STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265834	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on interview and record review, the facility failed to ensure staff followed the change of condition policy for one resident (Resident #50) when staff failed to ensure the resident's physician was aware of the resident's change of condition identified on [DATE]. The resident was transported to the hospital for assessment and treatment when the physician was notified on [DATE] after the resident was found unresponsive and with slow shallow breaths. Four residents were sampled for change in condition. The census was 116. Review of the facility's Notification Of A Change In Condition policy, revised on [DATE], showed: -Policy: The Attending Physician/Physician Extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the Resident Representative will be notified of a Change in a Resident's Condition, per Standards of Practice and Federal and/or State Regulations; -Responsibility: All Licensed Nursing Personnel, Nursing Administration, and Director of Nursing; -Procedure: -1. Guidelines for Notification of Physician/Resident Representative: -Significant Change or Unstable Vital Signs; -Emesis (vomit)/Diarrhea; -Change in Level of Consciousness; -Abnormal Complaints of Pain, Ineffective Relief of Pain from current Regimen; -Unusual Behavior; -2. Document in the Interdisciplinary Team (IDT) Notes: -Resident Change in Condition; -Physician Notification; (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notification of Resident Representative. 1. Review of Resident #50's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Severe cognitive impairment; -Eating and oral hygiene: Partial/moderate assistance (helper does less than half the effort); -Toileting, bathing, upper body dressing, lower body dressing, put on/take off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, sit to stand, chair to bed transfer, and toilet transfer: substantial maximal assistance (helper does more than half the effort); -Swallowing disorder: Coughing or choking during meals or when swallowing medication, and complaints of difficulty or pain with swallowing; -Nutritional approaches: Mechanically altered diet and therapeutic diet; -Diagnoses included diagnoses included dementia, diabetes, cognitive communication deficit, and dysphagia (difficulty swallowing). Review of the resident's order summary, showed: -Code status: Cardiopulmonary resuscitation (CPR), order date [DATE]. Review of the resident's speech therapy treatment encounter notes, dated [DATE] through [DATE], showed: -Evaluation dated [DATE]: Resident also presents with mild-moderate oral dysphagia characterized by prolonged mastication (chewing), decreased bolus formation (swallowing abnormality that occurs when the tongue has reduced coordination to form a bolus after chewing), and requiring occasional cues to swallow. Recommend downgrading to mechanical soft with thin liquids, 1:1 assistance for small bites/sips and alternating bites of food and sips of liquid; -[DATE]: Resident seen this A.M. for speech therapy to target cognitive skills and swallow function. Resident observed at breakfast time with mechanical soft foods and thin liquids. Resident required assistance to put correct condiments on desired foods (i.e., jam on biscuit), and consistent verbal cues to alternate bites of food and sips of liquid. Discussed with nursing. Resident seen in the gym to target attention/visual scanning. Resident able to find and match top and bottom of cards with 70 percent (%) accuracy given moderate verbal and visual cueing; -Oral intake: Swallowing abilities: Moderate, Current diet: Mechanical soft textures, Current liquids: Thin liquids; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: Resident seen this afternoon for speech therapy to target swallow function. Resident increasingly confused. Oral care administered prior to PO trials. Resident with oral residue from previous meal. Attempted to administer a small amount of nectar thick liquid via TSP. Resident required max verbal cueing to accept and swallow small amounts. Trials stopped due to resident fatigue/alertness. Called family to discuss a plan and options (nothing by mouth (NPO) verses (vs) percutaneous endoscopic gastrostomy (PEG, a flexible plastic tube that is inserted into the stomach through the abdominal wall to provide nutrition, fluids, and medication) vs. Puree/nectar pleasure diet. Family reported understanding of risks and said to continue puree with nectar with swallowing precautions (1:1 feeding assistance, small sips/bites, sips via tsp, only feeding when alert). Family reported wanting to know why resident was increasingly altered the past few days and not being able to get a hold of nursing. Speech Therapist (ST) X reported that he/she could not give an answer as to the change but would report concerns to nursing. ST X discussed with the nursing regarding the steady decline seen in resident the past few days and that resident's family wanted to talk with the nurse. Nurse reported he/she would call family and talk with the doctor about getting labs; -Oral intake: Swallowing abilities: Marked resident attempts to initiate participate, current diet: Puree consistencies, Current liquids: Nectar thick liquids. Review of the nurse's notes, dated [DATE] at 10:39 P.M., showed Speech Therapy (ST) X and the resident's family had concerns. ST X stated the resident has difficulty swallowing and may be at risk for aspiration. Moist lung sounds auscultated (listened to) to both lobes. Call placed to exchange, unable to contact anyone, will report to next shift. Review of the nurses notes, dated [DATE], did not show staff attempted to contact the physician. Review of the nurses note, dated [DATE] at 2:30 P.M., showed Certified Nurse Aide (CNA) S and Certified Medication Technician (CMT) DD made nurse aware the resident appears to have a change in condition. Nurse called out to resident with no answer and eyes remained closed. Resident noted slow shallow breaths. CMT DD begins to take vital signs noting no critical results. Sternal rub (the application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert) given to further evaluate awareness and resident begins to blink eyes, no further movement assessed, breaths remain same. With CMT DD remaining at bedside, this nurse notes CPR noted in documentation. This nurse alerts registered nurse (RN) on sister unit of resident's change and possible emergent condition that required immediate evaluation. Face sheet and orders printed, 911 notified. This nurse also alerts administrator of resident's needed evaluation. Nurse back at bedside and remained on the line with 911 operator per request awaiting fire and ambulance arrival. Emergency Medical Technician's (EMT) arrive to facility to evaluate and transport resident to hospital for evaluation and treatment if indicated. Resident remaining eyes closed, slow breathes, leaving facility via ambulance transport. Review of the hospital record, dated [DATE], showed: -Arrival time 3:23 P.M. BP ,d+[DATE], heart rate 41 beats per minute, pulse 39, temperature 84.1 (rectal); -Radiology: chest-scattered bilateral ground glass opacities with pleural effusions which is favored to represent pneumonia; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3:58 P.M., ST X called the family on Friday ([DATE]) that resident may be aspirating; -diagnosed with shock, symptomatic bradycardia (slow heart rate), hypothermia (low body temperature) and unspecified anemia (low levels of healthy red blood cells to carry oxygen throughout your body). During an interview on [DATE] at 12:08 P.M., ST X said the resident was evaluated on [DATE] and the resident was pretty confused. Originally when she saw the resident, she put him/her on mechanical soft diet, for mild oral dysphagia. On [DATE] at breakfast, the resident was still really confused. The ST X reported to nursing the resident needed assistance alternating bites of food with liquid, but did not change his/her diet. ST X told the nurse. The nurse was supposed to inform the CNAs. ST X put the diet communication order into the physician's mailbox when an order is changed. ST X does not call the physician. On [DATE], ST X noticed the resident's swallowing was decreasing again. ST X put him/her on pureed and nectar thin liquids. ST X spoke with nursing. On [DATE], ST X added instructions and modified instructions: Pureed texture, Nectar consistency, alternate bites/sips, 1:1 feeding assistance for aspiration precautions, provide liquid via a teaspoon, to receive oral care three times daily. ST X saw the resident later in the day and he/she was more confused, had something in his/her mouth and wasn't managing secretions and the swallow function was not safe. He/She was not safe for by mouth (PO) trials, and was at high risk for aspiration. ST X called the daughter and explained the situation. The resident seemed like he/she was getting worse, as it was progressing quickly. ST X consulted his/her supervisor to report the resident's change of condition and asked what should she do in the situation. If the resident is not consuming food and liquids safely, see if the family wants to go PEG, or PEG and pleasure feedings, or to continue with PO diet - continue the oral feedings with the safe strategies with 1:1, small bites, small sips, sips via teaspoon only feeding when alert. ST X talked to the nurse during shift change and relayed the resident had rapidly declined over the past three days and questioned when the resident should be sent to the hospital. The nurse said he/she would call the doctor. ST X was concerned as the resident was at high risk for aspiration and concerned he/she had aspirated. On [DATE], late in the day, ST X woke the resident. He/She was kind of out of it. ST X cleaned his/her mouth, there were food in his/her mouth. ST X said PO intake doesn't appear safe and nobody told her the doctor didn't respond. ST X felt the physician should have been aware of her observations. ST X did not contact the physician. During an interview on [DATE] 9:20 A.M., Licensed Practical Nurse (LPN) Y said he/she worked the evening shift on [DATE]. He/She was informed by ST X the resident was having difficulty swallowing during shift change. ST X asked if he/she needed to be sent out to the hospital. LPN Y said he/she would follow up with the doctor to see if the resident needed any labs or he/she had any other orders. LPN Y called the exchange line more than 3 times. He/She wasn't able to leave a message, so he/she put it on the 24 hour report sheet and notified the next shift. The LPN was unable to contact the physician or leave a message, so LPN Y entered a nursing note and passed the information to the next nurse. During an interview on [DATE] at 10:18 A.M., LPN Z said he/she worked on the night shift of [DATE]. LPN Z said and it was not passed in shift report that ST X reported the resident's difficulty swallowing and wanted the doctor notified to see if the doctor wanted him/her sent to the hospital or labs or x-rays done. LPN Z passed onto the next shift they were waiting on a phone call from the doctor to discontinue Seroquel (antipsychotic that helps regulate mood and behaviors) and that the doctor had not called her back. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:48 A.M., LPN BB said he/she worked [DATE] from 3:,d+[DATE]:00 P.M. LPN BB was not given report on the resident. He/She did not know ST X reported the resident had difficulty swallowing and wanted the doctor notified to see if the doctor wanted him/her sent to the hospital or and labs or x-rays done. During an interview on [DATE] 8:46 A.M., the Primary Care Physician (PCP) said she expected staff to follow the change of condition policy. She expected staff to follow physician orders, including special diets. Staff did not contact her regarding a change in condition reported to them by ST X on [DATE]. The PCP expected to be contacted with any change of condition and if staff are unable to reach the PCP, staff should call the exchange and if unable to reach the exchange, staff should contact the Medical Director (MD). During an interview on [DATE] at 10:08 A.M., the MD said staff did not contact her on [DATE] regarding the resident. She expected to be notified if a resident has a change in condition. If staff could not contact the resident's PCP, she expected staff to notify her. If staff contacted her on [DATE] with the resident's change of condition, she would have had staff send the resident to the hospital on [DATE]. During an interview on [DATE] at 2:24 P.M. the Administrator and Director of Operations (DOR) said they expected staff to be knowledgeable of and to follow the facility's policies and procedures. They expected if a resident had a change of condition, to notify the physician, nurse management, and the resident representative. They expected the change of condition and notifications to be documented in the resident's progress notes. MO00246651 MO00246669

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 46970 Based on observation, interview and record review, the facility failed to maintain air temperature at the preference of Resident #6 in his/her room and failed to maintain a properly functioning thermostat in the same resident's room. He/She complained about the cold room temperature. Per the resident, the cold temperature caused him/her to not get enough sleep. This had the potential to affect Resident #6 and Resident #19. The census was 129. Review of the facility's Maintenance Supervisor job description, revised 05/2022, showed: -Essential functions of Maintenance Supervisor: -Report to the Administrator regarding the physical and structural conditions of the center and the status of work in progress; -Perform all assigned tasks in a professional manner to reflect the highest integrity of the Maintenance Department; -Coordinate the repair of equipment or recommend the replacement of or additions to equipment or center as necessary; -Schedule and supervise maintenance repair work, alterations, remodeling, minor construction and the checkout, installation and servicing of mechanical and electrical equipment and building systems. Review of the facility's Maintenance Assistant job description, showed: -Essential functions of maintenance assistant: -Assist in the care of the center's physical plant and grounds; -Perform repairs as directed; -Help to assure the maintenance of the physical plant is in proper order; Qualification of maintenance assistant: Requires knowledge of building maintenance to include minor electrical repair. 1. Review of Resident #6's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 8/12/24, showed: -Moderate cognitive impairment; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included asthma, chronic pulmonary obstructive disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), or chronic lung disease (e.g. chronic bronchitis and restrictive lung). Review of the resident's temperature summary, showed; -On 7/28/24 at 11:59 A.M., 97.4 degrees F (Fahrenheit, denoting a scale of temperature) forehead (non-contact), warning: low of 97.8 exceeded; -On 8/12/24 at 2:24 P.M., 96.0 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/12/24 at 10:24 P.M., 97.6 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/13/24 at 11:55 A.M., 96.1 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/14/24 at 11:58 A.M., 96.1 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/15/24 at 3:56 P.M., 96.5 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/16/24 at 1:09 P.M., 96.0 degrees F, forehead (non-contact), warning: low of 97.8 exceeded; -On 8/17/24 at 1:20 P.M., 96.6 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/17/24 at 10:25 P.M., 96.1 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/19/24 at 1:59 P.M., 96.4 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/19/24 at 10:47 P.M., 96.6 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/20/24 at 11:54 A.M., 96.4 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/20/24 at 10:56 P.M., 96.5 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/21/24 at 10:51 P.M., 94 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/22/24 at 1:42 P.M., 96.9 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/24/24 at 3:11 P.M., 96.6 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/24/24 at 9:06 P.M., 96.4 degrees F, forehead (non-contact) warning: low of 97.8 exceeded; -On 8/25/24 at 2:10 P.M., 96.1 degrees F, forehead (non-contact) warning: low of 97.8 exceeded. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/24 at 11:08 A.M., the resident said he/she talked to the maintenance people about the cold room but got put off. He/She had been waiting nine weeks for the thermostat with no progress. The resident said he/she had reported the cold room to the Maintenance Supervisor, some nurses, and Certified Nurse Assistants (CNA). He/She was getting frustrated about the cold room and didn't want to get sick again. He/She said the Maintenance Supervisor told him/her this morning that they had the part but couldn't come because of moving furniture. He/She hadn't been sleeping well because the room was too cold. He/She told the Administrator about the cold room and the Administrator said she would talk to the Maintenance Supervisor. The resident said the Maintenance Assistant told him/her he/she was going to the store yesterday to get the part, but he/she didn't come back to the room. He/She was waiting on him. Observation on 9/17/24 at 11:08 A.M., showed: -[NAME] thermostat control box in the resident's room; -Auto position, heat position, heat on; -Room temperature 71 degrees; -Thermostat set to 78 degrees; -Call for service. 2. Review of Resident #19's annual MDS, dated [DATE], showed: -Cognition in tact; -Diagnoses included arthritis, asthma, chronic pulmonary obstructive disease or chronic lung disease, and anxiety disorder (Intense, excessive, and persistent worry and fear about everyday situations). During an interview on 9/17/24 at 10:30 A.M., the resident said the cold air would not turn off and he/she was getting sick because of it. Observation showed an air condition unit/blower high above the resident's bed, blowing out continuous cold air and the temperature on the room thermostat was 71 degrees. He/She said the air conditioner was turned off, but it was still blowing out cold air. At night, he/she slept underneath two blankets and wore a sweater to bed because the room was so cold. He/She said Maintenance told him/her they were waiting on a part to fix it but he/she hadn't heard anything else about it from Maintenance. He/She was on a blood thinner, was cold, and couldn't take it anymore. Observation showed temperature on the room thermostat to be 71 degrees F, set to 78 degrees F and heat. Observation on 9/17/24 at 11:08, showed staff came into the resident's room to assist the resident. The resident told staff he/she was cold. The resident asked staff if the staff member was cold and staff told him/her no, he/she was comfortable. 3. Review of the facility's test and log air temperatures, showed: -On 07/22/24, a temperature of 73 degrees for the resident room; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/19/24, a temperature of 72 degrees for the resident room. Review of an invoice containing the replacement part of the resident's room thermostat, dated 08/01/24, showed: -Item # 3MY10 Low volt NP Digital TSTAT H or C, Plug-in Manufacturer # 01F78 144S1 ([NAME] Low Voltage Thermostat: Heat or Cool, Manual, B/G/O/RC/RH/W/Terminal Designations, Auto-On); -Caller: Maintenance Supervisor. Review of a receipt dated 9/16/24 at 9:54 A.M., showed, a new thermostat had been purchased. 4. During an interview on 9/17/24 at 12 P.M., the Activity Director said Resident #6, or his/her roommate told her about the room being too cold. She said Resident #6 said he/she had already told the Maintenance Supervisor. The Activity Director said she asked the Maintenance Supervisor about the resident's request, and he told her that he knew and was waiting on a part. She heard Resident #6, or his/her roommate tell the Maintenance Assistant about the room being too cold, but she couldn't remember which resident it was. She had been in the resident's room lately but didn't want to say it was too cold because she didn't know how the room felt to them but Resident #6 was more adamant about the room being too cold. 5. During an interview on 9/17/24 at 12:38 P.M., the Maintenance Supervisor said he bought a new thermostat the day before and had it with him today. He knew Resident #6 didn't like it cold, but his/her roommate did. He said the cold room was reported to him yesterday. The Maintenance Director said he and the Maintenance Assistant looked at the thermostats in resident rooms when they checked the temperature and if the light was flashing, they changed the battery, if needed. He didn't know the thermostat in Resident #6's room said need service. He didn't know the thermostat was set to heat or that the temperature didn't rise above 71 degrees F. He said if the temperature was set for 78 degrees F, the temperature should rise. He said he expected the thermostat in Resident #6 room to work properly and expected Resident #6 to be able to adjust the temperature to his/her preference. The Maintenance Director said he was going to reset the resident's thermostat and if that didn't work, he would replace the part. He expected the resident's thermostat to have been reset or repaired before today. Staff were supposed to put maintenance requests into TELs system (System for facility staff to upload maintenance requests). Those requests went directly to his cell phone. 6. During an interview on 9/18/24 at 10:25 A.M., the Administrator said she could see when the maintenance request was put into the system. She said Resident #6 had told her that his/her room was too cold. She thought the temperature in the resident's room was 73 degrees F, but that didn't seem too cold. She said she didn't remember Resident #6's room being cold all this time. The Maintenance Supervisor told her he had recently ordered a part. The Administrator said Resident #6 had the right to chose what temperature he/she wanted his/her room to be, and she expected the thermostat to being working. She expected the Maintenance Supervisor to have troubleshooted the resident's thermostat before today. The Administrator and Director of Nursing expected the resident's air conditioner and heat to be in working condition. MO00240418

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16909 Based on observation, interview and record review, the facility failed to ensure residents were free from neglect. Facility staff failed to provide prompt and adequate incontinence care. Four out of four sampled residents, who were incontinent of bowel and/or bladder (Residents #33, #34, #45 and #46), were observed with two incontinence briefs on, both of which were saturated and with strong odors of urine and feces. Three residents (Residents #31, #43 and #44) said staff do not check on them every two hours, leaving them wet for extended periods of time, and it can take several hours for staff to answer call lights. Additionally, facility staff neglected to respond to a call light for one resident, with a history of bypass surgeries (Resident #24) who was having chest pains, turned on his/her call light and when staff did not respond in 10 minutes the resident called 911. Emergency Medical Services (EMS) responded but could not find facility staff until they found one staff member curled up on the couch asleep. Another resident (Resident #25) returned from the hospital with EMS at the same time that Resident #24 was having chest pains and that EMS crew could not find staff readily available. Additionally, another resident's hospital Emergency Department (ED) report showed the resident called 911 and said staff had left him/her on the toilet for three hours, causing stiffness and pain (Resident #20). This had the potential to affect all residents. The census was 118. 1. Review of Resident #34's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 7/31/24, showed: -Unclear speech; -Rarely/never understood by others; -Rarely/never was able to understand others; -Short and Long term memory problems present; -Severely impaired cognitive skills for daily decision making; -Impairment to upper body on one side; -Impairment to lower body on both sides; -Wheelchair used for mobility; -Always incontinent of bowel and bladder; -Dependent on staff for toileting hygiene, shower/bathe self, upper and lower dressing, personal hygiene and all transfers; and -At risk for pressure ulcers. -Diagnoses included stroke, heart failure, and diabetes mellitus. (continued on next page)

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	265834	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of the resident's Braden Scale, dated 7/31/24, showed the resident was at high risk for developing pressure ulcers. Review of the resident's care plan, undated, showed: -Problem: The resident had the potential for impaired skin integrity and/or development of pressure-related ulcers and/or breakdown related to incontinence and bedfast. Interventions included: Assist with toileting needs an incontinence care on routine rounds and as needed; Assist as needed with toileting hygiene and with wearing and changing incontinence undergarments; -Problem: The resident was frequently incontinent of bowel and bladder. Interventions included: Check and change for incontinence. Observation on 10/28/24 at 4:34 A.M., showed: -A strong odor of urine emitting from the room into the hall. -The resident lay in his/her bed on a low air loss mattress. -Registered Nurse (RN) D pulled the resident's bed covers down to show the resident wore two briefs. -The resident's outer brief was soaked with urine, with the padding in the brief in clumps. -The resident lay in a pool of urine, with visible brown rings of urine on the sheet extending from the resident's thighs to his/her shoulders. During an interview on 10/28/24 at 4:35 A.M., RN D said: -He/She did not think the resident was changed over the night shift. -He/She verified the resident wore two briefs, both soaked with urine, and lay in urine extending up to his/her shoulders. During an interview on 10/28/24 at 5:49 A.M., Certified Nurse Aide (CNA) E said: -He/She worked from 11:00 P.M. to 7:00 A.M. that day. -He/She was the only CNA assigned to care for the resident on the hall. -He/She checked on the resident between 2:45 A.M. and 3:00 A.M. and the resident was not wet and did not require incontinence care. -He/She had just provided incontinence care to the resident. -He/She confirmed the resident was wearing a shirt that was wet with urine up to the middle of his/her back and the resident lay on a wet absorbent pad before he/she gave the resident incontinence care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	2. Review of Resident #33's admission MDS, a federally mandated assessment instrument completed by facility staff, dated 8/6/24, showed: -Moderate cognitive impairment; -Rejection of care, not exhibited; -Upper extremity impairment on both sides; -Toileting, shower, lower body dressing, put on and take off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer: substantial maximal assistance (helper does more than half the effort); -Eating, oral hygiene, upper body dressing: Partial moderate assistance; -Always incontinent of bowel and bladder; -Risk of pressure ulcers, yes; -Diagnoses included deaf nonspeaking, muscle weakness, dementia, reduced mobility and insomnia (a sleep disorder that makes it hard to fall or stay asleep). Review of the resident's Braden Scale (used for predicting pressure ulcer risk), dated 9/4/24, showed the resident was at high risk for developing pressure ulcers. Review of the resident's current care plan, showed: -Focus: Activities of daily living (ADLs, bathing, toileting, dressing, etc.) self-care performance deficit; -Goal: Resident requires assistance with ADL care and mobility; -Interventions: -Requires staff assistance to turn and reposition in bed; -Requires staff assistance to dress; -Transfer one assist; -Focus: The resident has bowel incontinence related to immobility; -Goal: The resident will have less than two episodes of incontinence per day through the review date; -Interventions: -Check resident every two hours and assist with toileting as needed; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Observe pattern of incontinence and initiate toileting schedule if indicated; -Provide loose fitting, easy to remove clothing; -Provide peri care after each incontinent episode; -Focus: Resident is incontinent of bowel and bladder; -Goal: Resident will remain free from skin breakdown due to incontinence and brief use through the review date; -Interventions: -Assist resident to bathroom as desired/indicated, offer toileting before meals, after meals and at bedtime; -Clean peri-area with each incontinence episode; -Focus: Resident has the potential for impaired skin integrity; -Goal: Resident will maintain or develop clean and intact skin by the review date; -Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. During an observation and interview on 10/28/24 at 4:23 A.M., RN D said residents do not get changed often on night shift because there isn't enough staff to get everything done. The resident lay in bed on his/her right side. RN D pulled the white quilt back and pulled the resident's sweatpants down, showing the resident had two briefs on. The brief that was closest to the resident's body was a pull up brief and the second brief (secured with fastening tape on the wings that attaches to the front of the brief) was located over the pull up. The brief was taped on both sides. The inner pull up was soiled with urine and dried feces and the outer brief was soiled with urine. The white quilt had large yellow spots on it. RN D said the resident had not been changed on the night shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 10/28/24 at 5:54 A.M., with CNA E and Assistant Director of Nursing (ADON) M, CNA E said the resident takes himself/herself to the bathroom. CNA E and ADON M entered the resident's room, and the resident lay in bed on his/her right side. CNA E removed the white quilt that had yellow spots on it from the resident and pulled the resident's sweatpants down, showing the resident had two briefs on. The pull up brief closest to the resident's body had dried and fresh feces and the outer brief was soiled with urine. CNA E said the resident has the outer brief over the pull up because the resident doesn't keep the pull up on. CNA E said he/she checked the resident around 1:30 A.M. or 2:00 A.M. and did not remember if the resident had both a pull up and brief on at that time. CNA E said he/she only checked the resident when he/she was walking down the hall because the resident takes himself/herself to the bathroom. CNA E said he/she glanced/peeked at the resident when he/she was walking down the hall. CNA E assisted the resident in standing from the bed and the resident's sweatpants were wet down to his/her knees and the resident's shirt was wet up to his/her waist below his/her elbows. CNA E walked and guided the resident to the bathroom. Once CNA E entered the bathroom, there was a large amount of dried feces on the right side of the toilet seat and side of the toilet. CNA E left the room and obtained supplies to clean the toilet. ADON M verified the resident was soiled and began looking for clean clothing for the resident in the resident's closet and then had to exit the room to obtain clean clothing for the resident. CNA E returned and cleaned the toilet and the resident sat on the toilet seat. CNA E had the resident then stand and began cleaning the resident. During an interview on 10/28/24 at 6:05 A.M., CNA E said: -The resident often walked around the unit during the night; -He/She checked the resident for incontinence while the resident was walking the halls last night; -CNA E checked for incontinence by peeking in the resident's brief and by touching the resident's brief on the outside of his/clothes on his/her lower buttocks. If the CNA felt the brief was hard that meant the resident was incontinent and needed care. During an interview on 10/31/24 at 6:31 A.M., CNA E said he/she works the night shift. About 70% of the time, there are two CNAs scheduled to work the downstairs units instead of three. When there is one CNA on each unit, he/she cannot check and change residents every two hours. He/She can only do two checks per his/her eight-hour shift. During an interview on 10/31/24 at 7:23 A.M., ADON M said he/she expected staff to make rounds on the resident every two hours to check for incontinence. ADON M said it is inappropriate to feel the resident's brief through his/her clothing while they are walking down the hall to see if the resident is soiled. ADON M expected staff to provide privacy and to visually check the residents brief to see if the resident is soiled. It is inappropriate to place a brief on top of a pull up to prevent a resident from removing the pull up. 3. Review of Resident #45's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition. -Wheelchair for locomotion. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Required maximal assistance for toileting hygiene, to shower/bathe self, for upper and lower body dressing, personal hygiene and to roll left and right in the bed. -Dependent on staff for chair/bed-to-chair transfers. -Always incontinent of bowel and bladder. -At risk for pressure ulcers. -Moisture Associated Skin Damage (MASD) present. -Pressure reducing device for bed. -Diagnoses included morbid obesity, depression, anxiety, metabolic encephalopathy (chemical imbalance in the blood that affects brain function) and polyneuropathy (damage to nerves causing pain, discomfort and mobility difficulties). Review of the resident's care plan, undated, showed: -Problem: ADL self-care performance deficit related to activity intolerance, cognitive impairment, debility and decreased mobility. Interventions included: Required staff assistance to turn and reposition in bed; Required skin inspection with cares. Observe for redness, open areas, scratches, cuts, bruises and report changes to Nurse; -Problem: Bladder and bowel incontinence and was at risk for urinary tract infections. Interventions included: Apply incontinence cream after each incontinence episode; The resident wore briefs; Check and change for incontinence; -Problem: Potential for impairment to skin integrity/pressure ulcer development related to bowel/bladder incontinence and impaired mobility. Interventions included: Apply incontinence cream after each incontinence episode; Pressure reducing mattress while in bed. Observation on 10/28/24 at 4:50 A.M., showed: -A strong odor of urine and bowel movement emitting from the room into the hall. -The odor of urine and feces was so strong upon entry into the room, the surveyor's eyes burned. -The resident lay in his/her bed on a low air loss mattress. -The resident wore two briefs which were soaked with urine. -The resident lay on an absorbent pad, placed under his/her buttocks, which was visibly soaked with urine. -The resident's sheet was visibly soaked with urine extending from below the resident's buttocks up to the resident's neck, with brown rings outlining the urine-soaked areas. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-The resident wore a hospital gown that was also urine soaked. -The resident had dried feces on his/her buttocks and inside of the inner brief. -The resident's mattress was visibly wet with urine. -The resident's bilateral buttocks were reddened. -The resident's inner thighs were reddened. During an interview on 10/28/24 at 4:52 A.M. and at 5:06 A.M., the resident said: -He/She had not received incontinence care since the evening before around 6:00 P.M. (eleven hours). -The staff did not usually provide incontinence care during the night shift. -Lying in a pool of urine on the wet sheet was annoying to the resident. -He/She did not like wearing two briefs at once, as the briefs cut into his/her inner thighs in a sawing motion and caused him/her pain. During an interview on 10/28/24 at 5:06 A.M., RN D said: -The resident's bilateral buttocks were red with suspected Moisture Associated Dermatitis (MASD). -The resident also had MASD located on his/her inner thighs. During an interview on 10/28/24 at 5:17 A.M., CNA F said: -He/She began work yesterday around 11:30 P.M. -He/She rounded on his/her assigned residents every two hours to check if they needed incontinence care. -He/She was not able to get to the resident until 4:50 A.M. and he/she gave the resident incontinence care at that time. -He/She only put two briefs on residents if they asked for them. -It was not right to put two briefs on a resident because it was not possible to see if the inner brief was wet. -It was difficult for CNA F to give care to all his/her residents last night due to the lack of staff. -The resident required the assistance of two people when giving incontinence care and CNA F had to wait until CNA E, who worked the other hall, was able to assist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During observation and interview on 10/29/24 at 6:19 A.M., the resident said he/she was changed at 10:00 P. M. last night and one other time early this morning. The resident's room had a very strong urine odor. The resident said he/she was unsure if he/she had two briefs on. The resident said it depends on what staff changes him/her if they put one or two briefs on. The resident said it seems like they put two on all the time. The resident said he/she is changed and repositioned one time each shift and said he/she needed changed and repositioned more often. When he/she turns his/her call light on, it takes an hour to an hour and a half before staff respond to the call light. The resident also said staff did not offer ice water. The resident had a water pitcher on his/her bed side table without a lid that had approximately 2 inches of water. The resident said the water in the cup was left over from the ice he/she requested yesterday after dinner. The resident would like ice water to be passed each shift. During an observation and interview on 10/29/24 at 6:36 A.M., RN D entered the resident's room and asked if he/she could check to see if the resident was wet. The resident agreed. RN D verified the resident had two briefs on and the briefs were soaked with urine. RN D said it is not appropriate for any resident to have two briefs on. If a resident has two briefs on, the staff might think the resident is dry by only looking at the outer brief. If residents are left soiled for an extended period of time, it can cause skin integrity issues such as redness and skin breakdown that could lead to open areas. Observation and interview on 10/29/24 at 6:40 A.M., showed: -The resident wore two briefs which were both visibly soaked with urine. -He/She did not like to wear two briefs, as they were uncomfortable, were too tight between his/her legs and cut into his/her groin. Review of the resident's weekly skin assessment, dated 10/29/24 at 12:01 P.M., showed the resident had redness at his/her buttocks and groin. 4. Review of Resident #46's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Rejection of care not exhibited; -Toileting and personal hygiene: substantial maximal assistance; -Shower transfer, dependent; -Frequently incontinent of bladder; -Always incontinent of bowel; -Risk of pressure ulcers, yes; -Diagnoses included muscle weakness, dementia, difficulty in walking, and need for assistance with personal care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 10/28/24 at 4:51 A.M., RN D entered the resident's room and asked permission to check the resident's brief. The resident agreed. The resident said the last time he/she had been changed was at 5:00 P.M. the previous day (almost 12 hours). The resident said he/she had not been changed all night. The resident had two briefs on. The inner brief was brown and was saturated with urine. The resident's room had a strong urine odor. During an interview on 10/28/24 at 12:01 P.M., the resident said he/she does not like to be soiled for extended periods of time. The resident also said his/her family gets ice water for him/her on the days they are at the facility. On days the family is not at the facility, he/she does not get offered ice water. Observation and interview on 10/29/24 at 7:30 A.M. and at 9:24 A.M., showed: -There was a cup with approximately 4 inches of water on his/her bedside table, within reach; -He/She did not have fresh ice water; -He/She could not remember the last time staff gave him/her fresh ice water; -He/She was last checked on by staff around 6:00 A.M. that morning and he/she was not sure when staff would return; -The resident wanted fresh ice water and hoped staff would fill up his/her cup, as that sure would be nice. During an interview on 10/31/24 at 6:20 A.M., the resident said he/she had not been changed since 10:00 P.M. the previous day. The resident said he/she was wet and needed changed. The resident's room had a strong odor of urine. During an observation and interview on 10/31/24 at 6:24 A.M., ADON M entered the resident's room and asked permission to check the resident's brief and the resident agreed. The resident's room had a strong odor of urine. The resident wore one brief that was saturated with urine. The resident lay on an absorbent pad that was saturated with urine. The fitted sheet under the absorbent pad was also saturated with urine and had brown rings which extended up to the middle of the resident's back. The resident's shirt was also saturated up to the middle of the resident's back. ADON M washed his/her hands and exited the room. ADON M walked up to CNA J, who was sitting in the hallway, and asked CNA J who had the resident. CNA J said the resident was on another CNA's assignment. ADON M told CNA J the resident needed a full bed change and CNA J said he/she would assist the resident. During an interview on 10/31/24 at 7:23 A.M., ADON M said it was not appropriate for staff to not complete rounds every two hours on residents. ADON M said it was not appropriate for a resident to not be changed from 10:00 P.M. until 6:30 A.M. the following day. Night shift starts at 11:00 P.M. and the resident was not changed for the entire night shift. ADON M said he/she spoke to the night shift charge nurse and CNA J was the CNA responsible for completing rounds and changing the resident. ADON M said he/she did not have an opportunity to speak with CNA J before he/she left. ADON M said CNA J reported to ADON M that the resident was on another CNA's assignment. ADON M said he/she expected staff to be knowledgeable of and follow the facility' policies. ADON M expected staff to make rounds on the residents every two hours and know what residents they are responsible for each shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	5. Review of Resident #31's quarterly MDS, dated [DATE], showed the resident: -Cognitively intact. -Rejection of care not exhibited. -Frequently incontinent of bowel and bladder. -At risk for pressure ulcers. -Diagnoses included need for assistance with personal care, abnormalities of gait and mobility, muscle weakness and reduced mobility. Review of the resident's current care plan, showed: -Focus: ADL self-care performance deficit. -Goal: Resident requires assistance with ADL care and mobility. -Interventions: -Bed mobility requires staff assistance to turn and reposition in bed. -Toilet use requires staff assistance of one. -Transfer requires staff assistance of one. -Encourage use of call light. During an interview on 10/28/24 at 8:08 A.M., the resident said staff do not come in and offer to change him/her when he/she is soiled. The resident said he/she must get out of bed and change himself/herself and put the soiled briefs in the trash can next to his/her bed. The trash was just changed and was overflowing with soiled briefs and the staff member who came in and took the trash, threw a fit wanting to know why all the briefs were in the trash can. The resident then became tearful and said he/she is doing the best he/she can. The resident said it would be helpful if the staff would assist him/her in changing his/her brief when he/she is soiled but said staff will not assist him/her because there was not enough staff. The resident said it takes up to two hours for staff to answer his/her call light, if they come at all. The resident said staff do not pass or offer ice water. The resident said he/she has a small green cooler he/she keeps on his/her walker and the resident fills this small cooler up himself/herself. 6. Review of Resident #43's annual MDS, dated [DATE], showed: -Adequate hearing. -Clear speech - distinct intelligible words. -Makes Self Understood: Understood. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Ability To Understand Others: Understands - clear comprehension. -Cognitively intact. -Always incontinent of bowel and bladder. -Diagnoses of anxiety and depression. Review of the resident's current care plan, showed: -11/9/21: Focus -ADL self-care performance deficit. Goal - Resident requires assistance with ADL care and mobility. Interventions: Personal hygiene, one assist. Toilet use, utilize check and change to manage incontinence; -10/23/24: Focus - Frequently incontinent bowel and bladder. Goal - Will remain free from skin breakdown. Interventions: Incontinent - Check and change for incontinence. During an interview on 10/30/24 at 7:47 A.M., the resident said he/she is incontinent of bowel and urine. Most nights, staff check him/her for incontinence one time, which is not enough. Staff tell him/her there is not enough help to check him/her more than once. If he/she turns on his/her call light, it can take hours for staff to answer it, or they will answer it, turn the call light off, then leave without taking care of him/her. It makes him/her feel bad when he/she is left wet for long periods. 7. Review of Resident #44's annual MDS, dated [DATE], showed: -Adequate hearing. -Clear speech - distinct intelligible words. -Makes Self Understood: Understood. -Ability To Understand Others: Understands - clear comprehension. -Cognitively intact. -Always incontinent of bowel and bladder. -Diagnoses of anxiety and depression. Review of the resident's current care plan, showed: -8/22/23: Bladder incontinence related to impaired mobility. Goal: Will remain from skin breakdown due to incontinence and brief use. Interventions: Check as required for incontinence. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/30/24 at 7:37 A.M., the resident said he/she is incontinent of bowel and bladder. Most night shifts, staff will check and change him/her twice at the most, sometimes only once, and in the past couple of weeks, there had been some nights no one came to check him/her at all. When he/she is checked once or not at all, he/she lays in a puddle of urine. Most nights, he/she is unable to turn on his/her call light because staff do not leave the call light where he/she can reach it. When the call light is in reach and he/she turns it on, it can take hours for someone to answer it. He/She feels ignored by staff. 8. Review of Resident #24's electronic medical record (EMR), showed: -Diagnoses of high blood pressure and a-fib. -A progress note, dated 9/27/24 at 3:47 A.M., and documented by Licensed Practical Nurse (LPN) N: This nurse was notified that resident called 911 stating he/she was having chest pain. His/Her chest felt like it was filling with water. EMS arrived asking resident why he/she did not turn on his/her call light for this nurse to evaluate him/her. Resident stated he/she just wanted to go to the hospital. Resident transferred to stretcher going to hospital for evaluation. No signs or symptoms noted. Review of the staffing schedule for the night shift of 9/26/24 (the shift started at 11:00 P.M. on 9/26/24 and ended at 7:00 A.M. on 9/27/24), showed one nurse working on the two units on the first floor where Resident #24 resided. Review of the resident's Des [NAME] Department of Public Safety report (EMS/ambulance report) dated 9/27/24, showed: -911 Caller: Resident #24. -Alarm: 3:15 A.M. Dispatched: 3:17 A.M. Arrived: 3:21 A.M. -3:34 A.M.: Had to wake up staff to locate the resident. -3:36 A.M.: Caller (resident) states he/she has been having chest pains for 45 minutes. -3:37 A.M.: Attempted to contact staff two times no answer to locate resident's room number. -3:38 A.M.: EMS has been on the scene for over 10 minutes at the front door. -3:40 A.M.: Staff was contacted a third time and finally picked up. Dispatch advised that DSFD (Des [NAME] Fire Department) was on scene and ambulance was there for over 10 minutes. Staff was asked to check a resident name for a room number. They advised they would have to go downstairs and look for it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Narrative: Upon arrival, observed Resident #24 laying supine (on the back) in bed. The resident could speak without deficit and appeared to be stable. The resident advised he/she was having substernal (behind the breastbone) chest pain that did not radiate for approximately and hour and a half. Resident advised he/she tried to call staff for approximately one hour however, no one would answer his/her call light. It should be noted, staff was found sleeping in the hallway wrapped in blankets sleeping and other staff members coming in from their vehicles in the parking lot. An ECG was conducted at which time A-fib was observed. The resident was provided with 324 milligram aspirin orally. During transport (to the hospital) no changes in the resident's vitals were observed. -Call closed at 4:12 A.M. During an interview on 9/27/24 at 7:29 A.M., Emergency Medical Technician (EMT) AA said they had been at the facility for 10 minutes and could not find any staff. Dispatch called the facility and did not get an answer. Upon entrance to the facility, several call lights were flashing and there was no staff in sight. While walking around trying to find the resident's room, the paramedics saw a someone curled up on the couch, asleep. Resident #24 said he/she yelled for help for 10 minutes. When they didn't respond, he/she called 911. Two staff eventually appeared, and several staff were seen exiting their cars and returning to the building. The lights were off at the nurse's station and one of the staff had to restart the computer to get the resident's face sheet. During an interview on 10/31/24 at 6:31 A.M., CNA E said he/she worked on the night shift of 9/26/24. He/She worked on the same floor, but not the same unit where the resident resided. During that shift EMS was in the building and said they had been looking for staff because the resident had called them and said he/she was having chest pain. He/She also saw a policeman in the building at the same time EMS was in the building. He/She was not sleeping on duty and did not see other staff sleeping. 9. Review of Resident #25's EMR, showed: -admitted [DATE]. -Diagnoses of syncope (fainting), vertigo (light headed/dizziness), A-fib and cognitive communication deficit; -A progress noted dated 9/26/24 at 8:36 P.M.: Resident complained of feeling like he/she did when he/she had a brain bleed. He/She said he/she wants to go to the hospital for evaluation. Physician and DON notified. -A progress note dated 9/27/24 at 3:37 A.M.: Resident returned from hospital. Family arrived with resident. During an interview on 9/27/24 1:50 P.M., Family Member (FM) MM said he/she arrived at the facility from the hospital on 9/27/24 at 3:30 A.M. The Des [NAME] Police Department (PD) and ambulance were in the building. The paramedic said they had been walking around trying to find staff and the resident who called the police for 20 minutes. There were call lights going off. Another resident was having chest pain, had his/her call light on, and when no one answered it, he/she called 911. FM M walked around with the paramedics for an additional 20 minutes before staff came out of a dark room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/31/24 at 8:17 A.M., the Director of Nursing (DON) said no one told her the paramedics and police could not locate staff when they responded to Resident #24's emergency call or when Resident #25 returned to the facility. No one told her a staff member was found sleeping by the EMS crew. If they would have called her, she would have come in at that time and began an investigation as to why the staff could not be found and why a staff member was sleeping on duty. 10. Review of Resident #20's EMR, showed: -admitted [DATE]. -Diagnoses included: Heart failure, below the knee amputation (BKA) of right leg and diabetes mellitus. Review of the resident's progress notes, showed: -On 9/11/24, at 7:15 P.M., Fire and Ambulance arrived, making nurse aware 911 had been called for the resident's room. This nurse approached room noting this resident in bathroom on toilet. Two EMTs entered the restroom to assess resident. Resident stated he/she would like to be transported to ED for eval for pain. Resident left facility at this time remaining alert and able to make needs known. During an interview on 9/27/24 at 12:09 P.M., EMT AA said EMS was dispatched to the facility on Labor Day weekend and staff were seen sleeping. The residents were complaining they had not received their medication. The agency staff said there was not a nurse in the building, and they didn't pass meds, because the residents were new admits and they had not received their meds from the pharmacy. Review of the resident's hospital ED records, showed: -Arrival Date/Time: 9/11/24 at 6:20 P.M -Chief Complaint: The resident was unable to get off toilet at Skilled Nursing Facility. There for BKA on right knee. Alert and orientated time three to four (to self, place, time, and situation). -History of Present Illness: The patient was brought in EMS with complaints of being left on the toilet for the past three hours per the patient, resulting in stiffness and pain to his/her buttocks. -Nurse ED note, dated 9/11/24 at 8:17 P.M., Multiple attempts have been made to contact nursing staff at the facility with no response. Patient is amenable to waiting until contact can be made and then returned to facility. Des [NAME] PD has been contacted and is sending a patrol officer to conduct a wellness check on the staff at the facility as the patient, ED Nursing staff and PD have n

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 46970 Based on interview and record review, the facility failed to follow their written policy when staff did not permit one resident (Resident #2) to return to the facility after he/she had been transported to the hospital. The census was 129. Review of the facility's Discharge Transfer Involuntary policy, last reviewed 10/7/21, showed: Policy: -Transfer and discharge include movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless specific criteria, as outlined below, are met. Responsibility: -All staff monitored by the Director of Nursing (DON) and Administrator; Procedure: -A written or telephone order is required from the attending physician for the discharge of a resident, except in emergency situations; -The Interdisciplinary team and the resident's physician must document in the resident's record when a resident is transferred or discharged ; -If transferred to another health care facility upon order of the physician, a transfer form is completed, and a copy is sent with the resident; -Before a facility can transfer a resident to a hospital or allows a resident to go on therapeutic leave the nursing facility must provide written information to the resident and the resident representative or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding the bed-hold; -The resident may be transferred or discharged on ly when the Interdisciplinary Care Team, in consultation with the resident's designated representative, determines that one or more of the following criteria are met: -The facility may discharge a resident for nonpayment. Nonpayment occurs when the resident and/or the designated representative fail to make full payment for facility charges incurred by the resident either from private funds, or through Medicare, Medicaid or other third-party payor. Discharges from the facility for nonpayment shall be in accordance with applicable state law and regulation. Nonpayment applies if the resident does not submit the necessary paperwork for third-party payment; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In the case of a resident who is receiving Medicaid benefits, it is the policy of the facility that non-receipt by the facility of the resident's Medicaid assigned amount is cause for involuntary discharge of the resident; -The facility may involuntary transfer or discharge the resident (Bullets 1 through 4 require physician documentation in the medical record): 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; 2. The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; 3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; 4. The health of individuals in the facility would otherwise be endangered; 5. The resident's urgent medical needs require an immediate transfer or discharge; 6. If the facility closes or ceases to exist; -Involuntary discharge will be effective after the minimum notice requirements prescribed by applicable state law and regulation, or thirty (30) day notice if no state law or regulation is applicable (unless the health or safety of others in the facility is jeopardized), subject to any legal rights of appeal or challenge prescribed by law; -Prior to resident being transferred or discharged , the facility must provide a written notice to the resident, and if known, a family member or legal representative of the resident. This must be issued at least 30 days before the resident is transferred or discharged ; -The written discharge notice must contain the following information: -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident is transferred or discharged to; -A statement that the resident has the right to the action to the State Long-Term Care Ombudsman, including the name, address, and telephone number of the Ombudsman; A copy of the transfer notice is to be sent to a representative of the Office of the State Long-Term Care Ombudsman; -A statement that, if the resident whose proposed discharge is based on improved health or failure to pay, appeals the transfer to discharge to the Department of Health within 15 days of being notified, the resident may remain in the facility pending the appeal determination; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility may not transfer or discharge a resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice unless the failure to transfer or discharge would endanger the health or safety of the resident or other individuals in the facility. Review of Resident #2's physician order sheet, showed: -Admit to skilled services 8/5/24; -No hospital transfer order. -Review of the resident's Nursing Evaluation and Baseline Care Plan, dated 8/5/24 at 9:24 P.M., showed: -Confused, short-term and long-term memory problem; -Self-care: admission performance - dependent; -Mobility: admission performance - dependent. Review of Emergency Medical Service (EMS) Patient Care Report, dated 8/7/24 at 4:33 A.M., showed: -Type of service requested: Hospital to non-hospital facility transfer; -Response mode to scene: Non-emergent; -Provider impression: No apparent illness or injury (Adult); -Narrative: Dispatch to hospital for the transport of patient back to the facility for extended care. Patient was transported to ambulance and loaded by crew. It should be noted that charge nurse and other nursing staff was unable to get ahold of the nursing home and the staff was unsure of whether the facility would accept him/her back despite a legal responsibility to do so. At destination patient was unloaded from the ambulance and brought into facility. In facility, nurse in charge of care refused to sign a transfer of care for the patient. Crew then transported patient to the ambulance and loaded him/her. Review of the EMS narrative dated 8/7/24 at 5:57 A.M., showed: -Continuing from previous incident, the facility refused to sign a transfer of care and accept the patient; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Emergency Medical Technician (EMT) contacted the charge Registered Nurse (RN) at the hospital to inform them of the returning patient. Charge RN requested to speak with facility staff. EMT obliged and re-entered the building to speak with nursing home staff. EMT repeated what Charge RN had said that the nursing facility has a legal obligation to accept the patient back as a resident as they have not given proper notice. The facility nurse in charge of area responded that since the patient had called 911, he/she did not want to be there and that it wasn't his/her problem. The facility nurse also stated that he/she didn't have any information on the patient as their system was down and the patient left before he/she arrived. Charge RN was put on speaker phone and Charge RN reiterated hospitals position that since patient had been medically cleared, they could not keep in emergency room (ER) bed. Charge RN also reiterated the legal responsibility of the nursing facility and that they would report them for not accepting patient. After this Charge RN told EMT that they would accept patient back at the hospital. EMT once again asked if the facility nurse would he/she sign a transfer of care, nurse once again refused. EMT returned to ambulance. Review of the resident's progress notes, showed: -No nursing note documentation related to the notification of the physician and/or order to transfer the resident to the hospital; -No nursing note documentation related to hospital updates and/or the resident's status; -No documentation of the resident's return from the hospital, refusal to admit the resident back upon EMT arrival, or rational for refusal to permit the resident back to the facility; -No documentation of bed-hold; -No documentation of a 30-day discharge notice; -No written or telephone physician order to discharge the resident; -No documentation to show the resident was unsafe or a danger to self or others. Review of the facility's admission, discharge, and hospitalization , dated 8/1/24 through 9/15/24, showed, no documentation of the resident's admission, hospitalization , or discharge. During an interview on 9/18/24 at 10:32 A.M., both the Administrator and DON said they didn't know who the resident was or where he/she was at. The Administrator said she only just now found out the resident was transferred to another facility on 8/17/24. The Administrator and DON expected nursing to have documented the status of the resident and any updates from the hospital. During an interview on 9/18/24 at 11:07 A.M., the Administrator said she expected staff to accept the resident back. She said the only reason the resident would not have been accepted back would have been if the facility couldn't meet the resident's needs. The Administrator said no staff member could make the decision to not take the resident back. She said they usually discuss when they are not taking a resident back, but no discussion was had about the resident not returning. MO00240172

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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** 22409 Surveyor: [NAME], [NAME] Based on interview and record review, the facility failed to ensure residents had complete, accurate, and individualized care plans to address the specific needs of one of three sampled residents (Resident #10). The census was 129. Review of the facility's Comprehensive Person-Centered Care Plan Policy and Procedure, reviewed [DATE], showed: -Policy: Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences and goals that identify how the interdisciplinary team will provide care; -Procedure: The comprehensive care plan shall be fully developed within 7 days after the completion of the Admission Minimum Data Set (MDS). The interdisciplinary team, along with the resident and/or resident representative, will identify the resident problems, needs, strengths, life history, preferences, and goals. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -admitted [DATE]; -Diagnoses included high blood pressure, peripheral vascular disease (lack of blood flow to the legs), diabetes, high cholesterol and stroke; -Cognitively intact; -Wounds. Review of the resident's care plan, in use at the time of the survey, showed: -A history of/potential for resistance to care adjustment to a nursing home dated [DATE] (from a previous admission); -Interventions included: Allow the resident to make decisions about treatment regimen, to provide sense of control; -Resident's responsible party, requests code status of Full Code - Initiate CPR (life saving methods) dated [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:13 P.M., the MDS/Care Plan Coordinator said a comprehensive care plan should be done within 14 days of admission. During the morning clinical meeting, she takes notes and then makes changes to the care plan at a later time. She is aware that a comprehensive care plan was not in the resident's chart on [DATE]. She said I am doing the best I can. During an interview on [DATE] at 1:22 P.M., Director of Nursing and Administrator said the expectation is that every resident has a comprehensive care plan done within the 14 days of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure resident care plans were revised timely. One resident returned from the hospital with a diagnosis of aspiration pneumonia (a type of lung infection that is due to material from the stomach or mouth entering the lungs) and aspiration precautions to be used during meals which had not been added to the care plan (Resident #5). In addition, the facility failed to add fall interventions to another resident's care plan (Resident #13). The census was 129. Review of the facility Fall Management policy, last reviewed on 2/28/23, showed: -Policy: To provide an environment that remains as free of accident hazards as possible. The facility will complete a Morse Fall Scale Evaluation on residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further falls and/or to reduce injuries; -Responsibility: Nursing Personnel, Nursing Administration, and Director of Nursing (DON); -Prevention/Treatment: The care plan should be reviewed after every fall and updated with a new intervention; -Interdisciplinary Team: Review post-fall residents within 24-72 hours during clinical meeting. Revise/modify care plan. Implement interventions according to treatment approach to minimize further falls and reduce injury. Review of the Licensed Practical Nurse (LPN) job description, revised 5/2022, showed: -Initiates and leads individualized nursing care plans; -Accurately and promptly implements physician's orders. 1. Review of Resident #5's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 8/14/24, showed: -Speech Clarity: Unclear speech - slurred or mumbled words; -Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Severely impaired cognition; -Eating: Partial/moderate assistance - Helper does less than half the effort; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of renal (kidney) insufficiency and depression; -Weight: 98 pounds (lbs); -Special Treatments and Programs: Dialysis (a treatment for kidney failure that rids the body of unwanted toxins, waste products, and excess fluids by filtering your blood). Review of the resident's care plan, located in the EMR, showed: -6/28/24: Focus: activities of daily living (ADL) self-care performance deficit. Goal: Increase in strength, mobility, endurance, and independence. Interventions: The resident requires assistive device to maximize independence with eating; -6/28/24: Focus: Dialysis related to renal failure. Goal: Will have no signs/symptoms of complications from dialysis. Interventions: Encourage resident to go for the scheduled dialysis appointments. Review of the resident's progress note, located in the EMR, showed: -9/10/24 at 2:07 P.M.: This nurse called to room by resident who stated he/she did not feel good and requested to be sent to the hospital. Upon assessment, resident lying in bed, unable to hold head up looking weak and slightly lethargic. Contacted resident's physician's Nurse Practitioner, ok'd transfer (to hospital). Review of a hospital discharge summary, dated 9/14/24, showed: -Resident presented to hospital on 9/10/24 for chief complaint of weight loss, diarrhea. He/She was diagnosed with colitis (inflammation of the colon or the large intestine), as well as aspiration pneumonia. GI (gastroenterologist) was consulted for replacement of PEG (percutaneous endoscopic gastrostomy - a tube is inserted into the stomach through the abdominal wall) this admission; -Aspiration Precautions: Sit at 90 degree angle (chin to neck angle-not HOB (head of bed)). Alternate liquids and solids, small, single sips, small bites, no straws, 100% supervision. Review of the resident's progress note, located in the EMR, showed: -9/14/24 at 5:56 P.M.: Resident arrived via stretcher with EMS (emergency medical services) from hospital. Orders received to continue hospital discharge orders. Review of the resident's POS, showed: -9/14/24: Aspiration precautions - sit at 90 degree angle (chin to neck angle - not head of bed), alternate liquids and solids, small, single sips, small bites, no straws, 100% supervision. Review of the resident's care plan on 9/17/24, showed the care plan had not been updated to show the aspiration precautions ordered on 9/14/24. Observation on 9/17/24, showed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9:10 A.M.: The resident lay in bed. Certified Nurse Aide (CNA) D served the resident breakfast then left the room. The resident had no supervision at that time. At 9:30 A.M., the resident remained without supervision in his/her room with the breakfast tray in front of him/her. The resident's breakfast tray was untouched. The resident said he/she can feed himself/herself, and he/she did not have any swallowing problems; -12:41 P.M.: CNA D served the resident lunch. The CNA fed the resident a few normal sized bites of food. The resident was not instructed to hold his/her chin to neck while eating. The CNA left the room and returned with a straw for the orange drink. While the CNA was gone to get the straw, the resident ate some of his/her cake. The CNA gave the resident a drink with the straw and a couple more normal sized bites of food. The CNA said the resident did not have any aspiration precautions he/she was aware of. The CNA left the resident unsupervised at that time. At 12:50 P.M. CNA H and LPN C entered the room. The CNA said the resident had a poor appetite. He/She fed the resident a couple more normal sized bites of food. The CNA and LPN said they were not aware of any aspiration precautions for the resident and neither knew the resident required supervision at all times while eating. During an interview on 9/17/24 at 12:03 P.M., the MDS/Care Plan Coordinator said she did a 5 day assessment when a resident returned from the hospital to see if there was anything new that should be added to the care plan. The admitting nurse should notify her if something new should be added to the care plan. The aspiration precautions should be on the care plan. During an interview on 9/18/24 at 9:34 A.M., the Administrator and DON said the aspiration orders should have been added to the care plan. 2. Review of Resident #13's admission MDS dated [DATE], showed: -Speech Clarity: No speech - absence of spoken words; -Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Functional limitation of one upper extremity and both lower extremities; -Roll left to right: Dependent; -Diagnoses of traumatic brain injury (a brain injury caused by an outside force such as a bump, blow or jolt to the head), and respiratory failure; -Falls in the last 2 to 6 months prior to admission?: Yes; -Any falls since admission?: No. Review of the resident's care plan. located in the EMR, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/3/24: Focus: Limited physical mobility related to neurological deficits. Goal: Will remain free from complication related to immobility. Interventions: Ambulation - does not walk. Locomotion - dependent on one person via wheelchair; -7/3/24: Focus: Communication problem identified, expressive aphasia (absence of speech); Goal: Will develop communication abilities. Interventions: Anticipate and meet needs. Ensure/provide safe environment. Bed in lowest position; -7/3/24: Focus: The resident is at risk for falls. Goal: Resident will be free of minor injury. Interventions: Anticipate and meet the resident's needs. Be sure the call light is within reach and encourage the resident to use it for assistance as needed. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Review of the resident's progress note's, located in the EMR, showed: -7/26/24 at 4:15 A.M.: During routine rounds, resident found under the bed. Resident is unable to explain what happened due to medical condition. EMS here to transport resident to hospital for evaluation and treatment; -7/30/24 at 6:58 P.M.: Resident readmitted . Resident is alert and follows person with eyes but remains nonverbal. Resident displays no acute distress or evidence of pain. New order received and noted for bilateral fall mats (placed on the floor next to the bed) maintenance notified of need (for fall mats). Review of the resident's POS, located in the EMR, showed: -8/30/24: Low bed with fall mats on each side. Observation on 9/16/24 at 7:27 A.M. and 12:55 P.M., showed the resident lay in bed with one mattress on the floor between the bed and the room door, but no mattress between the bed and the window. Observation on 9/17/24, showed: -8:24 A.M., the resident lay in bed with one mat on each side of the bed. The height of the bed was 37 inches () from the floor to the top of the mattress; -11:55 A.M., the resident lay in bed with one mat on each side of the bed. The height of the bed was 30 from the floor to the top of the mattress. During an interview on 9/17/24 at 12:03 P.M., the MDS/Care Plan Coordinator said the use of the mats and the bed in the lowest position should have been added to the resident's care plan. She did not know why she had not added those interventions after the resident's fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/18/24, showed at 7:10 A.M., the resident lay in bed with one mat on each side of the bed. CNA H said the mats were on the floor because the resident was at risk to fall from the bed. He/She worked this past weekend and the resident only had one mat on the floor. He/She told the nurse the resident only had one mat, but when he/she left on Sunday, the resident still had one mat. The resident had not fallen out of the bed as far as he/she was aware. Therapy had been working with the resident and the resident could swing his/her legs over the side of the bed now. The bed should always be in the lowest position when staff were not working with the resident. He/She raised the resident's bed to the highest possible level and it was 39" from the floor to the top of the mattress. He/She lowered the bed to the lowest possible position and it was 20. During an interview on 9/18/24 at 9:34 A.M., the Administrator and DON said the policies they provided are current and what they expect staff to follow. There should be a mat on both sides of the resident's bed, not just one side. When staff were not in the room working with the resident, the bed should be left in the lowest possible position. The mats and the lowest bed position should be added to the care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on interview and record review, the facility failed to provide services that meet professional standards of clinical practice. On the day shift (7:00 A.M.-3:00 P.M.) of 12/15/24, on [NAME] Hall, the facility failed to ensure a Licensed Practical Nurse (LPN) or a Registered Nurse (RN) was available to administer medications and gastrostomy (g-tube) flushes, provide treatments, complete assessments, and/or monitoring of residents as ordered and the Director of Nursing (DON), who arrived at the facility between 3:00 P.M. and 4:00 P.M. on 12/15/24, falsely documented he/she administered medications and g-tube flushes, completed treatments and assessments and/or monitoring of residents from 7:00 A.M. through 3:00 P.M. Forty-one residents resided on [NAME] hall. Fifteen were sampled and problems were identified with all 15 (Residents #6, #14, #34, #43, #44, #50, #56, #57, #58, #59, #60, #61, #62, #6, and #64). In addition, LPN FF and/or Certified Medication Technician (CMT) GG obtained resident blood glucose levels and/or administered insulin to residents on the day shift of 12/15/24, but were unable to record the blood glucose levels and insulin administration into the Medication Administration Record (MAR). A list of the blood glucose levels and a list of the residents who received insulin was left with the DON who entered those blood glucose levels and insulin administration in the MAR using his/her electronic signature/initials, falsely indicating the DON had obtained the blood glucose levels and had given the insulin. The facility identified 17 residents who received blood glucose levels and/or received insulin on the [NAME] Hall. Ten were sampled and problems were found with all 10 (Residents #6, #14, #44, #57, #58, #60, #61, #62, #63 and #64). The census was 116. Review of the facility's Medication Administration - General Guidelines policy, dated 12/2017, showed: -Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions; -2. Medications are administered in accordance with written orders of the prescriber; -3. When medications are administered by mobile cart taken to the resident's location, medications are administered at the time they are prepared; -7. The person who prepares the dose for administration is the person who administers the dose; -D. Documentation: -1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medication; -4. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7. If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due to specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs are described in the system's user manual. These procedures should be followed. 1. Review of the following MARs and/or Treatment Administration Records (TARs), dated 12/1/24 through 12/31/24, showed the DON initialed the following orders after he/she arrived at the facility between 9:00 P.M. and 10:00 P.M. on 12/15/24, for residents who resided on the [NAME] Hall: Review of Resident #6's MAR/TAR, showed: -Order Date 12/10/24: May have 1 liter of oxygen to keep oxygen saturation above 92% (normal oxygen saturation is 92-100%). The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 12/12/24: Pain scale (assessment) 1-10 (pain is assessed on a scale of 1-10, the higher the number the greater the pain) every shift. The DON initialed the pain scale for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; -Order Date 12/10/24: Apply moisturizer two times a day for dry skin. The DON initialed the order was completed at 8:00 A.M.; -Order Date 12/10/24: Apply heel boots (pressure relieving boots) while in bed every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 12/10/24: Float heels off mattress every shift. The DON initialed the order from 7:00 A.M.-3:00 P.M. Review of Resident #14's MAR/TAR, showed: -Order Date 10/15/24: Maintain aspiration precautions (interventions to prevent fluid/foods from entering the lungs) every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/14/22: Offer resident snacks three times a day. The DON initialed the resident was offered a snack at 9:00 A.M.; -Order Date 9/14/24: Record pain on 0 to 10 scale. The DON initialed the pain scale for 7:00 A.M.-3:00 P.M., and documented a pain level of 0. Review of Resident #34's MAR, showed: -Order Date 10/15/24: Maintain aspiration precautions every shift. The DON initialed the order for 7:00 A.M. -3:00 P.M.; -Order Date 7/23/24: Pain assessment. The DON initialed the pain scale for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 9/19/24: Water flush to gastrostomy tube (g-tube, inserted into the stomach through the abdomen for the purpose of administering nutrition, hydration, medications) 200 milliliters (ml) every four hours for hydration. The DON initialed she administered the flush at 12:00 P.M. Review of Resident #43's MAR/TAR, showed: -Order Date 10/23/24: Barrier cream may be used to bilateral buttocks. The DON initialed the barrier cream order for 7:00 A.M.-3:00 P.M.; -Order Date 5/28/24: Artificial tears ophthalmic solution (Visine), instill 1 drop in both eyes three times a day. The DON initialed the eye drop order as administered at 12:00 P.M.; -Order Date 8/8/23: Baclofen (skeletal muscle relaxant) 5 milligrams (mg). Give two tablets via g-tube three times a day. The DON initialed she administered the medication at 2:00 P.M.; -Order Date 1/18/24: Behavior monitoring agitation. The DON initialed the resident had no behaviors from 7:00 A.M.-3:00 P.M.; -Order Date 5/3/24: Sinemet (Parkinson's medication) 25-100 mg. Give one tablet via g-tube three times a day. The DON initialed she administered the medication at 2:00 P.M.; -Order Date 5/11/24: Flush g-tube with 250 ml water every four hours. The DON initialed she administered the g-tube flush at 12:00 P.M.; -Order Date 5/29/24: Petroleum jelly lip treatment. Apply to lips every day and every evening. The DON initialed she applied the petroleum jelly to the resident's lips for 7:00 A.M.-3:00 P.M.; -Order Date 12/1/22: Mouth care every shift. The DON initialed the resident's mouth care was completed for 7:00 A.M.-3:00 P.M. -Order Date 10/30/24: Off loading boots every shift. The DON initialed the resident wore the off loading boots for 7:00 A.M.-3:00 P.M.; -Order Date 11/17/24: Record pain on a 0 to 10 scale. The DON initialed the pain score for 7:00 A.M.-3:00 P.M., and documented a pain level of 0. Review of Resident #44's MAR/TAR, showed: -Order Date 3/29/23: Monitor for anticoagulant (blood thinner) side effects. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 1/18/23: Monitor behaviors for agitation. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/8/22: Low bed and floor mat in place at all times. The DON initialed the order for 7:00 A.M.-3:00 P.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 8/24/22: Offer resident snacks three times a day. The DON initialed the order at 9:00 A.M.; -Order Date 8/24/22: Record pain on a 0 to 10 scale. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; -Order Date 2/9/23: Reposition resident to the center of the bed every 2 hours to prevent bruising, skin abrasion, and other trauma to left arm. The DON initialed the order at 10:00 A.M. and 1:00 P.M Review of Resident #50's MAR, showed: -Order Date 12/8/24: Pain scale 1-10 every shift. The DON initialed the pain score for 7:00 A.M.-3:00 P.M., and documented a pain level of 0. Review of Resident #56's MAR, showed: -Order Date 12/6/23: Ipratropium-Albuteral inhalation solution (bronchodilators that relax muscles in the airways and increases air flow) 3 ml inhale orally via nebulizer every four hours for shortness of breath. The DON initialed the order was administered at 8:00 A.M. and 12:00 P.M.; -Order Date 10/15/24: Maintain aspiration precautions every shift. The DON initialed the order for 7:00 A.M. -3:00 P.M.; -Order Date 10/30/23: Oxygen at 2 liters via nasal cannula. The DON initialed the order for 7:00 A.M.-3:00 P. M.; -Order Date 10/30/23: Hydralazine (blood pressure medication) 25 mg. Give 1 tablet via g-tube every 8 hours. The DON initialed the medication was administered at 8:00 A.M., and documented a blood pressure of 124/82; -Order Date 11/1/23: Resident should have on booties while in bed. The DON initialed the booties were on at 8:00 A.M.; -Order Date 10/30/23: Valproic acid (anticonvulsant/seizure medication) give 5 ml via g-tube every 8 hours anticonvulsant related to seizures. The DON initialed the medication was administered at 8:00 A.M. and 2:00 P.M. Review of Resident #57's MAR/TAR, showed: -Order Date 12/3/24: Elevate float heels every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/28/24: Oxygen at 3 liters per nasal cannula continuously. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 12/1/24: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. The resident's pain score was not documented; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 12/3/24: Reposition every 2 hours every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 12/1/24: Hoyer lift (a machine used to transfer a resident who cannot bear weight) every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. Review of Resident #58's MAR, showed: -Order Date 12/5/24: Antibiotic charting (the resident started doxycycline 100 mg at 8:00 A.M. and 10:00 P.M. , for infection on 12/4/24) every shift for the duration of antibiotic therapy. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/8/23: Antianxiety monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/8/23: Anticoagulant medication monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/8/23: Behavior monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 9/8/23: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. The resident's pain level was not documented; -Order Date 9/8/23: Sedative/Hypnotic (sleeping pill) monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. Review of Resident #59's MAR, showed: -Order Date 11/8/24: Behavior monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/9/24: Fall precautions every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/8/24: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; -Order Date 11/11/24: Seizure precautions every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/12/24: Monitor for side effects for antidepressant every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented NO for side effects; -Order Date 11/8/24: Monitor for side effects for sedative/hypnotic. The DON initialed the order for 7:00 A.M. -3:00 P.M. Review of Resident #60's MAR, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 2/20/24: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented a pain level of 0. Review of Resident #61's MAR/TAR, showed: -Order Date 2/24/24: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. The resident's pain level was not documented; -Order Date 2/25/24: Weekly skin evaluation. The DON initialed the order for 7:00 A.M.-3:00 P.M. Review of Resident #62's MAR, showed: -Order Date 10/9/24: Monitor for anticoagulant side effects. The DON initialed the order for 7:00 A.M.-3:00 P. M.; -Order Date 6/12/24: Pain scale 1-10 every shift. The DON initialed the order 7:00 A.M.-3:00 P.M. The resident's pain level was not documented. Review of Resident #63's MAR, showed: -Order Date 11/12/24: Aspiration precautions every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/12/24: Monitor for anticoagulant side effects every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 11/12/24: Pain scale 1-10 every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; -Order Date 11/12/24: Monitor for antidepressant side effects. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented NO for side effects. Review of Resident #64's MAR/TAR, showed: -Order Date 4/10/24: Check bruit and thrill (bruit, a rumbling sound you can hear and thrill, a rumbling sensation you can feel. Both are assessments for residents with dialysis fistulas (an access port for dialysis)) every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M.; -Order Date 10/14/24: Monitor for signs/symptoms of fluid overload every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented no; -Order Date 4/10/24: Monitor for side effects for antipsychotic use. The DON initialed the order for 7:00 A.M. -3:00 P.M., and documented NO; -Order Date 4/10/24: Pain assessment every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M., and documented a pain level of 0; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 4/10/24: Behavior monitoring every shift. The DON initialed the order for 7:00 A.M.-3:00 P.M. 2. Review of the following MARs, dated 12/1/24 through 12/31/24, showed the DON initialed the following insulin administration, blood glucose results and vital signs that had been administered, completed and/or obtained by LPN FF (night shift) and/or CMT GG (day shift) on the day shift (7:00 A.M.-3:00 P.M.) on 12/15/24, for residents who resided on the [NAME] Hall: Review of Resident #6's MAR, showed: -A blood pressure of 133/66 at 8:00 A.M., obtained by LPN FF. Review of Resident #14's MAR, showed: -A blood glucose level of 179 at 8:00 A.M., obtained by LPN FF. A blood glucose level of 149 at 12:00 P.M., obtained by CMT GG Review of Resident #44's MAR, showed: -A blood glucose level of 133 at 8:00 A.M., obtained by LPN FF. Review of Resident #57's MAR, showed: -A blood glucose level of 179 at 8:00 A.M., obtained by LPN FF. A blood glucose level of 133 at 11:00 A.M., obtained by CMT GG. Review of Resident #58's MAR, showed: -A blood glucose level of 142 at 8:00 A.M., obtained by LPN FF. A blood glucose level of 133 at 12:00 P.M., obtained by CMT GG; -Order Date 9/18/23: Lispro (a fast acting insulin) 12 units (u) at 8:00 A.M., and administered by LPN FF. Lispro 12 u at 12:00 P.M., and administered by CMT GG. Review of Resident #60's MAR, showed: -A blood glucose level of 149 at 8:00 A.M., obtained by LPN FF. Review of Resident #61's MAR, showed: -A blood glucose level of 142 at 8:00 A.M., obtained by LPN FF. Review of Resident #62's MAR, showed: -Order Date 8/14/24: Insulin glargine (a long acting insulin) 25 u at 8:00 A.M., administered by LPN FF; -A blood glucose level of 245 at 8:00 A.M., obtained by LPN FF; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date 10/3/24: Lispro 3 u administered per sliding scale (insulin is administered based on the blood glucose level) by LPN FF; -A blood glucose level of 142 at 12:00 P.M., obtained by CMT GG; -Lispro 1 u administered per sliding scale by CMT GG. Review of Resident #63's MAR, showed: -A blood glucose level of 192 at 8:00 A.M., obtained by LPN FF: -Order Date 12/4/24: Lispro 5 u at 8:00 A.M., administered by LPN FF. Review of Resident #64's MAR, showed: -A blood glucose level of 133 at 8:00 A.M., obtained by LPN FF. A blood glucose level of 149 at 11:30 A.M., obtained by CMT GG; -Order Date 10/2/24: Lantus (long acting insulin) 5 u at 9:00 A.M., administered by LPN FF. 3. During an interview on 12/19/24 at 3:03 P.M., LPN CC said he/she worked downstairs on the day shift of 12/15/24. He/She did not see the DON in the building until 5:00 P.M. to 5:30 P.M. During an interview on 12/20/24 at 10:25 A.M., Business Office Manager Q said he/she was Manager On Duty on 12/15/24, and was at the facility from 8:00 A.M. until 1:45 P.M. He/She did not see the DON while he/she was at the facility. During an interview on 12/20/24 at 11:42 A.M., RN W said he/she arrived for work on the [NAME] hall on 12/15/24 at 3:00 P.M. The DON did not come up to [NAME] until later, after he/she arrived, to give RN W his/her electronic log in. RN W could not recall the exact time. The DON left after that and he/she did not see the DON for the remainder of his/her shift. RN W did not see the DON on the hall with the treatment cart or medication cart. He/She did not see the DON doing any treatments or passing any medications. During an interview on 12/23/24 at 8:46 A.M., the physician for Residents #6, #34, #50, #56, #57 and #63, said she expected staff to document medications, treatments, blood glucose levels and assessments accurately. A staff member should not document any medication, treatment, blood glucose level or assessment they did not do. That would be a major issue, an ethics issue. It could be harmful to a resident for a staff member to document a medication or treatment was administered when it was not. During an interview on 12/23/24 at 10:08 A.M., the facility's Medical Director said she expected staff to document medications, treatments, and assessments accurately. Staff should never document a medication or treatment had been administered or completed if it had not been. That would be lying. If medications or treatments are missed, the resident's physician should be notified. If a medication or treatment cannot be administered, staff should contact her. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/23/24 at 1:01 P.M., the DON said medications, treatments, assessments, vital signs should be initialed as completed at the time they are completed. Staff should follow facility policies and physician orders. If medications and treatments are not completed, the physician should be notified and it should be documented in the resident's progress notes. She arrived at the facility on 12/15/24 between 3:00 P.M. and 4:00 P.M., and left between 9:30 P.M. and 10:00 P.M. She spent her time going over admissions that came in and looking over documentation. She stayed in her office for a little bit, then went upstairs to inservice staff. She was not notified there was not a nurse on [NAME] hall upstairs. She was not in the building on the day shift. She initialed several of the day shift medications, treatments, assessments and monitoring as completed, but she did not do them. LPN FF and CMT GG left her a list of blood glucose levels and insulins they did. LPN FF worked the night shift and clocked out on 12/15/24 at 8:46 A.M. CMT GG is insulin certified and was working on another hall on the day shift. During an interview on 12/23/24 at 2:24 P.M., the Administrator and Regional Director of Operations said medications, treatments and assessments should be initialed as completed when they are done. They were aware the DON initialed the blood glucose levels and insulins for LPN FF and CMT GG. They were not aware the DON initialed the medications, treatments and assessments that were not done. They would not have approved of that had they known. They expected the DON to contact the physician and let him/her know the medications and treatments had not been done rather than initial she did them. During an interview on 12/31/24 at 4:53 P.M., the Administrator said she asked the DON why she documented something she did not do. The DON said it was not done maliciously. There was confusion and miscommunication. MO00246651 MO00246669

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F 0677 Level of Harm - 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** 22409 Based on observation, interview and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living, including toileting and incontinence care, received the necessary services to maintain good personal hygiene. This affected four out of four residents who were incontinent of bowel and/or bladder (Resident #33, #34, #45 and #46) when staff failed to provide incontinence care in a timely manner. Two additional residents (Residents #43 and #44) said staff frequently did not check them for incontinence every two hours and failed to answer their call lights timely when they needed to be changed. They were left wet for extended periods of time. The facility also failed to provide fresh ice water to three residents (Resident #31, #46 and #45). The census was 118. Review of the facility's Incontinent Care Policy, dated 7/21/22, showed: -Policy: The facility will provide incontinent care as directed in the plan of care. Incontinent care will include a skin evaluation of the resident; promoting hygiene and skin prevention with infection/irritation; -Responsibility: Nursing Assistant, Licensed Nurses, Nursing Administration, Infection Control Preventionist and Director of Nursing (DON). Review of the facility's Certified Nurse Aide (CNA) job description, revised 1/2024, showed: -Facilitates all care and service in a friendly customer-driven approach; assures Residents are treated with dignity and respect at all times; -Provides for activities of daily living by assisting with serving meals; feeding Residents as necessary; and ambulating, turning. and positioning Residents; toileting assistance; and providing fresh water and nourishment between meals; -Provides Residents with hygiene supports including nail care, light hair or other grooming, oral hygiene, bathing, and incontinence care; -Follows all company policies and procedures. 1. Review of Resident #33's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 8/6/24, showed: -Moderate cognitive impairment; -Rejection of care, not exhibited; -Upper extremity impairment on both sides; (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	-Toileting, shower, lower body dressing, put on and take off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer: substantial maximal assistance (helper does more than half the effort); -Always incontinent of bowel and bladder; -Diagnoses included deaf nonspeaking, muscle weakness, dementia, reduced mobility and insomnia (a sleep disorder that makes it hard to fall or stay asleep). Review of the resident's care plan during the survey, showed: -Focus: ADL, self-care performance deficit; -Goal: Resident requires assistance with ADL care and mobility; -Interventions: -Requires staff assistance to turn and reposition in bed; -Requires staff assistance to dress; -Transfer one assist; -Focus: The resident has bowel incontinence related to immobility; -Goal: The resident will have less than two episodes of incontinence per day through the review date; -Interventions: -Check resident every two hours and assist with toileting as needed; -Observe pattern of incontinence and initiate toileting schedule if indicated; -Provide loose fitting, easy to remove clothing; -Provide peri care after each incontinent episode; -Focus: Resident is incontinent of bowel and bladder; (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	During an interview and observation on 10/28/24 at 4:23 A.M., the resident lay in bed on his/her right side. Registered Nurse (RN) D said residents do not get changed often on the night shift. RN D pulled the white quilt back and pulled the resident's sweatpants down. Observation showed the resident wore two briefs. The brief that was closest to the resident's body was a pull up brief and the second brief (secured with fastening tape on the wings that attaches to the front of the brief) was located over the pull up. The brief was taped on both sides. The inner pull up was soiled with dried feces and the outer brief was soiled with urine. The white quilt had large yellow spots on it. RN D said the resident had not been changed on the night shift. Before exiting the room, RN D went to wash his/her hands in the resident's bathroom and there was a large amount of dried feces on the left side of the toilet seat. During an interview and observation on 10/28/24 at 5:54 A.M., with CNA E and Assistant Director of Nursing (ADON) M, CNA E said the resident took himself/herself to the bathroom. CNA E and ADON M entered the resident's room, and the resident lay in bed on his/her right side. CNA E removed the white quilt that had yellow spots on it. He/She pulled the resident's sweatpants down which showed the resident wore two briefs. The pull up brief closest to the resident's body had dried and fresh feces and the outer brief was soiled with urine. CNA E said the resident had the outer brief over the pull up, because the resident doesn't keep the pull up on. CNA E said he/she checked the resident around 1:30 A.M. or 2:00 A.M. and did not remember if the resident had both a pull up and brief on at that time. CNA E said he/she only checked the resident when he/she walked down the hall because the resident took himself/herself to the bathroom. CNA E said he/she glanced, peeked at the resident when he/she walked down the hall. CNA E assisted the resident in standing from the bed and the resident's sweatpants were wet down to his/her knees. The resident's shirt was wet up to his/her waist and below his/her elbows. CNA E walked and guided the resident to the bathroom. When CNA E entered the bathroom there was a large amount of dried feces on the right side of the toilet seat and side of the toilet. CNA E left the room and obtained supplies to clean the toilet. ADON M verified the resident was soiled and began looking for clean clothing for the resident in the resident's closet. ADON M had to exit the room to obtain clean clothing for the resident. CNA E returned and cleaned the toilet as the resident sat on the toilet seat. CNA E had the resident then stand and began cleaning the resident. The resident had no open areas or red areas. CNA E did not change the resident during the night shift. During an interview on 10/28/24, at 6:05 A.M., CNA E, said: -The resident often walked around the unit during the night; -He/She checked the resident for incontinence while the resident walked the halls last night; -CNA E checked for incontinence by peeking in the resident's brief. He/She also touched the resident's brief on the outside of his/clothes, on his/her lower buttocks. If the CNA felt the brief was hard it meant the resident was incontinent and needed care. During an interview on 10/31/24 at 7:23 A.M., ADON M said he/she expected staff to make rounds on the resident every two hours to check for incontinence. ADON M said it was inappropriate to see if the resident was soiled by feeling the resident's brief through his/her clothing while the resident walked down the hall. ADON M expected staff to provide privacy and to visually check the resident's brief to see if the resident was soiled. It was inappropriate to place a brief on top of a pull up to prevent a resident from removing the pull up. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	2. Review of Resident #34's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Unclear speech; -Rarely/never understood by others; -Rarely/never was able to understand others; -Short and Long term memory problems present; -Severely impaired cognitive skills for daily decision making; -Impairment to upper body on one side; -Impairment to lower body on both sides; -Wheel chair used for mobility; -Always incontinent of bowel and bladder; -Dependent on staff for toileting hygiene, shower/bathe self, upper and lower dressing, personal hygiene and all transfers. Review of the resident's care plan, undated, showed: -Problem: The resident had the potential for impaired skin integrity and/or development of pressure-related ulcers and/or breakdown related to incontinence and bedfast; -Interventions included: Assist with toileting needs an incontinence care on routine rounds and as needed; Assist as needed with toileting hygiene and with wearing and changing incontinence undergarments; -Problem: The resident was frequently incontinent of bowel and bladder; -Interventions included: Check and change for incontinence. Observation on 10/28/24 at 4:34 A.M., showed: -There was a strong odor of urine emitting from the resident's room into the hall; -The resident lay on his/her bed on a low air loss mattress; -RN D pulled the resident's bed covers down to show the resident wore two briefs; -The resident's outer brief was soaked with urine, with the padding in the brief in clumps; (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	-The resident lay in a pool of urine, with visible brown rings of urine on the sheet extending from the resident's thighs to his/her shoulders. During an interview on 10/28/24, at 4:35 A.M., RN D said: -He/She did not think the resident was changed during the night shift; -He/She verified the resident wore two briefs, both soaked with urine, and was lying in urine extending up to his/her shoulders. During an interview on 10/28/24, at 5:49 A.M., CNA E said: -He/She worked from 11:00 P.M. to 7:00 A.M. that day; -He/She was assigned to care for the resident; -He/She checked on the resident between 2:45 A.M. and 3:00 A.M. and the resident was not wet and did not require incontinence care; -He/She had just provided incontinence care to the resident; -He/She confirmed the resident was wearing a shirt that was wet with urine up to the middle of his/her back and the resident was lying on a wet absorbent pad before CNA E gave the resident incontinence care. 3. Review of Resident #45's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Wheelchair for locomotion; -Required maximal assistance for toileting hygiene, to shower/bathe self, for upper and lower body dressing, personal hygiene and to roll left and right in the bed; -Dependent on staff for chair/bed-to-chair transfers; -Always incontinent of bowel and bladder. Review of the resident's care plan, undated, showed: -Problem: ADL self-care performance deficit related to activity intolerance, cognitive impairment, debility and decreased mobility; -Interventions included: Required staff assistance to turn and reposition in bed; Required skin inspection with cares. Observe for redness, open areas, scratches, cuts, bruises and report changes to Nurse; -Problem: Bladder and bowel incontinence and was at risk for urinary tract infections; (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	-Interventions included: Apply incontinence cream after each incontinence episode; The resident wore briefs; Check and change for incontinence; -Problem: Potential for impairment to skin integrity/pressure ulcer development related to bowel/bladder incontinence and impaired mobility; -Interventions included: Apply incontinence cream after each incontinence episode; Pressure reducing mattress while in bed. Review of the resident's progress notes, showed no documentation the PCP or RRP was alerted to a change in the resident's skin or that a new order for treatment was obtained. Review of the resident's weekly skin assessment, dated 10/21/24, showed no new skin issues noted. There was no documentation to show existing skin issues. Observation on 10/28/24 at 4:50 A.M., showed: -A strong odor of urine and feces emitting from the resident's room into the hall; -The odor of urine and feces was strong upon entry into the room; -The resident was lying in his/her bed on a low air loss mattress; -The resident wore two briefs which were soaked with urine; -The resident was lying on an absorbent pad, placed under his/her buttocks, which was visibly soaked with urine; -The resident's sheet was visibly soaked with urine extending from below the resident's buttocks up to the resident's neck, with brown rings outlining the urine soaked areas; -The resident was wearing a hospital gown that was also urine soaked; -The resident had dried feces on his/her buttocks and inside the inner brief; -The resident's mattress was visibly wet with urine; -The resident's bilateral buttocks were reddened; -The resident's inner thighs were reddened. During an interview on 10/28/24, at 4:52 A.M. and at 5:06 A.M., the resident, said: -He/She had not received incontinence care since the evening before around 6:00 P.M.; -The staff did not usually provide incontinence care during the night shift; -Lying in a pool of urine on the wet sheet was annoying to the resident; (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	-He/She did not like wearing two briefs at once as the briefs cut into his/her inner thighs in a sawing motion and caused him/her pain. During an interview on 10/28/24, at 5:06 A.M., RN D said: -The resident's bilateral buttocks were red with suspected moisture associated skin damage (MASD); -The resident also had MASD located on his/her inner thighs. During an interview on 10/28/24, at 5:17 A.M., CNA F said: -He/She began work yesterday around 11:30 P.M.; -He/She rounded on his/her assigned residents every two hours to check if they needed incontinence care; -He/She was not able to get to the resident until 4:50 A.M. and he/she gave the resident incontinence care at that time; -He/She only put two briefs on residents if they asked for them; -It was not right to put two briefs on a resident because it was not possible to see if the inner brief was wet; -It was difficult for CNA F to give care to all his/her residents last night due to the lack of staff; -The resident required the assistance of two people when giving incontinence care and CNA F had to wait until CNA E, who worked the other hall, was able to assist. Review of the resident's weekly skin assessment, dated 10/28/24 at 12:43 P.M., showed no documentation of skin issues at the resident's buttocks or groin. During an interview on 10/29/24 at 6:19 A.M., the resident said he/she was changed at 10:00 P.M. last night and one other time earlier this morning. The resident's room had a very strong urine odor. The resident said he/she was unsure if he/she had on two briefs. The resident said it depended on what staff changed him/her if they put one or two briefs on. The resident said it seemed like they put two briefs on all the time. The resident said he/she was changed and repositioned one time each shift, but needed changed and repositioned more often. The resident said when he/she turned his/her call light on it took an hour to an hour and a half before staff responded to the call light. The resident also said staff did not offer ice water. The resident had a water pitcher on his/her bed side table without a lid with approximately 2 inches of water. The resident said the water in the cup was left over from the ice he/she requested yesterday after dinner. The resident would like ice water to be passed out each shift. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 10/29/24 at 6:36 A.M., RN D entered the resident's room and asked if he/she could check to see if the resident was wet. The resident agreed. RN D verified the resident had on two briefs and the briefs were soaked with urine. RN D said it was not appropriate for any resident to have on two briefs. If a resident wore two briefs, staff could think the resident was dry by only looking at the outer brief. If residents were left soiled for an extended periods of time it could cause skin integrity issues such as redness and skin breakdown that could lead to open areas. Observation and interview on 10/29/24 at 6:40 A.M., with the resident, showed: -He/She wore two briefs which were both visibly soaked with urine; -He/She did not like to wear two briefs as they were uncomfortable, too tight between his/her legs and cut into his/her groin. During an interview on 10/31/24 at 7:23 A.M., ADON M expected residents to be rounded on every two hours. ADON M expected residents to only have one brief on. The resident's skin integrity was at risk due to the moisture. It could cause skin break down because the briefs did not allow for oxygen to get to the skin. It was imperative to only use one brief on residents. 4. Review of Resident #46's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Rejection of care not exhibited; -Toileting, shower, upper and lower body dressing, put on and take off footwear, personal hygiene, and roll left and right: substantial maximal assistance; -Shower transfer, dependent; -Eating and oral hygiene: Partial moderate assistance (helper does less than half the effort); -Frequently incontinent of bladder; -Always incontinent of bowel; -Diagnoses included muscle weakness, dementia, difficulty in walking, and need for assistance with personal care. During an observation and interview on 10/28/24 at 4:51 A.M., RN D entered the resident's room and asked permission to check the resident's brief. The resident agreed. The resident said the last time he/she had been changed was at 5:00 P.M. the previous day. The resident said he/she had not been changed all night. The resident wore two briefs. The inner brief was brown and saturated with urine. The resident's room had a strong urine odor. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/28/24 at 12:01 P.M., the resident said he/she did not like to be soiled for extended periods of time. The resident also said his/her family got ice water for him/her on the days they were at the facility. On days the family was not at the facility, the resident was not offered ice water. During an interview on 10/29/24 at 7:30 A.M. and at 9:24 A.M., the resident, said: -There was a cup with approximately four inches of water on his/her bedside table, within reach; -He/She did not have fresh ice water; -He/She could not remember the last time staff gave him/her fresh ice water; -Staff last checked on the resident around 6:00 A.M. that morning. The resident was not sure when staff would return; -The resident wanted fresh ice water and hoped staff would fill up his/her cup as it sure would be nice. During an interview on 10/31/24 at 6:20 A.M., the resident said he/she had not been changed since 10:00 P.M. the previous day. The resident said he/she was wet and needed changed. The resident's room had a strong odor of urine. During an observation and interview on 10/31/24 at 6:24 A.M., ADON M entered the resident's room and asked permission to check the resident's brief, and the resident agreed. The resident's room had a strong odor of urine. The resident wore one brief that was saturated with urine. The resident was lying on an absorbent pad that was also saturated with urine. The fitted sheet under the absorbent pad was also saturated with urine and had brown rings extending up to the middle of the resident's back. The resident's shirt was also saturated up to the middle of the resident's back. ADON M washed his/her hands and exited the room. ADON M walked up to CNA J who was sitting in the hallway and asked CNA J who had the resident. CNA J responded the resident was on another CNA's assignment. ADON M told CNA J the resident needed a full bed change and CNA J said he/she would assist the resident. During an interview on 10/31/24 at 7:23 A.M., ADON M said it was not appropriate for staff to not complete rounds every two hours on residents. He/She said it was not appropriate for a resident to not be changed from 10:00 P.M. unit 6:30 A.M. the following day. He/She said night shift started at 11:00 P.M. and the resident was not changed for the entire night shift. ADON M said he/she spoke to the night shift charge nurse and CNA J was the CNA responsible for completing rounds and changing the resident but he/she did not have an opportunity to speak with CNA J before he/she left. ADON M said CNA J reported the resident was on another CNA's assignment. ADON M said he/she expected staff to be knowledgeable of and follow the facility's policies. ADON M said he/she expected staff to make rounds on residents every two hours and know what residents they were responsible for each shift. 5. Review of Resident #43's annual MDS, dated [DATE], showed: -Adequate hearing; -Clear speech - distinct intelligible words; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0677 Level of Harm - Actual harm Residents Affected - Some	-Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; -Cognitively intact; -Always incontinent of bowel and bladder; -Diagnoses of anxiety and depression. Review of the resident's care plan, located in the electronic medical record (EMR), showed: -11/9/21, Focus: ADL self-care performance deficit; -Goal, Resident requires assistance with ADL care and mobility; -Interventions: Personal hygiene, one assist. Toilet use, utilize check and change to manage incontinence; -10/23/24, Focus: Frequently incontinent bowel and bladder; -Goal: Will remain free from skin breakdown; -Interventions: Incontinent. Check and change for incontinence. During an interview on 10/30/24 at 7:47 A.M., the resident said he/she was incontinent of bowel and bladder. It was not uncommon for staff to put two incontinent briefs on him/her on the night shift, which he/she did not mind. Most nights staff checked him/her for incontinence one time, which was not enough. Staff told the resident there was not enough help to check him/her more than once. If he/she turned on his/her call light it could take hours for staff to answer it. Or, they would answer it, turn the call light off and leave without taking care of him/her. It made him/her feel bad when he/she was left wet for long periods. 6. Review of Resident #44's annual MDS, dated [DATE], showed: -Adequate hearing; -Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; -Cognitively intact; -Always incontinent of bowel and bladder; -Diagnoses of anxiety and depression. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	Review of the resident's care plan, located in the EMR, showed: -8/22/23, Focus: Bladder incontinence related to impaired mobility; -Goal: Will remain from skin breakdown due to incontinence and brief use; -Interventions: Check as required for incontinence. During an interview on 10/30/24 at 7:37 A.M., the resident said he/she was incontinent of bowel and bladder. Most night shifts, staff would check and change him/her twice at the most; sometimes only once. In the past couple of weeks there had been some nights no one came to check him/her at all. Sometimes staff put two incontinent briefs on him/her but he/she would prefer only one. When he/she was checked once or not at all, he/she laid in a puddle of urine. Most nights he/she was unable to turn on his/her call light because staff did not leave the call light where he/she could reach it. When the call light was in reach and he/she turned it on, it could take hours for someone to answer it. He/She felt ignored by staff. 7. Review of Resident #31's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Rejection of care not exhibited; -Frequently incontinent of bowel and bladder; -Diagnosis included need for assistance with personal care, abnormalities of gait and mobility, muscle weakness, and reduced mobility. Review of the resident's care plan during the survey, showed: -Focus: ADL self-care performance deficit; -Goal: Resident requires assistance with ADL care and mobility; -Interventions: -Bed mobility requires staff assistance to turn and reposition in bed; -Toilet use requires staff assistance of one; -Transfer requires staff assistance of one; -Encourage use of call light. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/28/24 at 8:08 A.M., the resident said staff did not come in and offer to change him/her when he/she was soiled. The resident said he/she must get out of bed and change himself/herself and put the soiled briefs in the trash can next to his/her bed. The resident said the trash was just changed and was overflowing with soiled briefs. The staff member who came in and took the trash threw a fit and wanted to know why all the briefs were in the trash can. The resident then became tearful and said he/she was doing the best he/she could. The resident said it would be helpful if the staff assisted him/her to change his/her brief when soiled, but said staff would not assist him/her. The resident said it took up to two hours for staff to answer his/her call light if they came at all. The resident said staff did not pass or offer ice water. The resident said he/she had a small green cooler he/she kept on his/her walker. The resident filled this small cooler up himself/herself. 8. During an observation on 10/31/24 at 6:44 A.M. a resident walked up to the ice chest next to the nurse's station and opened the lid and said there was no ice in the cooler. The cooler was half full of water at that time. The resident made the comment that he/she last received ice before he/she went to bed. 9. During an interview on 10/28/24, at 4:10 A.M., RN D, said: -He/She worked the night shift from 11:00 P.M. until 7:00 A.M. last night; -There were two CNAs for 58 residents and one nurse during his/her shift; -He/She did not feel the residents were getting appropriate care as there was not enough staff to care for them; -Sometimes it took them over an hour to answer call lights and the residents were left wet for all that time because there were so many residents who required two people for direct care; -He/She had not told the Administrator or DON, as he/she understood they were already aware; -He/She had to wake CNA F around 1:00 A.M. to answer call lights. CNA F was sleeping at the nurses' station in a chair with a blanket; -He/She found CNA E asleep in a bed in an un-occupied resident room at 3:30 A.M.; -The CNAs typically started to round on residents at 5:00 A.M. to clean up the residents before day shift came in. During an interview on 10/28/24 at 5:18 A.M., CNA F said rounds should be completed every two hours. While making rounds residents were checked to see if they need to be changed, repositioned, trash was checked to see if it needed to be taken out and see if the residents needed fresh ice and water. CNA F said he/she completed rounds on night shift between 11:30 P.M. and 12:00 P.M., 2:00 A.M. and 5:00 A.M. CNA F said if residents wore two briefs, it helped the urine not go all the way to the resident's back. CNA F said it was not normal to put two briefs on residents. He/She would only put two briefs on a resident if they requested it. CNA F said when a resident had two briefs on it was hard to determine if the resident was wet. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/30/24 at 7:22 A.M., CNA F said night shift was from 11:00 P.M. to 7:00 A.M. and rounds were completed two times before 5:00 A.M. When he/she came in at 11:00 P.M. he/she made rounds with the evening shift CNA. During rounds he/she checked to see if residents needed ice water, tv remote, call light, if the residents needed to be changed or taken to the bathroom and made sure the residents were breathing. If a resident had on two briefs it was not good because the outer brief could look dry and the inner brief could be wet. He/She would be reluctant to change them if the resident looked dry. If residents were not changed it could cause them to get red bottoms or bed sores. CNA F said when there was only one CNA on each side and one nurse it took a long time to answer call lights. CNA F said if four to five call lights were on he/she would quickly go to each person with a call light on to make sure there was not an emergency like slipping off the bed or a fall. CNA F said he/she would then start changing the first resident that had the call light on. It took up to 20 minutes to change one resident because he/she had to go to the room see what he/she needed, then go to the clean utility closet and get supplies, then go back to the resident's room to clean and change the resident. CNA F said it could take up to an hour and forty minutes to answer a call light at times. During an interview on 10/30/24 at 7:00 A.M., CNA K said he/she worked the day shift, 7:00 A.M. until 3:00 P. M. When he/she started to get residents ready after first arriving on duty, it was not uncommon to find several residents wearing two incontinent briefs soaked through with urine. This occurred several times a week. He/She did not think those residents could possibly have been checked and changed every two to three hours. He/She had not told the nurses. During an interview on 10/30/24 at 7:27 A.M., CNA L said he/she worked the day shift. When he/she reported to work he/she started to get residents ready for the day. He/She frequently found residents heavily saturated in urine. Sometimes some residents wore two incontinent briefs, and they were saturated with urine. He/She did not feel those residents could possibly have been checked for incontinence every two hours. During an interview on 10/30/24 at 11:16 A.M., the Administrator and DON said they expected call lights to be answered within 15 to 20 minutes. They said it was not appropriate for residents wait for a call light to be answered over the period of one to two hours. If a resident waited one to two hours for a call light to be answered there was a risk if the resident needed to use the restroom, they could attempt to take themselves and fall. They wanted call lights answered as promptly as possible because the staff did not know what the resident needed. Ice water should be passed every shift at a minimum and more if needed. It was not appropriate to feel a resident's brief through the resident's clothing in the hallway to check and see if the resident was soiled. MO00242946 MO00241933 MO00243961

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to follow their policy by failing to ensure residents received care consistent with professional standards. Staff failed to follow physician orders and perform wound treatments for three of three residents sampled (Residents #10, #8 and #1). The facility also failed to assess a resident at the time of admission for one of three sampled residents (Resident #18). The census is 129. Review of the facility Wound Management policy, last reviewed on 11/15/22, showed: -Policy: To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders; -Procedure: Wound Management: -Wound treatment will be provided in accordance with physician's orders: Cleansing method, type of dressing and frequency of dressing change; -Charge Nurse will notify physician in the absence of treatment orders; -Wound dressings will be applied in accordance with manufacturer's recommendations; -Wound Characteristics/Documentation: Location of the wound. Size (shape, depth, tunneling and/or undermining), volume and drainage characteristics. Pain evaluation. Condition of the wound bed. Condition of the peri-wound (skin surrounding the wound); -Guidelines for Dressing Selection: Obtain physician's order; -Treatments will be documented on the Treatment Administration Record (TAR); -The effectiveness of the treatments will be monitored through ongoing evaluation of the wounds. Review of the facility Physician Orders policy, last reviewed on 9/28/22, showed: -Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines; -Responsibility: Licensed Nursing, Administration, and Director of Nursing (DON); -Procedure: Orders must be recorded in the medical record by the Licensed Nurse authorized to transcribe such orders. Physician orders must be documented clearly in the medical record. Physician orders must be documented clearly in the medical recorded. Physician orders will be transcribed to the appropriate administration record electronic medication administration record (eMAR) or electronic treatment administration record (eTAR). Review of the facility's Admission/Readmission Assessment policy revised 1/24/19, showed; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-Policy: Residents are to be evaluated upon admission or readmission; -Procedure: Complete the section for skin. Review of the Licensed Practical Nurse (LPN) job description, revised 5/2022, showed: Essential Functions of LPN: Assesses and documents the resident's condition and nursing needs. Performs treatments for assigned residents. Documents treatments as required. 1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/21/24, showed: -admitted [DATE]; -Diagnoses included high blood pressure, peripheral vascular disease (lack of blood flow to the legs), diabetes, high cholesterol and stroke; -Cognitively intact; -Wounds. Review of the resident's eTAR, dated September 2024, showed: -An order, dated 9/7/24, at 3:00 P.M., both lower extremities cleanse with wound cleanser, apply betamethasone valerate 0.1% ointment (a steroid that treats inflammation), cover with silicone dressing gauze and wrap with kerlix (gauze) every evening shift, every other day; -On 9/15/24 the treatment was documented as completed. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's treatment to both lower extremities. Observation on 9/16/24 at 6:52 A.M., showed the resident lay in bed. The resident said the dressings on his/her legs were not being done like the doctor said. The resident pulled the cover back and there were three dressings: left knee dated 9/14, dressing to right lower extremity dated 9/14 and left lower extremity dated 9/14. Certified Nursing Assistant (CNA) C read the dates on the dressing and confirmed the dates. Observation on 9/17/24 at 6:59 A.M., showed the resident lay in bed. The resident said the nurse came in and changed his/her dressings that morning around 5:30 A.M. The resident pulled the covers back and all three dressings were dated for 9/16. Observation on 9/17/24 at 3:49 P.M., showed the resident informed the wound doctor and wound nurse the dressing had not been changed on schedule. The wound nurse said the date showed 9/16, but the resident said the dressings were done that morning around 5:30 A.M. Observation on 9/18/24 at 8:08 A.M., showed the resident lay in bed. He/She reiterated the dressings were changed yesterday morning, and he/she remembered the nurse's name. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/18/24 at 8:15 A.M., LPN D said he/she changed the dressings on the resident the morning of 9/17/24, but could not recall the time. During an interview on 9/18/24 at 12:22 P.M., LPN E said dressings should be done as ordered by the physician and should be dated and initialed when the dressing was applied. During an interview on 9/18/24 at 1:22 P.M., the DON said the expectation was the nurses performed wound dressing changes as ordered to, initialed and dated the dressing when completed, and document the treatment had been completed. 2. Review of Resident #8's admission face sheet, showed: -admitted [DATE]; -Diagnoses of cellulitis (a bacterial skin infection) of left lower limb, malignant (cancerous) melanoma (skin cancer) of the left lower limb, high blood pressure and renal (kidney) disease. Review of the resident's skin observation tool, located in the electronic medical record (EMR), showed: -Date: 9/9/24 at 3:25 P.M., and Lock Date 9/16/24 at 3:30 P.M.: No documentation about a skin tear on the resident's left wrist/hand area. Review of the resident's progress note, located in the EMR, showed on 9/12/24 at 11:58 P.M., LPN G documented the resident slid to the floor onto his/her bottom while attempting to ambulate with walker to the restroom. Resident stated he/she became weak and slid to the floor. Zero complaints of pain or discomfort upon assessment. The documentation did not show the resident sustained any injuries as a result of the incident. Observation on 9/16/24 at 7:03 A.M., showed the resident lay in bed with a dressing on his/her left wrist/hand. The dressing was dated 9/12/24. The resident said the skin tear occurred when he/she fell a few days ago. No one had changed the dressing since 9/12/24. Review of the resident's Physician's Order Summary (POS) and TAR on 9/17/24, showed no order for a skin tear to the resident's left wrist/hand. During an interview on 9/17/24 at 10:35 A.M., LPN G said the resident fell on [DATE], and obtained a skin tear on his/her left wrist/hand. He/She cleaned the skin tear, applied a dressing and wrote the date 9/12 on the dressing. He/She should have contacted the physician and got an order and entered the order on the POS and TAR. LPN G got busy and forgot. The resident was admitted to the hospital yesterday and was not available for observation of the skin tear. During an interview on 9/18/24 at 12:47 P.M., the DON said LPN G should have assessed the resident's skin tear, called the physician, obtained an order and entered the order on the POS and TAR. All of that should have been documented. Normally a skin tear treatment would be ordered to be changed daily. If the order was not entered on the TAR, the EMR system would not alert the nurses to change the dressing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	3. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Diagnoses of Alzheimer's Disease, anxiety disorder and depression. Review of the resident's POS, showed: -An order dated 8/24/24, to cleanse right lateral forearm, clean with wound cleanser. Apply A&D ointment (a skin protectant that helps treat and/or prevent diaper rash/chapped skin) and wrap with kerlix, change every other day; -An order dated 8/29/24, to right proximal (located close/nearby) posterior (located behind) leg, clean with wound cleanser. Apply A&D ointment and wrap with kerlix, change dressing every other day. Review of the resident's TAR, showed the treatments initialed as completed every other day. Observation on 9/16/24 at 7:05 A.M., showed the resident had an undated dressing to the right lower extremity and right upper extremity. During an interview on 9/18/24 at 12:22 P.M., LPN E said dressings should be done as ordered by the physician and should be dated and initiated when the dressing is applied. During an interview on 9/18/24 at 1:22 P.M., the DON said the expectation was for nurses to perform wound dressing changes as ordered and initial and date the dressing when completed, and document the treatment had been completed. 4. Review of Resident #18's admission MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact. Review of the resident's medical record, showed diagnoses included hip fracture, high cholesterol, diabetes and anxiety disorder. Review of the resident's admission nursing assessment, dated 9/5/24, showed no assessment of a surgical wound to the right hip. Review of the resident's POS, showed no order for a dressing to the surgical incision to the right hip. Review of the resident's telephone hospital discharge summary to the nurse, not dated, showed: -Gauze dressing as needed; -Bruising to the right leg. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Observation and interview on 9/16/24 at 6:52 A.M., showed the resident had an undated dry dressing to the right hip. The dressing appeared to be old and the tape was soiled. The resident said that he/she did ask the nurses about the dressing this morning because he/she had a follow up with the orthopedic surgeon today. The response from the nurse was to let the doctor remove the dressing. Observation and interview on 9/16/24 at 7:14 A.M., showed the resident had an undated dry dressing to his/her right hip. The dressing appeared to be old and the tape was soiled. The resident said the nurses had not changed the dressing since he/she arrived at the facility. During an interview on 9/18/24 at 12:22 P.M., LPN E said a resident should be assessed from head to toe during an admission assessment and any dressings or surgical wounds should be noted on the assessment. If a resident has a dressing in place during the assessment and there is no order, the nurse should call the doctor for clarification. Surgical wounds should be assessed daily for drainage and infection. During an interview on 9/18/24 at 1:22 P.M., the DON said the expectation is the nurses perform a complete skin assessment when a resident admits to the facility. The nurses should note any dressings and wounds and clarify with the physician for treatment orders. Surgical wounds should be looked at daily and documented. MO00240093 MO00241424 MO00241889

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure staff followed aspiration precautions for one resident with a recent diagnosis of aspiration pneumonia (a type of lung infection that is due to material from the stomach or mouth entering the lungs) (Resident #5). In addition, the facility failed to ensure one resident with a history of falls, had a mat on the floor on both sides of his/her bed, and failed to ensure staff kept the resident's bed in the lowest possible position when the resident was in bed and unattended (Resident #13). The census was 129. Review of the facility Fall Management policy, last reviewed on 2/28/23, showed: -Policy: To provide an environment that remains as free of accident hazards as possible. The facility will complete a Morse Fall Scale Evaluation on residents to determine who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent to minimize further falls and/or to reduce injuries; -Responsibility: Nursing Personnel, Nursing Administration, and Director of Nursing (DON); -Prevention/Treatment: The care plan should be reviewed after every fall and updated with a new intervention; -Interdisciplinary Team: Review post-fall residents within 24-72 hours during clinical meeting. Revise/modify care plan. Implement interventions according to treatment approach to minimize further falls and reduce injury. Review of the Licensed Practical Nurse (LPN) job description, revised on 5/2022, showed: -Initiates and leads individualized nursing care plans; -Accurately and promptly implements physician's orders. Review of the Certified Nursing Assistant (CNA) job description, revised on 1/2024, showed: -Essential Functions of CNA: Provides for activities of daily living (ADL) by assisting with serving meals and feeding residents as necessary; -Assures all infection control, emergency planning, and other safety protocols are followed at all times. 1. Review of Resident #5's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 8/14/24, showed: -Speech Clarity: Unclear speech - slurred or mumbled words; (continued on next page)

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Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Severely impaired cognition; -Eating: Partial/moderate assistance - Helper does less than half the effort; -Diagnoses of renal (kidney) insufficiency and depression; -Weight: 98 pounds (lbs); -Special Treatments and Programs: Dialysis (a treatment for kidney failure that rids the body of unwanted toxins, waste products, and excess fluids by filtering your blood). Review of the resident's care plan, located in the EMR, showed: -6/28/24: Focus: activities of daily living (ADL) self-care performance deficit. Goal: Increase in strength, mobility, endurance, and independence. Interventions: The resident requires assistive device to maximize independence with eating; -6/28/24: Focus: Dialysis related to renal failure. Goal: Will have no signs/symptoms of complications from dialysis. Interventions: Encourage resident to go for the scheduled dialysis appointments. Review of the resident's physician order sheet (POS), located in the electronic medical record (EMR), showed: -An order, dated 9/10/24: In house dialysis on Monday/Wednesday/Friday. Review of the resident's progress note, located in the EMR, showed: -9/10/24 at 2:07 P.M.: This nurse called to room by resident who stated he/she did not feel good and requested to be sent to the hospital. Upon assessment, resident lying in bed, unable to hold head up looking weak and slightly lethargic. Contacted resident's physician's Nurse Practitioner, ok' d transfer (to hospital). Review of a hospital discharge summary, dated 9/14/24, showed: -Pertinent Discharge Diagnoses and Associated Hospital Course: Active hospital problems (included): Failure to thrive and history of stroke with residual deficit; -Resident presented to hospital on 9/10/24 for chief complaint of weight loss, diarrhea. He/She was diagnosed with colitis (inflammation of the colon or the large intestine), as well as aspiration pneumonia. GI (gastroenterologist) was consulted for replacement of PEG (percutaneous endoscopic gastrostomy, a tube is inserted into the stomach through the abdominal wall) this admission; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diet: Regular texture with regular liquids. Tube feeding: Nepro (liquid supplement) continuous at 35 milliliters (ml) per hour. Reason for tube feeding: Malnutrition; -Aspiration Precautions: Sit at 90 degree angle (chin to neck angle-not HOB (head of bed)). Alternate liquids and solids, small, single sips, small bites, no straws, 100% supervision. Review of the resident's progress note, located in the EMR, showed: -9/14/24 at 5:56 P.M.: Resident arrived via stretcher with EMS (emergency medical services) from hospital. Orders received to continue hospital discharge orders. Review of the resident's POS, showed: -9/14/24: Aspiration precautions, sit at 90 degree angle (chin to neck angle - not head of bed), alternate liquids and solids, small, single sips, small bites, no straws, 100% supervision. Review of the resident's care plan, on 9/17/24, showed the care plan had not been updated to include the resident's aspiration precautions ordered on 9/14/24. Observation on 9/17/24, showed: -9:10 A.M.: The resident lay in bed. CNA D served the resident breakfast then left the room. The resident had no supervision at that time. The menu slip on the breakfast tray did not show the resident's aspiration precautions. At 9:30 A.M., the resident remained without supervision in his/her room with the breakfast tray in front of him/her. The resident's breakfast tray was untouched. The resident said he/she could feed himself/herself, and he/she did not have any swallowing problems; -12:41 P.M.: CNA D served the resident lunch. The menu slip on the lunch tray did not show the resident's aspiration precautions. The CNA fed the resident a few normal sized bites of food. The resident was not instructed to hold his/her chin to neck while eating. The CNA left the room and returned with a straw for the orange drink. While the CNA was gone to get the straw, the resident ate some of his/her cake. The CNA said the resident's appetite varied. The CNA gave the resident a drink with the straw and a couple more normal sized bites of food. The CNA said the resident did not have any aspiration precautions he/she was aware of. The CNA left the resident unsupervised at that time. At 12:50 P.M. CNA H and LPN C entered the room. The CNA said the resident had a poor appetite. He/She fed the resident a couple more normal sized bites of food. The CNA and LPN said they were not aware of any aspiration precautions for the resident and neither knew the resident required supervision at all times while eating. During an interview on 9/17/24 at 1:04 P.M. Speech Therapist (ST) I and ST J said the resident was being seen for memory and a new goal for swallowing with a history of aspiration pneumonia. The aspiration precautions were ordered at the hospital. Staff should be following those orders at least until they could complete a swallowing evaluation at the facility. During an interview on 9/18/24 at 9:34 A.M., the Administrator and DON said the nurse that readmitted the resident and added the aspiration precaution orders should have made staff aware by giving report at the end of shift. The aspiration orders should have been added to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #13's admission MDS dated [DATE], showed: -Speech Clarity: No speech - absence of spoken words; -Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Functional limitation of one upper extremity and both lower extremities; -Roll left to right: Dependent; -Diagnoses of traumatic brain injury (a brain injury caused by an outside force such as a bump, blow or jolt to the head), , and respiratory failure; -Falls in the last 2 to 6 months prior to admission?: Yes; -Any falls since admission?: No. Review of the resident's care plan. located in the EMR, showed: -7/3/24: Focus: Limited physical mobility related to neurological deficits. Goal: Will remain free from complication related to immobility. Interventions: Ambulation - does not walk. Locomotion - dependent on one person via wheelchair; -7/3/24: Focus: Communication problem identified, expressive aphasia (absence of speech); Goal: Will develop communication abilities. Interventions: Anticipate and meet needs. Ensure/provide safe environment. Bed in lowest position; -7/3/24: Focus: The resident is at risk for falls. Goal: Resident will be free of minor injury. Interventions: Anticipate and meet the resident's needs. Be sure the call light is within reach and encourage the resident to use it for assistance as needed. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Review of the resident's progress notes, located in the EMR, showed: -7/26/24 at 4:15 A.M.: During routine rounds, resident found under the bed. Resident is unable to explain what happened due to medical condition. EMS her to transport resident to hospital for evaluation and treatment; -7/30/24 at 6:58 P.M.: Resident readmitted . Resident is alert and follows person with eyes but remains nonverbal. Resident displays no acute distress or evidence of pain. New order received and noted for bilateral fall mats (placed on the floor next to the bed) maintenance notified of need (for fall mats). Review of the resident's POS, located in the EMR, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/30/24: Low bed with fall mats on each side. Observation on 9/16/24 at 7:27 A.M. and 12:55 P.M., showed the resident lay in bed with one mattress on the floor between the bed and the room door, but no mattress between the bed and the window. Observation on 9/17/24, showed: -8:24 A.M., the resident lay in bed with one mat on each side of the bed. The height of the bed was 37 inches () from the floor to the top of the mattress; -11:55 A.M., the resident lay in bed with one mat on each side of the bed. The height of the bed was 30 from the floor to the top of the mattress. Observation on 9/18/24, showed: -7:10 A.M., the resident lay in bed with one mat on each side of the bed. CNA H said the mats are on the floor because the resident is at risk to fall from the bed. He/She worked this past weekend and the resident only had one mat on the floor. He/She told the nurse the resident only had one mat, but when he/she left on Sunday, the resident still had one mat. The resident had not fallen out of the bed as far as he/she was aware. Therapy had been working with the resident and the resident could swing his/her legs over the side of the bed now. The bed should always be in the lowest position when staff were not working with the resident. He/She raised the resident's bed to the highest possible position and it was 39" from the floor to the top of the mattress. He/She lowered the bed to the lowest possible position and it was 20. During an interview on 9/18/24 at 9:34 A.M., the Administrator and DON said the policies they provided are current and what they expect staff to follow. There should be a mat on both sides of the resident's bed, not just one side. When staff are not in the room working with the resident, the bed should be left in the lowest possible position. The mats and the lowest bed position should be added to the care plan. MO00240399

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to ensure residents received prompt and adequate care. This affected four out of four residents who were incontinent of bowel and/or bladder (Residents #33, #34, #45 and #46), when staff failed to provide incontinence care in a timely manner. Three additional residents (Residents #31, #43 and #44) said staff do not check on them every two hours, leaving them wet for extended periods of time, and it can take hours for staff to answer call lights. In addition, one resident, with a history of bypass surgeries (Resident #24) contacted Emergency Medical Services (EMS) with chest pains after he/she used his/her call light and staff did not respond in 10 minutes. When EMS responded, they were unable to find facility staff, until they found one staff member curled up on the couch asleep. Another resident (Resident #25) returned from the hospital with EMS at the same time Resident #25 was having chest pains and that EMS crew also could not find staff readily available. In addition, another resident's hospital Emergency Department (ED) report showed the resident called 911 and said staff had left him/her on the toilet for three hours, causing stiffness and pain (Resident #20). This had the potential to affect all residents. The census was 118. Review of the Facility Assessment, dated 8/2/24, showed: -Purpose: The Facility Assessment is a complete review of the internal human and physical resources required by the facility to care for residents competently during day to day (including nights and weekends) and emergency operations. The facility assessment identifies your capabilities as a skilled nursing services provider. The Facility Assessment will be the basis for surveyors to ascertain whether your are prepared to competently take care of the population you have identified that you serve; -There are three components to the review: -1. Resident profile including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethic/cultural/religious factors that impact care; -2. Services and care offered based on resident needs; -3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, and education and training; -The assessment is not intended to be a static tool but is intended to be a living document. It should include the business plan, staffing plan, the types of resident served, and the resources and physical plant required to competently care for the identified populations; -People Involved in Completing: Administrator, Director of Nursing (DON), Maintenance Director, Human Resources/Payroll Director, Activities Supervisor, Social Services Director and Medical Director; -Resident Profile: Average daily census - 120-130; (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-Special Treatments and Conditions (a daily average): Radiation - 0-2, Oxygen Therapy - 20-30, Suctioning - 0-5, Tracheostomy Care - 0-5, Behavioral Health Needs (including wandering, aggression, anxiety, depression, socially inappropriate) - 50-60, Active or Current Substance Use Disorders - 15-25, Intravenous (IV) Medications - 10-15, Injections - 20-30, Advanced Wound Care Needs - 10-20, Dialysis - 10-20, Ostomy Care - 0-5, Hospice Care - 0-10, and Isolation or Quarantine for Active Infectious Disease - 0-20; -Assistance with Activities of Daily Living (ADLs): Bed Mobility Sit to Lying - Supervision/Partial/Moderate Assist (86 residents) and Dependent/Maximum Assist (15), Mobility Sit to Stand - Supervision/Partial/Moderate Assist (92) and Dependent/Maximum Assist (19), Bathing - Supervision/Partial/Moderate Assist (96) and Dependent/Maximum Assist (34), Transfers - Supervision/Partial/Moderate Assist (105) and Dependent/Maximum Assist (14), Eating - Supervision/Partial/Moderate Assist (105) and Dependent/Maximum Assist (6), Toileting - Supervision/Partial/Moderate Assist (105) and Dependent/Maximum Assist (12); -Current Staff on Payroll: Licensed Nurses (Licensed Practical Nurses (LPNs) and Registered Nurses (RNs)) 20-28, Nurse Aides (Certified Nursing Assistants (CNAs)) 30-40, Other nursing personnel (e.g., Administrative Duties) 7; -The assessment did identify how many nurses and/or CNAs were needed to provide prompt and adequate care by shift (day shift 7:00 A.M. - 3:00 P.M., evening shift 3:00 P.M. - 11:00 P.M. and night shift 11:00 P.M. - 7:00 A.M.). Review of the facility's Incontinent Care Policy, dated 7/21/22, showed: -Policy: The facility will provide incontinent care as directed in the plan of care. Incontinent care will include a skin evaluation of the resident; promoting hygiene and skin prevention with infection/irritation; -Responsibility: Nursing Assistant, Licensed Nurses, Nursing Administration, Infection Control Preventionist and Director of Nursing. Review of the facility's CNA job description, revised 1/2024, showed: -Facilitates all care and service in a friendly customer-driven approach; assures Residents are treated with dignity and respect at all times; -Provides for activities of daily living by assisting with serving meals; feeding Residents as necessary; and ambulating, turning. and positioning Residents; toileting assistance; and providing fresh water and nourishment between meals; -Provides Residents with hygiene supports including nail care, light hair or other grooming, oral hygiene, bathing, and incontinence care; -Follows all company policies and procedures. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	1. Observation during the initial tour of the facility on 10/28/24 at 4:00 A.M., showed two nurses on duty (one nurse was assigned to the two units downstairs, and one nurse was assigned to the two units upstairs) and five CNAs on duty (two CNAs assigned downstairs and three CNAs assigned upstairs). Review of the facility census report, dated 10/27/24, showed the following: -Joliet (downstairs unit): 22 residents; -[NAME] (downstairs unit): 38 residents; -[NAME] (upstairs unit): 31 residents; -Tranquility (upstairs unit): 27 residents. During an interview on 10/28/24 at 4:10 A.M., RN D said: -He/She worked the night shift from 11:00 P.M. until 7:00 A.M. last night; -There were only two CNAs for 58 residents and one nurse during his/her shift; -He/She did not feel the residents were getting appropriate care as there was not enough staff to care for them and the residents were neglected; -He/She did not feel the staffing ratio to residents was safe for the employees or the residents; -Sometimes it took them over an hour to answer call lights and the residents were left wet for all that time because there were so many residents who required two people for direct care. During an interview on 10/28/24 at 5:17 A.M., and 5:30 A.M., CNA F said he/she began work yesterday around 11:00 P.M. He/She worked on one of the two upstairs units. He/She was the only CNA working that unit, which is not unusual. It was difficult to give care to all his/her residents last night due to the lack of staff. If it's just him/her working, he/she cannot check the residents every two hours or answer the call lights timely. He/She can only check the residents two times at the most. When there are two CNAs on the unit, he/she is able to check the residents every two hours and is able to answer the call lights more promptly. During an interview on 10/28/24 at 6:13 A.M., Assistant Director of Nursing (ADON) M said there should be three to four CNAs working upstairs and downstairs on night shift and there should be one to two nurses upstairs and downstairs for night shift. ADON M said he/she was on call last night and did not receive any calls regarding staffing concerns. ADON M said he/she was not aware the facility only had one nurse upstairs and downstairs and two CNAs upstairs and downstairs. ADON M said if staff would have contacted him/her, he/she would have come into the facility to assist or would have given staff extra directions. ADON M said if the facility does not have the appropriate amount of staff, it could cause a deficit to resident care. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/30/24 at 7:00 A.M., CNA K said he/she worked the day shift, 7:00 A.M. until 3:00 P. M. When he/she started to get residents ready after first arriving on duty, it was not uncommon to find several residents wearing two incontinent briefs soaked through with urine. This occurred several times a week. He/She did not think those residents could possibly have been checked and changed every two to three hours. He/She had not told the nurses because it would not do any good. During an interview on 10/30/24 at 7:22 A.M., CNA F said night shift is from 11:00 P.M. to 7:00 A.M. and rounds are completed two times before 5:00 A.M. When he/she comes in at 11:00 P.M., he/she makes rounds with the evening shift CNA. During rounds, CNA F checks to see if the resident needs ice water, remote, call light, see if the residents need changed or taken to the bathroom and to make sure the residents are breathing. If a resident has on two briefs, it is not good for the resident because the outer brief can look dry and the inner brief could be wet. CNA F would be reluctant to change them if the resident looked dry. If residents are not changed, it can cause them to get red bottoms or bed sores. CNA F said when there is only one CNA on each side and one nurse, it takes a long time to answer call lights. CNA F said if four to five call lights are on, he/she will quickly go to each person with a call light on to make sure there is not an emergency like they are slipping off the bed or have fallen. CNA F will then start changing the first resident who had the call light on. It takes up to 20 minutes to change one resident because he/she has to go to the room see what he/she needs, then go to the clean utility closet and get supplies, and then go back to the resident's room to clean and change the resident. CNA F said it can take up to an hour and forty minutes to answer a call light at times. CNA F said sometimes when you go back to the resident who had the call light on, they have called 911 and say nobody was answering their call light. CNA F said sometimes staff on night shift will fall asleep and when it happens the first time, they are given a warning. If it happens a second time, they would get fired. CNA F said sometimes when sitting in a chair if it is quiet at night, staff can doze off but it does not happen often. If a resident is a two person assist, then CNA F has to go and find another staff member to assist and the resident has to wait on care to be provided. During an interview on 10/30/24 at 7:27 A.M., CNA L said he/she worked the day shift. When he/she reported to work, he/she started to get residents ready for the day. He/She frequently found residents heavily saturated in urine. Sometimes, some residents wore two incontinence briefs, and they were saturated with urine. He/She did not feel those residents could possibly have been checked for incontinence every two hours. During an interview on 10/30/24 at 11:30 A.M., the Administrator said based on current resident acuity levels identified in the Facility Assessment, the facility needs the following number of staff on the midnight shift: -One nurse on all four units for a total of 4 nurses; -Three CNAs for the two units downstairs (one on each unit and to one split between the two units); -Four CNAs on the two units upstairs (two on each unit) for a total of seven CNAs on night shift. Four nurses and seven CNAs total are needed to ensure residents receive appropriate care in a timely manner. There should always be at least one staff member on each unit at all times. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of the facility nursing staffing reports (staff in/out time punches) for the midnight shifts from 10/14/24 through 10/29/24, showed the facility failed to provide the Administrator's expected staffing (four nurses) on the following dates: 10/16, 10/17, 10/18, 10/19, 10/21, 10/22, 10/23, 10/24, 10/25 and 10/27/24. Review of the facility nursing staffing reports for the midnight shift from 10/14/24 through 10/29/24, showed the facility failed the Administrator's expected staffing (seven CNAs) on the following dates: 10/14, 10/16, 10/18, 10/19, 10/23, 10/24, 10/25, 10/26, 10/27 and 10/28/24. During an interview on 10/31/24 at 6:09 A.M., LPN A said he/she worked the night shift last night. He/She was the only nurse working the two downstairs units. There is supposed to be one nurse for each unit. If he/she is covering just one unit, he/she can get everything done even if something unexpected happens. If he/she is covering both units, he/she can get everything done, but it may not be timely. If something unexpected happens while he/she is covering two units, he/she may not be able to get everything done. It is not too often that three CNAs are scheduled for the two downstairs units. During an interview on 10/31/24 at 6:31 A.M., CNA E said he/she works the night shift. About 70% of the time, there are two CNAs scheduled to work the downstairs units instead of three. When there is one CNA on each unit, he/she cannot check and change residents every two hours. He/She can only do two checks per his/her eight-hour shift. 2. Review of Resident #33's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/6/24, showed: -Moderate cognitive impairment; -Rejection of care, not exhibited; -Upper extremity impairment on both sides; -Toileting, shower, lower body dressing, put on and take off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, chair/bed-to-chair transfer: substantial maximal assistance (helper does more than half the effort); -Eating, oral hygiene, upper body dressing: Partial moderate assistance; -Always incontinent of bowel and bladder; -Risk of pressure ulcers, yes; -Diagnoses included deaf nonspeaking, muscle weakness, dementia, reduced mobility and insomnia (a sleep disorder that makes it hard to fall or stay asleep). Review of the resident's Braden Scale (used for predicting pressure ulcer risk), dated 9/4/24, showed the resident was at high risk for developing pressure ulcers. Review of the resident's current care plan, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-Focus: Activities of daily living (ADLs, bathing, toileting, dressing, etc.) self-care performance deficit; -Goal: Resident requires assistance with ADL care and mobility; -Interventions: -Requires staff assistance to turn and reposition in bed; -Requires staff assistance to dress; -Transfer one assist; -Focus: The resident has bowel incontinence related to immobility; -Goal: The resident will have less than two episodes of incontinence per day through the review date; -Interventions: -Check resident every two hours and assist with toileting as needed; -Observe pattern of incontinence and initiate toileting schedule if indicated; -Provide loose fitting, easy to remove clothing; -Provide peri care after each incontinent episode; -Focus: Resident is incontinent of bowel and bladder; -Goal: Resident will remain free from skin breakdown due to incontinence and brief use through the review date; -Interventions: -Assist resident to bathroom as desired/indicated, offer toileting before meals, after meals and at bedtime; -Clean peri-area with each incontinence episode; -Focus: Resident has the potential for impaired skin integrity; -Goal: Resident will maintain or develop clean and intact skin by the review date; -Interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 10/28/24 at 4:23 A.M., RN D said residents do not get changed often on night shift because there isn't enough staff to get everything done. The resident lay in bed on his/her right side. RN D pulled the white quilt back and pulled the resident's sweatpants down, showing the resident had two briefs on. The brief that was closest to the resident's body was a pull up brief and the second brief (secured with fastening tape on the wings that attaches to the front of the brief) was located over the pull up. The brief was taped on both sides. The inner pull up was soiled with urine and dried feces and the outer brief was soiled with urine. The white quilt had large yellow spots on it. RN D said the resident had not been changed on the night shift. During an observation and interview on 10/28/24 at 5:54 A.M., with CNA E and ADON M, CNA E said the resident takes himself/herself to the bathroom. CNA E and ADON M entered the resident's room, and the resident lay in bed on his/her right side. CNA E removed the white quilt that had yellow spots on it from the resident and pulled the resident's sweatpants down, showing the resident had two briefs on. The pull up brief closest to the resident's body had dried and fresh feces and the outer brief was soiled with urine. CNA E said the resident has the outer brief over the pull up because the resident doesn't keep the pull up on. CNA E said he/she checked the resident around 1:30 A.M. or 2:00 A.M. and did not remember if the resident had both a pull up and brief on at that time. CNA E said he/she only checked the resident when he/she was walking down the hall because the resident takes himself/herself to the bathroom. CNA E said he/she glanced/peeked at the resident when he/she was walking down the hall. CNA E assisted the resident in standing from the bed and the resident's sweatpants were wet down to his/her knees and the resident's shirt was wet up to his/her waist below his/her elbows. CNA E walked and guided the resident to the bathroom. Once CNA E entered the bathroom, there was a large amount of dried feces on the right side of the toilet seat and side of the toilet. CNA E left the room and obtained supplies to clean the toilet. ADON M verified the resident was soiled and began looking for clean clothing for the resident in the resident's closet and then had to exit the room to obtain clean clothing for the resident. CNA E returned and cleaned the toilet and the resident sat on the toilet seat. CNA E had the resident then stand and began cleaning the resident. CNA E did not change the resident during the night shift. During an interview on 10/31/24 at 6:31 A.M., CNA E said he/she works the night shift. About 70% of the time, there are two CNAs scheduled to work the downstairs units instead of three. When there is one CNA on each unit, he/she cannot check and change residents every two hours. He/She can only do two checks per his/her eight-hour shift. - this interview is listed under #1. During an interview on 10/28/24 at 6:05 A.M., CNA E said: -The resident often walked around the unit during the night; -He/She checked the resident for incontinence while the resident was walking the halls last night. During an interview on 10/31/24 at 7:23 A.M., ADON M said he/she expected staff to make rounds on the resident every two hours to check for incontinence. 3. Review of Resident #34's quarterly MDS, dated [DATE], showed: -Unclear speech; -Rarely/never understood by others; (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-Rarely/never was able to understand others; -Short and Long term memory problems present; -Severely impaired cognitive skills for daily decision making; -Impairment to upper body on one side; -Impairment to lower body on both sides; -Wheelchair used for mobility; -Always incontinent of bowel and bladder; -Dependent on staff for toileting hygiene, shower/bathe self, upper and lower dressing, personal hygiene and all transfers; -At risk for pressure ulcers; -No skin issues present; -Pressure reducing device for bed; -Diagnoses included stroke, heart failure, and diabetes mellitus. Review of the resident's Braden Scale, dated 7/31/24, showed the resident was at high risk for developing pressure ulcers. Review of the resident's care plan, undated, showed: -Problem: The resident had the potential for impaired skin integrity and/or development of pressure-related ulcers and/or breakdown related to incontinence and bedfast. Interventions included: Assist with toileting needs an incontinence care on routine rounds and as needed; Assist as needed with toileting hygiene and with wearing and changing incontinence undergarments; -Problem: The resident was frequently incontinent of bowel and bladder. Interventions included: Check and change for incontinence. Observation on 10/28/24 at 4:34 A.M., showed: -There was a strong odor of urine emitting from the room into the hall; -The resident lay in his/her bed on a low air loss mattress; -RN D pulled the resident's bed covers down to show the resident wore two briefs; -The resident's outer brief was soaked with urine, with the padding in the brief in clumps; (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-The resident lay in a pool of urine, with visible brown rings of urine on the sheet extending from the resident's thighs to his/her shoulders. During an interview on 10/28/24 at 4:35 A.M., RN D said: -He/She did not think the resident was changed over the night shift; -He/She verified the resident wore two briefs, both soaked with urine, and lay in urine extending up to his/her shoulders. During an interview on 10/28/24 at 5:49 A.M., CNA E said: -He/She worked from 11:00 P.M. to 7:00 A.M. that day; -He/She was the only CNA assigned to care for the resident on the hall; -He/She checked on the resident between 2:45 A.M. and 3:00 A.M. and the resident was not wet and did not require incontinence care; -He/She had just provided incontinence care to the resident; -He/She confirmed the resident was wearing a shirt that was wet with urine up to the middle of his/her back and the resident lay on a wet absorbent pad before CNA E gave the resident incontinence care. 4. Review of Resident #45's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Moderately impaired cognition; -Wheelchair for locomotion; -Required maximal assistance for toileting hygiene, to shower/bathe self, for upper and lower body dressing, personal hygiene and to roll left and right in the bed; -Dependent on staff for chair/bed-to-chair transfers; -Always incontinent of bowel and bladder; -At risk for pressure ulcers; -Moisture Associated Skin Damage (MASD) present; -Pressure reducing device for bed; (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-Diagnoses included morbid obesity, depression, anxiety, metabolic encephalopathy (chemical imbalance in the blood that affects brain function) and polyneuropathy (damage to nerves causing pain, discomfort and mobility difficulties). Review of the resident's care plan, undated, showed: -Problem: ADL self-care performance deficit related to activity intolerance, cognitive impairment, debility and decreased mobility. Interventions included: Required staff assistance to turn and reposition in bed; Required skin inspection with cares. Observe for redness, open areas, scratches, cuts, bruises and report changes to Nurse; -Problem: Bladder and bowel incontinence and was at risk for urinary tract infections. Interventions included: Apply incontinence cream after each incontinence episode; The resident wore briefs; Check and change for incontinence; -Problem: Potential for impairment to skin integrity/pressure ulcer development related to bowel/bladder incontinence and impaired mobility. Interventions included: Apply incontinence cream after each incontinence episode; Pressure reducing mattress while in bed. Observation on 10/28/24 at 4:50 A.M., showed: -There was a strong odor of urine and bowel movement emitting from the room into the hall; -The odor of urine and feces was so strong upon entry into the room, the surveyor's eyes burned; -The resident lay in his/her bed on a low air loss mattress; -The resident wore two briefs which were soaked with urine; -The resident lay on an absorbent pad, placed under his/her buttocks, which was visibly soaked with urine; -The resident's sheet was visibly soaked with urine extending from below the resident's buttocks up to the resident's neck, with brown rings outlining the urine soaked areas; -The resident wore a hospital gown that was also urine soaked; -The resident had dried feces on his/her buttocks and inside of the inner brief; -The resident's mattress was visibly wet with urine; -The resident's bilateral buttocks were reddened; -The resident's inner thighs were reddened. During an interview on 10/28/24 at 4:52 A.M. and at 5:06 A.M., the resident said: -He/She had not received incontinence care since the evening before around 6:00 P.M.; (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-The staff did not usually provide incontinence care during the night shift; -Lying in a pool of urine on the wet sheet was annoying to the resident; -He/She did not like wearing two briefs at once, as the briefs cut into his/her inner thighs in a sawing motion and caused him/her pain. During an interview on 10/28/24 at 5:06 A.M., RN D said: -The resident's bilateral buttocks were red with suspected Moisture Associated Dermatitis (MASD); -The resident also had MASD located on his/her inner thighs. During an interview on 10/28/24 at 5:17 A.M., CNA F said: -He/She began work yesterday around 11:30 P.M.; -He/She rounded on his/her assigned residents every two hours to check if they needed incontinence care; -He/She was not able to get to the resident until 4:50 A.M. and he/she gave the resident incontinence care at that time; -He/She only put two briefs on residents if they asked for them; -It was not right to put two briefs on a resident because it was not possible to see if the inner brief was wet; -It was difficult for CNA F to give care to all his/her residents last night due to the lack of staff; -The resident required the assistance of two people when giving incontinence care and CNA F had to wait until CNA E, who worked the other hall, was able to assist. Review of the resident's weekly skin assessment, dated 10/28/24 at 12:43 P.M., showed there was no documentation found of skin issues at the resident's buttocks or groin. During observation and interview on 10/29/24 at 6:19 A.M., the resident said he/she was changed at 10:00 P.M. last night and one other time in the early this morning. The resident's room had a very strong urine odor. The resident said he/she was unsure if he/she had two briefs on. The resident said it depends on what staff changes him/her if they put one or two briefs on. The resident said it seems like they put two on all the time. The resident said he/she is changed and repositioned one time each shift and said he/she needed changed and repositioned more often. When he/she turns his/her call light on, it takes an hour to an hour and a half before staff respond to the call light. The resident also said staff did not offer ice water. The resident had a water pitcher on his/her bed side table without a lid that had approximately 2 inches of water. The resident said the water in the cup was left over from the ice he/she requested yesterday after dinner. The resident would like ice water to be passed each shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 10/29/24 at 6:36 A.M., RN D entered the resident's room and asked if he/she could check to see if the resident was wet. The resident agreed. RN D verified the resident had two briefs on and the briefs were soaked with urine. RN D said it is not appropriate for any resident to have two briefs on. If a resident has two briefs on, the staff might think the resident is dry by only looking at the outer brief. If residents are left soiled for an extended period of time, it can cause skin integrity issues such as redness and skin breakdown that could lead to open areas. Observation and interview on 10/29/24 at 6:40 A.M., showed: -The resident wore two briefs which were both visibly soaked with urine; -He/She did not like to wear two briefs, as they were uncomfortable, were too tight between his/her legs and cut into his/her groin. Review of the resident's weekly skin assessment, dated 10/29/24 at 12:01 P.M., showed the resident had redness at his/her buttocks and groin. 5. Review of Resident #46's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Rejection of care not exhibited; -Toileting, shower, upper and lower body dressing, put on and take off footwear, personal hygiene, and roll left and right: substantial maximal assistance; -Shower transfer, dependent; -Frequently incontinent of bladder; -Always incontinent of bowel; -Risk of pressure ulcers, yes; -Diagnoses included muscle weakness, dementia, difficulty in walking, and need for assistance with personal care. Review of the resident's forms list on 10/31/24 at 12:44 P.M., showed no Braden assessment completed for the resident in 2024. During an observation and interview on 10/28/24 at 4:51 A.M., RN D entered the resident's room and asked permission to check the resident's brief. The resident agreed. The resident said the last time he/she had been changed was at 5:00 P.M. the previous day. The resident said he/she had not been changed all night. The resident had two briefs on. The inner brief was brown and was saturated with urine. The resident's room had a strong urine odor. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/28/24 at 12:01 P.M., the resident said he/she does not like to be soiled for extended periods of time. The resident also said his/her family gets ice water for him/her on the days they are at the facility. On days the family is not at the facility, he/she does not get offered ice water. Observation and interview on 10/29/24 at 7:30 A.M. and at 9:24 A.M., showed: -There was a cup with approximately 4 inches of water on his/her bedside table, within reach; -He/She did not have fresh ice water; -He/She could not remember the last time staff gave him/her fresh ice water; -He/She was last checked on by staff around 6:00 A.M. that morning and he/she was not sure when staff would return; -The resident wanted fresh ice water and hoped staff would fill up his/her cup, as that sure would be nice. During an interview on 10/31/24 at 6:20 A.M., the resident said he/she had not been changed since 10:00 P.M. the previous day. The resident said he/she was wet and needed changed. The resident's room had a strong odor of urine. During an observation and interview on 10/31/24 at 6:24 A.M., ADON M entered the resident's room and asked permission to check the resident's brief and the resident agreed. The resident's room had a strong odor of urine. The resident wore one brief that was saturated with urine. The resident lay on an absorbent pad that was saturated with urine. The fitted sheet under the absorbent pad was also saturated with urine and had brown rings which extended up to the middle of the resident's back. The resident's shirt was also saturated up to the middle of the resident's back. ADON M washed his/her hands and exited the room. ADON M walked up to CNA J, who was sitting in the hallway, and asked CNA J who had the resident. CNA J said the resident was on another CNA's assignment. ADON M told CNA J the resident needed a full bed change and CNA J said he/she would assist the resident. During an interview on 10/31/24 at 7:23 A.M., ADON M said it was not appropriate for staff to not complete rounds every two hours on residents. ADON M said it was not appropriate for a resident to not be changed from 10:00 P.M. unit 6:30 A.M. the following day. Night shift starts at 11:00 P.M. and the resident was not changed for the entire night shift. ADON M said he/she spoke to the night shift charge nurse and CNA J was the CNA responsible for completing rounds and changing the resident. ADON M said he/she did not have an opportunity to speak with CNA J before he/she left. ADON M said CNA J reported to ADON M that the resident was on another CNA's assignment. ADON M said he/she expected staff to be knowledgeable of and follow the facility' policies. ADON M expected staff to make rounds on the residents every two hours and know what residents they are responsible for each shift. During an interview on 10/2

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 30 opportunities observed, eight errors occurred resulting in a 26.66% error rate (Residents #41 and #42). The census was 118. Review of the facility's medication administration-Preparation and General Guidelines, revised August 2014, showed: -For residents able to swallow or who have difficulty swallowing tablets which can be appropriately crushed may be ground coarsely and mixed with appropriate vehicle (such as applesauce) so that the resident receives the entire dose ordered; Please consult with the product literature or Do Not Crush lists which the facility may have or with the pharmacist if there is a question about the medications to be crushed; -The need for crushing medications should be indicated on the resident's orders and the Administration Record (AR) so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if appropriate, during medication regimen reviews. Review of the facility's Oral Inhalation Administration policy, revised August 2014, showed: -Purpose: to allow for safe, accurate and effective administration of medication using an oral inhaler; -Review the packaging insert if unfamiliar with the inhalation device provided; -If necessary, prime inhaler. Prime new inhalers by depressing until a full dose is emitted. Review of the facility's Physician Orders policy, dated 9/28/22, showed: -Policy: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State and Federal Guidelines; -Physician Orders that are missing required components, are illegible or unclear must be clarified prior to implementation. -Physician Orders will be transcribed to the appropriate Administration Record. Review of the facility's policy, Medications That Should Not be Crushed, dated February 2023, showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Crushing pills can improve ease of administration, but some shouldn't be crushed. Crushing extended-release meds can result in administration of a large dose all at once. Crushing delayed-release meds can alter the mechanism designed to protect the drug from gastric (of the stomach) acids or prevent gastric mucosal (lining of the stomach) irritation. Hazardous meds below explicitly state not to crush in the product information; -Ferrous Sulfate (iron), tablet, due to modified-release and irritant (gastric); -Lubiprostone (laxative), capsule, due to stability is compromised; -Potassium Chloride (supplement), tablet, due to modified release. 1. Review of Resident #41's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/25/24, showed: -admitted on [DATE]; -Moderately impaired cognition; -Received a mechanically altered diet (consists of soft, moist foods); -Diagnoses included heart failure, kidney failure, diabetes mellitus, Parkinson's disease (disorder of central nervous system that affects movement) and dysphagia (difficulty swallowing). Observation of a medication administration on 10/30/24 at 7:51 A.M., showed Certified Medication Technician (CMT) O, prepared medications to administer to the resident. CMT O put the following medications in a medication cup with approximately two teaspoons of vanilla flavored pudding: -Calcium Carbonate (calcium supplement) 500 milligrams (mg), one tablet; -Ferrous Sulfate 325 mg, one tablet; -Multi Vitamin (supplement), one tablet; -Furosemide (diuretic) 40 mg, one tablet; -Potassium Chloride (mineral supplement) Extended Release (ER) 10 milliequivalents (mEq), one tablet; -Lubiprostone 24 micrograms (mcg), one capsule. During an interview on 10/30/24 at 7:55 A.M., CMT O said: -He/She verified he/she put six pills in a medication cup covered with the pudding; -The resident preferred to have his/her medications administered in pudding; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She entered the resident's bedroom to administer the medications to the resident and the resident refused the medications, stating he/she would take them after breakfast; -He/She would come back later to administer the medications to the resident. Observation on 10/30/24 at 7:55 A.M., showed CMT O placed the medication cup filled with six pills, covered in pudding, in the second drawer of his/her medication cart. The medication cup was not covered, was not labeled and was sitting in a metal cubby that had plastic medication packets filled with pills. Observation of a medication administration on 10/30/24 at 8:55 A.M., showed: -CMT O removed the medication cup filled with pills covered in pudding, from the second drawer of his/her medication cart. The medication cup was located in the same metal cubby, uncovered and unlabeled as observed at 7:55 A.M.; -CMT O entered the resident's room, confirmed the resident was ready to take his/her pills, and then spooned the contents of the medication cup directly into the resident's mouth; -CMT O exited the room with the medication cup. The medication cup had blue-green residue on the side of the cup mixed with pudding; -CMT O threw the medication cup into the trash. Review of the resident's electronic Medication Administration Record (eMAR), active as of 10/30/24 at 9:13 P. M., showed: -Order dated 10/25/24, for multi vitamin-minerals tablet, give once a day for supplement; Documentation showed administered on 10/30/24 at 8:30 A.M.; -Order dated 10/23/24, for Calcium Carbonate give one tablet twice a day; Documentation showed administered on 10/30/24 at 8:00 A.M.; -Order dated 10/23/24, for Ferrous Sulfate 325 mg, give one tablet twice a day for supplement; Documentation showed administered on 10/30/24 at 8:00 A.M., The medication was listed on the Do Not Crush list; -Order dated 10/23/24, Furosemide 40 mg, give one tablet twice a day for edema (swelling); Documentation showed administered on 10/30/24 at 8:00 A.M.; -Order dated 10/23/24, Lubiprostone 24 mcg, give one capsule twice a day for irritable bowel syndrome (IBS, intestinal disorder); documented as given on 10/30/24 at 8:00 A.M.; The medication was listed on the Do Not Crush list -Order dated 10/23/24, for Potassium Chloride ER 10 mEq, give twice a day for supplement; Documentation showed administered on 10/30/24 at 8:00 A.M.; The medication was on the Do Not Crush List; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation found showing an order of may crush appropriate medications as needed unless contraindicated. Review of the resident's electronic Physician Order Sheet (ePOS), active as of 10/30/24 at 9:40 A.M., showed: -No documentation for an order of may crush appropriate medications as needed, unless contraindicated. During an interview on 10/30/24 at 10:12 A.M., CMT O said he/she administered the medications to the resident, which were prepared at 7:51 A.M. in the medication cup with pudding and stored in his/her medication cart at 8:51 A.M. Review of the resident's care plan, active on 10/30/24 at 11:32 A.M., showed: -Problem: The resident had a swallowing problem related to swallowing assessment results; -Interventions included: Monitor/document/report as needed any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appearing concerned at mealtimes. During an interview on 10/30/24 at 12:45 P.M., the Director of Nursing (DON) and Administrator said: -They expected a resident's preference for receiving medications in pudding on their Kardex (snapshot of residents' plan of care while at the facility) so all staff were informed; -They expected nursing staff to write a note in the eMAR when a resident refused medication, documenting resident refusal and that they will come back to attempt to readminister medications; -They expected nursing staff to dispose of medications that were put in pudding and then pull new medications when the resident was ready to take their pills; -Placing a medication cup filled with pills and pudding inside of the medication cart was an infection risk; -Medications sitting in pudding for 65 minutes before administration reduced the efficacy of the pills as they would already start the breaking down process in the pudding. Also, there was a risk of the pudding spoiling as it was not kept cool. During an interview on 10/31/24 at 8:09 A.M., Assistant Director of Nursing (ADON) M said: -She expected nursing staff to have awareness of and follow facility policies; -When medications are put in pudding to soften, the medication softens and was the same as crushing them; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was not appropriate to keep medications in pudding for hour and over, as it changed the composition of the pill, and if the pills were ER, the efficacy would be altered; -She expected nursing staff to immediately give the medications to the patient after putting the pills in a cup with pudding; -She expected nursing staff to dispose of medications in a medication cup with pudding when a resident refused to take them; -It was not appropriate to store an open medication cup filled with pills and pudding in a medication cart due to infection control and risk of spoiling due to the milk based pudding; -She expected nursing staff to ask first if the resident wanted to take their medication before preparing them; -Residents should have a crush order for residents who preferred their medications to soften in pudding before administration; -She expected nurses to inform the Primary Care Physician (PCP) of the resident's preference for medications in pudding so the PCP could possibly change the order to liquid or an immediate release and get a crush order for crushed; -If resident had a preference for pills in pudding it should be care planned and discussed with PCP; -She expected nursing staff to have awareness of the Do Not Crush medication list; -Nursing staff needed to adhere to the Do Not Crush medication list for the safety of residents, to ensure residents received the correct dosage of medications and extended release medications per the physician order. During an interview on 10/31/24 at 12:23 P.M., the Regional Nurse said when a resident had an order that medications can be crushed, it was not appropriate for meds on the do not crush list to be altered or crushed prior to administration. 2. Review of Resident #42's Nursing Admission Evaluation and Baseline Care Plan, dated 10/25/24, showed: -admitted on [DATE]; -Communicated easily with staff; -Cognitively intact; -Required setup or clean up assistance with eating. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Face Sheet (a document containing the resident's medical and personal information), dated 10/30/24, showed his/her diagnoses included heart failure, emphysema (lung condition that causes shortness of breath), atrial fibrillation (A-fib, irregular heart beat) and chronic obstructive pulmonary disease (COPD, lung disease). Review of the resident's POS, active as of 10/30/24, showed: -An order dated 10/25/24, for aspirin 81 mg delayed release, give one tablet, one time a day, for cardiac (heart); -An order dated, 10/28/24, for Albuterol-Budesonide (bronchodilator, a medication used to open the lung airways) 90-80 microgram (mcg), give two puffs inhale orally every four hours for shortness of breath (SOB). Review of AirSupra product information, showed the following: -Use AirSupra exactly as your healthcare provider tells you to; -Before you use AirSupra for the first time, you will need to prime it; -Two puffs of the medicine is one dose; -Rinse your mouth with water after use of AirSupra to decrease the chance of getting a fungal infection (thrush) in your mouth and throat. Observation of a medication administration on 10/30/24 at 7:59 A.M., showed: -CMT O put aspirin 81 mg, chewable, one tablet in a medication cup and removed an AirSupra Aerosole (albuterol and budesonide) 90-80 mcg inhaler, from a new, unopened package; -CMT O entered the resident's room and gave the resident the aspirin tablet in a medication cup. The resident swallowed the pill and took a drink of water; -CMT O took the AirSupra inhaler, shook it, put it up to the resident's lips, depressed the inhaler once and instructed the resident to inhale the medication; -CMT O did not prime the new AirSupra inhaler before administering the medication to the resident; -CMT O failed to administer two puffs of the AirSupra inhaler to the resident; -CMT O failed to instruct the resident to rinse his/her mouth and spit after inhaling the medication. During an interview on 10/30/24 at 7:59 A.M., CMT O verified he/she administered one tablet of aspirin 81 mg, chewable, and had opened a new package of AirSupra Aerosole before administering one puff to the resident. Review of the resident's eMAR, active as of 10/30/24 at 9:06 A.M., showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Order dated 10/25/24, for aspirin 81 mg, delayed release, give one tablet once a day, was documented as administered on 10/30/24 at 8:00 A.M.; -Order dated 10/28/24, for Albuterol Budesonide, two puffs inhale orally every four hours for SOB, was documented as administered on 10/30/24 at 8:00 A.M. During an interview on 10/31/24 at 8:09 A.M., ADON M said she expected nursing staff to know difference between aspirin 81 mg chewable and aspirin 81 mg enteric coated. During an interview on 10/30/24 at 12:47 P.M., the DON and Administrator said: -They expected nursing staff to know to prime an inhaler before the first dose per manufacturer's instructions as there was a risk of not getting the full dose. -They expected nursing staff to instruct residents to rinse and spit after administering an inhaler to reduce thrush risk; -They expected nursing staff to read directions in the inhaler package if they had any question of proper administration; -They expected nursing staff to follow physician orders so residents get appropriate treatment. 3. During an interview on 10/30/24 at 12:45 P.M., the DON and Administrator said they expected nursing staff to administer medications as ordered as it could affect the plan of care. During an interview on 10/31/24 at 12:23 P.M., the Regional Nurse said she expected staff to have knowledge of and follow facility policies. MO00242738 MO00243961

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Surveyor: [NAME], [NAME] Based on interview and record review, the facility failed to ensure residents were free from significant medication error after one resident (Resident #12) received two different blood thinner medications simultaneously. The sample size was three residents. The census was 129. Review of the facility's Physicians Orders Policy, reviewed 9/28/22, showed: -Policy: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines; -Procedure: Physician orders will be transcribed to the appropriate administration record. Physician orders must be documented clearly in the medical record. Telephone/Verbal orders should be read back and verified with the prescriber. Review of Resident #12's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 9/4/24, showed: -Admission 9/4/24; -Able to make self understood; -Cognitively intact; -Diagnoses included anemia, heart failure, low blood pressure, kidney disease and high cholesterol. Review of the resident's care plan, initiated 9/11/24, showed: -Focus: Anticoagulant (blood thinner) medication use: At risk for abnormal bleeding, hemorrhage and/or increased/easy bruising related to anticoagulant use; -Goal: Resident will be free from signs and symptoms of abnormal bleeding; -Interventions: Administer anticoagulant as currently prescribed by the resident's doctor. Report to nursing any symptoms of unusual bleeding or bruising. Review of the physician's discharge orders that originated at the hospital, in the medical record system, dated 9/4/24, showed: -An order for apixaban (blood thinner) 5 milligrams (mg) tablet. Start taking one tablet (5 mg) by mouth in the morning and at bedtime starting on September 9, 2024; -An order for heparin (blood thinner) 5000 units/0.5 milliliters (ml). Inject 0.75 ml (7,500 units total) under the skin every eight hours for 4 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's discharge orders used by the nurse at the time of admission, dated 9/4/24, showed: -An order for apixaban 5 mg tablet. Start taking one tablet (5 mg) by mouth in the morning and at bedtime; -An order for heparin 5000 units/0.5 ml. Inject 0.75 ml (7,500 units total) under the skin every eight hours. Review of the resident's Medication Administration Record (MAR), dated September 2024, showed: -The resident received the apixaban 5 mg twice daily starting 9/5/24 through 9/10/24 and received a total of 12 doses; -The pharmacy was not able to fill the heparin. The physician approved Lovenox (blood thinner) 40 mg/0.4 ml subcutaneously (under the skin) in evening instead. The resident received 4 doses from 9/6/24 through 9/9/24. During an interview on 9/18/24 at 12:22 P.M., Licensed Practical Nurse (LPN) E said the nurse should write the medication orders as written on the admission orders. During an interview on 9/18/22 at 9:09 A.M., the Director of Nursing (DON) said she was not aware until yesterday that the apixaban was not to be started until 9/9/24 and the Lovenox was to be only administered for 4 days. She was not aware that there were two sets of discharge orders. She expected a nurse to question the physician when there were two blood thinners ordered. She said the nurse should have clarified the correct order and transcribed the order correctly. The Medical Director was made aware of the medication error on 9/17/24. During an interview on 9/18/22 at 10:47 A.M., the Medical Director said she expected for the nurses to have clarified the order.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure residents receiving dialysis (a treatment for kidney failure that rids the body of unwanted toxins, waste products, and excess fluids by filtering your blood) received their diets as ordered (Residents #5 and #17). The facility identified 14 residents that received in-house dialysis. Two were sampled and problems were found with both. The census was 129. Review of the Dietary Aide job description, revised 5/2022, showed: -Essential Functions of Dietary Aide: Prepare food trays for general and therapeutic diets. Prepare special diet foods as necessary. Review of the Certified Nursing Assistant (CNA) job description, revised on 1/2024, showed: -Essential Functions of CNA: Provides for activities of daily living (ADL) by assisting with serving meals and feeding residents as necessary. 1. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/14/24, showed: -Speech Clarity: Unclear speech - slurred or mumbled words; -Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Severely impaired cognition; -Eating: Partial/moderate assistance - Helper does less than half the effort; -Diagnoses of renal (kidney) insufficiency and depression; -Weight: 98 pounds (lbs); -Special Treatments and Programs: Dialysis. Review of the resident's physician's order sheet (POS), located in the electronic medical record (EMR), showed: -An order, dated 7/11/24: No added sodium diet. Regular texture. No orange juice, bananas, potatoes or tomatoes. Substitute potatoes with rice, pasta, corn or peas. Limit milk to 8 ounces in 24 hours; (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 9/10/24: In house dialysis on Monday/Wednesday/Friday. Review of the resident's care plan, located in the EMR, showed: -6/28/24: Focus: ADL self-care performance deficit. Goal: Increase in strength, mobility, endurance, and independence. Interventions: The resident requires assistive device to maximize independence with eating; -6/28/24: Focus: Dialysis related to renal failure. Goal: Will have no signs/symptoms of complications from dialysis. Interventions: Encourage resident to go for the scheduled dialysis appointments; -The care plan did not show the resident should not receive orange juice, bananas, potatoes or tomatoes. Observation on 9/17/24, showed: -9:10 A.M.: Certified Nursing Assistant (CNA) D served the resident breakfast in bed. Breakfast included a portion of fried breakfast potatoes. The menu slip on the breakfast tray showed: No orange juice, banana, tomato, potato. Substitute pasta, rice, corn or peas for potatoes. At 9:30 A.M., the resident's tray remained untouched on his/her bed table. The resident said he/she was not hungry; -12:41 P.M.: CNA D served the resident's lunch, which included mashed potatoes. The menu slip on the lunch tray showed the same dietary restrictions as the menu slip on the breakfast tray. Without reading the menu slip, the CNA fed the resident a few bites of food, including mashed potatoes then left the room without the lunch tray. At 12:50 A.M. Licensed Practical Nurse (LPN) C and CNA H entered the room. CNA H, without reading the menu slip, began feeding the resident, including a couple of bites of mashed potatoes. The CNA was asked if there was anything on the resident's plate he/she should not have. The CNA read the menu slip and said the resident should not have had the mashed potatoes. He/She had worked at the facility two or three months and had not noticed the dietary restriction before. LPN C read the menu slip and said the resident should not have had the mashed potatoes. The LPN said the dietary staff should not have put the mashed potatoes on the plate. LPN C said the CNAs should be aware of what was on the menu slip. If the resident was served something he/she should not have had, then nursing should contact the dietary department for a replacement. 2. Review of Resident #17's admission MDS dated [DATE], showed: -Adequate hearing and vision; -Speech Clarity: Clear speech -distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands - clear comprehension; -Cognitively intact; -Eating: Independent; (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of anemia (the blood has a reduced ability to carry oxygen), renal insufficiency, and diabetes mellitus (a condition that affects blood sugar levels); -Weight: 213 lbs; -Special Treatments and Programs: Dialysis. Review of the resident's POS, located in the EMR, showed: -An order, dated 7/12/24: No added sodium diet. Regular texture. No orange juice, banana, tomato, potato. Substitute pasta, rice, corn or peas for potatoes. Review of the resident's care plan, located in the EMR, showed: -7/25/24: Focus: The resident needs dialysis related to renal failure. Goal: Will have no complications from dialysis. Interventions: Encourage resident to go to the scheduled dialysis appointments; -7/25/24: Focus: Diabetes Mellitus. Goal: Will have no complications related to diabetes. Interventions: Dietary consult for nutritional regimen and ongoing monitoring; -The care plan did not show the resident should not receive orange juice, bananas, potatoes or tomatoes. During an interview on 9/18/24 at 6:57 A.M., the resident lay in bed. The resident said he/she received dialysis at the facility in the afternoon on Monday, Wednesday and Friday. Yesterday he/she received fried potatoes at breakfast and mashed potatoes at lunch. The resident knew he/she was not supposed to have potatoes. That was not the first time he/she had received foods he/she was not supposed to have. Yesterday, he/she ate the fried potatoes and mashed potatoes even though the resident knew he/she should not have them. If he/she hadn't eaten them, he/she would have been hungry. He/She would eat the substitutes for the potatoes had it been on the resident's plate. During an interview on 9/18/24 at 8:57 A.M., the Dietary Manager (DM) printed out the resident's menu slips for breakfast, lunch and dinner, which showed: No orange juice, banana, tomato, potato. Substitute pasta, rice, corn or peas for potatoes. 3. During an interview on 9/18/24 at 6:44 A.M., the Registered Nurse in the facility's dialysis unit confirmed both Resident #5 and Resident #17 received dialysis on Mondays, Wednesday and Fridays. He/She confirmed the residents' dietary restrictions, and said the restrictions should be followed because those food items contained electrolytes (minerals involved in many essential processes in the body). Residents with renal failure could not regulate electrolytes. A build-up of electrolytes could cause cramping, cardiac arrhythmia's (irregular heart rate), and even cardiac arrest (the heart stops beating) in dialysis patients. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 9/18/24 at 8:57 A.M., the DM said the Dietary Aides used the dietary menu slips to know what a resident should and should not be served. If there were foods a resident should not have, the Dietary Aide should provide the substitution. For breakfast, they would substitute some type of fruit or breakfast item, not pasta or rice. She did not understand why the Dietary Aides were not following the instructions on the menu slip. If the nursing department noticed a food being served that should not have been, they should call the dietary department and a substitution would be brought to the resident. 5. During an interview on 9/18/24 at 9:34 A.M., the Administrator and Director of Nursing (DON) said they expected staff to follow physician orders as written. The dietary department should ensure residents were not receiving food items they should not have. Nursing should compare the menu slips to what was on a resident's plate. If the resident had a food item they should not have, then nursing should contact the dietary department for an appropriate meal tray.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 22409 46970 Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented, in accordance with accepted professional standards and practices, for one resident who had a change of condition on 8/6/24 and went to the hospital where he/she was admitted (Resident #2). The sample was 18. The census was 129. Review of the facility's Discharge Transfer - Involuntary Policy, last reviewed 10/7/21, showed: -Responsibility: All staff monitored by the Director of Nursing (DON) and Administrator; Procedure: -The Interdisciplinary team and the resident's physician must document in the resident record when a resident is transferred or discharged ; -Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and the resident's representative or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding bed-hold. Review of Resident #2's physician order sheet, showed: -Admit to skilled services 8/5/24; -No hospital transfer order. -Review of the resident's Nursing Evaluation and Baseline Care Plan, dated 8/5/24 at 9:24 P.M., showed: -Confused, short-term and long-term memory problem; -Self-care: admission performance - dependent; -Mobility: admission performance - dependent. Review of the resident's progress notes, showed: -A progress note dated 8/6/24 at 6:49 P.M., Interact SBAR (a tool that helps nurses and other healthcare professionals communicate information about a patient's condition to a clinician) Summary for Providers Change in Condition evaluation are/were: Chest Pain (uncontrolled); Primary Care Provider Feedback: Primary Care Provider Responded the following feedback: Recommendations: Send to ER; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265834	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had just returned to the facility from the hospital on the same day at 4:30 P.M. Then at the time the SBAR was written, a progress note with the same time, showed: -A progress note dated 8/6/24 at 6:49 P.M., this nurse made aware by staff that the resident called 911 again to be sent back to the hospital. Resident stated to Emergency Medical Technician (EMT) that his/her Atrial Fibrillation (Afib, an irregular and often very rapid heart rhythm) was acting up. EMT and police here at this time to transport resident back to the hospital; -No documentation of the notification of the physician and/or order to transfer the resident to the hospital; -No documentation of hospital updates and/or the resident's status. Review of the facility's admission, discharge, and hospitalization report, dated 8/1/24 through 9/15/24, showed no documentation of the resident's admission, hospitalization , or discharge. During an interview of 9/18/24 at 10:32 A.M., both the Administrator and DON said they didn't know who the resident was or where he/she was at. The DON said she did not remember completing the facility's hospital transfer form on 8/6/24 for the resident. She said she wasn't sure about who or where the resident was. The Administrator and DON said they had to look up the information about the resident before they could answer any questions. The Administrator said she only just now found out the resident was transferred to another facility on 8/17/24. The Administrator said it looked like the resident's admission notes were missing. The nurse should have documented in the resident's record. The Administrator said she didn't know why the documentation was missing for the resident and someone dropped the ball. The Administrator said there were no notes related to the resident so she couldn't really answer any questions. She didn't remember the resident. The Administrator and DON expected nursing to have documented the status of the resident, physician notification, any orders, and updates from the hospital. MO00240172