Review of Resident #7's quarterly MDS dated [DATE] showed the following: -Able to make self understood and able to understand others, unable to make appropriate decisions; -Requires extensive assistance with ADL's and oral hygiene and oral status section blank; -Diagnoses of hypertension, diabetes, Alzheimer's disease, stroke with paralysis on one side. Review of the resident's care plan dated 5/16/24 showed no care plan for oral hygiene. Observation of the resident on 6/14/24 at 8:30 A.M. showed the resident with a white coating noted on his/her teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/14/24 at 8:55 A.M. in the resident's room showed the following: -A bag of oral care supplies, two electric toothbrushes and a tube of toothpaste with a hand written date of 2/18/24 on the tube. A small amount of paste was missing from the tube; -There were two regular toothbrushes that were dry and appeared unused. 6. During an interview on 6/14/24 at 8:31 A.M. Licensed Practical Nurse (LPN) A said the aides should be assisting residents with oral hygiene. During an interview on 6/14/24 at 8:36 A.M. Certified Nurse Aide (CNA) B said: -He/She had only worked at the facility a few times as an agency CNA; -He/She will try to get resident oral hygiene completed. During an interview on 6/14/24 at 12:15 P.M. Assistant Director of Nursing (ADON) C said: -He/She has received numerous complaints from residents and resident family members, regarding care and oral hygiene; -He/She had in-serviced the staff and agency staff on providing oral hygiene; -He/She has done monitoring to ensure that care has been completed, but it has been a struggle with agency staff to get them to provide all the care. During an interview on 6/14/24 at 2:30 P.M. the Director of Nursing said the following: -Oral hygiene should be done per the facility policy; -It has been difficult getting agency staff to complete all the required ADL tasks; -If an agency aide does not complete the required ADL tasks then they were not allowed to return to the facility; -These were newer issues that had been identified and felt agency staff were responsible. MO236465

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34003 Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of four sampled residents, received care and treatment in accordance with professional standards of practice when staff failed to obtain an x-ray in a timely manner after the resident sustained a fall and was in pain. The resident fell at 2:15 A.M. and the responsible party (RP) chose not to send the resident to the hospital and requested a mobile x-ray. Staff obtained a physician order for a STAT mobile x-ray at 3:00 A.M. on 6/30/24. The x-ray provider did not arrive until 10:30 A.M. on 6/30/24 to complete the x-ray and sent the x-ray results to the facility at 10:50 A.M. by fax and directly to the facility's electronic medical record system and the facility failed to administer pain medication or alternate interventions for the resident's pain. Staff did not communicate the x-ray results to the physician until 1:30 P.M. Resident #1 was subsequently sent to the emergency room and diagnosed with a fractured right shoulder. The facility also failed to follow the emergency room discharge orders for pain medication until the resident was seen by his/her physician for 12 days after the initial injury. The facility census was 117. The facility shared no policy upon request for reporting x-ray results or expectation for following discharge instructions. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 5/16/24 showed the following: -Brief Interview for Mental Status (BIMS, a test used to assess cognitive function. A BIMS score can range from 0 to 15, with lower scores indicating a decline in cognitive performance) of 3, which indicated severe cognitive impairment; -Required maximum assistance of staff for transfers, standing and unable to walk; -Diagnoses of Alzheimer's disease, stroke with paralysis one one side, and dementia. Review of the resident's care plan for falls dated 5/21/24 showed the the resident was at risk for falls with or without injury related to altered balance while standing and/or walking, and altered mental status. Review of the resident's progress note dated 6/30/24 at 10:26 A.M., signed by Licensed Practical Nurse (LPN) D showed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Summoned to the resident's room approximately at 2:15 A.M. Upon starting rounds at 2:15 A.M. staff found the resident on the floor on his/her right side. The resident complained of right shoulder and arm pain. The resident's pain was assessed and observed to be in the right shoulder and arm. The resident was unable to complete full range of motion (ROM). Resident transferred by two staff members to bed. At 2:23 A.M., the resident's physician was notified for possible ER visit and evaluation. The physician said to follow up with the RP to see if he/she wanted resident to go to hospital or have an in house mobile x-ray. Contacted the RP at 2:30 A.M. and RP declined hospital transfer, but agreed to in house mobile x-ray. Mobile x-ray notified at 3:00 A.M. and an order for a x-ray was placed. As needed pain medication administered with good results. At 10:03 A.M. the facility mobile x-ray provider was in the facility to complete the x-ray. Currently awaiting the results. No other alternate interventions for pain were documented. During an interview on 8/2/24 at 1:40 P.M. LPN D said the following: -An aide came notified him/her on 6/30/24 around 2:15 A.M. that Resident #1 was on the floor; -He/She found the resident on his/her right side of the bed on a fall mat. The resident complained of pain in the right shoulder and could not move his/her right arm; -He/She called the physician and the physician gave an order for a STAT x-ray by the mobile x-ray provider or to send to the ER depending upon what the RP wanted; -The RP was notified and requested that the mobile x-ray provider take the x-ray; -He/She called the mobile x-ray provider numerous times and finally got someone on the phone around 3:00 A.M.; -The resident was in pain; -The mobile x-ray provider arrived at 10:00 A.M. and obtained the x-ray; -The RP was in the facility. Review of the Medication Administration Record (MAR) dated June 2024 showed no documentation staff administered Tylenol. Review of the resident's electronic medical record (EMR) showed the x-ray results were available to be viewed from the x-ray provider on 6/30/24 at 10:37 A.M. Review of the faxed x-ray report sent by the facility mobile x-ray provider dated 6/30/24 at 10:46 A.M. showed a complete fracture involving proximal right humerus (the largest bone of the upper arm) with displacement. Review of the resident's nurses notes dated 6/30/24 at 1:21 P.M. signed by LPN E showed the resident's shoulder x-ray results reported to the physician. New order received to send the resident to the ER for further evaluation. During an interview on 7/25/24 at 2:50 P.M. LPN E said the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-LPN D reported the resident had fallen and an order was received for an x-ray; -The mobile x-ray provider was in the facility around 10:00 A.M. on 6/30/24 and took an x-ray of the resident's right shoulder; -The resident had been complaining of pain in the shoulder and the resident's RP was in the facility; -The RP asked several times throughout the morning if the results were available and he/she had not received any; -After lunch he/she received a phone call from the resident's physician inquiring about the results, he/she called the mobile x-ray provider and was told the results had been faxed to the facility around 10:30 A.M.; -He/She checked the fax machine on the hall he/she was working and the machine was broken; -Around 1:00 P.M., he/she checked the fax machine on the other halls and the x-ray results was there; -He/She notified the physician and received orders to send to the resident to the hospital ER for evaluation; -He/She worked for an agency and the facility had not informed him/her x-ray results would be uploaded in the EMR. Review of the resident's nurses note dated 6/30/24 at 1:31 P.M. showed the resident left the facility for treatment and evaluation at a local hospital. Review of the resident's progress note dated 6/30/24 at 7:05 P.M., showed the resident returned from the local hospital via EMS (emergency medical services). Instructions from the hospital included to keep the sling on at all times for comfort and support. The resident was non weight bearing of the right upper extremity. Follow up with physician in two to three weeks. Continue to take Tylenol as needed for pain. Use Lidoderm patch (brand name for lidocaine medication used to help reduce pain) as directed. Resident is at baseline and all vitals with in normal limits. Call placed to primary physician to notify of return. Awaiting return call. Review of the resident's hospital discharge orders showed an order for lidocaine 5% (pain medication in the Lidoderm patch), one patch daily for pain. Review of the resident's Medication Administration Record (MAR) for June 2024 showed no order for the Lidocaine (Lidoderm) patch. Review of the nurses notes dated 6/30/24 at 7:14 P.M. showed staff notified the resident's primary physician of the resident's return and no new orders. Review of the resident's MAR for July 2024 showed no order for the lidocaine patch 7/1/24 through 7/12/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the follow up orders from a local hospital orthopedic clinic dated 7/12/24 showed please apply lidocaine patch at least once a day to the right shoulder. Review of the MAR for July 2024 showed an order for lidocaine external patch 4 % patch. Apply to right shoulder topically one time a day for right shoulder pain with a start date of 7/16/24. The MAR showed the patch was applied daily starting 7/16/24 through 7/24/24. During an interview on 7/24/24 at 2:45 P.M. Registered Nurse F said the following: -He/She was the house supervisor on 6/30/24 but worked the 300 hall as the nurse; -LPN E reported Resident #1 had fallen in the night, had an x-ray done by the mobile x-ray company around 10:00 A.M. and had been sent to the hospital for evaluation after lunch; -He/She did not know the time the x-ray was available to be reviewed; -The x-ray should be uploaded by the x-ray provider in the EMR. He/She verified the x-ray had been uploaded in the EMR on 6/30/24 at 10:37 A.M.; -The x-ray provider also sends a fax report of the x-ray to the facility; -He/She did not know if the x-ray was faxed or if the nurse on the resident's hall was aware the report was also uploaded in the EMR. During an interview on 7/24/24 at 3:04 P.M., Representative A from the mobile x-ray provider said the following: -X-ray reports are faxed to the facility and verified the resident's x-ray report was faxed on 6/30/24 at 10:50 A. M.; -The report was also uploaded into the resident's EMR on 6/30/24 at 10:37 A.M.; -Some facilities will also set up a for a phone call notification of results that are positive for a fracture, he/she was not sure if this facility had this set up. During an interview on 7/31/24 at 9:57 A.M. Representative B from the mobile x-ray provider said the following: -The facility did not set in their contract to receive a phone call with results from x-rays; -The facility set up for results to be faxed to the facility, uploaded in the EMR and have text messages sent out to management personnel who were no longer employed at the facility; -Verification of the emails that were set up to receive text messages were for the former Director of Nursing (DON), Assistant Director of Nursing (ADON) and managers; -No one currently employed at the facility received any text messages to alert them of the results. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The facility called the order for the x-ray as a STAT order; -It is their policy that a STAT order can take from 4-6 hours to complete. Since the order was placed on a weekend, it would have taken longer to be completed; -Since the STAT order was obtained on a Sunday morning at 3:00 A.M., the completion time of 10:30 A.M. would have been considered acceptable; -He/she does not know if this timeframe was communicated to the facility. During an interview on 7/30/24 at 2:00 P.M. RP A said: -He/She came to the facility in the early hours the morning of 6/30/24; -He/She told the facility not to send the resident to the hospital but to have the facility mobile x-ray provider take the x-ray to save the resident the trauma of having to go to the hospital; -The nurse did not report the results until after lunch; -He/She would have had the resident sent to the hospital if he/she would have known it would have taken so long to get the x-ray and the results; -The resident has been in pain from the fractured shoulder and he/she has asked the nursing staff to call the physician for pain medication; -The resident came from the hospital with an order for lidocaine patches and the facility did not put the patch on for 12 days. During an interview on 7/24/24 at 3:30 P.M. the DON said: -He/she is not aware of the timeframes that the x-ray provider set for STAT orders; -He/she would not accept a turn around time of 4-6 hours or 7 and half hours for a STAT order to be completed; -He/she would expect staff to call the x-ray provider if they were not in the facility sooner than 4-6 hours and for sure before 7 hours; -He/she would expect staff to call the mobile x-ray provider if a report was not available within an hour. During an interview on 7/30/24 at 9:10 A.M. the Administrator said: -He does not know the time frame for the x-ray provider to come to the facility on ce called on a weekend; -He would not consider 1-3 hours as a long time to wait for results; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He would consider up to 3 hours an acceptable time frame for the physician to be notified of the results of the x-ray. During an interview on 7/25/24 at 9:27 A.M. the Medical Director said the following: -She would expect a STAT order to be completed sooner that 7 hours; -She would expect the facility to notify a physicians within an hour of the facility receiving results from x-rays or labs; -The facility should ensure all staff are aware of where to find these results, report timely and notify the physician of any pain a resident is having, and obtain orders for a stronger pain medication if needed; -The facility should have administered the lidocaine patch when ordered by the ER physician. MO238488

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to identify weight loss, notify the physician and dietician of further weight loss, implement interventions, or evaluate effectiveness of the interventions for three residents (Resident #2, #3, and #4) out of four sampled residents who had significant weight loss. Resident #2 had a 5.9% weight loss in five months; Resident #3 had a 9.3 % weight loss in 3 months and Resident #4 had a 17% weight loss in seven months. The facility failed to notify the physician or the registered dietician of the weight loss. The facility failed to implement and communicate the interventions that the Registered Dietician had put in place for Resident #4 to help prevent further weight loss. The facility census was 117. Review of the facility policy for Weight Assessment and Intervention dated 3/2023 showed the following: -Resident weights are monitored for undesirable or unintended weight loss or gain; -Residents are weighed upon admission and at intervals established by the interdisciplinary team; -Weights are recorded in each unit's weight record chart and in the individual's medical record; -Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing; -Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time; -The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. one (1) month - 5% weight loss is significant; greater than 5% is severe; b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; 6 months - 10% weight loss is significant; greater than 10% is severe; -If the weight is desirable, this is documented; -Evaluation: Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes: the resident target weight range (including rationale if different from ideal body weight); the residents calorie, protein, and other nutrient needs compared with the resident's current intake; the relationship between current medical condition or clinical situation and recent fluctuations in weight and; whether and to what extent weight stabilization or improvement can be anticipated; -The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss; -The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The staff and physician will define the individual's current nutritional stats (weight, food/fluid intake and pertinent laboratory values) and identify individuals with anorexia, weight loss or gain, and significant risk for impaired nutritional; -The physician will consider whether any assessment including diagnostic testing is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition; -The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. 1. Review of Resident #2's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by staff dated 4/12/24 showed the following: -Usually able to make self understood and usually able to understand others; -Brief Interview for Mental Status (BIMS, an assessment used in nursing homes and other long-term care facilities to monitor cognition. The assessment involves three sections with the ultimate purpose of testing short-term word recall and orientation in time) of 5 - indicating severe cognitive impairment; -Independent with eating, oral hygiene, bathing, dressing, personal hygiene, transfer and ambulation. Assistance with toilet hygiene and putting on shoes; -Diagnoses of arthritis, dementia, and malnutrition; -Weight of 118 pounds. Review of the resident's care plan for malnutrition dated 4/15/24 showed the following: -Resident has a diagnosis of protein calorie malnutrition as evidenced by dementia and selective eater; -Goal: Will maintain adequate nutritional status as evidenced by stable weight; -Allow adequate time for meal consumption; Cater to food preferences: family brings in Honey Nut Cheerios and resident often requests only this for breakfast meal; Encourage adequate nutrition and hydration; Provide diet as ordered: regular. -The care plan did not address interventions when the resident did not come out for a meal or that it was his/her preference to sleep through a meal. Review of the resident's weights from 4/12/24 through 7/17/24 showed the following: -3/12/24 117 pounds; -4/19/24 112.6 pounds; -5/1/24 113.8 pounds; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-6/21/24 113.0 pounds; -7/17/24 100.2 pounds. --5.98 % weight loss in five months. Review of the resident's progress notes from 4/12/24 through 7/17/24 showed no documentation from the Registered Dietician or the physician regarding the resident's weight loss. Review of the resident's physician order sheet (POS) for July 2024 showed an order for a regular diet and monthly weights. Observation on 7/23/24 at 11:48 A.M., showed Resident #2 in bed with his/her eyes closed. Observation on 7/23/24 from 11:50 A.M. through 1:15 P.M. showed the following: -At 11:50 A.M., staff assisted residents into the dining room on the memory care unit and began to serve the noon meal; -Staff assisted some residents with the meal, serving drinks and dessert; -One staff member exited the dining room at 12:26 P.M., and walked down the hall looking into each room. This staff entered room [ROOM NUMBER] and brought a resident to the dining room and served him/her a meal; -No staff entered Resident #2's room; -At 12:45 P.M., a dietary staff member removed the food from the kitchenette on the memory care and took it back to the kitchen leaving two covered plates in the kitchenette. Neither of the plates were labeled with Resident #2's name; -At 1:15 P.M., Resident #2 was in his/her room coming out of the bathroom. When asked if he/she was hungry, he/she replied, Yes; -No observation of staff following up with the resident and asking if the resident wanted to have lunch or providing the resident cereal or other food rather than the lunch service. During an interview on 7/23/24 at 1:00 P.M. Certified Nurse Aide (CNA) A said the following: -Resident #2 doesn't always come out for lunch; -We let him/her sleep and he/she will let us know if he/she wants to eat; -The family has brought in cereal for him/her, that is what he/she usually eats. 2. Review of Resident #3's quarterly MDS dated [DATE] showed the following: -Usually able to make self understood and usually able to understand others; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-BIMS of a 6 - indicating severe cognitive impairment; -Required supervision with eating and assistance of staff with Activities of Daily Living (ADLs); -Diagnoses of Alzheimer's disease, dementia, anxiety, and depression; -Weight of 174 pounds. Review of the resident's monthly weights showed the following: -4/25/2024 176.0 pounds; -5/9/2024 174.4 pounds. Review of the care plan for nutrition dated 5/9/24 showed the following: -Resident is receiving mechanically altered diet; -Goal: Resident will maintain nutrition and hydration status as evidenced by good consumption; -Intervention: Feeds self in Memory Care Dining Room with set up assistance and cues. Review of the resident's malnutrition assessment form dated 5/9/24 showed the following: -No nutritional concerns identified; -Not at risk for malnutrition. Review of the resident's monthly weight dated 6/21/24 showed a weight of 168.6 pounds. Review of the resident's progress noted dated 6/21/24 signed by the Registered Dietician showed a weight loss nutrition note: weight: 168.6# on 6/21/24, -3.3% in 1 month. Feeds self in Memory Care dining Room. Recommend add NIP (nutritional interventions protocol) foods with meals to help increase nutritional intake. Recommend weekly weights x 4 weeks to follow trend. Will continue to follow and intervene further as needed. Review of the resident's progress notes dated 6/22/24 through 7/24/23 showed no documentation of weekly weights, no documentation of resident's intake, and no documentation of physician of weight loss. Review of the resident's medical record monthly weight showed the following: -7/17/24 157.8 pounds. -No weekly weights were documented; -A 9.3% weight loss in 3 months. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Observation on 7/23/24 at 11:50 A.M. of the dining room on the memory care unit showed the following: -Staff assisted Resident #3 to a dining room table and served a meal of white rice, pureed meat and chopped broccoli; -Staff unwrapped the silverware and placed it in front of the resident then served the other residents. Observation on 7/23/24 from 11:50 A.M. to 12:45 P.M. showed no staff assisted Resident #3 with the meal, no staff asked the resident if he/she wanted anything different to eat. Observation on 7/23/24 at 12:45 P.M. showed Resident #3 sat in the same spot with a plate of food in front of him/her, he/she had not eaten any of the food. Staff took the resident away from the table back to his/her room and offered no substitutes to the meal. 3. Review of Resident #4's face sheet showed the resident admitted to the facility on [DATE]. Review of the monthly weights showed the following: -1/27/2024 - 131.0 pounds; -2/6/2024 - 126.8 pounds; -2/20/2024 - 126.8 pounds; -3/19/2024 - 138.4 pounds; -3/27/2024 - 124.6 pounds; -4/23/2024 -112.4 pounds; -4/30/2024 - 119.8 pounds. Review of the quarterly MDS dated [DATE] showed the following: -Usually able to make self understood and usually understands others; -BIMS of 4, indicating severe cognitive impairment; -Supervision with eating; -Diagnoses of anemia, Alzheimer's disease, dementia, seizure disorder, anxiety, and respiratory failure; -Weight of 120 pounds. (continued on next page)

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St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's malnutrition assessment dated [DATE] showed the resident was at risk for malnutrition and the dietician should follow. Review of the resident's care plan for malnutrition dated 4/30/24 showed the following: -Resident at risk for malnutrition based on significant weight loss and inconsistent consumption; -Goal: Resident will maintain nutrition and hydration status as evidenced by adequate consumption through next review; -Interventions: Encourage food and fluids with and between meals and high calorie snacks between meals. Feeds self in Memory Care dining room with setup assistance and cues/prompts/encouragement; Regular diet with fortified foods. Review of the resident's progress notes dated 5/8/24 at 3:34 P.M. titled Care Conference Meeting showed the following: -Dietary: Appetite fluctuates. The family wants to make sure he/she is not sleeping through dinner time. If he/she doesn't like meals offer grilled cheese sandwiches or mac and cheese or potatoes. Enjoys breakfast related food. Enjoys sweets; -Reviewed weights and has had significant weight loss since admission. Offering fortified foods. Review of the POS for July 2024 showed an order for a regular diet with fortified foods with a start date of 4/17/24. Review of the resident's progress notes dated 5/8/24 through 7/17/24 showed no documentation from the Registered Dietician or a review of the weights. Review of the resident's monthly weight dated 7/17/24 showed a weight of 108.6 lbs. for a 17% weight loss in seven months. Review of the resident's progress notes dated 7/17/24 through 7/23/24 showed no documentation staff notified the physician of the resident's significant weight loss. Observation on 7/23/24 at 11:40 A.M. through 1:15 P.M. showed CNA A take Resident #4 into the dining room in a wheelchair and position the resident at a table with three other residents; -At 11:50 A.M., the Dietary Aide began serving the noon meal of white rice, broccoli and diced roast beef. CNA A served Resident #4 a plate of white rice, broccoli and diced beef that was served out of the same steam table pans as all of the other plates of food. There was no other food, protein or high calorie food added to the regular service to make it fortified; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-CNA A sat the plate in front of the resident and then served the other residents; -Resident #4 wheeled him/herself out of the dining room several times and staff wheeled the resident back in to the dining room to the same spot, but did not offer to assist the resident with the meal; -At 12:18 P.M., CNA B served the residents in the dining room an ice cream sandwich; -Resident #4 ate the ice cream sandwich but did not eat any of the rice, broccoli or diced beef; -Staff removed the resident's uneaten plate of food at 12:40 P.M. and pushed Resident #4 into the sitting area. During an interview on 7/23/24 at 2:00 P.M. the dietary manager said the following: -Fortified foods should have been rice with butter and perhaps a roll with butter; -She was not sure if Resident #4 was on a fortified diet; -She does not attend any meetings about weight loss; -The weights are reviewed by the Registered Dietician and nursing. 4. During an interview on 7/24/24 at 10:00 A.M. the Registered Dietician said the following: -She will review the weights that are provided by nursing each time she comes into the facility; -She will review any resident who has had a weight loss to see if the weight loss continues; -She will document her assessment and plan in the progress note section of the electronic medical record and generate a report with her recommendations that goes to the Administrator, the Director of Nursing (DON), Unit Managers, MDS coordinator and the Dietary Manager. Once she makes her recommendations, she will follow up on her next visit to see if the recommendations have been followed; -If she makes a recommendation for weekly weights for four weeks, she will review after four weeks. She is assuming that nursing is following through with the recommendations; -She will re-evaluate a resident's weight if it shows back up on the weight report. Resident #2, #3, and #4 have not shown back up on the weight report. During an interview on 7/24/24 at 10:30 A.M. Unit Manager, Licensed Practical Nurse C said the following: -He/She has not completed any of the weights for a while, he/she does not think that the weights are accurate; -He/She spoke with the former DON about this concern and was waiting on guidance from him. He resigned several weeks ago, and he/she has not discussed this with the new DON yet; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-He/She should go through the reports from the registered dietician and call the physician for orders and update the family. He/She had not done this. During an interview on 7/24/24 at 10:30 A.M. the DON said she was use to discussing the weights at risk management meetings but she has only been at the facility for a week and has not had the opportunity to review the weights or attend a risk management meeting. During an interview on 7/24/24 at 12:00 P.M. the MDS coordinator said the following: -The dietary manager should be taking the orders received and updating the care plan and the diet orders; -He/She was not sure if this had been done. During an interview on 7/30/24 at 9:10 A.M. the Administrator said he would expect nursing to review and discuss the registered dietician's recommendations and notify the physician of these recommendations. During an interview on 7/25/24 at 9:25 A.M. the Medical Director said she would expect the facility to monitor residents weights, notify the physician of any weight loss and registered dietician recommendations; -She would expect the facility to provide the diet as ordered. MO238155

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 34003 Based on interview and record review, the facility failed to provide appropriate services to attain the highest practical well-being for one resident (Resident #2), with a diagnosis of dementia, in a review of four sampled residents. Facility staff identified the resident had behaviors affecting the resident and other residents, however, did not evaluate and implement further approaches to address the resident's care needs related to his/her diagnosis of dementia. Resident #2 had an increase in behaviors which resulted in the administration of anti-anxiety IM (intramuscular) medication and psychotropic medication (a psychoactive drug taken to exert an effect on the chemical makeup of the brain and nervous system) without trying alternative interventions first. The resident's physician placed an order for the resident to be seen by psychiatry due to the increase in behaviors on 6/24/24 and the facility failed to schedule the resident for the consultation. The resident continued to have behaviors and subsequent increase in administration by staff of psychotropic medications as an intervention for the resident's behaviors. The facility census was 117. Review of the facility policy for Dementia Care dated 11/2018 showed the following: -As part of the initial assessment, the physician will help identify individuals who have been diagnosed as having dementia and those with otherwise impaired cognition; -The Interdisciplinary Team (IDT) will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes; -The physician will identify individuals taking cholinesterase inhibitors or other medications used to try to stabilize cognitive function, or medications such as antipsychotic medications and mood stabilizers that are commonly ordered to try to manage problematic behavior and disturbed mood; -The staff and physician will review the current physical, functional, and psychosocial status of individuals with dementia, and will summarize the individual ' s condition, related complications, and functional abilities and impairments; -Individuals with dementia can also have a personality disorder, mental illness, psychosis, delirium, depression, adverse drug reactions (ADRs), or other conditions causing or contributing to impaired cognition and problematic behavior; -As needed, the physician may obtain a psychiatrist or neurologist consultation to assist with diagnosis, treatment selection, monitoring of responses to treatment, and adjustment of medications; -The facility will strive to optimize familiarity through consistent staff-resident assignments; -Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician will help define potential benefits and risks of medical interventions (including cholinesterase inhibitors and other medications used to enhance or stabilize cognition) based on individual risk factors, current conditions, history and details of current symptoms. -The physician will order appropriate interventions to address significant behavioral and psychiatric symptoms, based on pertinent clinical guidelines and consistent with regulatory requirements. -Medications will be targeted to specific symptoms and will be used in the lowest possible doses for the shortest possible time, unless a clinical rationale for higher doses or longer-term use is documented. -If a psychiatric consultant is called to help manage behavioral or psychiatric symptoms in the individual with dementia, the IDT will retain an active role by reviewing and implementing the consultant's recommendations, addressing issues that affect mood, cognition, and function, monitoring for complications related to treatment, and evaluating progress. -The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician; -The IDT will adjust interventions and the overall plan depending on the individual ' s responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. -The physician and staff will review the effectiveness and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated. Review of the facility policy for Behavioral Assessment, Intervention and Monitoring dated 3/2019 showed the following: -The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. -Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. -Behavioral health services will be provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents. -Residents will have minimal complications associated with the management of altered or impaired behavior; -The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. -Behavioral or Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot. -Current guidelines recommend the use of non-pharmacological interventions for BPSD. -As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: a. The resident's usual patterns of cognition, mood and behavior; b. The resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; c. The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers; d. The resident's previous patterns of coping with stress, anxiety, and depression. -The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm; -The care plan will incorporate findings from the comprehensive assessment determinations (as appropriate), and be consistent with current standards of practice; -The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement, or attempts to include the resident and family in care planning and treatment, will be documented; -Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities; -Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior; -Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms; -When medications are prescribed for behavioral symptoms, documentation will include: a. Rationale for use; b. Potential underlying causes of the behavior; c. Other approaches and interventions tried prior to the use of antipsychotic medications; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident will be able to locate room, communicate basic needs, continue to recognize family, have daily needs met and respond to simple direction; -Anticipate needs and meet promptly; discuss concerns regarding overall status/health with resident/family as needed; invite, encourage, remind and escort to activity programs as desired; monitor for changes in cognitive status. Notify physician if observed. Review of the resident's care plan for Psychosocial-Behavior dated 4/12/24 showed the following: -The resident exhibits risk for behavior symptoms of being verbally aggressive, physically combative, aggressive with other residents, taking other's items, packing room and rejecting care: -The resident will be compliant with nursing care, have needs met, will not harm self and/or others secondary to socially inappropriate and/or disruptive combative behavior, and will participate in out-of-room activities of choice for diversion and sensory stimulation; -Activities assessment for diversional activities, anticipate needs and meet promptly, document and record behavior episodes, establish a rapport, maintain a calm, slow, understandable approach, manage environmental factors to optimize comfort, observe and document changes in behavior, including frequency of occurrence and potential triggers. Observe resident's mood and response to medication, provide simple, direct reminders as indicated, social services visits as indicated. Review of the resident's care plan for Psychosocial-Behavior dated 4/18/24 showed the following: -The resident is at risk for complications due to trying to exit seek, locking staff out of room, arguing with others, and being aggressive verbally and physically with other residents and staff: -Interventions included an activity assessment for diversional activities and administer medication as ordered. Monitor for side effects and notify physician if observed. Anticipate needs and meet promptly, document and record behavioral episodes, encourage resident to verbalize feelings, environmental evaluation to assess room for safety, establish a rapport, maintain a calm, slow understandable approach, manage environmental factors to optimize comfort, observe and document changes in behavior, including frequency of occurrence and potential triggers, provide simple, direct reminders as indicated. Review of the resident's POS showed an order dated 4/19/24 for Zoloft (a medication used to treat depression) 100 mg, give one and one half tablets one time a day. Review of the resident's POS showed an order dated 4/24/24 for Seroquel (an antipsychotic medication used to treat bipolar disorder (depressive and manic episodes) and schizophrenia. Quetiapine extended-release tablet is also used together with other antidepressants to treat major depressive disorder. This medicine should not be used to treat behavioral problems in older adults who have dementia or Alzheimer's disease) 25 milligrams (mg) two times a day (BID) for agitation. Review of the resident's nurses notes showed the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/27/24 at 11:01 P.M., this resident started arguing and fighting with another resident by calling him/her stupid and talking about him/her to other residents. Resident was walking around trying to carry his/her packed bags to go home. Resident told the other resident that he/she could not have any of his/her tissues after retrieving them from his/her room. Resident stood by the door asking why he/she was here and why he/she was locked up and couldn't go home to take care of his/her children. Resident agreed to drink some juice and lie down. Resident has been up to the nurses station since then calling this nurse a bitch because the resident did not get the answer he/she liked. Resident went back down to his/her room and laid down -On 5/3/24 at 10:00 A.M., the Nurse Practitioner (NP) here at facility. Notified the NP, the resident needed an as needed (PRN) Ativan (antianxiety medication) order reinstated. New orders to reinstate Ativan 0.5 mg by mouth (PO) every 6 hours PRN for agitation. New orders noted; -On 5/3/24 at 11:44 A.M., the resident packed up his/her belongings and attempted to go out of the Memory Care unit. Resident continues to set off Memory Care door alarm. Staff attempting to redirect resident, unsuccessful. Administered PRN Ativan 0.5 mg PO without difficulty. Staff continue to redirect resident, with difficulty. Review of the resident's behavior notes dated 5/3/24 at 12:45 P.M., showed the following: -Certified Nurse Aide (CNA) notified this nurse that resident was throwing the remote and other things at staff and other family members. Resident continued to stand by the Memory Care doors. Resident continued to yell at staff and other family members. This nurse able to redirect resident to the nurse's station to call his/her family member. This nurse spoke with the resident's family member in regards to the resident's behavior. The resident's family member said he/she would call the resident back on the resident's telephone. Instructed the resident to wait in his/her room for his/her family member to call. Review of the POS dated 5/3/24 showed an order for lorazepam (Ativan) 0.5 mg take by mouth (PO) every six hours as needed. Review of the nurse notes dated 5/4/24 at 10:30 P.M., showed the following: - The resident was in the hall and was pushed to the floor by another resident. Fall was witnessed by this nurse and the certified nurse aide. Did not hit head. Assessed at time of fall. Range of motion and vital signs were within normal limits. Complained of pain to right hip. Skin assessed with no redness or bruising; -Updated the resident's responsible party and he/she had already talked to the resident regarding the complaint of right hip pain. Hip x-ray requested and physician updated about the x-ray request with new order received. Review of the resident's POS showed an order dated 5/6/24 order for Depakote (medication used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and challenging behaviors in Alzheimer's disease and other types of dementia) delayed release table 125 mg three times a day (TID) for a mood stabilizer. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's behavior note dated 5/11/24 at 10:02 P.M., showed the resident continued to have agitation. Resident continued to set off Memory Care doors with alarm. Staff continue to attempt to redirect. Resident continued to yell and curse at staff, unable to redirect. PRN Ativan PO administered at this time. Review of the resident's behavior note dated 5/11/24 at 5:03 P.M., showed a CNA notified this nurse the resident threw his/her walker at him/her and cursed. The resident continued to have increased agitation and was unable to redirect. PRN Ativan PO administered. Review of the resident's Medication Administration note in the electronic medical record (EMR) dated 5/11/24 at 10:07 P.M. showed Ativan injection solution 2 mg/ml Inject 0.25 milliliters intramuscularly every 12 hours as needed for agitation, combativeness, fighting, cussing, going in others' rooms and trying to get out the door. 11:29 A.M. note showed the injection was ineffective and the resident had been fighting all day. Review of the resident's progress notes dated 5/11/24 through 5/15/24 showed no documentation the resident had any behaviors. Review of the resident's Medication Administration Note dated 5/15/24 at 4:03 P.M. showed staff administered lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth. Review of the resident's behavior notes dated 5/15/24 at 4:13, late entry, showed the resident continued to have agitation, setting off Memory Care door alarm. Unable to redirect resident. Resident continued to say, I need to get home. My mother is looking for me. I need to get a hold of her. Staff continue to attempt to redirect, unsuccessful. PRN Ativan administered for behaviors. Review of the resident's behavior note dated 5/16/24 at 11:14 P.M., showed the resident continued to have agitation, continued to set off Memory Care door alarms. Resident continued to push on the door, to set off alarm. Resident attempted to swing his/her arm at this nurse. Resident cursing at this nurse, unable to redirect. PRN Ativan PO administered for agitation. Review of the resident's Medication Administration Note 5/16/24 at 1:02 P.M. showed staff administered lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth for increased agitation. Review of the resident's Medication Administration Note dated 5/18/24 at 9:21 P.M. showed Ativan injection solution 2 mg/ml inject 0.25 milliliter intramuscularly every 12 hours as needed for agitation, combativeness. Resident is constantly going to the doors saying he/she has to go home. Attempted to redirect and the resident became agitated and threatened staff. Gave PRN Ativan as ordered. Review of the resident's Medication Administration Note dated 5/19/24 at 2:17 A.M. showed Ativan Injection Solution 2 mg/ml inject 0.25 milliliter intramuscularly every 12 hours as needed for agitation, combativeness. The medication was effective and the resident is resting in bed. Review of the resident's behavior note dated 5/26/24 at 12:04 P.M. showed the following: -Resident sitting up in the dining room. Resident looking for a phone book, To call his/her mother. Attempted to explain that do not have access to a phone book; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Continues to take objects off the nurse's cart and paperwork from the nurse. Staff attempted to redirect resident , several times, unsuccessful -Resident continues to curse at this nurse, unable to redirect; -PRN Ativan 0.5 mg administered at approximately 11:50 A.M. Review of the resident's progress notes dated 5/26/24 through 6/4/24 showed no documentation of any behaviors. Review of the resident's Medication Administration Note dated 6/4/24 at 6:30 P.M., showed staff administered lorazepam oral tablet 0.5 mg. give 0.5 mg for increased agitation. Review of the resident's progress notes dated 6/4/24 showed no documentation of any behaviors or alternative interventions for behaviors. Review of the resident's Medication Administration Note dated 6/4/24 at 8:33 P.M., showed lorazepam oral tablet 0.5 mg., give 0.5 mg by mouth every six hours as needed for agitation. There was no documentation of any behaviors for the use of lorazepam or any alternative inventions used before the administration of the lorazepam. Review of the resident's behavior note dated 6/9/24 at 10:08 A.M.,. showed staff observed the resident throwing orange juice and cranberry juice on this nurse two times and CNA one time and when trying to redirect the resident, he/she tried hitting another resident. Attempted to get out backdoor one time, unsuccessful. Family member made aware and he/she said he/she would come to facility to take resident out for the day. Review of the resident's Medication Administration Note dated 6/11/24 at 6:49 P.M., showed staff administered lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth for increased agitation. Review of the resident's nurses note dated 6/11/24 at 7:00 P.M., showed the resident had increased agitation, exit seeking, name calling, attempting to hit staff with walker, hitting exit door with walker. Very difficult to redirect. PRN Ativan given per order. Review of the resident's Medication Administration Note dated 6/13/24 at 1:08 P.M., showed lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours a needed for agitation. There was no documentation of any behaviors or alternative interventions before the use of the lorazepam. At 8:44 P.M. lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours as needed for agitation. No documentation of any behaviors or alternative interventions before the use lorazepam. Review of the resident's Medication Administration Note dated 6/15/24 at 7:55 P.M. showed lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours as needed for agitation. Exit seeking/hard to redirect. There was no documentation of any behaviors or interventions used before the administration of lorazepam. Review of the resident's Medication Administration Note dated 6/20/24 at 6:48 P.M., showed: (continued on next page)

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	265824	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lorazepam oral tablet 0.5 mg., give 0.5 mg by mouth every six hours seeded for agitation. Resident is agitated. There was no documentation of the behaviors or alternative interventions used prior to the administration of lorazepam. Review of the resident's nurses note dated 6/21/24 at 5:45 P.M., showed Responsible Party (RP) A voiced concerns the resident was depressed and may need medication change. Requested to speak with the NP. Informed RP A would inform NP, message for physician. Review of the resident's Medication Administration Note dated 6/21/24 at 9:35 P.M. showed lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hour as needed for agitation. Administered for agitation. There was no documentation of alternative interventions attempted prior to the use of lorazepam. Review of the resident's progress notes dated 6/24/24 at 10:58 A.M., showed the NP saw the resident and spoke with RP A regarding medications. The NP informed this nurse psych will be coming the first week in July and resident was put on the list to be seen. The nurse called and informed RP A. Review of the resident's Medication Administration Note dated 6/24/24 at 7:45 P.M., showed lorazepam oral tablet 0.5 mg., give 0.5 mg by mouth every six hours as needed for agitation. There was no documentation the resident had any behaviors and no documentation of any alternative interventions used prior to administration of lorazepam. Review of the resident's progress notes dated 6/24/24 at 9:05 P.M., showed observed the resident sitting on his/her bottom in front of his/her recliner, digging through his/he belongings in a box. When questioned regarding how he/she came about sitting on the floor, the resident did not give much of a response. The resident denied hitting his/her head. Review of the resident's behavior notes dated 6/26/24 at 9:46 A.M., showed the resident had increased agitation and behaviors. Resident cursing at CNA and accusing staff of taking his/her belongings and money. Resident refused his/her morning medications. Resident said, I already took those like 40 minutes ago. Attempted to administer PRN lorazepam, resident refused. Review of the resident's Medication Administration Note dated 6/26/24 at 1:26 P.M., showed lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours as needed for agitation. Administered PRN Ativan at this time. There was no documentation of behaviors or alternative interventions used prior the administration of lorazepam. Review of the resident's Medication Administration Note dated 6/27/24 at 1:36 P.M., showed lorazepam injection solution 2 mg/ml inject 0.25 ml intramuscularly as needed for increased agitation, administered at 1:35 P.M. for combativeness and agitation. Review of the resident's Social Services Progress note dated 6/27/24 at 1:51 P.M. showed the the resident had increased agitation and was banging on the Memory Care doors. Social Worker was able to redirect to office and shared small talk. Review of the resident's behavior note dated 6/27/24 at 2:30 P.M. showed the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At approximately 1:30 P.M., the resident had increased agitation, combative with staff. Resident attempted to go out the Memory Care doors. Resident pushing his/her walker against CNA and the door. Resident also attempting to stab CNA with his/her pen. Resident cursing at CNA. Nursing staff unable to redirect; -Social services able to redirect the resident to his/her room with difficulty; -Administered PRN Ativan IM in left upper arm at 1:35 P.M. for behavior. Noted a small skin tear to resident's right outer wrist area. Notified resident's responsible party of resident's behavior and skin tear. Review of the resident's medical record dated 6/27/24 showed no alternative interventions attempted for the behavior of banging on the Memory Care door prior to the use of the IM Ativan. Review of the resident's medical record dated 6/24/24 through 6/27/24 showed no documentation of the resident being seen by psychiatrist or an appointment made to be seen by psychiatry. Review of the resident's behavior notes dated 6/28/24 showed the following: -At 9:47 A.M., the NP saw the resident this morning. Notified the NP the resident continues to have increased agitation, and was combative with staff. NP said, Last time I spoke with his/her family member, he/she said that I cannot change his/her meds. That the facility was getting a psych doctor next week and for the resident to see the psych doctor when he/she comes to the facility.; -At 5:28 P.M., the resident continues to have agitation, was combative with staff, and unable to redirect resident. As needed Ativan PO administered at 5:00 P.M. without difficulty. Resident spoke with his/her family member, on the phone. This nurse notified family member of resident behaviors; -At 9:10 P.M., resident continues with behavioral episodes towards staff. Resident observed raising voice at staff when trying to assist with resident's wants after resident asking for help. Ativan PRN given as ordered; -There was no documentation staff used a any alternative interventions to address the resident's behaviors prior to administering Ativan. Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg on 7/8/24 at 9:33 A.M. Review of the resident's progress notes dated 7/8/24 showed no documentation of alternative interventions used before the administration of the lorazepam. There was no documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg given on 7/9/24 at 9:29 A.M. Review of the resident's progress notes dated 7/9/24 showed no documentation of alternative interventions used before the administration of lorazepam and no documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg as follows: -On 7/11/24 at 9:40 A.M.; -On 7/11/24 at 4:05 P.M. Review of the resident's progress notes dated 7/11/24 showed no documentation of alternative interventions used before the administration of lorazepam and no documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg on 7/12/24 at 8:54 A.M. Review of the resident's progress notes dated 7/12/24 showed no documentation of alternative interventions used before the administration of lorazepam and documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the MAR for July 2024 showed staff administered lorazepam 0.5 mg. on 7/14/24 at 11:30 A.M. Review of the resident's progress notes dated 7/14/24 showed no documentation of alternative interventions used before the administration of the lorazepam and no documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg at 10:20 A.M. on 7/1/7/24. Review of the resident's progress notes dated 7/17/24 showed no documentation of alternative interventions used before the administration of lorazepam or documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the resident's MAR for July 2024 showed staff administered lorazepam 0.5 mg. on 7/22/24 at 7:45 P.M. Review of the resident's progress notes dated 7/22/24 showed no documentation of alternative interventions used before the administration of lorazepam or documentation of any consultation with psychiatry or any appointments made for the resident to be seen by psychiatry. Review of the resident's care plans for psychosocial behavior showed no new approaches to address the resident's behaviors or any documentation of interventions used prior to the administration of the PRN lorazepam. During an interview on 7/23/24 at 2:20 P.M., the facility's Social Worker said the following: -Resident #2's family was involved with the resident's care and visited frequently; -He/She has been in contact with the family; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not know anything about a psychiatrist to come into the facility. During an interview on 7/24/25 at 3:00 P.M., the Unit Manager, Licensed Practical Nurse C said the following: -The resident has behaviors and had received PRN PO lorazepam and IM lorazepam for the behaviors; -The resident's responsible party wanted the resident to be seen by a psychiatrist; -The former Director of Nursing (DON) said he/she was working on a contract with psychiatry, but then he/she left at the end of June and nothing had been done. During an interview on 7/24/24 at 3:30 P.M., the DON said she did not know why psychiatry was not started in the facility. During an interview on 7/30/24 at 9:10 A.M., the Administrator said he did not know anything about a psychiatrist coming to the facility. During an interview on 7/25/24 at 9:27 A.M., the Medical Director said the following: -Medications should be reviewed for behaviors, alternative interventions should be used before administration of IM medications; -If a resident needed to have psychiatric consultation, the facility should attempt to obtain the consultation; -The resident should have been seen by a psychiatrist. MO239091

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594 This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated [DATE]. Based on observation, interview, and record review, the facility failed to ensure the planned menu, reviewed by the Dietary Consultant, was followed and items listed on the menu were served to the residents. The facility also failed to serve the correct serving sizes per the facility diet spreadsheet. The facility's census was 115. Review of the facility untitled policy, dated 2023, showed the following: -Food will be served according to the posted menu. If the menu changes residents will be notified as reasonably able; -Each wait staff should serve one table completely before starting to serve the next table. 1. Review of the menu dated [DATE] showed the noon meal included: -Tossed salad with dressing; -Baked glazed ham; -One half of a baked sweet potato; -Green bean casserole; -Dinner roll with margarine; -Assorted desserts. Review of the facility diet spread sheet, dated cycle day 23, for the noon meal showed the following: -Tossed salad with dressing, one half cup; -Country gravy, two ounces; -Candied yams, half cup; -Wheat roll, one each; -Green bean casserole, half cup; -Assorted desserts, one each. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] of the noon meal service showed the following: -The dining room was full of residents; -Staff served residents lunch in a random order from table to table. Residents sat at tables watching other residents eat while staff served other tables; -A pan of lettuce with tomatoes and cheese was on a table at the front of the dining room covered with plastic wrap and was not chilled; -Staff did not offer salad to residents until most residents had been served their meals and were already eating; -Residents had to ask for drinks and sugar for their tea/coffee as there was not any or very limited amounts on the tables; -The ham was served without gravy as indicated on the spreadsheet; -The pieces of ham were all different sizes on the residents' plates; -Staff did not use measured scoops to serve the food for the residents. Review of the menu dated [DATE] showed the noon meal included: -Chicken and rice soup; -Turkey burger; -Relish plate; -Baked potato wedges; -Apple slaw; -Chocolate cake with icing. Review of the facility diet spread sheet, dated cycle day 24, for the noon meal showed the following: -Chicken rice soup, three fourths cup; -Turkey burger, three ounces meat/two slices bread; -Relish plate, one each; -Apple slaw, half cup; -Baked potato wedges, half cup; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Chocolate cake with icing, 2x3 square. Observation on [DATE] at 12:08 P.M. of lunch service in the main dining room showed the following: -The dining room was full of residents for the noon meal; -Some of the residents received chicken and rice soup. When the container of soup in the dining room was empty and additional residents asked for soup, dietary staff told them they were out; -The cook served residents one half of a turkey burger on a piece of bread cut in half; -The cook reached into the pan of potato wedges, grabbed a handful, and placed them on plates; -There was no apple slaw on the serving line. Observation on [DATE] at 12:05 P.M. showed the following: -The warming pot for the chicken and rice soup in the dining room was empty; -A stock pot half full of chicken and rice soup was on the stove simmering. During an interview on [DATE] at 12:08 Dietary Aide J said the following: -The dietary aide shrugged his/her shoulders and said he/she did not know why he/she didn't go to the kitchen to see if there was more soup; -He/She told residents they were out of soup; -The dietary aide was agitated and said I will get more soup, I will get more soup. Why are you still standing here? I said I would get more soup, when the surveyor asked him/her if there was more soup for the residents. During an interview on [DATE] at 12:55 P.M. Dietary Aide E said the following: -He/She said the previous dietary manager said the residents did not eat a whole turkey burger so he/she was to only serve one half of a turkey burger to each resident. Dietary Aide E was just doing what he/she was told before; -He/She just gave each resident a handful of potato wedges; it was about the same as using the tongs. Observation on [DATE] at 12:58 P.M. showed after the interview Dietary Aide E served a full turkey burger on a bun to the remaining residents. During an interview on [DATE] at 8:56 A.M. and 11:45 A.M., the Registered Dietitian said the following: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The dietary manager should have recipes the dietary staff follow to prepare meals but there aren't any in the kitchen; -The dietary manager is in charge of ordering food for the kitchen; During an interview on [DATE] at 12:30 P.M., the Medical Director said the following: -She expected the dietary staff to follow the menus and recipes to prepare foods; -She expected the dietary staff to clean and disinfect the kitchen every day; -She expected the facility to provide enough staff to serve the resident's meals timely; -There needed to be consistency of supervision in the kitchen. During an interview on [DATE] at 3:29 P.M., the Dietary Consultant said the following: -The current menus were put together from a previous dietary manager and are hard to follow, because he/she pieced them together however he/she wanted; -The dietary staff should be following recipes. The recipes tell how much to make for the amount of people you serve. During an interview on [DATE] at 4:20 P.M., the Administrator said the following: -She expected the dietary staff to follow the menu and serve what is posted; -She expected the dietary staff to serve the correct portion sizes to the residents; -She expected the dietary manager to oversee all aspects of the kitchen but since the facility is without a dietary manager right now, she would be responsible to monitor the dietary staff.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42594 Based on observation, interview, and record review, the facility failed to serve food to the residents at an appetizing temperature. Residents who ate meals in their rooms said the food was cold when served most of the time. The facility census was 115. The facility did not provide a policy for food temperatures upon request. Review of the dietary cook job description, dated 10/2016, showed the following: -The cook was responsible to record food temperatures for each meal; -The cook was to manage and operate the kitchen in the absence of the dietary supervisor. Review of the facility policy Tray Line Food Temperatures, showed the following: -Hot foods should be 135 degrees Fahrenheit or greater; -Cold Foods should be 41 degrees Fahrenheit or less: -Each day had three columns to take food temperatures (before, during, and after each meal served). 1. Review of the facility Tray Line Food Temperatures, dated 9/15/24 through 9/17/24, showed the following: -On 9/15/24 no food temperatures were taken during or after the breakfast meal was served; -On 9/15/24 no food temperatures were taken before or after the noon meal was served; -On 9/15/24 no food temperatures were taken for the evening meal; -On 9/16/24 no food temperatures were taken during or after the breakfast meal was served; -On 9/16/24 no food temperatures were taken before or after the noon meal was served; -On 9/16/24 no food temperatures were taken for the evening meal; -No food temperatures were taken for any meals from 9/17/24 through 9/22/24. Review of the facility weekly menu, dated 9/22/24 through 9/28/24, showed the lunch menu on 9/24/24 was chicken and rice soup, turkey burger, relish plate, baked potato wedges, apple slaw, and chocolate cake with icing. Review of the facility Tray Line Food Temperatures, dated 9/22/24 through 9/28/24, showed the following: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hot foods should be 135 degrees Fahrenheit or greater; -Cold Foods should be 41 degrees Fahrenheit or less: -Each day had three columns to take food temperatures (before, during, and after each meal served); -On 9/22/24 no food temperatures were taken for the morning, noon, or evening meals; -On 9/23/24 no food temperatures were taken for the morning, noon, or evening meals; -On 9/24/24 no food temperatures were taken during or after the breakfast meal was served; -On 9/24/24 no food temperatures were taken after the noon meal was served; -On 9/24/24 no food temperatures were taken for the evening meal; -On 9/25/24 no food temperatures were taken during or after breakfast was served; -On 9/25/24 no food temperatures were taken before or after the noon meal was served. Observation on 9/24/24 at 2:00 P.M. of the test tray provided by the facility staff after the last resident was served showed the following: -The residents trays were taken to the hall on an open cart; -The meal tray contained a plate that was covered with a plastic dome; -There was a turkey burger on a bun, potato wedges, and a relish plate (a leaf of lettuce, two sliced tomatoes, two slices of white onion, and four pickles) on the tray; -The turkey burger on a bun was 92 degrees Fahrenheit; -The potato wedges were 90 degrees Fahrenheit; -The sliced tomatoes were 72 degrees Fahrenheit; -There was no drink, silverware, napkin, condiments, chicken and rice soup, apple slaw or dessert on the tray, all of which were listed on the menu. During an interview on 9/24/24 at 7:30 A.M., Resident #10 said when he/she ate in his/her room the food was ice cold. It was never hot. During an interview on 9/24/24 at 3:59 P.M., Resident #11 said the following: -The resident ate in his/her room; -The food was usually cold when he/she received it. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 3:29 P.M., the dietary consultant said the food temperatures should be taken before the meals are served to the residents. During an interview on 9/25/24 at 4:20 P.M. the Administrator said the following: -The Dietary Manager quit yesterday, and she was overseeing the kitchen until a new manager was hired; -She expected the dietary department to maintain food temperatures so the residents got hot foods hot and cold foods cold. MO241453 MO242469

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34003 Based on observation and interview, the facility failed to prepare and serve food under sanitary conditions. The staff failed to ensure the kitchen floors were free from food, debris and rodent feces, failed to ensure surfaces of equipment in the kitchen were free from rodent feces, failed to label and date food when opened, failed to appropriately store food, and failed to discard food items that were compromised including ice cream and apples. The facility census was 117. Review of the facility policy for Sanitization dated 11/2022 showed: -The food service area is maintained in a clean and sanitary manner; -All kitchen, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. There was no policy provided regarding dating and labeling of foods or food storage. Review of the undated facility policy for Pest Control showed: -Our facility shall maintain an effective pest control program; -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents; -Garbage and trash are not permitted to accumulate and are removed from the facility daily. 1. Observation on 7/23/24 at 12:45 P.M., of the kitchenette on the memory care unit showed: -The refrigerator contained a cup of liquid from a fast food restaurant with no name in the refrigerator for resident food; -A plastic container of a green partially solid liquid that was half full with no label to identify the liquid or date on the container with a spoon wrapped in a napkin on top of the container; -A half package of fudge graham cracker cookies that were not dated; -A small single serve pizza in a closed plastic wrapper with no date and no label; -A jug of tomato juice, three fourths full with no name or date;-In a basket in a cabinet, there were two apples that were withered in a cart with bread that was open, an open bag of potato chips, and bagels; -A container partially full of ice cream that was undated with no expiration date and a build up of ice on top of the ice cream. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/23/24 at 2:14 P.M., in the main kitchen showed the following: -A stainless steel preparation table in the kitchen in front of the steam table with numerous black pellets that resembled rodent feces on the bottom rack of the table. Staff used the table to store and prepare food; -Behind the table on the floor there was a copious amount of rodent feces among packets of condiments and food particles; -A cart that contained covers for plates was dirty with food particles and rodent feces noted on the cart; -French fries and food particles under the main steam table with a copious amount of rodent feces; -A large trash can with rodent feces around the trash can; -Under the stove there were food particles and rodent feces; -Rodent feces under the beverage dispenser; -Packets of butter on the floor behind the refrigerator; -Potatoes on the floor by the stand that held utensils. During an interview on 7/23/24 at 2:15 P.M., the Dietary Manager (DM) said: -She has been at the facility for several months and there has been a problem with mice in the kitchen since she has been there; -She has reported the problem to the Administrator and the Maintenance Director; -There has been a shortage of staff in the kitchen and they are trying to keep things clean; -The cook that serves the memory care was responsible for keeping the kitchenette clean; -Food should be labeled and dated when opened; -No staff food should be kept in the refrigerator that was used for resident food; -Kitchen staff should sweep and mop and keep the kitchen clean. During an interview on 7/23/24 at 2:30 P.M., the Maintenance Director said the following: -He was aware of the rodent problem in the kitchen; -The kitchen was dirty and needed to be kept clean to help prevent mice from keep coming in; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He has told the DM the kitchen floors needed to be kept clean and food picked up prevent the mice from coming in the kitchen. During an interview on 7/24/24 at 10:00 A.M., the Registered Dietician said the following: -She was aware of the mice problem in the kitchen for some time; -She completes a kitchen inspection at least monthly and has indicated in her reports the kitchen was dirty and mouse droppings (feces) were present; -Her reports were shared with the administrator, Director of Nursing, nurse manager and DM. During an interview on 7/30/24 at 9:10 A.M., the Administrator said the kitchen and the kitchenette should be clean, and food should be labeled and dated when opened. During an interview on 7/25/24 at 9:27 A.M., the Medical Director said the following: -She would expect the kitchen to be clean and remain clean to prevent rodents; -The kitchen should be cleaned after every meal and at the end of the day. MO238155

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to develop a policy for Enhanced Barrier Precautions (EBP-Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multi drug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) and failed to ensure staff's adherence to use of personal protective equipment (PPE) for four of thirteen residents (Resident #8, #9, #10, and #11) who met criteria to be on enhanced precaution isolations. The census was 113. Review of the facility policy for Isolation - Categories of Transmission-Based Precautions dated September 2022 showed: -Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infections; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. -Notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for the and the type of precautions. The signage informs the staff of the type of CDC precautions(s), instructions for use of PPE, and/or instructions to see the nurse before entering the resident's room. -Contact Precautions: contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment; -Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest and increased potential for extensive environmental contamination and risk of transmission of a pathogen even before a specific organism has been identified; -Contact precautions are used for residents infected or colonized with MDRO's in the following situations: when a resident has wounds, secretions, or excretions that are unable to be contained and on units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring; -The policy did not address Enhanced Barrier Precautions, what constituted placement on EBP, what PPE staff should use and when, if the resident needs to be in a private room or if the resident needed to be in isolation. Review of the Centers for Medicare and Medicaid Services Guidance to Long Term Care Facilities for Enhanced Barrier Precautions in Nursing Homes dated 3/20/24, showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multi drug-resistance organism status; -EBP refer to an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employees targeted gown and glove use during high contact residents care activities; -EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing; -EBP are indicated for residents with any of the following: infections or colonization with a Centers for Disease Control (CDC) targeted MDRO when Contact Precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; -Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers; -Indwelling medical devices included central lines, urinary catheters, feeding tubes, and tracheotomies. 1. During an interview on 6/13/24 at 10:45 A.M. the Director of Nursing said the following: -EBP was indicated for residents who had gastric tubes (G-tubes - a tube inserted into the stomach to receive nutrition), indwelling catheters, and residents with respiratory issues; -Residents would have their name in yellow on their door; this was to alert staff that they needed to wear PPE. 2. During an interview on 6/13/24 at 10:45 P.M. Licensed Practical Nurse (LPN) D said the following: -There were three residents on the 400 hall that had indwelling catheters, Resident #8, Resident #9 and Resident #11. Resident #8 and Resident #11 both had pressure ulcers; -Nursing was to wear a gown when taking care of those residents; -He/She did not know what EBP meant. 3. Review of Resident #8's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 5/19/24 showed: -The resident is able understand others and able to make self understood; -Able to make decisions; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent upon staff for Activities of Daily Living (ADL's); -Indwelling catheter (a tube inserted in the bladder to drain urine); -Diagnoses of heart disease, wound infection, and diabetes. Review of the resident's care plan dated 5/21/24 showed no care plan for the indwelling catheter or directions of EBP. Review of the resident's Physician Order Sheet (POS) dated June 2024 showed an order for an indwelling catheter for chronic kidney disease and a pressure ulcer on the coccyx (tailbone). Observation on 6/13/24 at 10:45 A.M. of the resident's room showed: -No sign posted for the use of PPE when providing care to the resident; -No PPE available to staff; -The resident's name on the door was printed on white paper, not yellow. 4. Review of Resident #9's quarterly MDS dated [DATE] showed: -Usually understands other and usually able to make self understood; -Difficulty with making decisions appropriately; -Supervision to partial assistance with ADL's; -Has an indwelling urinary catheter; -Diagnoses of diabetes, dementia, anxiety and depression. Review of the resident's care plan dated 4/19/24 showed no care plan for the indwelling catheter or directions for EBP. Observation on 6/13/24 at 11:04 A.M. showed a three drawer container outside of the resident's room with gowns and gloves in the drawers. There was no sign posted to direct staff when they should wear PPE or why; -The resident's name on the door was printed on white paper; -The resident's urinary catheter collection bag was half full of urine that was a dark yellow in color. During an interview on 6/13/24 at 11:04 A.M. the resident said the following: -Staff do not always empty the catheter collection back and this causes urine to build up and a he/she then gets a urinary tract infection; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff do not always put gloves on when they empty the catheter bag. 5. Review of Resident #11's comprehensive MDS dated [DATE] showed the following: -Unable to make self understood or able to understand others; -Dependent upon staff for ADL's; -Indwelling urinary catheter; -Diagnoses of heart disease, Alzheimer's disease, malnutrition, and an unstageable pressure ulcer. Review of the resident's care plan dated 5/13/24 showed no care plan for the indwelling catheter or directions for EBP. Observation on 6/14/24 at 8:15 A.M. showed a three drawer container outside of the resident's room with gowns and gloves in the drawers. There was no sign posted directing staff when they should wear PPE or why; -The resident's name on the door was printed on white paper. 6. Review of Resident #10's quarterly MDS dated [DATE] showed the following: -Unable to make self understood and unable to understand others; -Dependent upon staff for ADL's; -Has a feeding tube for nutrition; -Pressure ulcers; -Diagnoses of heart disease, hypertension, Alzheimer's disease, and dementia. Review of the resident's care plan dated 5/15/24 showed no care plan for EBP. Review of the resident's POS for June 2024, showed orders to treat pressure ulcers to the right foot, left ankle and left hip; -Orders for nutrition through a feeding tube. Observation on 6/14/24 at 8:15 A.M. showed no cart with PPE or sign posted on the resident's door identifying the need for EBP, what PPE to be worn or when. During an interview on 6/14/24 at 8:36 A.M. Certified Nurse Aide (CNA) B said the following: -The three compartment containers in the hall way were for extra PPE in case staff need it; -He/She did not know what EBP meant. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/24 at 9:30 A.M. CNA F said he/she does not wear any PPE when giving care to the residents on the hall and was not aware what EBP meant. During an interview on 6/14/24 at 8:45 A.M. Certified Medication Technician (CMT) E said the following: -He/She does not wear any PPE when giving medication to the residents (including residents with catheters, feeding tubes or wounds); -He/She did not know what EBP meant. During an interview on 6/14/24 at 12:15 P.M. the Assistant Director of Nurses C said the following: -EBP meant gowns and gloves should be worn when caring for residents who have indwelling catheters and feeding tubes; -He/She was unaware of any facility policy regarding EBP; -He/She was not aware of guidance regarding EBP, only that PPE should be worn when providing direct resident contact or that a resident can come out of their room while on EBP. During an interview on 6/14/24 at 2:00 P.M. the Director of Nursing said: -The facility did not have a policy for EBP, their contact isolation covered this; -Staff should adhere to the facility policy for infection control. MO236465

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 34003 Based on observation and interview, the facility failed to maintain an effective pest control program to control the presence of rodents in the kitchen. The facility census was 117. Review of the facility's undated policy for Pest Control showed the following: -Our facility shall maintain an effective pest control program; -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents; -Garbage and trash are not permitted to accumulate and are removed from the facility daily. 1. Observation on 7/23/24 at 2:14 P.M., in the main kitchen showed the following: -A stainless steel preparation table in the kitchen in front of the steam table with numerous black pellets that resembled rodent feces on the bottom rack of the table. Staff used the table to store and prepare food; -Behind the table on the floor there was a copious amount of rodent feces among packets of condiments and food particles; -A cart that contained covers for plates was dirty with food particles and rodent feces noted on the cart; -French fries and food particles under the main steam table with a copious amount of rodent feces; -A large trash can with rodent feces around the trash can; -Under the stove there were food particles and rodent feces; -Rodent feces under the beverage dispenser; -Packets of butter on the floor behind the refrigerator; -Potatoes on the floor by the stand that held utensils. During an interview on 7/23/24 at 2:15 P.M., the Dietary Manager (DM) said the following: -She has been at the facility for several months and there has been a problem with mice in the kitchen since she has been there; -She has reported the problem to the Administrator and the Maintenance Director; -There has been a shortage of staff in the kitchen and they were trying to keep things clean; (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Kitchen staff should sweep and mop and keep the kitchen clean. During an interview on 7/23/24 at 2:30 P.M., the Maintenance Director said the following: -He was aware of the rodent problem in the kitchen; -The pest control company had been out numerous times to place glue traps and spray outside; -They had been treating off and on and the mice kept coming in; -The past three weeks, the mice had been really bad. He contacted the pest control company and they placed more traps; -The kitchen was dirty and needed to be kept clean to help prevent mice from keep coming in; -He has told the DM the kitchen floors needed to be kept clean and food picked up to prevent the mice from coming in the kitchen. During an interview on 7/24/24 at 10:00 A.M., the Registered Dietician said the following: -She was aware of the mice problem in the kitchen for some time; -She completes a kitchen inspection at least monthly and has indicated in her reports the kitchen was dirty and mouse droppings (feces) were present; -Her reports were shared with the administrator, Director of Nursing, nurse manager and the DM. During an interview on 7/30/24 at 9:10 A.M., the Administrator said the following: -Mice have been a problem for months, there was construction around the facility and the mice kept coming in; -They have been treating the problem. During an interview on 7/25/24 at 9:27 A.M., the Medical Director said the following: -She would expect the kitchen to be and remain clean to prevent rodents; -The kitchen should be cleaned after every meal and at the end of the day. MO238155