| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>27723<br><br>Based on interview and record review, the facility failed to respond to a report that the Business Office Manager (BOM) had been placed on the Employee Disqualification List (EDL, a listing of individuals disqualified from working in a certified nursing home) indicating he/she was ineligible to work in a certified long-term care facility, and continued to employ the staff member. The Department of Health and Senior Services (DHSS) notified the facility on 10/30/24 at 11:45 A.M., that the BOM was permanently placed on the EDL on 10/22/24, and he/she was still working at the facility when surveyors began the investigation on 11/14/24. The census was 95.<br><br>Review of the EDL Active Report, showed:<br><br>-The BOM's name and Social Security Number;<br><br>-Added: 10/22/24;<br><br>-Ordered Length: Permanent.<br><br>During an interview on 11/14/24 at 1:41 P.M., the Human Resources (HR) Director said he/she was not aware the BOM had been placed on the EDL. No one notified him/her of the placement. The BOM was currently employed by the facility and had worked as recently as the previous day. The BOM was out of the facility currently due to an emergency. The HR Director has only been in this position since August and had not been able to do quarterly EDL checks.<br><br>During an interview on 11/14/24 at 1:55 P.M., the Administrator said he was not aware the BOM was placed on the EDL. No one notified him of it until approximately five minutes prior. He checked his phone and there were no voicemails to that effect. The BOM was in the facility working this morning, but said he/she was in pain and needed to leave around the same time as DHSS entered the facility. The BOM is scheduled to have surgery on November 25th, so he did not think twice about it. He was aware screenings needed to be completed post-hire. He understood they were needed to ensure staff were not on the EDL. The HR Director had only been in the position for a few months. He was not sure how often the HR Director was checking the EDL. The EDL was checked, and the BOM was on the list. He will call and terminate him/her immediately. He had been unaware of his/her placement on the EDL.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/15/24 at 1:35 P.M., the HR Director said no one called and told him/her the BOM was placed on the EDL. If someone called, they did not speak with him/her. He/She just started at the end of August and is still trying to clean up things. He/She performed a facility-wide EDL check yesterday and would be checking them quarterly from this time forward.<br><br>During an interview on 11/15/24 at 10:40 A.M., the Administrator said he called and terminated the BOM the previous evening. He formally educated the HR Director on the importance of EDL checks and the protocol for how often to check it. An EDL check was run on all facility employees with no other issues. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926<br><br>Based on observation, interview and record review, the facility failed to ensure the vehicle used to transport residents was in proper working order, free from debris, and free from exposed wires. This had the potential to affect all residents who used the van. The facility also failed to ensure a completed and thorough investigation was performed and documented after each resident fall for two out of 10 sampled residents (Resident #5 and Resident #6). The census was 86.<br><br>Review of the facility's Safety and Supervision of Residents policy, undated, showed:<br><br>-Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities;<br><br>-Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. A facility-wide commitment to safety at all levels of the organization.<br><br>Review of the facility's Falls - Clinical Protocol, revised March 2018, showed:<br><br>-The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etcetera;<br><br>-Falls should be categorized as:<br><br>--Those that occur while trying to rise from a sitting or lying to an upright position;<br><br>--Those that occur while upright and attempting to ambulate;<br><br>--Other circumstances such as sliding out of a chair or rolling from a low bed to the floor;<br><br>-Falls should also be identified as witnessed or unwitnessed events.<br><br>1. During observation and interview on 9/4/26 at 10:09 A.M., the Maintenance Director said there was no formal tracking for preventative maintenance or services performed on the van. During the tour of the van, a used urinal with yellow urine hung from a folded van seat. There was a panel missing from the passenger side, wires were exposed and hung down. There was soiled linen on the floor pushed against the rear door. Water dripped from the roof of the van onto the walkway, between the seats. The panel lining in the ceiling was chipping away, leaving remnants on the floor of the van. A black substance, located on the wall behind the driver, was present from the roof of the van to the floor. Debris was located on the seats, a panel containing an audio speaker and loose wires were placed behind a bench seat. The driver was loading a resident in a wheelchair into the van for a dental appointment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observation and interview on 9/6/24 at 11:25 A.M., the Administrator opened the van door and said he was not aware of the condition of the inside of the van. The debris and linen which was observed on the floor on 9/4/24 was not removed or discarded. The panel containing the audio speaker was still behind the bench seat. The urinal contained more yellow liquid than observed on 9/4/24. The black substance was still present on the wall behind the driver.<br><br>During an interview on 9/6/24 at 11:46 A.M., the Administrator said he was unaware of the condition of the van. The expectation is that the van be clean and in good working order. The current van will be out of order and future transportation requests will be outsourced.<br><br>2. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/8/24, showed:<br><br>-Severely cognitively impaired;<br><br>-Required moderate assistance with toileting hygiene and showers;<br><br>-Occasionally incontinent of bladder;<br><br>-Had no falls since admission;<br><br>-Diagnoses included hypertension (high blood pressure), peripheral vascular disease (PVD, a circulatory condition that affects blood vessels outside of the heart and brain), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), right dominant sided hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke and frontotemporal neurocognitive disorder (the result of damage to neurons in the frontal and temporal lobes of the brain).<br><br>Review of the facility's Witnessed Fall Report, dated 8/26/24, showed:<br><br>-Incident Description: Resident wandered into another resident's room. When escorted out, the resident continued to try to go into other resident's room. Resident got into the first bed by door. This nurse was called to room to redirect resident out of room. While talking with resident, the resident whose room it was came over by the bed trying to pull on the resident. The bed moved or rolled back and the resident lost his/her balance and fell to the floor. The resident was lowered to floor while sliding down bed after it moved. No injuries. Resident's family member came to visit at dinner and was informed of above incident. Family member stated that the resident was not eating and barely talking. New behaviors were explained to the family member;<br><br>-Immediate Action Taken: None noted;<br><br>-Injuries Observed at Time of Incident: None;<br><br>-Mental Status: Alert and oriented to person;<br><br>-Mobility: Ambulatory without assistance;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Predisposing Environmental Factors: None;<br><br>-Predisposing Physiological Factors: None;<br><br>-Predisposing Situational Factors: None;<br><br>-Statements: No statements found.<br><br>Review of the resident's August 2024 progress notes, showed:<br><br>-8/25/24 at 3:06 P.M.: Resident wandered into another resident's room. When escorted out, the resident continued to try to go into other resident's room. Resident got into the first bed by door. This nurse was called to room to redirect resident out of room. While talking with resident, the resident whose room it was came over by the bed trying to pull on the resident. The bed moved or rolled back and the resident lost his/her balance and fell to the floor. The resident was lowered to floor while sliding down bed after it moved. No injuries. Resident's family member came to visit at dinner and was informed of above incident. Family member stated that the resident was not eating and barely talking. New behaviors were explained to the family member;<br><br>-8/26/24 at 4:35 A.M.: Resident remains on incident follow up related to a fall with no injury. The resident was in bed all night with complaints of pain or discomfort. Monitoring to continue;<br><br>-8/26/24 at 11:18 A.M.: Resident without complaint with getting blood pressure checked. Resident has been more confused this morning. Was in the shower fully clothed washing up. When staff tried to assist, the resident was resistive to care. While the Certified Nurse Aide (CNA) was trying to change the resident's clothes, the resident was trying to put the wet clothes back on. Resident had a mouth full of food and was resistive to help from nursing staff to remove the food. Gait is more off and unsteady this morning. Resident's responsible party arrived this morning at approximately 9:00 A.M. This writer reported above concerns to him/her. Responsible party stated that he/she was here to transport resident to a podiatrist appointment. Responsible party stated that he/she still will be transporting resident to his/her podiatrist appointment, and from there transport him/her to the emergency room . This writer called and reported above concerns and Responsible party's decision to take resident to the resident's physician's office. Resident exited facility at approximately 9:30 A.M. Assistant Director of Nursing (ADON) updated and will pass this information on in report;<br><br>-8/26/24 at 2:03 P.M.: Received call the hospital in reference to resident update and status. Resident was admitted to the Intensive Care Unit (ICU) for elevated sodium and chloride levels, in addition to white blood count (WBC) elevation;<br><br>-8/30/24 at 8:31 P.M.: Resident returned from the hospital via ambulance with an admitting diagnosis of altered mental status and hypernatremia (elevated sodium level in the blood). Resident was also treated for onset UTI. Alert and oriented times one (to self). Patient is on mechanical soft diet with thin liquids. No skin issues noted. Lungs clear. Incontinent of bowel and bladder. Resident voiced no concerns;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -8/30/24: Interdisciplinary team (IDT, made up of health professionals who work together to treat a patient's condition or injury) meeting held and resident discussed related to non-injury fall. Resident was pulling away from the nurse, lost balance and fell . Intervention: staff to monitor the resident for safety. Physician and responsible party were made aware.<br><br>Review of the facility's Witnessed Fall Report, dated 8/31/24, showed:<br><br>-Incident Description: This writer was called to the resident's room this morning at 8:00 A.M., by the CNA. Upon entering resident room. this writer observed resident lying on his/her back on the floor on the side of his/her bed. Resident was just saying help me up and extending his/her arms for assistance. The resident was able to move both lower extremities as well. Resident denied pain. Head to toe assessment completed, no visible injury or bruising noted. Resident unable to give description of the incident;<br><br>-Immediate Action Taken: Vital signs (blood pressure, pulse, respirations, temperature, and oxygen saturation) taken, neurological checks (neuro checks, a sensory response and motor strength test used to evaluate brain and nervous system functioning) initiated, head to toe assessment and pain assessment completed, and informed all parties;<br><br>-Injuries Observed at Time of Incident: None;<br><br>-Mental Status: Alert and oriented to person;<br><br>-Pain level: Zero;<br><br>-Mobility: Wheelchair bound;<br><br>-Predisposing Environmental Factors: None;<br><br>-Predisposing Physiological Factors: Confused, impaired memory and gait imbalance;<br><br>-Predisposing Situational Factors: None;<br><br>-Statements: No statements found.<br><br>Review of the resident's progress notes, showed:<br><br>-8/31/24 at 11:31 A.M.: This writer was called to resident room this morning at 8:00 A.M., by the CNA. Upon entering resident room, this writer observed the resident lying on his/her back, on the floor on the side of his/her bed. Resident was just saying help me up and extending his/her arms for assistance. Resident was able to move both lower extremities as well. Resident denied pain. Head to toe assessment completed. No visible injury or bruising noted. Neuro checks initiated. This writer placed a call out to the resident's physician to report fall with no injury at 10:09 A.M., and to the responsible party at 10:15 A.M. This writer will pass this information on in report. Management updated. At this time, the resident is sitting in the common area in his/her wheelchair watching TV. Nursing staff will continue to monitor;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -8/31/24 at 11:38 A.M.: Staff report that the resident's gait has been off since his/her arrival yesterday;<br><br>-9/1/24 1:46 P.M.: Resident remains on incident follow up related to a fall with neuro checks. No signs or symptoms of distress noted at this time. Resident alert and oriented to one, up ad lib with walker, received all routine medications and meals without difficulties, and denies pain. At this time, the resident is sitting in common area, nursing staff will continue to monitor;<br><br>-No other follow up notes noted.<br><br>Review of the resident's care plan, in use at the time of the investigation, showed:<br><br>-Focus: At risk for falls related to gait/balance problems. Walks with a rollator. The more he/she walks the more his/her gait becomes more impaired. 9/30/23: fell /slipped off his/her rollator in bathroom. No injuries. History of noncompliance with rollator. 7/23/24: fell while ambulating to the bathroom. No Injuries. 8/25/24: staff attempted to redirect resident from wandering into other resident ' s room. Resident fell . No injuries. 8/31/24: noted on the floor. No injuries noted. Date Initiated: 9/26/23. Revision on: 9/3/24;<br><br>-Goal: Resident will not sustain severe injuries related to falls through next review. Date Initiated: 10/9/23;<br><br>-Interventions:<br><br>--Uses rollator to ambulate. Date Initiated: 10/9/23;<br><br>--Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 10/9/23;<br><br>--Encourage resident to ask and wait for assistance. Date Initiated: 9/30/23;<br><br>--Encourage resident to use rollator to ambulate. Date Initiated: 10/18/23;<br><br>--Ensure that the resident is wearing appropriate footwear. Date Initiated: 10/9/23;<br><br>--Physical therapy to evaluate and treat resident as ordered or as needed (PRN). Date Initiated: 10/9/23;<br><br>--Sent to emergency room for evaluation. Date Initiated: 7/23/24;<br><br>--Assistance of one staff member with ambulating PRN. Date Initiated: 7/23/24;<br><br>--Redirect from wandering into other residents' rooms. Date Initiated: 8/25/24;<br><br>--8/30/24, IDT meeting intervention for staff to monitor the resident for safety was not added to the care plan;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -No updated interventions after the resident's un-witnessed fall on 8/31/24.<br><br>On 9/4/24 and 9/6/24, this surveyor requested the fall investigations, including any witness statements or neuro checks for this resident. The facility only provided the fall incident reports. No witness statements or neuro checks were provided.<br><br>During an interview on 9/6/24 at 1:18 P.M., the resident said he/she did not remember the incidents and could not tell what happened.<br><br>3. Review of Resident #6's significant change MDS, dated [DATE], showed:<br><br>-Severely cognitively impaired;<br><br>-Required moderate assistance with oral hygiene and putting on/taking off footwear;<br><br>-Required maximum assistance with personal hygiene, toileting hygiene and dressing lower part of body;<br><br>-Always incontinent of bowel and bladder;<br><br>-Used a walker and a manual wheelchair;<br><br>-Had one non-injury fall and one non-major injury fall since admission;<br><br>-Diagnoses included stroke, dementia, Alzheimer's dementia and hypertension.<br><br>Review of the facility's Un-Witnessed Fall Report, dated 8/16/24, showed:<br><br>-Incident Description: CNA reported to this nurse that during his/her rounds he/she went into resident's room and found him/her on the floor on the side of his/her bed. No injuries noted and signs of pain. Resident unable to explain what happened;<br><br>-Injuries Observed at Time of Incident: None;<br><br>-Mental Status: Alert and oriented to person;<br><br>-Mobility: Ambulatory with assistance;<br><br>-Predisposing Environmental Factors: None;<br><br>-Predisposing Physiological Factors: Confused, incontinent, gait imbalance and impaired memory;<br><br>-Predisposing Situational Factors: Ambulating without assistance;<br><br>-Statements: No statements found.<br><br>Review of the facility's Un-Witnessed Fall Report, dated 8/16/24, showed:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Incident Description: Resident fell to floor while attempting to stand and ambulate without assistance. No injury occurred with fall. Assessed and resident assisted up to wheelchair. Resident talking and carrying out simple commands. No acute distress noted, vital signs monitored per neuro check protocol;<br><br>-Injuries Observed at Time of Incident: None;<br><br>-Mental Status: Alert and oriented to person;<br><br>-Mobility: Ambulatory with assistance;<br><br>-Predisposing Environmental Factors: None;<br><br>-Predisposing Physiological Factors: Confused, gait imbalance and impaired memory;<br><br>-Predisposing Situational Factors: None;<br><br>-Statements: No statements found.<br><br>Review of the resident's August 2024 progress notes, showed:<br><br>-8/16/24 at 5:50 A.M.: CNA reported to this nurse that that during his/her rounds, he/she noted patient sitting on the floor on the side of his/her bed. No injuries noted at this time. Resident's family is aware. Full range of motion (ROM, the extent or limit to which a part of the body can be moved around a joint or a fixed point) performed. Resident denies having any pain. Resident is currently sitting in his/her wheelchair at the nurse's station for safety monitoring;<br><br>-No follow up or neuro checks for 8/16/24 fall noted;<br><br>-8/23/24 at 11:56 A.M.: Patient fell to floor and landed on his/her right side. Resident wears a helmet for protection. Patient alert and oriented times one with continued mental confusion. Resident monitored with neuro checks and sitting in wheelchair after assessed and assisted off of the floor. No injury noted. Talking and carrying out simple commands with staff. Physician and family notified. DON made aware. No new orders;<br><br>-8/24/24 at 2:15 P.M.: On observation related to fall. No complaints of discomfort voiced this shift. Resident up in wheelchair watching television at this time. Assistance of one staff given with ADLs. Decreased safety awareness noted. Will continue to assist and re-direct as needed;<br><br>-8/26/24 at 4:36 A.M.: Resident remains on observation for a fall with no injury. In bed all night. This nurse in to check on resident. Resident sleeping on extra pillows. Removed extra pillows from under resident's head related to the resident leaning head out of bed. Resident then readjusted to be in on one pillow;<br><br>-8/30/24 at 11:42 P.M.: IDT meeting held to discuss resident's non-injury fall while transferring self from couch in living room area. Intervention: staff to monitor resident for safety. Physician and responsible party were made aware.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's care plan, in use at the time of the investigation, showed:<br><br>-Focus: At risk for falls related to unsteady gait. Uses wheelchair. Wears a soft safety helmet. Decline in gait noted 6/1/24. Noted on the floor with an abrasion to the right knee. 6/23/24 fall with no injuries. 6/25/24 fall in room. 6/25/24 fall while family visiting. Scant amount of blood noted with small hematoma to posterior head. History of attempting to ambulate alone. 7/7/24 fall in his/her bathroom. 7/9/24 fall attempting to transfer self to the toilet. 7/17/24 noted on the floor with a skin tear to right knee. 7/27/24 and 7/28/24 falls with no injuries. 7/31/24 unwitnessed fall with no injuries. 8/13/24 attempted to get out of wheelchair and fell , no injuries. 8/16/24 noted on the floor next to his/her bed, no injuries. 8/23/24 fall with no injuries. Date Initiated: 06/14/24, Revision on: 08/26/24;<br><br>-Goal: Resident will not sustain severe injuries related to falls through next review.<br><br>Date Initiated: 06/14/24, Revision on: 07/05/24;<br><br>-Interventions:<br><br>--Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 06/14/24;<br><br>--Bed in lowest position when staff not providing care to resident. Date Initiated: 06/17/24;<br><br>--Ensure the resident is wearing appropriate footwear. Date Initiated: 6/14/24;<br><br>--Floor mat to left side of bed. Date Initiated: 06/14/24;<br><br>--Monitor closer. Date Initiated: 08/16/24, Revision on: 08/23/24;<br><br>--Soft safety helmet. Date Initiated: 08/01/24;<br><br>--Monitor head and scalp for changes in skin integrity every day and night shift for preventative. Date Initiated: 08/19/24;<br><br>--Monitor in common area for better visual care. Date Initiated: 06/25/24;<br><br>--Padded siderails and furniture in room for safety related to falls. Date Initiated: 07/16/24;<br><br>--Sent to emergency room and returned. Date Initiated: 07/31/24, Revision on: 08/01/24.<br><br>On 9/4/24 and 9/6/24, this surveyor requested the fall investigations, including any witness statements or neuro checks for this resident. The facility only provided the fall incident reports. No witness statements or neuro checks were provided.<br><br>During an interview on 9/6/24 at 1:27 P.M., the resident said he/she was not able to recall the incidents and could not explain what had occurred.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. During an interview on 9/12/24 at 9:44 A.M., CNA B said he/she has previously witnessed resident falls. No one had ever asked him/her to make a verbal or written statement after a resident has had a fall.<br><br>During an interview on 9/12/14 at 11:07 A.M. Licensed Practical Nurse (LPN) A said a head to toe assessment, progress note and fall incident report should be completed after each fall. Neuro checks should be completed if the resident hits their head. Neuro checks are done on paper and turned in to administration. He/She should also notify administration, the physician and responsible party of the fall. LPN A has never asked staff to make a written statement of what occurred. LPN A has never written a witness statement because his/her nurse's note is his/her statement. A new intervention should be added to the care plan after each fall. Anyone can add an intervention to the care plan. If an intervention is decided upon during the IDT meeting, it is administration who will put the intervention on the care plan.<br><br>During an interview on 9/6/24 at 11:33 A.M., the DON said a complete and thorough fall investigation should be completed after each fall. The investigation should include a fall incident report, resident and witness statements, resident assessments, and neuro checks if it was unwitnessed or if the resident hit his/her head. If any of the items are missing, the investigation is incomplete. A new intervention should be added to the care plan after each fall. All interventions decided upon during IDT meeting should be added to the care plan. She did not know what the policy said. She did not have access to the facility policies.<br><br>MO00240444<br><br>MO00241169<br><br>Surveyor: [NAME], [NAME] |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27723<br><br>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. Staff failed to discontinue a medication used to lower blood sugar as ordered for one resident (Resident #13). The census was 95.<br><br>Review of the facility's Medication and Treatment Orders Policy, dated 7/2016, showed the following:<br><br>-Policy: Orders for medications and treatments will be consistent with the principles of safe and effective order writing;<br><br>-1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such such medication in this state;<br><br>-3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart;<br><br>-4. All drug and biological orders shall be written, dated and signed by the person lawfully authorized to give such an order;<br><br>-9. Orders for medication must include: a. Name and strength of the medication. b. Number of doses, start and stop date and or specific duration of therapy. c. Dosage and frequency of of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed. f. Any interim follow up requirements.<br><br>Review of the facility's Administering Medications policy, updated 4/2019, showed the following:<br><br>-Medications are administered in a safe and timely mannered as prescribed;<br><br>-Medications are administered in accordance with prescriber orders, including any required time frames.<br><br>Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24, showed the following:<br><br>-Diagnoses of diabetes, high blood pressure and Parkinson's disease (a chronic brain disorder that affects movement, balance, and coordination);<br><br>-Required total assistance of staff for personal hygiene, bathing, dressing and toileting;<br><br>-Incontinent of bowel and bladder;<br><br>-Medication: Received insulin injection in the last seven days.<br><br>Review of the resident's progress notes, dated 9/20/24 at 8:39 A.M., showed the following:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265883 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/19/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road Ferguson, MO 63135 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Resident lay in bed. Poor response. Blood Sugar 81 (normal range, 70 and 100 milligram (mg)/dL);<br><br>-Grabbing and holding on to staff;<br><br>-Physician in the facility, new orders for urinalysis and blood work;<br><br>-Resident refused to open mouth, tremors noted;<br><br>-New order to send resident to the hospital for evaluation.<br><br>Review of the resident's Hospital Admission Orders, dated 9/20/24, showed the following:<br><br>-admitted : 9/20/24;<br><br>-admitted for altered mental status. Blood glucose noted to be 45;<br><br>-Given 200 milliliters (ml) of D 10 (10% Dextrose (intravenous fluid with sugar, used for patients with low blood sugar) enroute to the hospital.<br><br>Review of the resident's Hospital Transfer Orders, dated 9/25/24, showed the following:<br><br>-Discharge diagnosis: Hypoglycemia (low blood sugar);<br><br>-Stop taking this medication: Metformin (medication used to lower blood sugar).<br><br>Review of the resident's Physician's Order Sheet (POS), showed the following:<br><br>-admitted [DATE];<br><br>-Diagnosis of diabetes;<br><br>-Metformin 500 milligram (mg) one tablet by mouth twice a day;<br><br>-Administer Glucagon 1 mg for blood sugars less than 60.<br><br>Review of the resident's readmission progress notes, dated 9/25/24, showed the following:<br><br>-Returned to the facility;<br><br>-Physician notified of return;<br><br>-No new orders;<br><br>-No documentation regarding the Metformin.<br><br>Review of the resident's Medication Administration Record (MAR), dated 9/24, showed the following:<br><br>-Metformin 500 mg two time a day. Start date 8/16/24. Discontinued 9/26/24;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Staff documented medication administered on day shift 9/26/24.<br><br>Review of the resident's care plan, updated 9/25/24, showed the following:<br><br>-Problem: Has diagnosis of diabetes mellitus;<br><br>-Goal: Will be free from signs/symptoms of hypoglycemia (low blood sugar), hyperglycemia (high blood sugar), will be free from diabetes complications.<br><br>-Intervention: Diabetes medication as ordered by the physician. Monitor and document side effects and effectiveness.<br><br>Review of the resident's progress notes, dated 10/2024, showed the following:<br><br>-10/16/24 at 7:33 P.M.: Blood Sugar 40;<br><br>-Orange juice, glucose tablet and fudge brownie given;<br><br>-Blood sugar rechecked after 20 minutes: 107.<br><br>Review of the resident's MAR, dated 10/24, showed the following:<br><br>-Metformin 500 mg two time a day. Start date 9/26/24;<br><br>-Staff documented medication administered at 8:00 A.M. on 10/1 through 10/31/24;<br><br>-Staff documented medication administered at 5:00 P.M. on 10/1 through 10/31/24.<br><br>Review of the resident's MAR, dated 11/24, showed the following:<br><br>-Metformin 500 mg two time a day. Start date 9/26/24;<br><br>-Staff documented medication administered at 8:00 A.M. on 11/1 through 11/15/24;<br><br>-Staff documented medication administered at 5:00 P.M. on 11/1 through 11/14/24.<br><br>Review of the resident's progress notes, dated 11/14/24, showed the following:<br><br>-Blood sugar: 51. Glucagon 1 mg given for blood sugar less than 60;<br><br>-Physician notified, new order to reduce Levemir (insulin) to 15 units every evening.<br><br>Observation on 11/15/24 at 9:50 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) OO raised the head of the resident's bed and attempted to feed him/her breakfast. The resident was slow to respond and held food in his/her mouth. CNA OO reported to the nurse the resident held food in his/her mouth. The nurse checked the resident's blood sugar which was 66. He/She gave the resident orange juice with sugar at this time. He/She rechecked the blood sugar after 15 minutes, which showed a blood sugar of 83.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/15/24 at 1:35 P.M., the Director of Nurses said staff failed to discontinue the Metformin as ordered on the hospital discharge orders. She was unaware the Metformin wasn't discontinued as ordered. The nurse who was responsible was discharged due to another error. The physician has been notified and the Metformin was discontinued. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>49992<br><br>Based on observation, interview and record review, the facility failed to provide a resident with outlined food preferences to meet the needs of one of 3 sampled residents (Resident #4). The census was 86.<br><br>Review of the facility's Tray Identification policy, undated, showed:<br><br>-Appropriate identification shall be used to identify various diets;<br><br>-To assist in setting up and serving the correct food trays/diets to residents, the Food Service Department will use appropriate identification to identify the various diets.<br><br>Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/20/24, showed:<br><br>-Understood, understands, clear comprehension;<br><br>-Cognitively intact.<br><br>Review of the Resident #4's care plan, dated 6/21/24, showed:<br><br>-Assess the resident's likes and dislikes and attempt to accommodate;<br><br>-No pork, no cooked tomatoes or carrots;<br><br>-Prefers fresh vegetables and fruits, doesn't like cooked carrots or tomatoes. He/She prefers fish, chicken, and turkey. Turkey sausage and bacon. He/She prefers no gravy on his/her foods;<br><br>-Service diet as ordered.<br><br>Review of the Resident #4's Physician's Orders, dated 6/11/24, showed:<br><br>-Regular texture;<br><br>-Regular/Thin consistency;<br><br>-Double portions, three times a day;<br><br>-No pork at lunch and dinner meals;<br><br>-Dislikes cooked tomatoes and carrots.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265883 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbor Hills Nursing and Rehabilitation Center | 800 Chambers Road<br>Ferguson, MO 63135 |

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 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/4/24 at 12:07 P.M., the resident said the staff are still not honoring his/her wishes for meals. The staff are putting gravy on almost everything, serve food he/she dislikes, and the staff does not add the double portions. He/She has spoken with the Director of Nursing (DON) and the Administrator (AD).<br><br>Observation on 9/4/24 at 1:36 P.M., showed the resident's plate, with single portions of turkey patty, carrots, and chocolate chip cookies.<br><br>During an interview on 9/6/24 at 11:48 A.M., the Administrator said he is aware of the dietary issues, and it is being addressed. Resident preferences should be followed.<br><br>Observation on 9/6/24 at 1:00 P.M., showed the resident's tray was placed on the over the bed table, covered. It contained a piece of chicken, greens, spaghetti noodles with ground beef and stewed tomatoes.<br><br>During an interview on 9/19/24 at 12:05 P.M., the Dietary Director said resident food preferences are created in the electronic medical record and they are able to print out meal cards. The expectation is that when a dietary staff creates the tray, the resident food preferences, likes and dislikes should be followed. It is important for the resident to get the items listed on the meal card because each resident may have a different diet type. |