STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265839	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Senior Health	206 North Main Street O Fallon, MO 63366

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 42592 Based on observation, interview and record review, the facility failed to ensure residents were aware of posted resident rights in an easily accessible area for review at their leisure. The resident census was 49. Review of the facility's policy, Resident Rights, revised February 2021 showed the following: -Federal and state laws guarantee certain basic rights to all residents of the facility; -These rights include the resident's right to: -Communication with and access to people and services, both inside and outside the facility; -Be informed about his or her rights and responsibilities; -Communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter; -Copies of resident rights are posted throughout the facility. During group interview, on 10/23/24 at 10:02 A.M., seven of seven residents said they did not know where the resident rights were posted in the facility. Observation on 10/23/24 at 10:45 A.M., showed the resident rights posted along the wall around the corner from the nursing station, beside a portion of the wall and near the exit door to a different part of the facility. The location of the posted resident rights was not in a frequently traveled area for a resident in a wheelchair. The location of the resident rights on the second and third floor were in the same location. During an interview on 10/25/24 at 9:11 A.M., Registered Nurse (RN) A said the following: -Resident rights should be posted for all to see; -The location of the posted resident rights was not in an area the residents would frequently go past; (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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident rights would be better if they were in a different location for the residents to see; -Prior to the state agency (SA) showing him/her where the resident rights were posted, he/she could not have told anyone where they were posted as he/she did not realize the resident rights were posted where they were. During an interview on 10/25/24 at 9:30 A.M., the Assistant Director of Nursing (ADON) said the following: -Resident rights should be posted for all the residents to see and review; -Resident rights are posted on the first floor by the elevator and should also be at the nursing station; -The ADON was unable to show the SA where resident rights were posted. During an interview on 10/25/24 at 12:50 P.M., the Director of Nursing (DON) said resident rights should be readily accessible for residents to see and use. During an interview on 10/25/24 at 1:15 P.M., the Administrator said the following: -Resident rights should be readily accessible for resident to see and use; -He felt like the location of the resident rights was in a high traffic area.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 42592 Based on observation, interview and record review, the facility failed to protect the resident rights when the facility did not provide accessible information regarding the State Long Term Care Ombudsman program and the State Survey Agency in a location that was readily accessible and could be read by residents in the facility without assistance. The facility census was 49. Review of the facility's policy, Filing Grievance/Complaints, revised April 2017, showed the following: -Residents and their representatives have the right to file a grievance, either orally or in writing, to the facility staff or the agency designated to hear grievances (e.g. the State Ombudsman); -A copy of the grievance/complaint procedure is posted on the resident bulleting board. During group interview, on 10/23/24 at 10:02 A.M., seven of seven residents said the following: -They knew what the Ombudsman program was but was unaware of who their representative was or how to contact them; -They did not know how to contact the State Survey Agency if they had any concerns. Observation on 10/23/24 at 10:45 A.M., showed the following: -The resident rights poster was along the wall around the corner from the nursing station with the Ombudsman program number at the bottom of the poster; -The poster was located beside a portion of the wall and near the exit door to a different part of the facility; -The location of the posted Ombudsman number was not in a frequently traveled area for a resident in a wheelchair; -The posted State Survey Agency hotline number was located in a 8 x 10 inch picture frame, above the automated automatic defibrillator (AED) in an area and font type, that would be difficult for a resident to read, especially if the resident was seated in a wheelchair or had impaired vision; -The location of the Ombudsman information and State Survey Agency hotline contact information on second and third floors were in the same location. During an interview on 10/25/24 at 9:11 A.M., Registered Nurse (RN) A said the following: -Resident rights, the Ombudsman's number and state agency hotline number should be posted for all to see; (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The location of the posted Ombudsman number and state agency hotline number was not in an area the residents frequently go past; -Prior to the state agency (SA) showing him/her where the Ombudsman number and state agency hotline number were posted, he/she did not realize the information was located where it was. During an interview on 10/25/24 at 9:30 A.M., the Assistant Director of Nursing (ADON) said the following: -The Ombudsman program number and state survey agency hotline number should be posted for all the residents to see and review; -She felt like the Ombudsman number and state agency hotline number should be posted in a higher traffic area for residents to see and where they are at could be hard for the residents to review. During an interview on 10/25/24 at 12:50 P.M., the Director of Nursing (DON) said the Ombudsman number and State Survey Agency hotline number should be readily accessible for residents to see and use. During an interview on 10/25/24 at 1:15 P.M., the Administrator said the following: -The Ombudsman number and State Survey Agency hotline number should be readily accessible for resident to see and use; -He felt like the location of the Ombudsman number and State Survey Agency hotline number was in a high traffic area.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50189 Based on interview and record review, the facility failed to provide two residents (Residents #4 and #26), or their responsible party, with a bed hold policy at the time of transfer to the hospital, in a review of 20 sampled residents. The facility census was 49. Review of the facility's policy, Bed Hold Policy, revised May 2024, showed the following when a resident was transferred to a hospital: -Neither a resident nor the responsible party is required to pay a nursing facility to hold a bed; -If the resident/responsible person chooses to, he/she may pay a nursing facility in order to reserve the same bed the participant is leaving; -A nursing home has an obligation to inform a resident or the responsible person that paying them to hold a bed is voluntary; -When a resident is transferred to a hospital, the nursing home is required, both by Federal statute and by Federal regulation, to readmit the resident immediately upon the first availability of a bed in a semiprivate room. 1. Review of Resident #4's undated Face Sheet showed the resident had a responsible party. Review of the resident's Progress Notes, dated 08/06/24 at 11:57 A.M., showed the resident was sent to the hospital at the family's request due to uncontrolled back pain. Review of the resident's Hospital Transfer Form, dated 08/06/24, showed the following: -The resident was transferred to the hospital on 08/06/24; -The resident's responsible party was notified of the clinical situation and the transfer. Review of the resident's Progress Notes, dated 08/06/24 at 6:13 P.M., showed the resident was admitted to the hospital. Review of the resident's Progress Notes, dated 08/13/24 at 5:55 P.M., showed the resident was readmitted to the facility at 4:30 P.M. Review of the resident's medical record showed no documentation staff provided the resident or his/her responsible party with a copy of the facility's bed hold policy/agreement at the time of the resident's transfer to the hospital on 08/06/24. 2. Review of Resident #26's undated Face Sheet showed he/she had a responsible party. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's Progress Notes, dated 09/15/24 at 2:45 P.M., showed the resident was sent to the emergency room for extreme leg pain and shortening of leg, despite negative x-ray results. Responsible party was made aware. Review of the resident's Progress Notes, dated 09/15/24 at 10:07 P.M., showed the resident returned to the facility at 7:40 P.M. with a diagnoses of hip pain, but no hip fracture. Review of the resident's medical record showed no documentation staff provided the resident or his/her responsible party with a copy of the facility's bed hold policy/agreement at the time of the resident's transfer to the hospital on 09/15/24. Review of the resident's progress notes, dated 09/16/24 at 1:28 P.M., showed the emergency room called the facility to report the x-ray was read inaccurately and the resident did have a hip fracture and should return to the hospital. Review of the resident's Progress Notes, dated 09/16/24 at 3:46 P.M., showed the resident was sent to the hospital for a fracture of the left hip. The resident's responsible party was made aware of the transfer. Review of the resident's Progress Notes, dated 09/18/24 at 5:14 P.M., showed the resident was admitted back to the facility with a diagnoses of left hip fracture. Review of the resident's medical record showed no documentation staff provided the resident or his/her responsible party with a copy of the facility's bed hold policy/agreement at the time of the resident's transfer to the hospital on 09/16/24. 3. During an interview on 10/25/24 at 10:34 A.M. and 12:50 A.M., the Director of Nursing (DON) said she was not sure what was in the facility policy, as far as the timing of issuing the bed hold policy, but staff should provide notice of bed holds with every transfer to the hospital. During an interview on 10/25/24 at 1:15 P.M., the Administrator said the facility should issue the bed hold notice as soon as the resident is sent to the hospital, but the facility will automatically hold the bed for 24 hours, to allow the facility time to contact the family, in the event they are not at the facility at the time of transfer. Residents/families were not required to hold their bed. If they want to hold the bed, the form was signed and social services was responsible for documenting the bed hold.

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to review the baseline care plan with the resident/responsible party within 48 hours of admission or provide a copy of the baseline care plan to the resident/responsible party for two residents, (Resident #202 and #207) in a review of 20 residents. The facility census was 49. Review of the facility policy, Baseline Care Plans, revised March 2022, showed the following: -A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission; -The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: -The stated goals and objectives of the resident; -A summary of the resident's medication and dietary instructions; -Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; -Any updated information based on the details of the comprehensive care plan, as necessary; -Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #202's face sheet showed the following: -admitted to the facility on [DATE]; -The resident was his/her own responsible party; -Diagnoses included acute and chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body that can be all at once or come on over time), chronic combined systolic and diastolic heart failure (a condition where the ventricles of the heart are unable to contract and relax properly and fails to push adequate blood into circulation), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and obstructive sleep apnea (occurs when your breathing is interrupted during sleep, sometimes for longer than 10 seconds). Review of the resident's progress notes, dated 10/18/24 at 2:34 P.M., showed the following: -The resident arrived by private transportation; (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	-Prior to admission he/she lived at home with family; -Arrived by wheelchair; -Alert and oriented to person, place, time and situation; -Speech was clear and he/she was able to understand and was understood; -Used continuous positive airway pressure (CPAP) (a machine to help with sleep apnea); -Continent of bladder; -Gait is unsteady. Review of the resident's medical record showed a baseline care plan was started on 10/18/24 with no signature of the resident and no signature of staff completing the baseline care plan. No documentation to show the baseline care plan was offered to the resident or that the resident had refused the offering. During an interview on 10/24/24 at 3:00 P.M., the resident said he/she did not have his/her baseline care plan explained to the resident and he/she had not received a copy of the baseline care plan. The resident's spouse was present during the interview and said he/she also had not had the baseline care plan explained to him/her and had not received a copy of the baseline care plan. 3. Review of Resident #207's face sheet showed the following: -admitted to the facility on [DATE]; -The resident was his/her own responsible party; -Diagnoses included wedge compression fracture of T9-T10 vertebra (a break in the thoracic spine that occurs when the vertebrae collapse under pressure), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of the resident's progress notes, dated 10/18/24 at 4:56 P.M., showed the following: -Resident arrived by private transportation; -Prior to admission the resident lived alone; -Adequate vision; -Alert and oriented to person, place and time; -Communicated verbally, speech is clear, is able to understand and be understood when speaking; (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	-Continent of bladder; -Skin issue on front left shoulder; -Uses wheelchair and assist of one staff with gait belt and walker. Review of the resident's medical record showed a baseline care plan started on 10/18/24 with no signature of the resident and no signature of staff completing the baseline care plan. No documentation to show the baseline care plan was offered to the resident or that the resident had refused the offering. During an interview on 10/25/24 at 9:00 A.M., the resident said he/she did not have his/her baseline care plan explained to him/her and he/she had not received a copy of the baseline care plan. During an interview on 10/31/24 at 8:55 A.M., Licensed Practical Nurse (LPN) S said the following: -He/She was not sure who specifically was responsible for initiating the baseline care plan, but there is a baseline care plan tab that the admitting nurse starts; -The Minimum Data Set (MDS) coordinator finishes the baseline care plan; -The baseline care plan should be signed by anyone that works on it; -A copy of the baseline care plan should be given to the resident during the care plan meeting or anytime the resident requests it. During an interview on 10/25/24 at 9:11 A.M., Registered Nurse (RN) A said the following: -Baseline care plans are started at the time of the resident's admission; -The baseline care plan should be signed by the staff member completing it; -The resident received a copy of the baseline care plan when they discharge, but he/she was unaware if they received one on admission. During an interview on 10/31/24 at 3:30 P.M., the MDS Coordinator said the following: -The admitting nurse was responsible for starting and completing the baseline care plan; -After the baseline care plan was completed, the resident should sign it, the staff should sign it and a copy should be given to the resident or resident representative; -In the past, she had done the baseline care plan, but it was a challenge to complete them within 48 hours if the resident admitted on off hours or on the weekend, which was the reason the admitting nurse was doing them. During email communication on 10/31/24 at 2:22 P.M., the Assistant Director of Nursing (ADON) said the following: (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	-The nurse that does the admission initiates the baseline care plan; -Different departments complete each section of the baseline care plan; -The resident should be given a copy of the baseline care plan once it was completed; -The baseline care plan should be signed by the people that complete it; -The only reason a resident would not be given a copy of their baseline care plan would be if they could not process the information; -A power of attorney should be given a copy of the baseline care plan; -She started the baseline care plan for Resident #202 and completed the sections she was responsible for; -She did not sign the baseline care plan for Resident #202. During an interview on 10/25/24 at 12:50 P.M., the Director of Nursing (DON) said the following: -The baseline care plan is started by the admitting nurse and the MDS Coordinator finishes the baseline care plan within 48 hours; -She would expect the nurse completing the baseline care plan to sign the care plan when completed; -She would expect the resident to be offered a copy of their baseline care plan and if they do not want one it should be documented that they were offered and refused. 42592

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32899 Based on observation, interview, and record review, the facility failed to ensure staff safely transported residents in wheelchairs for four residents (Residents #26, #27, #25, and #4), in review of 19 sampled residents, and for two additional residents (Residents #11 and #40). The census was 49. During an interview on 11/05/24 at 10:19 A.M., the Director of Nursing (DON) said the facility did not currently have a policy for transporting residents in wheelchairs or the use of wheelchair foot rests. 1. Review of Resident #26's undated face sheet showed the resident's diagnoses included difficulty in walking, unsteadiness on feet, psychoactive substance-induced sleep disorder, history of falls, major depression, anxiety disorder, and mild cognitive impairment. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/25/24, showed the following: -Severe cognitive impairment; -Impaired range of motion to one side of the lower extremities; -Used a manual wheelchair; -Dependent on staff for transfers; -Supervision or touching assistance to wheel 50 to 150 feet once seated. Review of the resident's Care Plan, revised 10/10/24, showed the following: -Alert with periods of forgetfulness; -Diagnosis of dementia; -Required assistance with all activities of daily living (ADLs); -Limited physical mobility related to weakness and poor balance; -Impulsive at times, related to dementia; -High risk for falls, related to gait and balance problems; -Ensure appropriate footwear or non-skid socks worn, when ambulating or mobilizing in wheelchair. -Not to be left alone while up in wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/23/24 at 9:26 A.M. showed Certified Nurse Assistant (CNA) T pushed the resident in his/her wheelchair from the dining area to his/her room, approximately 50 feet, without foot rests on the wheelchair. The resident wore house slippers and his/her feet dragged on the carpeted floor for the duration of the transport. Observation on 10/24/24 at 1:15 P.M. showed CNA K pushed the resident in his/her wheelchair from the dining area to his/her room, approximately 50 feet, without foot rests on the wheelchair. The resident wore house slippers, and held his/her feet up approximately one inch off the floor during the transport. Observation on 10/24/24 at 1:20 P.M. showed CNA K pushed the resident in his/her wheelchair from his/her room to the dining area, approximately 50 feet, without foot rests. The resident wore house slippers, and held his/her feet up approximately one inch off the floor during the transport. 2. Review of Resident #27's admission MDS, dated [DATE], showed the following: -Supervision or touch assist with transfers; -Used a manual wheelchair; -Partial to moderate assist needed to wheel 50 to 150 feet in wheelchair once seated. Review of the resident's Care Plan, dated 08/30/24, showed the following: -Assist of one staff for transfers due to impaired mobility and balance; -Wheelchair is main mode of transportation; -Assist of one staff to propel (in wheelchair). Review of the resident's Physician Order Sheets (POS), dated October 2024, showed the following: -Diagnoses included cognitive deficit, history of falls and right femur (thigh bone) fracture; -Weight bearing as tolerated to right lower extremity. Observation on 10/24/24 at 5:19 A.M., showed Certified Medication Technician (CMT) J pushed the resident out of his/her room to the dining room without any foot rests on the wheelchair. The resident wore tennis shoes. CMT J did not instruct the resident to hold up his/her feet. The resident's toes were pointed downward and close to the floor. Observation on 10/25/24 at 12:41 P.M. showed an unidentified staff pushed the resident out of his/her room in his/her wheelchair without foot rests to the dining room. The resident's feet hovered just above the floor. Staff did not instruct the resident to raise up his/her feet. During an interview on 11/5/24 at 10:36 A.M., CMT J said staff should not push residents in their wheelchairs without foot rests because their feet could drag on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #25's quarterly MDS, dated [DATE], showed the following: -Required substantial to maximum assist with transfers; -Impaired range of motion of one lower extremity; -Used a manual wheelchair; -Wheeled self (once seated) in wheelchair independently 50-150 feet. Review of the resident's care plan, last revised 7/29/24, showed the resident required extensive assist with activities of daily living and potential for injury related to impaired mobility, balance and history of falls. Review of the resident's POS, dated October 2024, showed the resident's diagnoses included displaced fracture of the right femur. Observation on 10/24/24 at 7:25 A.M. showed CNA N pushed the resident in his/her wheelchair, from his/her room to the dining room, without foot rests on his/her wheelchair. The resident wore non-skid socks and his/her feet hovered just off the floor. The staff did not direct the resident to lift his/her feet. During an interview on 10/25/24 at 12:20 P.M., CNA N said the following: -Staff should not push residents in wheelchairs without foot rests; -Residents who propelled themselves may not have foot rests, but they should be applied if staff need to push them; -Residents who self propelled did not have foot rests and in other cases the foot rests may be lost. 4. Review of Resident #4's undated face sheet showed the resident's diagnoses included muscle weakness, unsteadiness on feet, other abnormalities of gait and mobility, cognitive communication deficit, major depression, and falls. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impaired range of motion to one side of the upper extremities; -Used a manual wheelchair; -Required substantial to maximum assistance for all mobility; -Independent to wheel 50 to 150 feet once seated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Senior Health	206 North Main Street O Fallon, MO 63366

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Care Plan, revised 09/05/24, showed the following: -Required assistance with all ADLs relate to impaired mobility and balance; -Required assistance or escort to activity functions; -Potential for injury related to falls and impaired mobility and balance; -Educated to wait for assistance; -Ensure wears proper fitting shoes that are supportive with non-skin soles for ambulation. Observation on 10/24/24 at 1:23 P.M. showed CNA K pushed the resident from the dining room to his/her room, approximately 75 feet, without foot rests on his/her wheelchair. The resident wore house shoes and his/her feet hovered just above the carpeted floor during the transport. 5. Review of Resident #11's undated face sheet showed the resident's diagnoses included function deficit following a stroke, other abnormalities of gait and mobility, psychosis, and dementia. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No impairment of range of motion in upper or lower extremities; -Used a manual wheelchair; -Required substantial to maximum assistance for all mobility; -Partial to moderate assistance to wheel 50 feet and make two turns, once seated; -Dependent to wheel up to 150 feet once seated. Review of the resident's Care Plan, revised 10/03/24, showed the following: -Required assistance with ADL care; -Wheelchair was main mode of transportation; -Assistance of one staff for wheelchair locomotion; -Alert with periods of forgetfulness related to dementia; -Potential for injury related to falls -Poor safety awareness; -Ensure proper fitting shoes that are supportive with non-skid soles for ambulation; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Offer frequent reminders and cues. Observation on 10/24/24 at 1:08 P.M. showed CNA K pushed the resident from the dining room to his/her room, without foot rests on his/her wheelchair. The resident wore house shoes and his/her feet hovered just above the carpeted floor during the transport. 6. Review of Resident #40's undated face sheet showed the resident's diagnoses included fall, dementia, psychotic disturbance, mood disturbance, muscle weakness, unsteadiness on feet, and cognitive communication deficit. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Uses a manual wheelchair; -Supervision to touching assistance for all mobility; -Supervision to touching assistance to wheel 50 to 150 feet once seated. Review of the resident's care plan, revised 08/03/24, showed the following: -Assistance required for all ADLs related to impaired mobility and balance; -Alert with periods of forgetfulness; -Periods of disorganized thinking at times; -Wheelchair with one staff assistance for locomotion; -Potential for injury from falls related to impaired mobility and balance, history of falls and psychotropic drug use; -Ensure proper fitting shoes that are supportive with non-skid soles are worn for ambulation. Observation on 10/24/24 at 5:18 A.M. showed CNA Y pushed the resident in his/her wheelchair from his/her room to the dining room, without foot rests on his/her wheelchair. The resident wore house slippers and his/her feet hovered just above the carpeted floor during the transport. 7. During an interview on 10/25/24 at 9:32 A.M., CNA W said the following: -Many residents self propelled and did not like foot rests on their wheelchairs because they got in the way and they could not get close enough to the dining room tables for meals; -Residents told staff if they wanted foot rests on their wheelchairs; -Staff should not push residents in wheelchairs without foot rests. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/24 at 12:29 P.M., CNA K said if residents can hold their feet up, they don't need foot rests on their wheelchairs. During an interview on 10/25/24 at 12:06 P.M., the Education/Staffing Director said staff should not push residents in wheelchairs without foot pedals. During an interview on 10/25/24 at 1:00 P.M., the Director of Nurses said she expected staff to push residents in their wheelchairs with foot rests on the wheelchair. 50189

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to ensure bed rails assessments were consistent with facility policy to evaluate the resident's risk for entrapment and failed to conduct ongoing assessments to ensure the proper use and safety of the bed rails for eight residents (Residents #12, #102, #24, #25, #23, #207, #4 and #45), in a review of 20 sampled residents. The facility census was 49. Review of the facility policy, Bed Safety and Bed Rails, revised on August 2022, showed the following: -Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one- quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy bed rails include: side rails, safety rails, and grab/assist bars; -The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent; -The resident assessment to determine risk of entrapment includes, but is not limited to: -Medical diagnosis, conditions, symptoms, and/or behavioral symptoms; -Size and weight; -Sleep habits; -Medication(s); -Acute medical or surgical interventions; -Underlying medical conditions; -Existence of delirium; -Ability to toilet self safely; -Cognition; -Communication; -Mobility (in and out of bed); and (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Risk of falling. Review of the Food and Drug Administration's Guide of Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised April 2010, showed the following: -Residents who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling; -Assessment by the resident's health care team will help to determine how best to keep the patient safe; -Potential risks of bed rails may include strangling, suffocating, bodily injury or death when residents, or part of their body, are caught between rails or between the bed rails and mattress, more serious injuries from falls when residents climb over rails, skin bruising, cuts, and scrapes, feeling isolated or unnecessarily restricted, and preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet; -When bed rails are used, perform an on-going assessment of the resident's physical and mental status and closely monitor high-risk patients; -A process that requires ongoing evaluation and monitoring will result in optimizing bed safety; -Reassess the need for using bed rails on a frequent, regular basis. 1. Review of Resident #12's undated Face Sheet showed the following: -The resident was his/her own responsible party; -Diagnoses include multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves) and weakness. Review of the resident's Bed Rail/Assist Bar Evaluation, dated 03/06/24, showed the following: -Assessment did not specify if it was an admission, readmission, quarterly, annual or significant change assessment for bilateral assist bar/bed rail; -Has the resident expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort? Yes; -The resident does not have fluctuations in levels of consciousness or a cognitive deficit with episodes of confusion/behaviors; -Is the resident physically able to release bed rails/assist bar? No; -Is the resident able to follow directions? Retain safety information? Yes; -Is the resident able to get in bed safely without assistance? No; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Is the resident able to get out of bed safely without assistance? No; -Does the resident have a history of falls? No; -Is the resident having problems with balance or poor trunk control? No; -Will/Does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position (lying) to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension (also known as orthostatic hypotension)? No; -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Based on summary of findings: The resident has requested to have bed rails/assist bar while in bed and bed rails/assist bar are indicated and will serve as an enabler to promote resident independence; -The bed rail/assist bar evaluation did not evaluate the resident's for risk of entrapment per the facility's policy. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Range of motion impairment upper and lower extremity both sides; -The resident was dependent on staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfers. Review of the resident's Care Plan, revised on 10/23/24, showed the following: -He/She required assistance with activities of daily living (ADLs) related to mobility and impaired balance; -Assist him/her with repositioning every two hours and as needed with assistance of one to two; -Assist bars on bed are for mobility and transfer; -He/She required a mechanical lift with two staff for transfers. Review of the resident's October 2024 Physician Order Sheet (POS) showed an order for assist rail on both sides of the bed for positioning and to assist with mobility every day and night. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/23/24 at 2:16 P.M., showed the resident lay in bed. The resident had 1/8th assist rails in the raised position on both sides of his/her bed. During interview on 10/23/24 at 2:16 P.M., the resident said he/she was not able to grab the assist rail as much anymore but the assist rails made him/her feel safer when staff rolled him/her back and forth in bed. Observation on 10/24/24 at 10:38 A.M., showed staff transferred the resident from bed to his/her electric wheelchair. The resident had 1/8th assist rails in the raised position on both sides of his/her bed. 2. Review of Resident #102's undated Face Sheet showed the following: -admitted [DATE]; -The resident was his/her own responsible party; -Diagnoses include muscle weakness, fall, sacrum (tailbone) fracture and compression fracture of L2 (lumbar vertebra). Review of the resident's October 2024 POS showed an order for assist rails on both sides of the bed for positioning and to assist with mobility every day and night. Review of the resident's Baseline Care Plan, dated 10/21/24, showed the resident required one person for bed mobility and transfers. (The resident's care plan did not address use of bed rails/assist bars.) Review of the resident's Bed Rail/Assist Bar Evaluation, dated 10/23/24, showed the following: -Assessment was an admission assessment for bilateral assist bar/bed rail; -Has the resident expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort? Yes; -The resident does not have fluctuations in levels of consciousness or a cognitive deficit with episodes of confusion/behaviors; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to follow directions? Retain safety information? Yes; -Is the resident able to get in bed safely without assistance? No; -Is the resident able to get out of bed safely without assistance? No; -Does the resident have a history of falls? Yes, mechanical fall (an external force (e.g., environmental) caused the patient to fall); (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Is the resident having problems with balance or poor trunk control? Yes; -Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position (lying) to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension (also known as orthostatic hypotension)? No; -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Based on summary of findings: The bilateral bed rails/assist bars are indicated and will serve as an enabler to promote resident independence; -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Observation on 10/22/24 at 12:21 P.M., showed the resident sat in his/her wheelchair in his/her room. The resident had 1/8th assist rails in the raised position on both sides of his/her bed. During interview on 10/23/24 at 2:31 P.M., the resident said he/she used the assist rails to help him/her turn over in bed. 3. Review of Resident #24's undated Face Sheet showed he/she had a power of attorney. Review of the resident's Bed Rail/Assist Bar Evaluation, dated 03/19/24, showed the following: -Assessment was an admission assessment for bilateral assist bar/bed rail; -The resident did not have fluctuations in levels of consciousness or a cognitive deficit with episodes of confusion/behaviors; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to get in bed safely without assistance: No; -Is the resident able to get out of bed safely without assistance: No; -Is the resident able to follow directions? Retain safety information? Yes; -Does the resident have a history of falls? If yes, explain. Yes -fall leading to hospitalization ; -Is the resident having problems with balance or poor trunk control? If yes, explain. Yes - no explanation noted; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position (lying) to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension (also known as orthostatic hypotension)? No; -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Summary of findings: The resident is cognitively intact. The summary did not indicate what type of bed rail would be used, that the resident requested bed rails or that the family and physician were notified. -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Review of the resident's Care Plan, last revised 07/22/24, showed the following: -Assist of one to two staff for bed mobility and transfers due to impaired mobility and impaired balance; -Assist rails on both sides of bed; -Assist bars make it possible for the resident to reposition himself/herself in bed, assist the resident with transfers in and out of bed, and to be more independent. Review of the resident's POS, dated October 2024, showed the following: -Diagnoses included dementia and multiple sclerosis; -Weight bearing as tolerated with sit to stand lift. -No order for assist rails. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Dependent on staff for transfers; -Required substantial to maximum assistance with bed mobility. Observation on 10/24/25 at 2:37 P.M. showed the resident lay in his/her bed with assist rails in the raised position on both sides of the bed. The left side of the bed was up against the wall. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #25's Bed Rail/Assist Bar Evaluation, dated 04/19/24, showed the following: -Assessment was an admission assessment for bilateral assist bar/bed rail; -The resident did not have fluctuations in levels of consciousness or a cognitive deficit with episodes of confusion/behaviors; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to get in bed safely without assistance: No; -Is the resident able to get out of bed safely without assistance: No; -Is the resident able to follow directions? Retain safety information? Yes; -Does the resident have a history of falls? If yes, explain. Yes -fall with a non displaced right femur fracture; -Is the resident having problems with balance or poor trunk control? If yes, explain. Yes - no explanation noted; -Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position (lying) to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension (also known as orthostatic hypotension)? Not addressed either way; -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Based on summary of findings: The resident has moderately impaired cognition. The resident requested the use of bilateral assist rails to serve as an enabler to promote independence. -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Supervised or touch assist with bed mobility; -Substantial to maximum assist for transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Impaired ROM one lower extremity. Review of the resident's Care Plan, last revised 07/29/24, showed the following: -Assist rails on both sides of bed per resident request; -Assist rails will assist the resident with repositioning in bed and with transferring in and out of bed; -The resident was aware of the risks involved with the assist rails and signed a consent; -Therapy evaluated the resident for appropriateness for assist rails, indicating they will serve as an enabler to promote independence. Review of the resident's POS, dated 10/2024, showed the following: -Diagnoses included osteoarthritis (flexible tissue at ends of bones wears down, causing pain), periprosthetic fracture (broken bone occurring near or around an orthopedic implant) around internal prosthetic right hip joint and muscle weakness; -Order for for assist rails on both sides for positioning and to assist with mobility (original order dated 4/19/24). Observation on 10/24/24 at 7:12 A.M. showed the resident lay in his/her bed. The resident had 1/8th assist rails in the raised position on both sides of his/her bed. The right side of the bed was pushed against the wall. 5. Review of Resident #23's undated face sheet showed the following: -The resident was his/her own responsible party; -Diagnoses include hemiplegia and hemiparesis following hemorrhage affecting right dominant side (weakness or paralysis affecting the right side only after a brain bleed) and orthostatic hypotension. Review of the resident's Bed Rail/Assist Bar Evaluation, dated 09/06/24, showed the following: -Assessment was an admission and readmission assessment for bilateral assist bar/bed rail; -The resident had fluctuations in levels of consciousness or a cognitive deficit with episodes of confusion/behaviors; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to follow directions? Retain safety information? Yes; -Does the resident have a history of falls? If yes, explain. Yes - no explanation noted; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Is the resident having problems with balance or poor trunk control? If yes, explain. Yes - no explanation noted; -Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position (lying) to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension (also known as orthostatic hypotension)? No (Staff did not answer this questions correctly as the resident had a diagnosis of orthostatic hypotension); -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Based on summary of findings: The resident has requested to have bed rails/assist bar while in bed and bed rails/assist bar are indicated and will serve as an enabler to promote resident independence; -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Impairment in range of motion to the upper and lower extremities one side of his/her body; -Required partial/moderate staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sit to standing transfer, chair/bed-to-chair transfers. Review of the resident's Care Plan, revised on 09/19/24, showed the following: -He/She required assistance with activities of daily living (ADLs) related to impaired mobility and impaired balance; -Assist him/her with repositioning every two to three hours and as needed with assistance of one; -Assist rails as ordered for mobility; -He/She required assistance from one to two staff for transfers. Review of the resident's October 2024 POS showed an order for assist rails on both sides of the bed for positioning and to assist with mobility every day and night. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Senior Health	206 North Main Street O Fallon, MO 63366

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/22/24 at 11:28 A.M., showed the resident lay in bed awake with 1/8th assist rails in the raised position on both sides of his/her bed. The rail was stationary and unable to be lowered. During an interview on 10/22/24 at 11:28 A.M., the resident said he/she used the assist rails to help with bed mobility and transfers. Observation on 10/24/24 at 5:10 A.M., showed the resident lay in bed sleeping with 1/8th assist rails in the raised position on both sides of his/her bed. 6. Review of Resident #207's undated face sheet showed the following: -The resident was his/her own responsible party; -Diagnoses included wedge compression fracture of T9-T10 vertebra (a break in the thoracic spine that occurs when the vertebrae collapse under pressure), dementia (a group of thinking and social symptoms that interferes with daily functioning) and anxiety disorder. Review of the resident's October 2024 POS showed an order for assist rail on both sides of the bed for positioning and to assist with mobility every day and night shift for cane rails. Review of the resident's Bed Rail/Assist Bar Evaluation, dated 10/21/24, showed the following: -Assessment was an admission assessment for bilateral assist bar/bed rail; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to follow directions? Retain safety information? Yes; -Is the resident able to get in bed safely without assistance? No; -Is the resident able to get out of bed safely without assistance? No; -Does the resident have a history of falls? If yes, explain. Yes - fall (have) self-transfer; -Is the resident having problems with balance or poor trunk control? If yes, explain. Yes - no explanation noted; -Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension? No; -Is there a risk to the resident if bed rails/assist bar are used? No; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Do the bed rails/assist bar alternatives/interventions create more risk than bed rails/assist bar use? No; -Based on summary of findings: Assist bar/bed rails: bilateral. Bed rails/assist bar are indicated and will serve as an enabler to promote resident independence; -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Observation on 10/22/24 at 2:10 P.M., showed the resident's bed had 1/8th assist rails in the raised position on both sides of the bed. The rail was stationary and unable to be lowered. During an interview on 10/22/24, at 2:10 P.M., the resident said he/she used the assist rails to help with bed mobility and transfers. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -No impairment in his/her range of motion; -Used wheelchair and walker; -Required partial/moderate staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sit to standing transfer, chair/bed-to-chair transfers; -History of falls prior to admission, fall within the last 2-6 months prior to admission, fracture related to fall in six months prior to admission; -No falls since admission. Review of the resident's Care Plan, revised on 10/23/24, showed the following: -He/She was at risk for falls related to impulsiveness and gait/balance problems; -The resident/resident's family had requested assist bars to be on the sides of his/her bed; -He/She was informed of the risks involved in having assist bars and the resident signed a consent form that he/she was aware and still wanted them; -He/She will be re-evaluated if there is a change in status; -On 10/22/24 at 3:44 P.M., staff observed the resident sitting on the floor in his/her room between the wheelchair and bed. Observation on 10/24/24 at 5:11 A.M., showed the resident lay in bed sleeping with 1/8th assist rails in the raised position on both sides of his/her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #4's undated Face Sheet showed the resident's diagnoses included muscle weakness, other abnormalities of gait and mobility, and falls. Review of the resident's Bed Rail/Assist Bar evaluation, dated 03/06/24, showed the following: -Assessment was marked as an other evaluation, but did not specify the reasoning; -The assist bar/bed rail is located on bilateral sides; -Has the resident expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort? Yes; -Does the resident have fluctuation in levels of consciousness or a cognitive deficit? No; -Is the resident physically able to release bed rails/assist bar? No; -Is the resident able to follow directions? Retain safety information? Yes; -Does the resident have any visual deficits? No; -Is the resident able to get in bed safely without assistance? Yes; -Is the resident able to get out of bed safely without assistance? Yes; -Does the resident have a history of falls? Yes, one on 02/23/24; -Is the resident having problems with balance or poor trunk control? No; -Is the resident able to voluntarily move their own body? Yes; -Will/does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension? No; -Is there a possibility the resident will climb over the bed rails/assist bar? No; -Is there evidence (reason to believe) the resident has (or may have) a desire to reason to get out of bed? No; -Does the resident receive any medications that would require safety precautions? No; -Is the resident continent of bowel and/or bladder? If no, explain: No, no explanation given; -Is there a risk to the resident if bed rails/assist bar are used? No; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Do the bed rails/assist bar alternatives/interventions create more risks than bed rails/assist bar use? No; -Will/does the bed rail/assist bar obstruct the resident's view? No; -Based on the summary of findings, signed by physical therapist on 05/01/24: the resident has requested to have bed rails/assist bar while in bed and the bed rails/assist bar are indicated and will serve as an enabler to promote resident independence; -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impairment in range of motion to one side of the upper extremities; -Required substantial to maximum assistance for all mobility needs. Review of the resident's Care Plan, revised 09/05/24, showed the following: -He/She required assistance with activities of daily living (ADLs) due to impaired mobility and impaired balance; -Assistance of one staff for repositioning every two or three hours and as needed; -He/She had assist rails to both sides of his/her bed; -Assist rails were to help him/her with positioning and mobility; -He/She had potential for injury related to impaired mobility; -Physical therapy evaluated if the assist rails would be a benefit for him/her; -He/She will be re-evaluated if there is a change in condition. Review of the resident's Physician's Order Sheet, dated October 2024, showed an order for assist rails on both sides for positioning and to assist with mobility every day and night. Observation on 10/24/25 at 5:10 A.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. 8. Review of Resident #45's undated Face Sheet showed the following: -admitted [DATE]; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of hemiplegia and hemiparesis affecting the left side, morbid obesity, and need for assistance with personal care; -The resident had a responsible party. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Impairment in range of motion on one side of upper and lower extremities; -Required moderate to substantial/maximal assistance for all mobility needs. Review of the resident's Care Plan, revised on 08/29/24, showed the following: -He/She required assistance with ADLs due to impaired mobility and impaired balance; -He/She had requested assist bars to both sides of his/her bed; -He/She was able to reposition himself/herself in bed and the assist bar with getting in and out of bed; -He/She will be reevaluated as needed; -Therapy had evaluated him/her for appropriateness of assist bars and it was indicated they enable him/her to be more independent. Review of the resident's bed rail/assist bar evaluation, dated 09/10/24, showed the following: -Assessment did not specify if it was an admission, readmission, quarterly, annual, significant change, or other evaluation; -The assist bar/bed rail is located on bilateral sides; -Has resident expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort? Yes; -Does the resident have fluctuation in levels of consciousness or a cognitive deficit? No; -Is the resident physically able to release bed rails/assist bar? Yes; -Is the resident able to follow directions? Retain safety information? Yes; -Does the resident have any visual deficits? No; -Is the resident able to get in bed safely without assistance? No; -Is the resident able to get out of bed safely without assistance? No; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Does the resident have a history of falls? No; -Is the resident having problems with balance or poor trunk? No; -Is the resident able to voluntarily move their own body? Yes; -Will/Does the resident use the bed rails/assist bar for positioning or support? Yes; -Does the bed rail/assist bar help the resident rise safely from a supine position to a sitting/standing position? Yes; -Does the resident have a history of postural hypotension? No; -Is there a possibility the resident will climb over the bed rails/assist bar? No; -Is there evidence (reason to believe) the resident has (or may have) a desire to reason to get out of bed? No; -Does the resident receive any medications that would require safety precautions? No; -Is the resident continent of bowel and/or bladder? If no, explain. No, no desire to toilet; -Is there a risk to the resident if bed rails/assist bar are used? No; -Do the bed rails/assist bar alternatives/interventions create more risks than bed rails/assist bar use? No; -Will/Does the bed rail/assist bar obstruct the resident's view? No; -No page two with the summary of findings; -The bed rail/assist bar evaluation did not evaluate the resident for risk of entrapment per the facility's policy. Review of the resident's POS, dated October 2024, showed an order for assist rail on both sides for positioning and to assist with mobility every day and night. Observation on 10/22/24 at 2:34 P.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. Observation on 10/23/24 at 8:31 A.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. Observation on 10/23/24 at 8:38 A.M. showed the Education/Staffing Director and Certified Nurse Assistant (CNA)/Certified Medication Technician (CMT) T repositioned the resident in bed. The resident did not utilize the assist rails as the staff worked together to move him/her up in his/her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/24/24 at 6:51 A.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. Observation on 10/24/24 at 1:01 P.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. 9. During an interview on 10/31/24 at 9:04 A.M., Physical Therapy R said the following: -The current therapy company took over therapy at the facility one week before the annual recertification survey began; -The physical therapist or occupational therapist completed the bed rail/assist bar evaluations for new admissions and for any resident the facility requested it to be completed on; -The therapists completed a bed rail/assist bar evaluation on all residents admitted since the therapy company began at the facility, but he/she was unsure if ongoing assessments would be completed; -Ongoing assessments would be at the direction of the facility; -The residents' risk for entrapment was not evaluated as the rails being used were assist bars and not bed rails. During an interview on 10/25/24 at 10:34 A.M., the Director of Nursing (DON) said the therapy department completed the bed rail assessments on admission and as needed. During an interview on 10/25/24 at 1:15 P.M., the Administrator said the following: -The therapy department completed the assist bar assessments when a resident was admitted ; -He did not feel like there were any rails in the facility that were classified as bed rails. The rails used were assistive devices for positioning; -He was unsure how often the therapy department completed the assessments other than on admission. 32899 42592 50189

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44665 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food to residents in a safe and sanitary manner when staff failed to employ proper hand hygiene and gloving practices and failed to store food in a manner that prevented potential contamination. Staff failed to ensure beverage and ice machines were clean and an air gap was present at ice machine drains. Staff failed to document and demonstrate knowledge of the use and testing parameters of the facility's dishwashing machines to ensure dishes were cleaned and sanitized properly. The facility census was 49. Review of the facility policy, Food and Nutrition Services Staff, revised [DATE], showed the following: -Food and nutrition services staff should wash their hands before serving food to residents; -Employees should wash their hands after collecting soiled plates and food waste and prior to handling food trays; -Bare hand contact with food is prohibited; -Gloves are worn when handling food directly and changed between tasks. Review of the undated facility policy, Procedures for Serving Food on Second and Third Floor, showed the following: -Wash your hands for 20 seconds, take paper towel, dry your hands, then turn off faucet, put on gloves; -After you finish tasks, take off gloves, wash hands, and with a new task comes new gloves; -Wash your hands before you serve food. 1. Observation on [DATE], from 4:52 P.M. to 5:05 P.M., in the third floor dining room during the dinner meal service, showed the following: -Dietary Aide I served food onto residents' plates from the steam table and counter serving area; -He/She used his/her gloved hands to grasp and move a newspaper from a resident to the nurses' station; -Without changing his/her gloves, he/she touched the inside surface of a bowl, ladeled soup into the bowl, and gave the bowl of soup to a resident; -He/She touched the handles of a resident's wheelchair, pushed the resident closer to the table, and touched the resident's arm; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She removed his/her gloves, did not wash his/her hands, put on new gloves, and removed soiled dishes from residents' tables to the counter; -He/She picked up a butter knife from the floor and placed it in the sink, took off one glove and put on a new glove, did not wash his/her hands, and served food onto residents' plates from the steam table; -With his/her same gloved hands, he/she turned off a faucet handle (the water was running at the sink), grabbed a piece of bread from a bag of bread, and placed the bread on a resident's plate; -He/She opened and closed the microwave door, pressed buttons on the microwave, touched resident meal cards, and continued serving residents' food during the meal service. Observation on [DATE], from 8:01 A.M. to 8:41 A.M., in the second floor dining room during the breakfast meal service, showed the following: -Dietary Aide H used his/her bare hands to pick up soiled dishes from residents' tables and placed the dishes into the sink; -Without washing his/her hands, he/she put a glove on his/her right hand, grabbed a piece of bread from a bag of bread, placed the bread in the toaster, and turned on the toaster using the toaster controls; -He/She rested his/her gloved hand on the top of the steam table, wiped his/her gloved hand on his/her apron, and grabbed another slice of bread and placed the bread in the toaster; -Without washing his/her hands or changing his/her gloves, he/she removed toast from the toaster and held the toast in his/her left bare hand while using a knife in his/her right gloved hand to spread butter on the toast; -He/She served the buttered toast to a resident, removed soiled dishes from residents' tables, poured a cup of coffee for a resident, and brought clean silverware to a resident; -He/She removed his/her glove, discarded the glove into the trash can, did not wash his/her hands, put on new gloves, and placed more bread in the toaster; -With his/her gloved hands, he/she ate food, drank from a cup, and used a napkin to wipe his/her mouth while standing at the food preparation counter; -He/She moved soiled dishes from the counter to the sink, removed his/her gloves, discarded the gloves in the trash can, and moved soiled dishes from residents' tables to the sink; -Without washing his/her hands, he/she used his/her bare hands to remove the lid of a resident's coffee mug and refill the mug with coffee; -He/She picked up soiled dishes from residents' tables and placed them on the counter by the sink; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She obtained a clean drinking glass, opened the refrigerator door, poured milk from a jug into the glass, and carried the glass with his/her bare hands touching the upper drinking-edge portion of the glass and gave the glass of milk to a resident. During an interview on [DATE] at 9:36 A.M., Dietary Aide D said the following: -Staff should wash their hands after performing dirty tasks, when changing gloves, and before performing clean tasks; -Staff should not eat or drink personal items in the food preparation and serving areas, such as in the second and third floor kitchenettes, and should instead consume these items in the employee breakroom; -Staff should handle dishware by the non-eating and non-drinking surfaces of those items. During an interview on [DATE] at 1:08 P.M., the Dietary Manager said the following: -She expected staff to serve, store and prepare food and beverages under safe and sanitary conditions; -Staff should wash their hands properly and change their gloves appropriately; -Staff should not handle ready-to-eat foods with their bare hands or soiled gloves; -Staff should wash their hands and change their gloves when changing tasks, after completing dirty tasks (such as picking items up from the floor) and prior to conducting clean tasks (such as serving food to residents); -Staff should not consume food or beverages in the food preparation area and should instead eat in the breakroom or dining room; -Staff should handle clean dishware by the non-eating and non-drinking sides of those items. Review of the facility policy, Food Receiving and Storage, revised [DATE], showed foods shall be received and stored in a manner that complies with safe food handling practices. 2. Observation on [DATE] at 10:55 A.M., in the kitchen dry storage room, showed the following: -The top of an open 5-pound bag of buttermilk pancake mix was loosely folded over and not securely sealed; -The dates [DATE] and [DATE] were written in marker on a zippertop bag containing approximately 10 flour tortillas. Observation on [DATE] at 9:05 A.M., in the kitchen dry storage room, showed the top of an open 5-pound bag of buttermilk pancake mix was loosely folded over and not securely sealed. Observation on [DATE] at 1:01 P.M., in the kitchen walk-in freezer, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A bag of frozen chicken breasts was not sealed and was open to the air; -A bag of frozen chicken tenders, located in a cardboard box with flaps that were loosely closed, was not sealed and was open to the air; -A bag of frozen potatoes was not sealed and was open to the air; -A bag of frozen manicotti, located in a cardboard box with flaps that were loosely closed, was not sealed and was open to the air. During an interview on [DATE] at 1:08 P.M., the Dietary Manager said she expected staff to properly seal, label, and date food items. She expected staff to discard expired and past-dated food items. 3. Review of the ice machine vendor cleaning records showed the following: -The kitchen ice machine was cleaned, descaled, and sanitized on [DATE]; -The second floor ice machine was cleaned and sanitized on [DATE]; -The third floor ice machine was cleaned and sanitized on [DATE]; Observation on [DATE] at 4:25 P.M., in the kitchen, showed the following: -The ice machine had a heavy accumulation of white and brown crusty debris on the back side of the exterior surface; -Several dried white stains were visible across the front, back, and sides of the exterior surface; -A moderate accumulation of moist black debris was on the metal horizontal surface, located above the ice holding area, on the interior portion of the ice machine; -Approximately 0.25 inches of standing water sat in a blue plastic holder (located next to the ice machine) and a metal ice scoop sat in contact with the water. There was a moderate accumulation of dried white debris on the inside surface of the plastic scoop holder. Observation on [DATE] at 11:01 AM, in the second floor dining beverage area, showed the following: -A heavy accumulation of white and black crusty debris was visible in and around the dispensing area of the ice and water machine; -A moderate accumulation of black debris was visible between and around the nozzles of the juice dispenser; -A moderate accumulation of dark gray debris speckled the surface around the nozzles of the coffee machine. Observation on [DATE] at 7:19 AM, in the third floor dining beverage area, showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Senior Health	206 North Main Street O Fallon, MO 63366

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An excessive accumulation of white crusty debris and black buildup was visible in and around the dispensing area of the ice and water machine; -An excess accumulation of black debris was visible between and around the nozzles of the juice dispenser; -A moderate accumulation of dark gray debris speckled the surface around the nozzles of the coffee machine. During an interview on [DATE] at 1:08 P.M., the Dietary Supervisor said the following: -She cleaned the nozzles of the juice dispenser weekly; -She wiped the area around the spouts and primed the coffee machine on Monday ([DATE]); -When showed the photos of the machines around the nozzles and spouts, she was unaware the machines were that dirty. During an interview on [DATE] at 1:08 P.M., the Dietary Manager said the following: -A company cleaned and sanitized the ice machines about once per quarter, and dietary staff cleaned the outside of the machines monthly; -Dietary staff cleaned and sanitized the kitchen ice machine scoop weekly by running it through the dishwasher. She did not realize the kitchen ice scoop holder was holding water. 4. Observation on [DATE] at 8:37 A.M., in the third floor dining room, showed the following: -An approximate 2-foot section of 1-inch diameter PVC pipe extended from the ice machine drain into a 4-inch flanged PVC floor drain; -The 1-inch PVC pipe extended approximately 2 inches below the flood rim level of the flanged drain and contained no air gap to prevent potential backflow from the drain back into the machine. Observation on [DATE] at 8:31 A.M., in the second floor dining room, showed the following: -An approximate 2-foot section of 1-inch diameter clear hose extended from the ice machine drain into a 4-inch flanged PVC floor drain; -The clear hose extended approximately 1.5 inches below the flood rim level of the flanged drain and contained no air gap to prevent potential backflow from the drain back into the machine. During an interview on [DATE] at 1:08 P.M., the Dietary Manager said the following: -She expected there to be an adequate air gap at the ice machine drains to prevent potential backflow into the machines; -Maintenance staff were responsible for ensuring proper air gaps at the ice machine drains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:35 P.M., the Maintenance Assistant said the following: -A company came every three to four months to clean and descale the ice machines; -He cleaned the ice machine drains monthly and as issues arose; -He checked to ensure there was an air space around the second and third floor ice machine drains that went into the flanged drains but was unaware the drains did not contain an adequate air gap (above the flood rim level of the flanged drain) to prevent potential backflow into the machines. 5. Review of the manufacturer's specification sheet for the kitchen dishmachine showed the following: -Operating temperatures: -Wash (minimum): 140 degrees Fahrenheit (F); -Sanitizing rinse (minimum): 120 degrees F; -Water flow pressure (required): ,d+[DATE] PSI (pounds per square inch); -Chemical sanitizer rinse (minimum): 50 PPM (parts per million) chlorine. Observation on [DATE] at 1:19 P.M., of the facility log Daily Temperatures for Dishwasher, located in the kitchen dishwashing room, showed the following: -Columns on the form read: Date, A.M. Test Strip, Initials, P.M. Test Strip, Initials; -A checkmark was placed in the A.M. Test Strip column for [DATE] through [DATE]; -A checkmark and/or the date was placed in the P.M. Test Strip column for [DATE] through [DATE], [DATE], [DATE], and [DATE]; -No A.M. or P.M. test strip information was logged for [DATE] or [DATE]; -No A.M. test strip information was logged for [DATE]; -No P.M. test strip information was logged for [DATE], [DATE], or [DATE]; -No chemical test strip parameters or values were written on the form; -No water temperature or water pressure parameters or values were written on the form. Observation on [DATE] from 1:13 P.M. to 1:31 P.M., in the kitchen, showed Dishwasher F operated the conveyor-style dishmachine by placing racks of soiled dishes into the entry to the machine and taking out racks of clean dishes from the exit of the machine. The following parameters were observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 1:13 P.M., the rinse temperature (indicated on the machine's dial gauge) was 115 degrees F and the wash temperature was 100 degrees F; -At 1:16 P.M., the rinse temperature was 110 degrees F and the wash temperature was 100 degrees F; -At 1:19 P.M., the rinse temperature was 108 degrees F and the wash temperature was 100 degrees F; -At 1:22 P.M., the rinse temperature was 109 degrees F and the wash temperature was 100 degrees F; -At 1:26 P.M., the rinse temperature was 108 degrees F and the wash temperature was 95 degrees F. During an interview on [DATE] at 1:16 P.M., Dishwasher F said the following: -He/She didn't think the kitchen's dish machine got the dishes clean and didn't think the water in the machine got hot enough; -He/She knew he/she needed to keep the sanitizer filled for the machine but was unaware if he/she needed to monitor the water temperature or water pressure. During an interview on [DATE] at 9:41 A.M., Dishwasher Q said the following: -Staff should check the sanitizer concentration of the kitchen dishwasher at the beginning of each shift using a test strip; -The test strip should be a really dark purple (200 PPM as indicated on the test strip bottle); -The water temperature and water pressure didn't really matter for the dishwasher, it was mainly the sanitizer that was important to have at the correct level. During an interview on [DATE] at 11:45 A.M., the Dietary Supervisor said the dishwashing staff kept turning off the kitchen dishwasher and it took a long time to heat up the water again. 6. Review of the manufacturer's specification sheet for the second and third floor dishmachines showed the following: -Operating temperatures: -Wash (minimum): 120 degrees F; -Rinse (minimum): 120 degrees F; -Water flow pressure (required): ,d+[DATE] PSI; -Chemical sanitizer (minimum): 50 PPM chlorine. Review on [DATE] at 8:12 A.M., of the untitled facility log, located in the second floor kitchenette, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Columns on the form read: Date, A.M. Test Strip 200 PPM, Initials, P.M. Test Strip 200 PPM, Initials; -A checkmark was placed in the A.M. Test Strip column for [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE]; -A checkmark was placed in the P.M. Test Strip column for [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] , and [DATE]; -No A.M. or P.M. test strip information was logged for [DATE]; -No A.M. test strip information was logged for [DATE] and [DATE]; -No P.M. test strip information was logged for [DATE], [DATE] to [DATE], [DATE], and [DATE]; -No water temperature or water pressure parameters or values were written on the form. Review on [DATE] at 8:12 A.M., of the untitled facility log, located in the third floor kitchenette, showed the following: -Columns on the form read: Date, A.M. Test Strip 200 PPM, Initials, P.M. Test Strip 200 PPM, Initials; -A checkmark was placed in the A.M. Test Strip column for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] to [DATE], [DATE] to [DATE]; -A checkmark was placed in the P.M. Test Strip column for [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]; -No A.M. or P.M. test strip information was logged for [DATE] or [DATE]; -No A.M. test strip information was logged for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]; -No P.M. test strip information was logged for [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]; -No water temperature or water pressure parameters or values were written on the form. Observation on [DATE], of the second floor kitchenette dishwasher, showed the following: -At 8:44 A.M., Dietary Aide H started a load of dishes. The wash temperature (indicated on the unit's digital display) was 119 degrees F and the rinse temperature was 87 degrees F; -At 8:45 A.M., the wash temperature was 113 degrees F and the rinse temperature was 95 degrees F; -At 8:46 A.M., the cycle ended and the wash temperature was 113 degrees F and the rinse temperature was 103 degrees F; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No water pressure gauge was visible for the dishwasher. Observation on [DATE], of the third floor kitchenette dishwasher, showed the following: -At 8:22 A.M., Dietary Aide D started a load of dishes. The wash temperature was 91 degrees F and the rinse temperature was 87 degrees F; -At 8:23 A.M., the wash temperature was 91 degrees F and the rinse temperature was 102 degrees F; -At 8:24 A.M., the cycle ended and the wash temperature was 91 degrees F and the rinse temperature was 102 degrees F; -No water pressure gauge was visible for the dishwasher. During an interview on [DATE] at 8:41 A.M., Dietary Aide H said the following: -Staff washed the dishes (other than the silverware) from the second and third floor dining rooms in the in the second and third floor kitchenette dishwashers; -He/She did not monitor the water temperature or water pressure of the dishwasher located on the second floor; -He/She tested the sanitizer chemical level for the dishwasher at the end of the day. If the test strip was black, then it had enough sanitizer. If the test strip started turning white, then he/she needed to refill the sanitizer (located below the sink). During an interview on [DATE] at 9:36 A.M., Dietary Aide D said the following: -He/She turned on the dishwasher, located in the third level dining room, at the beginning of his/her shift, let it run, and then tested the sanitizer level with a chemical test strip; -The test strip should show a color that was not too light and not too dark; it should be in between the colors on the test strip bottle; -He/She was unaware of a minimum operating water temperature or water pressure the dishwasher needed to reach. During interviews on [DATE] at 11:45 A.M. and 1:08 P.M., the Dietary Supervisor said the following: -Staff should check chemical levels for the dishwashers, located in the kitchen and second and third floor kitchenettes, using chemical test strips at the beginning of each shift; -She was unaware of minimum water temperature or water pressure levels the dishwashers needed to reach. During interviews on [DATE] at 1:40 P.M. and on [DATE] at 1:08 P.M., the Dietary Manager said the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All of the dishwashers were low temperature machines with chemical sanitization; -The chlorine level from the sanitizer should be at least 100 parts per million; -She was unaware of a minimum water temperature or water pressure required for the dishwashers; -She expected staff to be knowledgeable on the use of and testing parameters of the dishwashers and to follow manufacturer's instructions for the machines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to provide care in a manner to prevent the development and transmission of diseases and infections for eight residents (Residents #24, #12, #39, #27, #102, #103, #202, and #42), in a review of 20 sampled residents. Staff failed to failed to utilize Enhanced Barrier Precautions (EBP) during personal care for three residents (Residents #24, #12, and #39) who had urinary catheters (a tube inserted into the bladder to drain urine); failed to maintain a system to ensure one resident's (Resident #24's) urinary catheter tubing and dignity bag (containing the urinary drainage bag) were kept off the floor; failed to utilize proper handwashing and gloving when providing incontinence care to one resident (Resident #27); failed to ensure nebulizer masks (mask used to administer breathing treatments) and CPAP (a method of respiratory therapy in which air is pumped into the lungs through the nose or nose and mouth during spontaneous breathing, used in the treatment of sleep apnea and other respiratory disorders) masks were covered when not in use for three residents (Residents #102, #103 and #202); and failed to ensure staff used proper technique and hand hygiene during a medication pass for one resident (Resident #42). The facility census was 49. Review of the facility's undated policy, Enhanced Barrier Precautions, showed the following: -It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms; -Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities; -Policy explanation and compliance guidelines: -All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; -All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions; -The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities; -Initiation of Enhanced Barrier Precautions: -The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC; -An order for enhanced barrier precautions will be obtained for residents with any of the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO (multi-drug resistant organism); -Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply; -Implementation of Enhanced Barrier Precautions: -Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e. wound irrigation, tracheostomy care); -Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility's policy, Urinary Catheter Care, last revised August 2022, showed the following: -The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections; -Use aseptic technique when handling or manipulating the drainage system; -Be sure the catheter tubing and drainage bag are kept off the floor. 1. Review of Resident #24's Care Plan, last revised 08/08/24, showed the following: -Urinary catheter due to neurogenic bladder (urinary condition where someone does not have bladder control) and urinary retention (difficulty urinating and completely emptying the bladder); -Will remain free from infection; -Place urine collection bag in privacy bag when out of bed; -Hang urine collection bag from the side of the bed, away from the door when in bed. Review of the resident's Physician Order Sheets (POS), dated 10/2024, showed to change urinary catheter monthly. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/05/24, showed the following: -Indwelling urinary catheter; -Dependent for transfers; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Substantial to maximum assist with bed mobility and dressing; -Used a wheelchair. Observation on 10/23/24 at 8:15 AM. showed the resident sat in his/her wheelchair in the dining room where the dignity bag, which contained the urinary catheter drainage bag, hung from the back of the chair and touched the floor. Observations on 10/24/24 showed the following: -At 12:35 P.M., the resident lay in his/her bed. The resident's urinary catheter drainage bag hung from the right side of the bed and the catheter tubing (which contained yellowish urine) lay on the floor; -At 1:30 P.M., the urinary catheter tubing remained on the floor. During an interview on 10/25/24, at 12:50 P.M., the Director of Nurses (DON) said she expected staff to keep catheter bags and tubing off of the floor. Observation on 10/24/24 at 2:37 P.M. showed the following: -There was no signage to indicate the resident was on EBP outside the resident's room and no cart with PPE located outside or near the resident's room. -The resident lay in the bed and the catheter tubing (which contained yellow urine) remained on the floor; -Licensed Practical Nurse (LPN) L and Certified Medication Technician (CMT) O entered the room and performed perineal care and catheter care on the resident; -Neither staff wore a gown. During an interview on 10/25/24 at 12:15 P.M., CMT O said the following: -He/She was not sure what EBP was; -He/She thought it would be used when working with anyone with infections, contagious blood or any bodily fluids and would include gowns, gloves and a face shield or goggles. 2. Review of Resident #12's significant change in status MDS, dated [DATE], showed the following: -Urinary catheter; -Dependent on staff for hygiene and to roll right to left in bed; -Application of dressing to feet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Nurses Notes, dated 10/9/24, showed the wound nurse practitioner visited on 10/8/24. Left lateral foot 0.8 centimeters (cm) by 1.0 cm by eschar (dead tissue that eventually sloughs off healthy skin after an injury). Today maintenance will add padding to wheelchair foot rests. Review of the resident's Care Plan, last revised 10/23/24, showed the following: -The resident had a suprapubic catheter related to neurogenic bladder and urinary retention; -Provide catheter care as ordered; -Cleanse the suprapubic drain site with normal saline or soapy water, pat dry, apply new dressing and secure. It is to be done daily and as needed; -The resident was at risk for impaired skin integrity due to pressure areas; -Left lateral (outside) foot 0.6 centimeters (cm) by 0.8 cm by 0.2 cm. Treatment of mupirocin 2% ointment (antibiotic ointment used for skin infections), alginate/bordered form (absorbent dressing) three times a week and as needed. (The resident's care plan did not identify the need for or use of EBP when providing care for resident.) Review of the resident's POS, dated October 2024, showed the following: -Change suprapubic catheter once monthly on the 15th; -Cleanse suprapubic drain site with normal saline or soapy water, pat dry. Apply drain dressing daily and as needed for dislodgement; -Catheter care every shift; -Obtain catheter output every shift; -Mupirocin 2% ointment to left lateral foot every day shift on Monday, Tuesday and Thursday for wound. Cleanse left lateral foot, apply mupirocin ointment 2% and alginate cover with ordered form three times per week and as needed. Review of the resident's nurses note, dated 10/22/24, showed the wound nurse practitioner documented left lateral foot 0.6 cm by 0.8 cm by 0.2 cm, 100% yellow, treatment mupirocin 2% ointment, alginate with bordered foam three times a week and as needed. Observation on 10/22/24 at 2:18 P.M., showed the resident sat in his/her wheelchair in his/her room. There was no signage to indicate the resident was on EBP outside the resident's room and no cart with personal protective equipment (PPE) located outside or near the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/23/24 at 2:16 P.M., showed the resident sat in his/her bed in his/her room. There was no signage outside the resident's room and no cart with PPE located outside or near the resident's room. During interview on 10/23/24 at 2:16 P.M., the resident said staff do not wear gowns when providing cares. Staff only wear gloves when providing care. Observation on 10/24/24 at 12:00 P.M., showed the following: -Registered Nurse (RN) A and the Infection Preventionist (IP) entered the resident's room; -The resident lay on his/her back in bed; -RN A and the IP washed their hands and put on gloves; -RN A removed the dressing from the wound on the resident's left foot; -There was a scant amount of yellowish drainage; -RN A removed his/her gloves, used hand sanitizer, and put on new gloves; -RN A cleansed the resident's wound with wound cleanser and 4x4 gauze; -While RN A washed his/her hands and changed his/her gloves, the IP applied mupirocin 2% ointment to the wound; -RN A applied alginate to the wound and covered the wound with a bordered bandage; -RN A and the IP washed their hands and changed gloves; -RN A cleaned around the resident's suprapubic catheter insertion site with a soapy washcloth, cleaned around the site again with another wet washcloth, dried the area with a towel and placed a split sponge around the catheter tubing and secured the dressing with tape; -RN A and the IP did not wear a gown while providing treatment to the wound on the resident's foot and when providing catheter care. During an interview on 10/25/24 at 9:11 A.M., RN A said the following: -The facility did not have any current residents on EBP; -EBP was used for things like COVID-19, diarrhea, surgical incisions, MRSA (methicillin-resistant staphylococcus aureus)/VRSA (vancomycin-resistant staphylococcus aureus), pressure wounds and any wound with a wound vac; -EBP was indicated by a sign and EBP supply cart outside the room door, as well as information passed on in report. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 10/25/24 at 9:16 A.M., the IP said the following: -The facility had no residents on EBP; -The facility policy said if a resident had MRSA, ESBL (Extended Spectrum Beta-Lactamase - an enzyme produced by some bacteria that may make then resistant to some antibiotics), VRE (VRE are resistant to vancomycin, the drug often used to treat infections caused by enterococci) or C-diff (a bacterium that causes an infection of the colon) then staff would need to wear gown, gloves and mask when providing direct care and there would be signage outside the resident's room; -She was aware of the new guidance for EBP to also include chronic wounds, G-tubes (a tube inserted through the belly that brings nutrition directly to the stomach), catheters and ports (port-a-cath is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs) but this was not the facility's policy. 3. Review of Resident #39's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Urinary catheter. Review of the resident's Care Plan, revised on 09/04/24, showed the following: -The resident had a urinary catheter; -Change urinary catheter monthly. Review of the resident's Physician's Orders, dated October 2024, showed the following: -Change urinary catheter every month on the 27th; -Urinary catheter care every shift; -Obtain urinary catheter output every shift, day and night. Observation on 10/22/24 at 1:41 P.M. showed no EBP signage on or near the resident's room door and no PPE available near the resident's room. During an interview on 10/23/24 at 8:49 A.M., the resident said staff always wore gloves when providing care, but he/she never saw staff wear a gown or mask when providing care to his/her catheter. Observation on 10/24/24 at 12:42 P.M., showed the following: -CNA K washed his/her hands, donned gloves, and assisted the resident to walk from the reclining chair to the bed using a walker and gait belt; -CNA K pulled down the resident's pants and asked him/her to sit on the bed; (continued on next page)

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	265839	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA K and CNA U removed the resident's shoes and assisted the resident to lay in bed; -CNA U provided perineal care and catheter care for the resident. CNA U did not wear a gown; -CNA K drained the urine from the urinary catheter drainage bag into a urinal. CNA K wore gloves, but did not wear a gown or face protection (as directed by facility policy when performing an activity with risk of splash or spray); -CNA U wiped the tip of the urinary catheter drain with a wipe, placed it back in the holder, removed his/her gloves, and washed his/her hands; -CNA K dumped the urinal into the toilet; -CNA U placed shoes on the resident; -CNA K helped the resident to stand using a gait belt and walker, then pulled up the resident's pants; -CNA U helped the resident walk from the bed to the recliner using a gait belt and walker. -CNA U and CNA K did not wear a gown when providing care to the resident who had a urinary catheter. During an interview on 10/25/24 at 12:29 P.M., CNA K said the following: -He/She was aware of what EBP was from a training he/she received; -Any resident with an open wound, a catheter, or certain types of infections should be on EBP; -Most EBP required a gown and gloves, and some required masking as well; -If a resident was on EBP, they would have a sign on their door stating they were on EBP and they would have a PPE cart outside of their room door; -He/She was not aware of any resident who was currently on EBP; -Resident #39 should be on EBP because of his/her urinary catheter. 4. During an interview on 10/25/24 at 12:20 P.M., CNA N said the following: -The nurse would alert staff as to when EBP should be used; -EBP would include the use of a gown, gloves and a mask and would be stored in a container outside of the room; -He/She had been educated to use EBP if a resident had a wound, a catheter, or a feeding tube; -The EBP would be worn at all times when providing cares; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There were no residents requiring the use of EBP at this time as nursing had not directed staff to use them. During an interview on 10/25/24 at 12:06 P.M., the Education/Staffing Director said the following: -The facility policy for EBP was only for qualifying infections; -Catheters and wounds in general did not qualify for EBP, unless the resident had an active infection that met the facility criteria; -If a resident was on EBP, they would have a sign on their door that showed they were on EBP and the PPE requirements, and they would have a PPE cart outside of their room. During an interview on 10/25/24 at 9:30 A.M., the Assistant Director of Nursing (ADON) said the following: -EBP was used with infections and if the physician requested it; -Staff was made aware of EBP being used by a meeting, group talk, the sign outside the door and the EBP cart outside the resident's door; -No residents were on EBP at present. During an interview on 10/25/24 at 12:50 P.M., the DON said the following: -There were currently no residents on EBP; -EBP was used if there was a catheter or wound that had a microorganism that had been identified; -If a resident had a chronic wound or catheter, that didn't not necessarily constitute EBP, it depended on the organism in the wound/urine/etc.; -She expected staff to follow the facility policy for EBP; -The facility policy did not identify each person with a catheter or wound would be on EBP; -The facility should follow the Center for Disease Control (CDC) guidelines for EBP; -She was unaware of the current CDC or Centers for Medicare and Medicaid Services (CMS) recommendations related to EBP. During an interview on 10/25/24, at 1:15 P.M., the Administrator said the following: -The only time EBP was used was if there was some type of infection that would be problematic, otherwise EBP was not used routinely; -He was aware there had been talks of changes related to EBP, but was unaware changes had been made by CDC or CMS; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility should follow the guidelines from CDC and CMS related to EBP; -The facility was currently following their policy related to infections. Review of the facility's policy, Handwashing/Hand Hygiene, revised August 2019, showed the following: -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors; -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty; before and after direct contact with residents; before preparing or handling medications; before performing any non-surgical invasive procedures; before and after handling an invasive device (e.g., urinary catheters, IV access sites); before donning sterile gloves; before handling clean or soiled dressing, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; after removing gloves; before and after entering isolation precaution settings; before and after eating or handling food; before and after assisting a resident with meals and after personal use of the toilet or conducting your own personal hygiene; -Hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of the facility policy, Personal Protective Equipment - Using Gloves, revised September 1010, showed the following: -Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed; -Wash your hands before and after removing gloves. (Note: Gloves do not replace handwashing.); -Remove gloves before removing the mask and gown and discard them into the designated waste receptacle inside the room. 5. Review of #27's admission MDS, dated [DATE], showed the following: -Supervision to touch assist for bed mobility, transfer and toileting; -Occasionally incontinent of bladder; -Used a wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 08/30/24, showed the following: -Occasionally incontinent of bladder; -Assist of one staff for hygiene, toileting, dressing, bed mobility and transfers; -Used a wheelchair. Observation on 10/24/24 at 5:19 A.M. showed the following: -The resident lay on a urine soaked cloth pad and disposable pad on his/her back in the bed; -Certified Nurse Aide (CNA) J entered the room, and without washing hands, put on gloves; -He/She exited the room while wearing the gloves, returned with plastic bags and placed a bag in the trash can; -He/She put on a second pair of gloves over the first pair; -He/She rolled the resident to his/her left side by touching the resident's hip area, rolled the urine soiled pads underneath the resident, wiped the resident's urine soiled back side with incontinent wipes; -Without removing his/her gloves, CNA J placed a clean incontinence brief under the resident, rolled the resident, secured the brief, picked up the resident's pants and put them on the resident, assisted the resident to sit on the side of the bed, and put socks and shoes on the resident; -He/She removed his/her gloves, and without washing or sanitizing his/her hands, put on new gloves; -He/She took the pajama top off the resident, put a clean shirt on the resident, and then transferred the resident to the wheelchair. -CNA J then removed his/her gloves and washed his/her hands. During an interview on 11/5/24 at 10:36 A.M., CNA J said the following: -He/She should wash his/her hands before cares, after perineal care, with gloves changes and when moving from a dirty to clean task; -He/She should change his/her gloves when they become soiled, after perineal care, and after touching trash. During an interview on 10/25/24, at 12:50 P.M., the DON said the following: -She expected staff to change their gloves during resident care when they become soiled; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected staff to wash their hands to be washed when they enter a resident care area, when they change their gloves, and when care was completed. Staff could use hand sanitizer between changing gloves. Review of the facility's policy, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 2001 and last revised October 2010, showed the following: -The purpose of this procedure is to safely and aseptically administer aerosolized particles of medications into the resident's airway; -Rinse and disinfect the nebulizer equipment according to facility protocol, or: -Wash pieces with warm soapy water; - Rinse with hot water; -Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes); -Rinse all pieces with sterile water (NOT tap, bottles or distilled); and -Allow to air dry on a paper towel; -When equipment is completely dry, store in a plastic bag with the resident's name and date on the bag. The facility did not have a policy directing staff how to store CPAP masks when not in use. 6. Review of Resident #102's POS, dated October 2024, showed the following: -admitted [DATE]; -CPAP to be worn at bedtime per home settings; -Diagnoses included obstructive sleep apnea (episodes of a complete (apnea) or partial collapse (hypopnea) of the upper airway with an associated decrease in oxygen saturation or arousal from sleep) and cardiomyopathy (causes the heart to lose its ability to pump blood well). Review of the resident's Care Plan, dated 10/22/24, showed no evidence the resident used CPAP at bedtime. Observation on 10/23/24 at 2:31 P.M., showed the resident's CPAP mask lay uncovered on the bedside table. Observation on 10/24/24 showed the following: -At 5:15 A.M., the resident lay on his/her back in bed with his/her eyes closed. The CPAP mask was on the resident's face; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 5:30 A.M., the resident lay in his/her bed on his/her back with his/her eyes closed. The CPAP mask lay uncovered on the bedside table; -At 9:39 A.M., the resident's CPAP mask lay uncovered in the same location on the bedside table. 7. Review of Resident #103's POS, dated October 2024, showed the following: -Readmitted [DATE]; -Continuous supplemental oxygen at 2 to 4 liters per nasal cannula; -Albuterol Sulfate inhalation 2.5 mg per milliliter (ml) 0.083%, 3 ml orally via nebulizer every six hours as needed for asthma or COPD; -Diagnoses included acute on chronic respiratory failure, dependence on supplemental oxygen, and lobar pneumonia (a type of pneumonia characterized by the infection and inflammation of one or more lobes of the lung). Review of the resident's Care Plan, dated 10/20/24, showed the following: -The resident was on oxygen therapy related to respiratory illness; -Oxygen via nasal cannula at 2 to 4 liters continuously. Observation on 10/22/24 showed the following: -At 11:23 A.M., the resident lay in bed with his/her eyes closed. A nebulizer mask lay uncovered on the bedside table; -At 12:19 P.M., the resident sat on the side of the bed for lunch with his/her oxygen on per nasal cannula. A nebulizer mask lay uncovered on the bedside table; -At 4:55 P.M., the resident lay in bed with his/her eyes closed. A nebulizer mask lay uncovered on the bedside table. Review of the resident's Significant Change MDS, dated [DATE], showed the following: -Cognitively intact; -Oxygen therapy; -Diagnoses included COPD and pneumonia. Observation on 10/23/24 showed the following: -At 8:57 A.M., the resident sat on the side of the bed for breakfast with his/her oxygen on per nasal cannula. A nebulizer mask lay uncovered on the bedside table; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 2:26 P.M., the resident sat on the side of the bed with his/her oxygen on per nasal cannula. A nebulizer mask lay uncovered on the bedside table. Observations on 10/24/24 showed at 5:10 A.M., 7:48 A.M. and 9:39 A.M., the resident lay in bed with his/her eyes closed. A nebulizer mask lay on the bedside table uncovered. 8. Review of Resident #202's face sheet showed the following: -admitted to the facility on [DATE]; -Diagnoses included acute and chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body that can be all at once or come on over time), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and obstructive sleep apnea (occurs when your breathing is interrupted during sleep, sometimes for longer than 10 seconds). Review of the resident's October 2024 POS showed an order for CPAP at bedtime every night shift. Review of the resident's Baseline Care Plan, dated 10/18/24, showed the resident used a CPAP. Observation on 10/22/24 at 1:57 P.M., showed the resident's CPAP mask lay uncovered on the resident's bed near his/her pillow. During interview on 10/22/24 at 1:57 P.M., the resident said he/she took care of his/her CPAP equipment and had not had it covered since admission. Observation on 10/23/24 at 8:45 A.M., showed the resident's CPAP mask lay uncovered on top of the resident's bed pillow. Observation on 10/24/24 at 7:36 A.M., showed the resident's CPAP mask lay uncovered on the resident's bed near his/her pillow. 9. During an interview on 10/25/24 at 9:11 A.M., RN A said oxygen supplies like nasal cannulas and CPAP masks should be covered with a clear bag when not in use. During interview on 10/25/24 at 9:16 A.M., the IP said nebulizer masks and CPAP masks should be on a towel or paper towel when not in use or in a bedside table drawer. During an interview on 10/25/24 at 12:50 P.M., the DON said she expected CPAP masks to be stored in a plastic bag when not in use. The masks should not be left sitting on the bed or bedside table. Review of the facility's policy, Administering Oral Medications, dated 2001 and last revised October 2010, showed the following: -The purpose of this procedure is to provide guidelines for the safe administration of oral medication; -Do not touch the medication with your bare hands; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a medication falls to the floor, discard and document per facility protocol. 10. Review of Resident #42's POS, dated October 2024, showed the following: -Coreg (medication used to treat high blood pressure) 25 milligrams (mg) by mouth twice daily; -Anagrelide HCL (a medication used to decrease blood clots) 0.5 mg by mouth Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Observation on 10/23/24 at 8:24 A.M., showed the following: -CMT P sanitized his/her hands, opened the medication drawer and retrieved a prepackaged slip of medications containing both Coreg and the anagrelide; -CMT P placed the prepackaged slip of medications back into the medication drawer. As he/she laid the slip into the drawer, two white pills fell out of the package and into the medication drawer; -With his/her bare hands, CMT P picked up the two pills and lay them on top of the prepackaged slip and closed the medication cart drawer; -CMT P walked over to Resident #42 and obtained his/her blood pressure; -CMT P walked back to the medication cart, sanitized his/her hands, opened the medication cart drawer, picked up the two white pills with his/her bare hands, and placed them in a medication cup; -CMT P prepared the rest of the resident's morning medication and administered all the medications, including the two medications that lay directly in the medication cart drawer, to the resident. During interview on 10/23/24 at 2:25 P.M., CMT P said he/she shouldn't have touched the pills with his/her bare hands. He/She thought since the pills fell in the medication drawer, they were okay to give to the resident. If the pills had fallen on top of the medication cart, then he/she would have discarded them and gave the resident new pills. During an interview on 10/25/24, at 12:50 P.M., the DON said if a medication fell out of a pill packet and dropped into the medication cart, she would expect staff to discard the pill and get a new pill to administer to the resident. 32899 42592 50189

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview and record review, the facility failed to complete inspection of bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for eight residents (Resident #12, #102, #24, #25, #23, #207, #4 and #45), in a review of 20 sampled residents. The facility census was 49. Review of the facility policy, Bed Safety and Bed Rails, revised on [DATE], showed the following: -Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup; -Bed frames, mattresses and bed rails are checked for compatibility and size prior to use; -Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA; -Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks; -The maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee. Review of the Food and Drug Administration's (FDA) Guide to Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised [DATE], showed the following: -Between 1985 and [DATE], 803 incidents of residents getting caught, trapped, entangled or strangled in beds with rails were reported to the U.S. FDA; -Of those reported, 480 died and 138 had non-fatal injuries; -Most residents were frail, elderly or confused; -Potential risks of bed rails may include strangulation, suffocation, bodily injury or death when residents, or parts of their body, are caught between rails and mattresses, more serious injury from falls when patients climb over rails, skin bruising, cuts and scrapes, feeling isolated or unnecessarily restricted, and preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. 1. Review of Resident #12's undated Face Sheet showed the following: -The resident was his/her own responsible party; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses include multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves) and weakness. Review of the resident's Bed Rail/Assist Bar Evaluation, dated [DATE], showed the resident requested to have bed rails/assist bar while in bed, and bed rails/assist bar were indicated and would serve as an enabler to promote resident independence. Review of the facility provided documentation of Entrapment Assessment showed the last entrapment assessment was completed on [DATE]. The assessment did not show measurements, only four zones and pass/fail status. All the areas indicated as passed for the room the resident was assigned to. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument, dated [DATE], showed the following: -Cognitively intact; -Impairment in range of motion impairment on the upper and lower extremities on both sides of his/her body; -The resident was dependent on staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfers. Review of the resident's care plan, revised on [DATE], showed the following: -He/She required assistance with activities of daily living (ADL's) related to mobility and impaired balance; -Assist bars are for mobility and transfer on his/her bed. Observation on [DATE] at 2:16 P.M., showed the resident lay in bed. The resident had ,d+[DATE]th assist rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no documentation staff routinely inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 2. Review of Resident #102's undated Face Sheet showed his/her admitted was [DATE]. Review of the resident's baseline care plan, dated [DATE], showed the following: -Required one person for bed mobility and transfers; -The care plan did not address use of side rails/assist bars. Review of the resident's Bed Rail/Assist Bar Evaluation, dated [DATE], showed bilateral bed rails/assist bars were indicated and would serve as an enabler to promote resident independence. Observation on [DATE] at 12:21 P.M., showed the resident sat in his/her wheelchair in his/her room. The resident had ,d+[DATE]th assist rails in the raised position on both sides of his/her bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no documentation staff inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 3. Review of Resident #24's Bed Rail/Assist Bar Evaluation, dated [DATE], showed staff completed an admission assessment for bilateral assist bar/bed rail. The assessment did not identify if assist bars/bed rails were indicated. Review of the resident's Care Plan, last revised [DATE], showed the following: -Assist of one to two staff for bed mobility and transfers due to impaired mobility and impaired balance; -Assist rails on both sides of bed; -Assist bars make it possible for the resident to reposition himself/herself in bed, assist the resident with transfers in and out of bed, and to be more independent. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Dependent on staff for transfers; -Required substantial to maximum assistance with bed mobility. Observation on [DATE] at 2:37 P.M. showed the resident lay in his/her bed with assist rails in the raised position on both sides of the bed. The left side of the bed was up against the wall. Review of the resident's medical record showed no documentation staff routinely inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 4. Review of Resident #25's Bed Rail/Assist Bar Evaluation, dated [DATE], showed the resident requested the use of bilateral assist rails to serve as an enabler to promote independence. Staff completed an admission assessment for the bilateral assist bar/bed rail. The assessment did not identify if assist bars/bed rails were indicated. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Supervised or touch assist with bed mobility; -Substantial to maximum assist for transfers. -Impaired ROM one lower extremity. Review of the resident's Care Plan, last revised [DATE], showed the following: (continued on next page)

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	265839	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Senior Health	206 North Main Street O Fallon, MO 63366

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assist rails on both sides of bed per resident request; -Assist rails will assist the resident with repositioning in bed and with transferring in and out of bed; -The resident was aware of the risks involved with the assist rails and signed a consent; -Therapy evaluated the resident for appropriateness for assist rails, indicating they will serve as an enabler to promote independence. Observation on [DATE] at 7:12 A.M. showed the resident lay in his/her bed. The resident had ,d+[DATE]th assist rails in the raised position on both sides of his/her bed. The right side of the bed was pushed against the wall. Review of the resident's medical record showed no documentation staff inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 5. Review of Resident #23's Bed Rail/Assist Bar Evaluation, dated [DATE], showed he resident requested to have bed rails/assist bar while in bed and bed rails/assist bar were indicated and would serve as an enabler to promote resident independence. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Impairment in range of motion to the upper and lower extremities one side of his/her body; -Required partial/moderate staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sit to standing transfer, chair/bed-to-chair transfers. Review of the resident's Care Plan, revised on [DATE], showed the following: -He/She required assistance with activities of daily living (ADLs) related to impaired mobility and impaired balance; -Assist rails as ordered for mobility. Observation on [DATE] at 11:28 A.M., showed the resident lay in bed awake with ,d+[DATE]th assist rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no evidence of measurements or evaluation for entrapment zones on the resident's bed. Review of the resident's medical record showed no documentation staff inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #207's Bed Rail/Assist Bar Evaluation, dated [DATE], showed staff completed an admission assessment for bilateral assist bar/bed rails. Bed rails/assist bar were indicated and would serve as an enabler to promote resident independence Observation on [DATE] at 2:10 P.M., showed the resident's bed had ,d+[DATE]th assist rails in the raised position on both sides of the bed. The rail was stationary and unable to be lowered. During an interview on [DATE], at 2:10 P.M., the resident said he/she used the assist rails to help with bed mobility and transfers. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Required partial/moderate staff assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed, sit to standing transfer, chair/bed-to-chair transfers; -History of falls prior to admission, fall within the last ,d+[DATE] months prior to admission, fracture related to fall in six months prior to admission; -No falls since admission. Review of the resident's Care Plan, revised on [DATE], showed the following: -He/She was at risk for falls related to impulsiveness and gait/balance problems; -The resident/resident's family had requested assist bars to be on the sides of his/her bed; -He/She was informed of the risks involved in having assist bars and the resident signed a consent form that he/she was aware and still wanted them; -He/She will be re-evaluated if there is a change in status; -On [DATE] at 3:44 P.M., staff observed the resident sitting on the floor in his/her room between the wheelchair and bed. Observation on [DATE] at 5:11 A.M., showed the resident lay in bed sleeping with ,d+[DATE]th assist rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no documentation staff inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 7. Review of Resident #4's face sheet showed the following: -admitted : [DATE]; -Diagnoses of muscle weakness, other abnormalities of gait and mobility, and unspecified falls. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Bed Rail/Assist Bar evaluation, dated [DATE], showed the resident had requested to have bed rails/assist bar while in bed and the bed rails/assist bar were indicated and would serve as an enabler to promote resident independence. Review of the facility provided documentation of Entrapment Assessments, showed the last entrapment assessment was completed [DATE]. The assessment does not show measurements, only four zones and pass/fail status. All areas indicated as passed for the room the resident was currently assigned to. Review of the resident's Significant Change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impairment in range of motion to one side of the upper extremities, no impairment in the lower extremities; -Substantial to maximum assistance for all mobility needs. Review of the resident's Care Plan, revised [DATE], showed the following: -He/She required assistance with activities of daily living (ADLs) due to impaired mobility and impaired balance; -Assistance of one staff for repositioning every two or three hours and as needed; -He/She had assist cane rails to both sides of their bed; -Assist rails are to help him/her with positioning and mobility; -He/She had potential for injury related to impaired mobility; -Physical Therapy evaluated if the assist rails would be a benefit for him/her; -He/She will be re-evaluated if there is a change in condition. Observation on [DATE] at 5:10 A.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no documentation staff routinely inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 8. Review of Resident #45's face sheet showed the following: -admitted [DATE]; -Diagnoses of hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and/or facial muscles) affecting the left side, morbid obesity, and need for assistance with personal care. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provided documentation of Entrapment Assessments, showed the last entrapment assessment was completed [DATE]. The assessment did not show measurements, only four zones and pass/fail status. The room the resident was currently assigned to was listed as having no bed rails. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Impairment in range of motion on one side of upper and lower extremities; -Required moderate to substantial/maximal assistance for all mobility needs. Review of the resident's Care Plan, revised on [DATE], showed the following: -He/She required assistance with ADLs due to impaired mobility and impaired balance; -He/She had requested assist bars to both sides of his/her bed; -He/She was able to reposition himself/herself in bed and the assist bar with getting in and out of bed; -He/She will be reevaluated as needed; -Therapy had evaluated him/her for appropriateness of assist bars and it was indicated they enable him/her to be more independent. Review of the resident's bed rail/assist bar evaluation, dated [DATE], showed staff did not identify the type of assessment (i.e. admission, quarterly, annual, etc) and did not identify if bed rails were indicated. Observation on [DATE] at 2:34 P.M. showed the resident lay in bed. The resident had assist rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no documentation staff routinely inspected the resident's bed and bed rails to identify risks and problems including potential entrapment risks. 9. During an interview on [DATE] at 11:55 A.M., the Maintenance Director said the following: -A staff member who no longer worked at the facility completed the entrapment risk assessments on [DATE]; -No one had completed as assessment, including measurements of the bed frame, mattresses or side rails, since [DATE]; -There was a tool to measure the beds, but he had not used the tool to do any measurements; -He was unaware of how often staff should assess the beds for risk of entrapment. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:34 A.M., the Director of Nursing (DON) said maintenance staff measured the beds with bed rails for entrapment zones when therapy approved the bed rails. During an interview on [DATE] at 1:15 P.M., the Administrator said the following: -Maintenance staff was responsible for measuring the entrapment zones; -There had been no ongoing assessments for risk of entrapment; -The assist rails were a positioning device and not a bed rail. 42592 50189