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	12/19/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observations, record review, interviews, and facility policy review, the facility failed to provide a dignified dining experience for three of 20 residents (Resident (R) 68, R98, and R88) who resided on the memory care unit by standing to assist to feed R68 and R98; by failing to obtain an alternate meal in a timely manner for R88 when she refused what was served; and by failing to provide continuous dining service for one resident (R102) on the long term care unit of 30 sample residents. This failure had the potential to affect resident dignified dining experiences. Findings include: Review of the facility's policy titled Assistance with Meals, dated 03/22, revealed Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals; b. keeping interactions with other staff to a minimum while assisting residents with meals; c. avoiding the use of labels when referring to residents (e.g., 'feeders); and d. avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident. 1. Review of R68's Admission Record located under the Profile tab in the electronic medical record (EMR) noted the resident was initially admitted on [DATE] with diagnoses that included dementia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated R68 was severely cognitively impaired. R68 was identified to require assistance with eating. During an observation on 12/16/24 at 12:53 PM, a Certified Nurse Aide (CNA) 5, was observed standing next to R68 while assisting to feed him lunch. During an interview on 12/16/24 at 1:00 PM, CNA5 stated, I know I should sit, I'm just ready to jump when someone needs something. During an observation on 12/18/24 at 12:23 PM, the MDS Coordinator (MDSC) was observed standing next to R68 while assisting to feed her lunch. When CNA6 told the MDSC to get a chair to sit next to R68, the MDSC stated, No, I'm good right here. During an observation on 12/18/24 at 12:30 PM when the MDSC left to pass a tray to another resident, a Certified Medication Technician (CMT) 1 stood next to R68 to continue feeding her lunch. CMT1 was asked why she was standing to assist R68 and stated, I don't know. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R98's Admission Record located under the Profile tab in the EMR noted the resident was admitted on [DATE] with diagnoses that included Alzheimer's disease. Review of the admission MDS with an ARD of 10/18/24 revealed a BIMS score of zero out of 15 which indicated R98 was severely cognitively impaired. R98 was identified to require assistance with eating. During an observation on 12/18/24 at 7:59 AM, CMT2 was observed standing next to R98 at the dining table, twice offered a spoonful of breakfast to the resident, before moving to assist another resident at another table. When asked why she was standing, CMT2 said Oh, I need to sit, I just can't stay in one place. 3. Review of R88's Admission Record located under the Profile tab in the EMR noted the resident was admitted on [DATE] with diagnoses that included dementia. Review of the annual MDS with an ARD of 08/23/24 revealed a BIMS score of three out of 15 which indicated R88 was severely cognitively impaired. Continuous observation of R88 on 12/16/24 revealed at 12:38 PM, R88 was served lunch, a fish fillet, potatoes, and bread. The resident pushed her plate away stating, I don't want that. An alternative meal was not offered. At 12:54 PM, R88 was given a bowl of pears which she immediately started eating. R88 was observed to shrug her shoulders as she looked around the dining room at the other residents eating. The resident was then asked if she wanted something else to eat. At 1:21 PM, a Dietary Aide (DA) 1, who had been cleaning the tables, was identified as going to get it [grilled cheese]. R88 received a grilled cheese sandwich at 1:26 PM, 48 minutes after stating she did not want the lunch that was served. R88 was observed to eat once the grilled cheese sandwich was provided. During an interview on 12/16/24 at 1:35 PM, the Licensed Practical Nurse (LPN) 2 said she did not realize the length of time before the resident received the sandwich stating, We were just trying to get everyone served and help them eat before getting the sandwich. During an interview on 12/19/24 at 4:33 PM, the Director of Nurses (DON) confirmed that the staff should have been seated to assist the residents with their meals. The DON said, They could have called the kitchen to send a sandwich. 4. Observation of the main dining room on 12/16/24 at 11:45 AM revealed four residents seated at the second table closest to the lobby area, all had their drinks. One resident received a meal at 12:04 PM, a second resident received a meal at 12:06 PM. The third resident received their plate at 12:13 PM and the fourth resident received a meal at 12:20 PM. During an interview on 12/16/24 at 12:21 PM with the fourth resident (R102) regarding waiting while the others at the table were eating started, It made me feel unloved. Review of R102's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included spinal stenosis, type II diabetes, and chronic kidney disease. Review of R102's admission MDS with an ARD of 12/01/24 revealed a BIMS score of 13 out of 15 which indicated R102 had intact cognition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/24 at 4:43 PM regarding one person watching others eat at the same dining table, the DON stated an expectation that all at a table should all be served so they could eat at the same time. In a follow up interview on 12/19/24 at 5:03 PM, the DON stated the facility did not have a policy that addressed residents at the same table eating at the same time. 28154

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and facility policy review, the facility failed to ensure three of three residents (Resident (R) 6, R16, and R54) reviewed for discharge to the hospital were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, and other information regarding the transfer, out of 30 sample residents. This failure has the potential to affect the residents by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of the facility's policy titled, Transfer or Discharge, Facility-Initiated, reviewed October 2022, revealed: Policy Statement. Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy .Notice of Transfer or Discharge (Emergent or Therapeutic Leave). 3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge .c. An immediate transfer or discharge is required by the resident's urgent medical needs .4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). 1. Review of R6's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included cerebral infarction, dysphagia, type II diabetes, acute respiratory failure, atrial fibrillation, anemia, and atelectasis (partial or total lung collapse). Review of R6's EMR Progress Notes tab showed on 09/15/24 at 9:13 PM a note regarding R6 transferred to the hospital for a change in a feeding tube's position with associated vomiting. A follow-up note on 09/16/24 at 10:39 AM showed that Social Services called R6's representative to discuss the Emergency Transfer Form and that the form would be mailed out. There was no documentation of the form being mailed on a certain date or to whom. Review of R6's Emergency Transfer Notice, provided by the facility, revealed a date of 09/16/24 regarding [R6's name] showed the letter was to serve as the transfer notice due to your need for urgent medical care. The form did not state who was receiving the document and did not note where R6 was being transferred to or the specific reason for the transfer. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/19/24 at 1:55 PM regarding the emergent transfer process, Licensed Practical Nurse (LPN) 4 stated, I would call the doctor and let them know [condition], get an order [to transfer], call 911, and get the paperwork ready. When asked what paperwork, LPN4 clarified a face sheet, orders, the discharge form which says why they are going out. When asked if that was for the resident, LPN4 responded, It's for the hospital. I notify the family, contact the first person or POA [Power of Attorney] from the face sheet. Then I call the hospital and give them a report. When queried if anything was given to the resident, family, and/or representative, LPN4 stated, Maybe like a bed hold policy, I think that's in the transfer form. When asked for a copy of the transfer form LPN4 referred to, a sample was printed from the EMR and was titled E-Interact SNF [Skilled Nursing Facility] to Hospital that included resident health and resident capabilities information for the hospital. LPN4 confirmed that it did not go to the resident or resident representative (RR). During an interview on 12/19/24 at 3:33 PM regarding emergent notices, the Director of Nursing (DON) stated Social Work always puts a note in [the EMR] on it. My expectation is that the resident and representative get it [written notice of transfer per policy]. At 3:39 PM, the DON affirmed that the notice should have a specific reason for transfer and to where the resident was being transferred. During an interview on 12/19/24 at 5:47 PM regarding evidence of mailing of the written notice of transfer for R6, the Social Worker (SW) stated, No, there is no documentation. We normally mail it out the same day we call and talk to them about the transfer notice. When queried if the social services office was staffed seven days a week, SW responded negatively. When posed the situation if a resident was transferred out late Friday night when the transfer notice would be provided, SW stated It would be on Monday. 2. Review of R16's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/21/24, located in the MDS tab of the EMR, revealed an admitted [DATE] and a Brief Interview for Mental Status (BIMS) of five out of 15, indicating R16 was severely cognitively impaired, and had diagnoses of urinary tract infection (UTI) with renal and ureteral calculous obstruction. Review of R16's Care Plan, dated 11/18/24 and located in the EMR under the Care Plan tab, revealed Resident is at risk for impaired complications related to E Coli urinary tract infection and right-side kidney stones with ureter stent placement. Review of R16's 72-hour Charting note, dated 11/11/24 and located in the EMR under the Progress Note tab, revealed Resident was in room slumped over in chair and hard to respond. Resident's temp was 98. 9-116/88-90%-110. Resident would not open his eyes. Call placed to sister, and she would like her sent out [Hospital Name]. Call placed to [Doctor Name] and message left. Ambulance called and resident was picked up and taken to [Hospital]. Review of R16's Social Service Note, dated 11/12/24 and located in the EMR under the Progress Note tab, revealed admitted to hospital with dx; UTI, and Sepsis. Review of R16's facility- initiated Emergency Transfer Notice, dated 11/12/24 and located in the EMR under the Document tab, did not include the date of the transfer, the reason for the transfer, the location of the transfer, or a statement and explanation of the appeals process. The notice included You can receive more information on the appeal process from the State Long Term Care Ombudsman program. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/19/24 at 2:00 PM when asked what she did when sending a resident out to the hospital. LPN1 stated, I send the face sheet and MD [Medical Doctor] orders with the ambulance people, I call the family, I call the Hospital and give report. When asked if she filled out a transfer form to send to the representative. LPN1 stated, No, I don't do that. During an interview on 12/19/24 at 2:15 PM, when asked what she did when a resident was sent out to the hospital. The Social Services Director (SSD) stated, I call the family and fill out an emergency transfer form and mail it to them. If the family doesn't know the resident diagnosis, we call and find out. When asked if she included the reason for resident transferring to the hospital and which hospital they went to. The SSD stated, No, we don't. 3. Review of R54's quarterly MDS with an ARD date of 11/21/24, located in the MDS tab of the EMR, revealed an admitted [DATE] and had a BIMS of 15 out of 15, indicating R54 was cognitively intact, and had diagnoses of heart failure, unspecified atrial fibrillation, and coronary artery disease. Review of R54's Care Plan, dated 11/22/24, located in the EMR under the Care Plan tab, revealed Cardiac: At risk for impaired cardiac function and complications related to atrial fibrillation, congestive heart failure (CHF), coronary artery disease (CAD), Diabetes. Review of R54's 72-hour Charting note, dated 10/20/24, located in the EMR under the Progress Note tab, revealed Patient complain chest pain and pulse running slow. Charge nurse assess patient took bp [blood pressure] it was 178/91 hr [hour] 61. Charge nurse called DON and reported patient findings. Called ems [emergency medical service] and sent patient out. EMS came and assess patient. Perform ekg [electrocardiogram]. ekg readings find bundle branch block. Patient was sent to [name] hospital. reported all too DON wctm [will continue to monitor]. During an interview on 12/18/24 at 1:25 PM, R54 was asked if she remembered receiving a transfer notice in writing when she went to the hospital on 10/20/24. R54 stated she did not receive a written notice but thought the facility called her daughter on the telephone. Review of R54's Social Service Note, dated 10/21/24 and located in the EMR under the Progress Note tab, revealed SW [social worker] spoke with residents [family member] and reviewed the emergency transfer/bed hold notice. [Family member] anticipates resident to return to the facility when discharged from the hospital- Resident was admitted to hospital with heart concerns- per [family member] hospital has ran several test, and haven't found any concerns. Emergency Transfer form mailed to [family member]. Ombudsman made aware of the discharge. SW will remain involved. Review of R54's facility- initiated Emergency Transfer Notice, dated 10/21/24 and located in the EMR under the Document tab, did not include the date of the transfer, the reason for the transfer, the location of the transfer, or a statement and explanation of the appeals process. The notice only included You can receive more information on the appeal process from the State Long Term Care Ombudsman program. During an interview on 12/18/24 at 10:47 AM, the SW was asked why R54's transfer notice, dated 10/21/24, didn't include the date of the transfer, the reason for the transfer, the location of the transfer, or a statement and explanation of the appeals process. The SW stated she was new to the facility and didn't know but would find out. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During a follow-up interview on 12/18/24 at 11:27 AM, the SW confirmed the transfer notice lacked some of the required information. SW stated she recognized the notice didn't include all the information compared to the notices from the facility she used to work at. 36190 39857

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and review of facility policy, the facility failed to ensure one of three residents (Resident (R) 6) reviewed for facility initiated emergent transfer to the hospital and/or their Resident Representative (RR) received a written bed hold notice that included all required information of 30 sample residents. This failure had the potential to contribute to possible denial of re-admission and loss of the residents' home following a hospitalization for residents transferred to the hospital. Findings include: Review of the facility's policy titled, Bed Holds and Returns, reviewed October 2022, revealed: Policy Interpretation and Implementation. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice I: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). 2. Reissuance of notice 1 must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued. 3. Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff were unable to reach and notify the representative timely. 4. The written bed-hold notices provided to the residents/representatives explain in detail: a. the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; b. the reserve bed payment policy as indicated by the state plan (for Medicaid residents); c. the facility policy regarding bed-hold periods; d. the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and e. the facility return policy . Review of R6's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included cerebral infarction, dysphagia, type II diabetes, acute respiratory failure, atrial fibrillation, anemia, and atelectasis (partial or total lung collapse). Review of R6's Emergency Transfer Notice provided by the facility revealed a date of 09/16/24 regarding [R6's name] and showed a section that stated what the facility bed hold policy was, but did not include any information regarding the financial commitment (e.g. daily cost) the resident or RR would be incurring if a bed hold was requested. Review of R6's EMR Progress Notes tab, showed on 09/15/24 at 9:13 PM, a note regarding R6 transferred to the hospital for a change in a feeding tube's position with associated vomiting. A follow-up note on 09/16/24 at 10:39 AM showed that Social Services called R6's representative to discuss the Emergency Transfer Form (which included the bed hold notice) and that the form would be mailed out. There was no documentation of the form being mailed on a certain date or to whom. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/19/24 at 1:55 PM regarding the emergent transfer process, Licensed Practical Nurse (LPN) 4 stated, I would call the doctor and let them know [condition], get an order [to transfer], call 911, and get the paperwork ready. When asked what paperwork, LPN4 clarified a face sheet, orders, the discharge form which says why they are going out. When asked if that was for the resident, LPN4 responded, It's for the hospital. I notify the family, contact the first person or POA [Power of Attorney] from the face sheet. Then I call the hospital and give them a report. When queried if anything was given to the resident, family, and/or representative, LPN4 stated, Maybe like a bed hold policy, I think that's in the transfer form. When asked for a copy of what transfer form LPN4 referred to, a sample was printed from the EMR and was an E-Interact SNF [Skilled Nursing Facility] to Hospital form that included patient health and capability information for the hospital. No bed hold information was included. During an interview on 12/19/24 at 3:33 PM regarding emergent transfer bed hold notices, the Director of Nursing (DON) confirmed the form did not state the debt to be incurred if a bed hold was requested and that she had an expectation that it would include the cost for informed consent. During an interview on 12/19/24 at 5:47 PM regarding evidence of mailing of the written notice of transfer, which included the bed hold notice for R6, the Social Worker (SW) stated, No, there is no documentation. We normally mail it out the same day we call and talk to them about the transfer notice. When queried if the social services office was staffed seven days a week, SW responded negatively. The situation was posed that a resident transfers out late Friday night when the bed hold notice would be provided, SW stated It would be on Monday.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 28154 Based on record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a discharge return anticipated (DCRA) Minimum Data Set (MDS) assessment was submitted timely for processing for one of one resident (Resident (R) 6) reviewed out of 30 sample residents. This failure had the potential to adversely affect care planning and care provision or payment to other facilities for any resident that may not have had a discharge assessment transmitted. Findings include: Review of the facility's policy titled, MDS Completion and Submission Timeframes, reviewed July 2017, revealed Policy Statement. Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation. 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Review of the October 2023 Resident Assessment Instrument (RAI) Manual, located at https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, page 2-19, chart showed the DCRA assessment should be transmitted by the MDS Completion Date + (plus) 14 calendar days. Review of R6's electronic medical record (EMR) MDS tab showed a DCRA MDS with an Assessment Reference Date (ARD) of 09/15/24 with a completed status not an accepted status. Review of the history tab for the assessment showed Assessment was never added to a batch. During an interview on 12/17/24 at 4:21 PM regarding the completed status and history of not added to a batch, the MDS Coordinator (MDSC) confirmed the unsubmitted status stating, I own that. It was not submitted.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and facility policy review, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and plans for two of six residents (Resident (R) 61 and R94) reviewed for psychoactive medication use of 30 sample residents. This failure had the potential to affect the ability for a physician to prescribe the lowest possible effective dose of psychoactive medications. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed: Policy Statement. A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation .7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes . 1. Review of R61's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included dementia, insomnia, and depression. Review of R61's EMR Orders tab an order for quetiapine (an atypical antipsychotic medication) 12.5 milligrams (mg) on 11/25/24 at bedtime for antipsychotic/antimanic agent but without a diagnosis. Review of R61's EMR Orders tab revealed R61 was also prescribed: -Trazodone 50 mg at bedtime for depression ordered 11/15/24, and -Bupropion 300 mg extended release (an antidepressant medication) ordered 11/16/24 daily for depression. Review of R61's Care Plan from the EMR Care Plan tab on 12/17/24 at 2:33 PM showed a focus of [R61's name] is on antipsychotic medications initiated 12/17/24. There were no care plan goals or interventions for the antipsychotic medication care plan. Further review of the Care Plan from the EMR Care Plan tab, revealed a focus of: Mood (Resident Mood Interview): I am at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to: feeling down, depressed, or hopeless, feeling tired or having little energy, trouble concentrating on things, such as reading the newspaper or watching television, trouble falling asleep, or sleeping too much. and I have a DX [diagnosis] of depression and I am on medications for altered mood. Both had an initiation date of 11/17/24. Neither of the care plans identified the target behavior being monitored for the three psychoactive medications that included a measurable goal (e.g., a baseline occurrence of the behavior with a goal for the next quarter). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R94's Admission Record, from the EMR Profile tab, showed a facility admitted [DATE] with medical diagnoses that included dementia, insomnia, and depression. Review of R94's EMR Orders tab showed prescribed psychoactive medications of -Ambien 10 mg (generic name zolpidem, a hypnotic medication) at bedtime for insomnia 09/06/24. -Lorazepam Intensol Oral Concentrate (an anxiolytic medication) 2 mg/ml (milligram/ milliliter) give 0.25 ml in the afternoon for increased agitation ordered 11/19/24. -Lorazepam Oral Concentrate 2 mg/ml give 0.5 ml every 4 hours as needed for anxiety. Ordered 11/21/24 with stop date stop 01/21/25. -Mirtazapine 15 mg (an antidepressant) at bedtime for depression/ sleep ordered 09/06/24. -Modafinil 100 mg (a stimulant medication) once daily for narcolepsy, sleep apnea, and shift work sleep disorder 09/06/24. -Prozac 60 mg (generic name fluoxetine, an antidepressant medication) once daily for depression ordered 09/06/24. -Trazodone 50 mg (an antidepressant medication) at bedtime for insomnia ordered 10/29/24. -Trazodone 25 mg twice daily for anxiety/depression ordered 11/15/24. -Vraylar 3 mg (generic name cariprazine, an atypical antipsychotic medication) once daily for behavior disorders in older adults with dementia ordered 09/06/24. Review of R94's EMR Care Plan tab showed a focus of: Medication - Hypnotic: Resident requires hypnotic medication related to insomnia. Date Initiated: 11/26/24. Goal: Will have improved sleep as evidenced by 6-8 hours per night after intervention. Date Initiated: 11/26/24. No sleep monitoring was found in R94's EMR to show a baseline of hours of sleep prior to use or current hours of sleep to monitor if goal was met. Further review of the Care Plan from the EMR Care Plan tab, revealed Focus: Medication- Antipsychotic: Resident requires antipsychotic medication related to bipolar disorder. Date Initiated: 11/26/24. Revision on: 11/26/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Will exhibit a therapeutic effect related to the use of the medication. Date Initiated: 11/26/24. No baseline of the therapeutic effect was established to enable the goal to be measurable. During an interview on 12/19/24 at 3:33 PM regarding measurable goals for psychoactive medications, the Director of Nursing (DON) stated, No, they wouldn't be because there is no shift documentation to be able to say there is a decrease or a baseline.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interview, and record review, the facility failed to provide toileting assistance when requested, which created the potential for discomfort and distress to one of 20 residents (Resident (R) 47) and failed to ensure an order was in place for catheters for one of four residents (R70) reviewed for catheters of 30 sample residents. This failure had the potential to cause discomfort and reoccurring urinary tract infections or other complications. Findings include: Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, dated 03/18, revealed 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 . elimination (toileting). Review of the facility's policy titled, Medication and Treatment Orders, dated 06/16, provided by the facility, revealed Orders for medications and treatments will be consistent with principles of safe and effective order writing . 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. 1. Review of R47's Admission Record located under the Profile tab in the electronic medical record (EMR), noted R47 was initially admitted on [DATE] with diagnoses that included dementia and Alzheimer's disease with late onset. Review of the quarterly Minimum Data Set (MDS) located under the Resident Assessment Instrument (RAI) tab in the EMR, with an Assessment Reference Date (ARD) of 10/24/24 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R47 was severely cognitively impaired. The MDS noted R47 required maximum assistance with toileting. During an observation on 12/16/24 at 12:56 PM, R47 was observed to wave at staff stating, I have to go to the bathroom. No one was observed to address the resident. At 1:07 PM, the resident was observed to be crying and again asked to go to the bathroom. At 1:08 PM, R47 was observed to state, ooh, ooh, bathroom. At 1:11 PM, the resident stated, I really have to go. R47 was observed crying and with a distressed look on her face. The resident then put her head into her hand and said, I need that lady. The Licensed Practical Nurse (LPN) 2 spoke to the resident stating, I'm sorry, you have to wait, they're helping others right now. At 1:15 PM Certified Nurse Aide (CNA) 6 stated, I'm back, and assisted R47 to the bathroom, 19 minutes after her request. R47 stated to CNA6, Oh, thank you. During an interview on 12/16/24 at 1:36 PM, LPN2 stated, We are doing the best we can, it's a little difficult when the CNAs are assisting others. There's only three of us and we're running. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R70s quarterly MDS with an ARD date of 11/13/24, located in the MDS tab of the EMR, revealed an admitted [DATE] and a BIMS score of 10 out of 15, which indicated R70's had moderately impaired cognition, indwelling catheter was not checked, and had diagnoses of cancer, urinary tract infection (last 30 days), and wedge compression fracture of the first lumbar vertebra, during a subsequent encounter for routine healing. Review of R70's Care Plan, revised 12/18/24 and located in the EMR under the Care Plan tab, revealed Renal/Urinary: Resident is at risk for complications with the renal/urinary system related to foley catheter for urinary retention and HX [history] of prostate CA [cancer] s/p [status post] treatment. An intervention included . Foley catheter care q [every] shift and PRN [as needed]. During an observation on 12/16/24 at 2:26 PM, R70 was in bed dressed, groomed, and a catheter bag hanging from the bed frame with a privacy cover. Review of R70's Daily Skilled Charting Form, dated 12/17/24 and 12/18/24, located in the EMR under the Evaluation tab, revealed under the Renal section a. Indwelling Catheter and Catheter Care Provided was blank and Not Applicable was checked. Review of R70's Orders and the December 2024 Treatment Administration Record (TAR) located in the EMR under the Order tab revealed no orders for an indwelling catheter or for catheter care. During an observation and interview on 12/17/24 at 2:48 PM, R70 was asleep in bed with a catheter bag hanging from the bed frame. CNA1 was standing outside R70's door. CNA1 was asked if R70 had a catheter and CNA1 said, Yes. CNA1 was asked if she provided R70 catheter care. CNA1 stated it was not her, but it was provided on another shift. During an observation on 12/18/24 at 7:58 AM, R70 was in his wheelchair in the dining room dressed and groomed. R70 had a catheter bag hanging under his wheelchair with a privacy cover and the tubing touched the floor. During an interview on 12/18/24 at 8:49 AM, LPN1 was asked if R70 had an indwelling catheter. LPN1 stated, Yes, LPN1 was asked if R70 had orders for the indwelling catheter. LPN1 stated, He should have. LPN1 checked the EMR and confirmed there were no orders. LPN1 stated, [R70] came from rehabilitation but the orders should have been in. LPN1 was asked who performed catheter care and LPN1 stated, the CNAs. LPN1 was asked where the CNA documentation was for catheter care. LPN1 stated she didn't know. During an interview on 12/18/24 at 9:19 AM, the Director of Nursing (DON) was asked if R70 had an indwelling catheter. The DON stated, Yes, and it was due to cancer of the prostate. The DON was asked should there be orders for R70's indwelling catheter and the DON stated, Yes. The DON was asked why there weren't any orders. The DON stated the orders came from urology and it was a staff oversight in not putting them in the EMR. The DON was asked how it could be confirmed if catheter care was performed. The DON stated it would be under the Treatment Administration Record for the nurses to document but if there were no orders, so it would not populate. The DON was asked what her expectations were for R70's catheter orders. The DON stated, to have all catheter orders in place that included French and balloon size, catheter care, and flushes. 36190

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F 0692 Level of Harm - Minimal harm or potential for 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** 36190 Based on observation, record review, interview, and facility policy review, the facility failed to implement weight loss interventions and/or provide meal encouragement for one of eight residents (Resident (R) 95) reviewed for nutrition of 30 sample residents. This had the potential to cause further weight loss. Findings include: Review of the facility's policy titled, Nutrition (Impaired)/Unplanned Weight Loss, revised 09/12, provided by the facility, revealed 1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. 1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). Review of the facility's policy titled, Nutrition (Impaired)/Unplanned Weight Loss, revised 02/22, provided by the facility, revealed 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% [percent] weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe . Review of R95's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/08/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE] and a Brief Interview for Mental Status (BIMS) of three out of 15, indicating R95 was severely cognitively impaired, and had diagnoses of malnutrition, Alzheimer's disease, and primary open-angle glaucoma in both eyes in an indeterminate stage. Review of R95's Order, dated 09/26/24, located in the EMR under the Order tab, revealed Fortified, Regular diet, Mechanical Soft with chopped meat texture, Thin Liquids consistency, Gravy/sauce on chopped meat, Chocolate milk with meals d/t [due to] Alzheimer's Disease. Review of R95's Care Plan, located in the EMR under the Care Plan tab, revealed no care plan for diet or nutrition. Review of R95's Nutrition Narrative Note, dated 10/10/24 and located in the EMR under the Progress Note tab, revealed Significant weight loss nutrition note. weight: 128.2# [pounds] 10/8/24, -8.6% in 1 month. Recent readmission after hospitalization from ,d+[DATE]-[DATE] for DVTs [Deep Vein Thrombosis]. Diet: mechanical soft with fortified foods Feeds self in Memory care Dining Room; however needs setup assistance and encouragement/cues/prompts. Resident has had poor appetite and consumption. Diet downgraded to mechanical soft as recommended. Receiving fortified foods with meals and encouraged to drink chocolate milk with meals and will add to high calorie snack list to help increase nutritional intake . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R95's Dietary Note, dated 11/26/24 and located in the EMR under the Progress Note tab, revealed Weight (11/19)-129.4 lbs, [pounds] BMI [body mass index]-20.3. Significant weight loss-10.8 lbs x 9/5(7.7%). Weight showing overall stability around 130 lbs since 9/24. Receiving fortified, mechanical soft diet with chopped meat. Gravy/sauce on chopped meat. Chocolate milk with meals for nutrition support. Intakes recently 50-100% at meals with cueing/assistance as needed. Eats in memory care DR [dining room]. Dx [diagnosis] of moderate protein calorie malnutrition. Continues to be at increased nutrition risk related to Alzheimer's disease progression. Continue to monitor, encourage intakes as needed, provide alternatives as indicated, and provide snacks as desired. Interventions in place. RD [Registered Dietitian] to f/u [follow up] PRN [as needed]. Review of R95's weight history located in the EMR under the Weight/Vital tab, revealed R95 had lost 9% of his body weight in three months. This included: -09/05/24 at 140.2 Lbs. -10/04/24 at 130.8 Lbs. -12/05/24 at 127.2 Lbs. Review of R95's Nutrition Narrative Note, dated 12/10/24 and located in the EMR under the Progress Note tab, revealed weight status Weight (12/5)-127.2 lbs, BMI -19.9. Significant weight loss-12.4 lbs x 3 months (8.9%). Weight overall stable since 10/8. Diet: mechanical soft, chopped meat with fortified foods Feeds self in Memory care Dining Room; however needs setup assistance and encouragement/cues/prompts. Hx [history] of decreased intakes, but recent documentation 50-100%. Receiving chocolate milk with meals and is also on the high calorie snack list for added nutrition support. Dx [diagnosis] of moderate protein calorie malnutrition. Multiple interventions in place to aid in weight maintenance. At increased risk for decline with Alzheimer's disease progression. Continue to monitor, encourage intakes as needed, provide alternatives as indicated, and provide snacks as desired. RD to monitor and f/u PRN. Review of R95's Nutritional Risk Review, dated 12/10/24 and located in the EMR under the Evaluation tab, revealed Significant Weight Changes: a. > [greater than] or = [equal to] 5% within 30 days, Encourage at meals; offer snacks as desired. During an observation on 12/17/24 at 9:35 AM, R95 was in his/her wheelchair in the back dining room with a full plate of food in front of him/her. The resident's breakfast included ground sausage, scrambled eggs, cut up waffles, juice, and coffee. The only item consumed was juice. No chocolate milk or fortified items were provided and R95 did not receive encouragement to consume his/her meal. At 9:44 AM, Dietary Aide (DA) 1 picked up R95's plate. R95's intake was poor. During an observation on 12/17/24 at 12:41 PM, R95 was feeding him/her in the back dining room. R95 was served shredded pork, mashed potatoes with gravy, fruit, green beans, a roll, two glasses of water, and ice cream. No chocolate milk was provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/17/24 at 1:04 PM, the Respiratory Therapist (RT) asked R95 if he had finished eating. The RT then removed R95's full plate of food and placed it on top of the meal cart, only leaving the resident the ice cream. R95's intake was poor. The RT was asked if the plate she just placed on the cart was R95's and she stated she didn't know and was she supposed to know. The RT was asked how much did R95 eat and did she record the amount consumed. R95 said she didn't know as she doesn't normally help in the dining room. No meal assistance or encouragement was provided. During an observation on 12/18/24 at 8:14 AM, R95 sat in hi/hers wheelchair in the back dining room for breakfast. R95 was served scrambled eggs, ground bacon, two mini muffins, oatmeal, juice, and water. No chocolate milk was provided. R95's meal ticket revealed R95 was to be served chocolate milk. During an observation and interview on 12/18/24 at 8:15 AM, the beverage cart was observed with a gallon of chocolate milk on the bottom shelf. Certified Nurse Aide (CNA) 2 was asked who put the beverages on resident's trays. CNA2 stated they did. CNA2 was asked if she was aware of any resident requiring chocolate milk as part of their diet order. CNA2 stated, No. During an interview on 12/18/24 at 8:37 AM, CNA4 was asked if R95 received chocolate milk with his breakfast meal. CNA4 confirmed that R95 did not receive chocolate milk. R95 was not provided with chocolate milk. During an interview on 12/18/24 at 8:40 AM, the Activity Director (AD) was asked to review R95's meal ticket. The AD confirmed the ticket and instructed staff to provide chocolate milk which was not provided. The AD then provided a glass of chocolate milk and R95 drank it. During an interview on 12/18/24 at 9:22 AM, the Director of Nursing (DON) was asked if she was aware of R95 significant weight loss. The DON stated she was aware. The DON was asked how she became aware. The DON stated the RD reviewed the weights and kept her posted weekly. The DON was asked what interventions were in place for R95. The DON stated R95 was prescribed a fortified regular texture diet, but the RD did not have any new recommendations on 11/26/24. The DON was asked if R95 should receive chocolate milk at meals. The DON stated, Yes, and confirmed it was in his diet order. The DON was asked who provided the chocolate milk on R95's tray. The DON stated the staff did after reading the meal ticket. The DON was asked why chocolate milk was not provided on several meals if staff were to read the meal ticket. The DON stated she was not sure because the milk was provided on every unit. The DON was asked if R95 needed encouragement to eat. The DON stated, as needed, if he's sleeping in front of his food or not taking bites and drinks on his own. The DON was asked why he did not receive encouragement to eat for two meals when his intake was poor. The DON stated she was not sure, but all residents should get encouragement, they have good and bad days and on some days they should step in and give encouragement. The DON was asked what R95's fortified diet included. The DON stated gravy with potatoes and meat and at breakfast it would be cereal. During an interview on 12/18/24 at 11:33 AM, the Dietary Manager (DM) was asked about R95's fortified diet. The DM stated R95's fortified diet would include the soup at lunch and oatmeal at breakfast. The fortified soup was observed on the tray line. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/18/24 at 12:39 PM, R95 sat in his/her wheelchair and staff served his/her lunch in the back dining room. R95's lunch included fish, peas, potatoes, roll, and water. No fortified soup or chocolate milk was provided per his meal ticket. R95 ate well. During an interview on 12/18/24 at 12:45 PM, CNA3 was asked if R95 received the fortified soup or chocolate milk. CNA3 stated, No, if it's not on the cart they don't give it and pointed to the cart. The cart was observed with no soup or chocolate milk. During a follow up interview on 12/18/24 at 2:55 PM, the DON was informed R95 didn't receive the fortified soup and chocolate milk at lunch. The DON confirmed that R95 needed extra calories, and she stated she had just talked to the CNA to ensure R95 got the fortified soup. During a telephone interview on 12/19/24 at 11:06 AM, the RD was asked if she was aware R95 had lost nine percent of his weight in three months. The RD stated she had only been at the facility since last month, but, Yes and she referenced her 12/24 notes. The RD was asked what interventions were in place. The RD stated R95 had been prescribed a fortified diet and chocolate milk with meals. The RD was asked if she was aware the fortified and/or chocolate milk weren't provided for three meals and when he ate poorly, he did not receive encouragement. The RD stated, not that she knows of. The RD stated if R95 wasn't eating well, he should be offered another option. During an interview on 12/19/24 at 3:40 PM, the DON was asked what her expectation was for her staff in carrying out R95's weight loss interventions. The DON stated that [R95] receives his/her nutrition and interventions at meals.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on interview, record review, and facility policy review, the facility failed to ensure there were documented indications for use of and that psychotropic medication efficacy was monitored for two of six residents (Resident (R) 61 and R94) reviewed for unnecessary medications or antipsychotic medication use of 30 sample residents. This failure had the potential to affect the ability for a physician to prescribe the lowest possible effective dose of medication. Findings include: Review of the facility's policy titled, Psychotropic Medication Use, revised July 2022, revealed: Policy Interpretation and Implementation. 1. A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics .Psychotropic medication management includes a. indications for use; .d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences. 4. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record .7. Categories of medications which affect brain activity such as antihistamines, anti-cholinergic medications, and central nervous system medications that are prescribed as a substitute for or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications. 1. Review of R61's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included dementia, hypertension, and insomnia. Review of R61's EMR Orders tab an order for quetiapine (an atypical antipsychotic medication) 12.5 milligrams (mg) on 11/25/24 at bedtime for antipsychotic/antimanic agent but without a diagnosis. Review of the EMR Progress Notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), or Medical Diagnosis did not show documented behaviors or medical diagnosis for the quetiapine. Review of R61's Order Summary from the EMR Orders tab revealed R61 was also prescribed: -Trazodone 50 mg at bedtime for depression, ordered 11/15/24 and -Bupropion 300 mg extended release daily for depression, ordered 11/15/24. During an interview on 12/19/24 at 2:18 PM, regarding the request for indications for use for the antipsychotic medication for R61, the Assistant Director of Nursing (ADON) 2 stated I was told it was because she was having some yelling at night. When asked if the behavior of nighttime yelling was documented anywhere, ADON2 stated No, that's just what I was told. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Orders tab showed an order to monitor R61 for antidepressant medication side effects, but no orders to monitor the psychoactive medications for efficacy. Further review of R61's EMR MAR, TAR, and Progress Notes, revealed no monitoring of target symptoms for the efficacy of the antidepressants or antipsychotic medication. During an interview on 12/19/24 at 3:25 PM regarding indications for use and monitoring for medication efficacy, the Director of Nursing (DON) stated, We are missing the supplemental documentation requirement [being] checked [in the EMR] for the rehab residents. Behaviors are supposed to be put in the progress notes. The progress notes and behaviors are documented, then the number of the non-pharmacological interventions tried. 2. Review of R94's Admission Record, from the EMR Profile tab, showed a facility admitted [DATE] with medical diagnoses that included dementia, insomnia, and depression. Review of R94's EMR Orders tab showed prescribed psychoactive medications of -Ambien 10 mg (generic name zolpidem, a hypnotic medication) at bedtime for insomnia 09/06/24. -Lorazepam Intensol Oral Concentrate (an anxiolytic medication) 2 mg/ml (milligram/ milliliter) give 0.25 ml in the afternoon for increased agitation ordered 11/19/24. -Lorazepam Oral Concentrate 2 mg/ml give 0.5 ml every 4 hours as needed for anxiety. Ordered 11/21/24 with stop date stop 01/21/25. -Mirtazapine 15 mg (an antidepressant) at bedtime for depression/ sleep ordered 09/06/24. -Modafinil 100 mg (a stimulant medication) once daily for narcolepsy, sleep apnea, and shift work sleep disorder 09/06/24. -Prozac 60 mg (generic name fluoxetine, an antidepressant medication) once daily for depression ordered 09/06/24. -Trazodone 50 mg (an antidepressant medication) at bedtime for insomnia ordered 10/29/24. -Trazodone 25 mg twice daily for anxiety/depression ordered 11/15/24. -Vraylar 3 mg (generic name cariprazine, an atypical antipsychotic medication) once daily for behavior disorders in older adults with dementia ordered 09/06/24. The Orders tab also showed the following orders for nursing: -Anti-Psychotic Medication Use - Observe resident closely for significant= 0= no side effects, 1=involuntary movements rigidity, tremor, 2= dry mouth, constipation urinary retention, 3= excessive sedation 4= slurred speech 5= muscle weakness 6= dizziness 7= other/describe in progress note every shift 09/10/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Behavior Monitoring: Insomnia, restless, narcolepsy, anxiety Non-Pharmacological Interventions 1) redirect to another area in the facility, 2) re-orient resident to current situation, 3) provide safe/secure environment, 4) psych f/u [follow up] as needed, 5) Divert attention to activity of choice.6) provide measures of comfort every shift 11/21/24. Review of R94's EMR MAR, TAR, and Progress Notes did not reveal any monitoring of target behaviors for medication efficacy. During an interview on 12/19/24 at 3:33 PM, the DON stated behaviors should be monitored each shift and how many times the behavior occurred.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, record review, interview, and facility policy review, the facility failed to ensure food preferences were obtained and honored for one of one resident (Resident (R) 54) reviewed for food preferences of 30 sample residents. This failure had the potential to cause R54 not to maintain proper nutrition. Findings include: Review of R54's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/21/24, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R54 was cognitively intact, and had diagnoses of heart failure, unspecified atrial fibrillation, and coronary artery disease. Review of R54's Care Plan, dated 11/20/24 and located in the EMR under the Care Plan tab, revealed Nutritional Risk: Resident has the potential for altered nutrition and/or hydration status related to mechanically altered diet. Interventions included Cater to food preferences, and Food preference per resident choice. Review of R54's Dietary Interview/Pre Screen, dated 09/18/24 and located in the EMR under the Evaluation tab, revealed the sections for Beverage Preferences .Snacks, and Food Likes/Dislikes were blank. Review of R54's diet Order, dated 10/25/24 and located in the EMR under the Order tab, revealed Regular diet, Mechanical Soft with chopped meat texture, Thin Liquids consistency. Review of R54's Nutrition Narrative Note, dated 12/11/24 and located in the EMR under the Progress Note tab, revealed weight status Weight (12/5)-147.2 lbs [pounds], BMI [body mass index]-25.3. Significant weight loss -13.6 lbs x 3 months (8.5% [percent]). Noted that this weight loss triggering from out of line higher than usual weights Aug/Sept. Current weight status in line with resident usual weight hx [history] of around 150 lbs. Receiving mechanical soft, chopped meat diet order with adequate intakes at meals. Eats in own room per preference. Does have some potential for weight fluctuation pending fluid status with CHF [congestive heart failure]/CKD [chronic kidney disease] dx [diagnosis]. Continue to monitor and encourage intake as needed. RD [Registered Dietitian] to f/u [follow-up] PRN [as needed]. Review of R54's 12/19/24 breakfast meal ticket, provided by the facility, revealed >3/4 cup Cornflakes Cereal and no dislikes listed. During observation and interview on 12/16/24 at 12:35 PM, R54 was awake in bed and groomed. R54 was asked about the facility food. R54 stated her meals include too much repetition and she was served her dislikes. R54 went on to say she received in one meal mashed potatoes and French fries. At breakfast, R54 stated she got scrambled eggs every morning and she did not like eggs. R54 stated no one asked her what her food preferences were. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 12/16/24 at 12:42 PM, R54 was served lunch in her room. R54's meal included French fries, mashed potatoes with gravy, hush puppies, pears, cut up fried fish with gravy, and juice. R54 expressed her disapproval of receiving mashed potatoes and French fries in the same meal. During observation and interview on 12/17/24 at 9:40 AM, R54 was served breakfast in bed. R54's meal included ground sausage, scrambled eggs, waffles, and juice. R54 stated she did not like eggs. During observation and interview on 12/18/24 at 8:33 AM, R54 was served breakfast in bed. R54's meal included scrambled eggs, two mini muffins, ground bacon, orange juice, and water. R54 stated she was served eggs again and had never been asked about food preferences. During an interview on 12/18/24 at 4:27 PM, the Dietary Manager (DM) was asked who talked to residents about food preferences. The DM stated he did the initial assessment. DM was asked why R54 was served eggs at breakfast when she didn't like them. DM stated he would talk to R54. During observation and interview on 12/19/24 at 8:51 AM, R54 was served breakfast in bed. Her meal included pancakes, scrambled eggs, ground sausage, and oatmeal. R54 pointed out the scrambled eggs, saying she was served eggs again and she didn't like them. During an interview on 12/19/24 at 9:02 AM, the Administrator was informed R54 has received scrambled eggs for three consecutive breakfasts and R54 did not like eggs, but her dislikes were not listed on the meal ticket. The Administrator reviewed the meal ticket and acknowledged eggs should have been listed under the dislikes. During a telephone interview on 12/19/24 at 11:15 AM, the Registered Dietitian (RD) was asked how food preferences were determined. RD stated it should be in the dietary interview in the EMR. RD stated she would obtain some preferences during her visits and relay them to the DM, but the DM would be the main person to obtain them. The RD was asked if she was aware R54 hadn't been asked about her food preferences and R54 received eggs at breakfast every morning when she did not like eggs. The RD stated, No, she wasn't told yet.

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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. 36190 Based on observation, interview, document review, and facility policy review, the facility failed to ensure the dish machine operated at the correct temperature and equipment and surfaces were kept clean for one of one kitchen. This had the potential to affect 113 of 113 residents who received meals prepared in the facility. Findings include: Review of the facility's policy titled, Sanitation, dated 11/22, revealed The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects .2. All utensils, counters, shelves and equipment are kept clean .5. Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are . b. Low-Temperature Dishwasher (Chemical Sanitization): (1) Wash temperature (120 F [Fahrenheit]) . The policy did not address the temperature of the rinse cycle. Review of the kitchen cleaning schedule dated 12/15/24- 12/20/24, provided by the facility, revealed Walls In Dish Room .Deep Fryer 2x [two times] a week, and Stove & Oven were not initialed as completed. The floors and the ventilation hood exterior and filters were not listed on the cleaning schedule. 1. During an observation and interview on 12/16/24 at 9:41 AM, the dish machine was observed in progress and the temperature for the wash and rinse cycle reached 100 degrees F. Dietary Aide (DA) 2 was asked about the temperature of 100 degrees F. DA2 stated 100 was the average temperature. The dish machine started again, and the wash and rinse cycle reached 100 degrees F. Review of the December 2024 log for the dish machine located on the wall revealed no documentation for the wash and rinse temperatures. The Dietary Manager (DM) stated he documented the results of the sanitation test strips on the log but not the temperatures for the wash and rinse. During an observation and interview on 12/16/24 at 10:04 AM, the Administrator checked the dish machine's manufacturer's requirements posted on the machine. The posted plaque revealed 120 F for the wash and rinse cycles. The DM confirmed there were no temperatures documented on the log. The DM was asked why no temperatures were documented for the wash and rinse cycles. The DM stated he didn't know. The DM was asked if the temperatures had been documented, would the low temperatures have been identified sooner. DM stated probably. During an interview on 12/17/24 at 8:36 AM, the Administrator was asked how long the dish machine had been operating with the wash and rinse temperatures at 100 F, not according to manufacturer's requirement. The Administrator stated he wasn't sure. 2. On 12/16/24 at 9:39 AM and on 12/17/24 at 2:51 PM, kitchen observations were conducted with the DM present and again on 12/18/24 at 4:30 PM with the Dietary Manager Consultant (DMC) 1 which revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The ventilation filters and exterior hood were noted to have a thick layer of grease present. The DM stated the dietary staff cleaned the exterior and filters every week. -The fryer was noted to be soiled with a collection of French fries and food particles inside the well. The side of the oven and grill touching the fryer contained a build-up of grease and food debris. The DM stated the dietary staff cleaned these areas every week. -The lower walls in and around the dish machine area contained an accumulation of dried splatters, a black substance, and a warped and gapping surface at the door. The booster heater box had an accumulation of debris. The floors in and around the dish machine contained dried spills, food and trash debris, and a dark build-up along the base boards and grout. The floor throughout the kitchen had white specks of food debris. During an interview on 12/18/24 at 4:30 PM, DMC1 was asked what kitchen items were cleaned at night. DMC1 stated the counter tops, any spills in ovens/range, floors, and the steam table. DMC1 was asked why the floors, walls, ventilation filters and exterior hood, and equipment were soiled 12/16/24, 12/17/24, and 12/18/24. DMC1 stated the kitchen had a cleaning schedule that should be followed. During a telephone interview on 12/19/24 at 11:06 AM, the Registered Dietitian (RD) was asked if she was aware of the dish machine not getting to the required temperatures for the wash and rinse cycles. The RD stated she had not been told about it but did hear the DM on the telephone discussing the repair. The RD was asked if she was aware the floors and various equipment had not been cleaned on the days of the survey. The RD stated, No she had not been told yet. The RD was asked if she conducted kitchen sanitation inspections. RD stated, Yes, monthly. The RD went on to say she just started working at the facility and conducted one inspection in November 2024.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 36190 Based on observation, interview, and facility policy review, the facility failed to ensure the facility's dumpster area was kept cleaned and the container lids were kept closed when not in use for 115 census residents. This had the potential to attract rodents and other pests that could enter the facility. Findings include: Review of the facility's policy titled, Food-Related Garbage and Rubbish Disposal, revised 04/06, revealed 1. All garbage and rubbish containing food waste shall be kept in containers. 2. All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use .7. Outside dumpsters provided by garbage pick up services will be kept closed and free of surrounding litter. During an observation with the Dietary Manager (DM) on 12/17/24 at 3:18 PM, the dumpster container area, located adjacent to the kitchen's rear exit hall had two dumpsters for garbage and one dumpster for recycling. Two dumpster containers for garbage each had two separate top lids. Both lids on the dumpster containers were open, exposing the numerous plastic garbage bags that filled the dumpsters. Two plastic garbage bags were noted to be sitting on the concrete next to the dumpsters. The Maintenance Assistant (MA) was observed picking the bags up and placing them in the dumpster containers but didn't close the lids. The DM was asked if staff should close the dumpster lids after they deposited garbage in them. The DM stated, Yes, the staff who put trash in should. During an observation on 12/18/24 at 1:08 PM, the lids to the two garbage dumpsters were observed open and exposing trash bags. During an observation with the Administrator on 12/19/24 at 1:40 PM, the lids to the two garbage dumpsters were open and food debris spillage was noted to be on the outside of the recycling dumpster. The Administrator stated lids should be closed each time trash was placed inside but it was hard to get all the departments to do that.