STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure facility residents were treated with kindness, dignity and respect. Activity Aide A spoke loudly towards one resident with severe cognitive impairment when the resident dropped a plastic wrapper on the floor (Resident #9). Additionally, direct care staff openly argued and cursed at the nurses' station in front of residents (Residents #12, #13, #14 and #21) about providing showers to residents. The sample was 17. The census was 86. Review of the Resident Right Policy, dated 12/2016, showed: -Policy statement: employees shall treat all residents with kindness, respect and dignity; -Policy Interpretation and implementation: federal and state laws guarantee basic rights to all residents of the facility. These rights include the resident's right to: -A dignified existence; -Be treated with respect, kindness, and dignity; -Self-determination; -Be free from abuse and neglect; -Be supported by the facility to exercise rights without interference, coercion or reprisal from the facility. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/16/24, showed: -Severe cognitive impairment; -Staff provide meal set up; -Diagnoses included dementia, malnutrition, end stage renal disease and stroke. Review of the care plan, updated 12/24/24, showed: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: the resident is at risk for psychosocial wellbeing problem related to dementia; -Goal: no indications of psychosocial wellbeing problems; -Interventions: staff monitor for changes in mood/behaviors, allow the resident time to answer questions and to verbalize feelings, and perceptions. Observation on 3/10/25 at 10:22 A.M., on the memory care unit, showed Activity Aide A opened a plastic wrapped peanut butter sandwich and handed it to the resident. The resident removed the sandwich from the wrapper and the plastic wrapper dropped to the floor. Activity Aide A stated loudly to the resident that's why I don't like giving you anything. You are always dropping things, man! Two staff members were at the nurses' station and observed the interaction. Neither staff intervened. During an interview on 3/11/25 at 9:20 A.M., LPN B said on 3/10/25 around 10:30 A.M., he/she observed Activity Aide A tell Resident #9, in a loud and rude voice, that's why I don't like giving you anything. You are always dropping things, man. LPN B said he/she told Activity Aide A to speak nicer and in a softer tone to the resident. LPN B said Activity Aide A was apologetic and no further incidents occurred. LPN B said he/she reported the incident to the DON soon after. During an interview on 3/12/25 at 9:54 A.M., the DON said all residents should be treated with respect and dignity. She was not informed of the incident on 3/10/25 by LPN A. When she was notified by the surveyor of the incident, she started in servicing regarding professionalism, dignity and resident rights. She had suspended the staff and begun and investigation. 2. Review of Resident #6's medical record, showed the following: -Moderately impaired cognitive skills for daily decision making. -Diagnoses include traumatic brain dysfunction, depression and psychotic disorder. Review of Resident #12's medical record, showed the following: -Moderately impaired cognitive skills for daily decision making. -Diagnoses include muscle weakness, dependent on wheelchair, and depression. Review of Resident #13's medical record, showed the following: -Severe cognitive skills for daily decision making; -Diagnoses include dementia. Observation on 3/12/25 at 11:06 A.M., showed Resident #13 in his/her wheelchair. The resident could not answer any questions. Review of Resident #14's medical record, showed the following: -Moderately impaired cognitive skills for daily decision making. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses include traumatic brain dysfunction. Review of Resident #21's medical record, showed the following: -Severe cognitive skills for daily decision making; -Diagnoses include traumatic dementia and depression. During an interview on 3/10/25 at 4:10 P.M., CNA G said: -Violation of resident rights was when a staff member used a threatening voice, refused to care for residents or refused to listen to residents' needs and/or wants; -He/She would notify the charge nurse or administrative staff of any violation of resident rights so they could investigate the incident; -He/She worked on 3/8/25 from approximately 2:45 P.M. until 8:59 P.M.; -He/She was asked by Resident #6's family member if he/she would give the resident a shower; -CNA G told LPN I that he/she needed a break from giving showers to residents and asked if the other CNAs on the hall could do the shower; -CNA J came up with CNA K and overheard the conversation regarding giving a shower to Resident #6; -CNA J raised his/her voice, shouting If I have to give a mother fucking shower then I am gonna leave after giving a mother fucking shower! while beating hard on the top of the nurses station; -CNA J left the unit because he/she did not want to work in that environment and wanted to go home; -He/She called the DON to tell her what happened, who told him/her to stay at work and to avoid CNA J; -He/She did not see any residents around who were potential witnesses to the event. During an interview on 3/11/25 9:18 A.M., LPN I said: -He/She worked on 3/9/25, from 7:00 A.M. until 7:00 P.M.; -He/She was at the nurses station with RN L when Resident #6's family member came by and asked if staff could give the resident a shower; -He/She asked CNA G to give a shower to Resident #6 because the family request; -CNA G refused saying he/she was always getting assigned showers for residents that were not on his/her assignment; -LPN I simply said ok; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA J heard CNA G refuse and was frustrated because he/she did not think CNAs should tell nurses no; -CNA J said if he/she had refused, he/she would get in trouble and then asked CNA G if he/she was going to do the resident's shower; -CNA J was speaking in a louder tone than usual, sounded frustrated, was cursing and hit the top of the nurses station once or twice to emphasize his/her words; -He/She did not notice if there were any residents around the nurses station; -CNA I left to go to another unit; -CNA J left with CNA K, who was a witness to the event; -RN L was a witness to the event; -He/She did not report the event to anyone because he/she did not feel there was a need; -It was not appropriate to be loud around residents or be heard arguing because it could possibly make the residents feed off the energy, get upset themselves, and could make them fearful; -If residents were witnesses to the incident, then they would have removed the staff member away from area and situation and tell management because it is inappropriate to curse around residents, because it is just wrong. During an interview on 3/11/25 at 12:06 P.M., CNA K said: -He/She worked on 3/9/25, from 7:00 A.M. until 7:00 P.M., to help CNA J with resident care; -He/She was walking up to the nurses station and heard CNA G tell LPN I that he/she would not give Resident #6 a shower; -CNA J was upset because he/she did not feel it was ok to refuse a nurse's directions; -CNA J and CNA G started to argue about who was going to give the shower to the resident; -Both CNA J and CNA G were loud but they did not hit the top of the nurses station; -There were three, maybe four residents in the living room during the event who were witnesses to the staff arguing; -CNA G left to another hall; -CNA J was upset and went to the break room to cry; -He/She expected the nurses to report the event to management; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident rights included the right to refuse anything, right to say what they want, right to feel safe as this was their home; -Witnessing the staff argue probably made the residents sitting in wheelchairs feel bad, hearing staff yell and saying they didn't want to give a resident a shower; -The residents had a right to not hear staff arguing; -If he/she could go back, CNA K would made sure the nurse reported the event to management so they could investigate to protect the residents and keep them safe. During an interview on 3/11/25 at 12:50 P.M., CNA J said: -He/She worked on 3/9/25, from 7:00 A.M. until 7:00 P.M.; -He/She was at the nurses station when he/she heard CNA G refuse to give Resident #6 a shower when LPN I asked; -CNA J asked CNA G how he/she was going to tell a nurse what he/she was going to do; -CNA G was complaining that he/she was tired, so tired that he/she was going to go home; -CNA J got upset, saying if CNA G went home, that would just leave him/her alone with all the residents; -CNA J remembers he/she may have gotten loud, may have slapped his/her hand against the table to make a point; -There were a few residents in the living room next to the nurses station who were witnesses to the argument; -The argument he/she had with CNA G could have intimidated the residents, making them feel scared and probably felt horrible hearing staff did not want to give another resident a shower; -He/She did not think of how the argument might have made the residents feel as he/she was so upset at CNA G's behavior; -If CNA J could go back, he/she would have walked away when he/she heard CNA G refuse the shower and let the nurses handle it; -CNA J felt really bad and even tried to smooth things over with CNA G later on during their shift on 3/9/25 as he/she wanted to work in a team-like, friendly environment. During an interview on 3/11/25 at 2:14 P.M., RN L said: -He/She worked on 3/9/25, from 7:00 A.M. until 7:00 P.M.; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was sitting at the nurses station with LPN I when LPN I asked CNA G to give Resident #6 a shower; -CNA G got really riled up, saying he/she felt overwhelmed, was doing all he/she could and was always getting dumped on; -CNA G got really loud, was almost crying, saying he/she was going to go home; -CNA J and CNA K came to the nurses station and heard CNA G complaining about not wanting to do showers; -CNA J used a confrontational tone with CNA G, telling CNA G he/she should go and do the resident's shower; -RN L did not remember CNA J hitting the top of the nurses station; -CNA J said he/she would give the resident his/her shower because CNA G was always whining and crying about the work load; -CNA G left the nurses station to another unit; -CNA J and CNA K left the nurses station as well; -He/She thought there were two residents in the living room area, next to the nurses station, who witnessed the event, he/she could not recall who as the RN was newly hired a week ago; -He/She did not receive any education regarding Resident Rights during onboarding; -Resident rights included the right to feel safe, refuse medications, privacy, right to not be abused or neglected; -If a resident was witness to the incident, it could make them feel they were not in a safe environment, feel threatened and not getting good care; -He/She did not report the event to management because he/she thought LPN I was going to report it; -When he/she left that day at the end of his/her shift, RN L did not know if the incident was reported; -In hindsight, RN L should have reported the incident to management; -The risk to the residents was psychological abuse. During an interview on 3/11/25 at 3:25 P.M., the DON said: -She watched the video of the staff members arguing at the nurses station on 3/9/25; -She concluded CNA J was not the aggressor in the event after watching the video; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA G was the aggressor as he/she was seen hitting the nurses station tabletop, pointing his/her finger at other staff, grabbing a piece of paper out of LPN I's hand and generally carrying on for a long period of time. While there was not audio, CNA G's body language looked like he/she was loud, a disgruntled employee; -Residents #12, #13, #14 and #21 were witnesses to the event as they were all sitting in the living room within eyesight and earshot of the nurses station; -She had CNA G in her office and would not allow him/her to work his/her scheduled shift that day; -She was going to suspend CNA G pending investigation with the plan to terminate; -She would not ask CNA G to write statement about the event as CNA G already lied to the DON saying it was CNA J who was the aggressor. During an interview on 3/12/25 at 7:30 A.M., the DON said: -The residents, even if they were nonverbal, could have been scared when they witnessed the argument between the staff members; it could have been detrimental to their physical and mental well-being; -She expected the nurses to not engage in an argument with a CNA, to stop the argument with the CNAs and to remove them from the floor if they continued to escalate; -She expected the nurses to assess the residents who were witnesses to the event, to see if there were any non-verbal signs of any distress and to reassure the residents of their safety; -She expected CNAs to take direction from the nurses; -The residents were all dependent on staff for care and hearing the CNAs refuse to give another resident a shower had the potential to make them feel like the CNAs would not provide them care, making them fearful; -Resident #6 did not get a shower that night from staff. His/Her family member washed up the resident; -Family member should feel confident nursing staff would care for the residents. 3. During an interview on 3/10/25 at 2:17 P.M., the DON said: -She expected staff to have knowledge of and to follow facility policies; -She expected staff to report all allegations of rude behavior and/or violations of residents' rights to management so they could investigate the incident; -The investigation included interviews of all staff involved, the resident involved and any possible witnesses; -She expected staff to remove residents to safety for their psycho-social well being; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected residents to have care plans if they had behaviors with appropriate interventions. MO00250551 MO00249022

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to ensure two out of 17 sampled residents were free from abuse. Certified Nurse Aide (CNA) N yelled at Resident #6 in the dining room and pulled on the resident's arm- telling the resident he/she needed to leave and eat in their room, causing the resident to cry and be afraid. CNA G scolded Resident #7 when he/she yelled for assistance with continence care, due to not having a call light within reach. CNA G told the resident it was the last time he/she was going to care for the resident in bed, causing him/her to feel hurt and disrespected. During a later event, CNA G spoke disrespectfully towards the resident while walking past them. The census was 86. Review of the abuse prevention policy, dated 9/16/24, showed: -Prevention and reporting: Suspected resident/patient abuse, neglect and/or misappropriation of property; -The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc; -The Administrator has the primary responsibility in the facility for the implementation of the abuse/neglect program: -The facility will follow all state and federal guidelines on preventing abuse, neglect, mistreatment, exploitation and misappropriation of property; -The facility encourages and supports all resident, staff and families in feeling free to report any suspected acts of abuse, neglect, misappropriation or injury. The facility takes all measures possible to ensure the resident, staff and families are free from fear of retribution if reports or incidents are filed with the facility; Allegations of abuse will be promptly reported and thoroughly investigated. The facility should immediately report all such allegations to the Administrator and to the Department of Health and Senior Services; -The administrator and Director of Nursing (DON) are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect: -Implementation and ongoing monitoring consist of the following: screening, training, prevention, identification, protection, investigation and reporting; -Definitions: -Abuse: -Willful infliction of an injury; -Unreasonable confinement; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Intimidation with resulting physical harm, pain or mental anguish; -Instances of abuse includes verbal, sexual abuse, physical and mental abuse; -Verbal abuse: oral, written or gestured language that includes disparaging and derogatory terms to the resident or their families with within their hearing distance; -Physical abuse: includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc; -Mental/emotional abuse: includes, but not limited to humiliation, harassment, and threats of punishment or deprivation; -Training: -Provide training for new employees and volunteers through new hire orientation and annually with ongoing training programs on abuse and neglect and the handling of abuse, and neglect. Training will include, but not limited to: -Definitions of abuse, neglect and mistreatment; -Identification and reporting of abuse, neglect and mistreatment; -Utilization of appropriate interventions to deal with aggressive and/or catastrophic (detrimental) reactions for resident; -How to provide protection for residents; -Investigation of abuse, neglect and mistreatment; -Document staff training and maintain with educational records in the facility; -Resident rights- how the residents are to be treated, including the right to be free from abuse and what to do if an employee/volunteer suspect that a resident has been violated; -Prevention: -Ensure that prevention techniques are implemented in the facility including, but not limited to an ongoing supervision of employees through visual observation or care delivery and recognition of signs of burnout, stress and frustration. It is the responsibility of the staff to promote a safe environment for the residents; -Identify, correct and intervene in situations where abuse, neglect and/or mistreatment are more likely to occur: sufficient staffing on each shift to meet needs of the residents, residents with needs and behaviors which might lead to conflict and supervision of staff to identify inappropriate behavior, such as rising derogatory language, rough handling and ignoring residents while giving care; -Instruct staff that they are required to report concerns and incidents; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Protection: -Provide for the immediate safety of the resident upon identification of the suspected abuse, including but not limited to: moving the resident to another room or unit, provide 1:1 monitoring as appropriate, immediate suspension of the suspected staff pending outcome of the investigation; -Initiate behavior crisis management interventions as applicable. -Reporting: -Any person witnessing or having knowledge of alleged violation involving abuse, neglect or misappropriation are to notify the Administrator and DON immediately. 1. Review of Resident #6's medical record, showed the following: -Moderately impaired cognitive skills for daily decision making. -Diagnoses include traumatic brain dysfunction, depression, and psychotic disorder. Review of the resident's care plan, in use during the survey, showed the resident has periods of crying and mood changes. Interventions included to provide active listening and support when needed, and to encourage the resident to express feelings. Observation of video footage, dated 3/8/25, showed the resident entered the dining room and walked towards a table. He/She pulled out the chair. Another resident approached the resident and spoke to him/her. Certified Nurse Aide (CNA) F approached the residents and motioned with his/her arms, then walked around both residents. CNA F pulled on the resident's left arm. Licensed Practical Nurse (LPN) G intervened and CNA F left the dining room. During an interview on 3/11/25 at 9:53 A.M., the resident said he/she was in his/her room and experienced an episode of urinary incontinence. A CNA entered the room, and helped him/her change clothes. The resident said his/her shoes were wet and the CNA said he/she could not go to lunch because his/her shoes were wet and he/she had to eat in his/her room. The resident walked to the dining room. While at his/her dining room table, the CNA began to yell at him/her and said you can not be in here without shoes, you have to eat in the room. The CNA pulled on his/her right arm. The resident said he/she cried and was very upset and felt terrible. It was just terrible, he/she is afraid of the CNA now, and didn't want the CNA working with him/her. During an interview on 3/12/25 at 1:13 P.M., Resident #20 said he/she sat at the table during lunch on 3/8/25. The resident saw a staff person push on Resident #6. It made Resident #20 scream, Stop that. Resident #6 was crying. Resident #20 was so scared because he/she couldn't do a damn thing. It scared Resident #20 because someone could also hurt him/her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/12/25 at 1:40 P.M., Visitor H said he/she was in the dining room during lunch with Resident #20 on 3/8/25. Visitor H saw Resident #6 at the dining room doorway, and staff telling the resident he/she couldn't come into the dining room without shoes on, and pushed the resident out. Other residents go to the dining room wearing socks without shoes. Resident #6 was crying. Staff grabbed and pulled at the resident, who yelled, Get your hands off me. Visitor H told the staff not to put his/her hands on people. The staff person said do what you want and left. Other staff were present but did not intervene. Visitor H said it was physical abuse. It could have made the resident fall, it wasn't safe and could be frightening to other residents. Resident #6 was crying and this upset Resident #20. Visitor H told another staff person, in the office across from the chapel, that staff pushed Resident #6. This staff person said he/she would report it but could not nothing about nursing. Visitor H said he/she expected the staff person to report it and for someone to stick up for Resident #6. During an interview on 3/12/25 at 12:52 P.M., the Social Worker said she didn't see the CNA pull the resident's arm, but she went to the resident's table because she heard the resident crying. The Social Worker called the Administrator about 1:00 P.M. on 3/8/25, to report the resident and CNA were arguing and the resident was crying. The Administrator instructed her to tell the DON, which she did on 3/10/25 between 7:30 and 8:00 A.M. During an interview on 3/10/25 at 2:27 P.M., the DON said the incident occurred over the weekend. She found out about it on 3/10/24 before lunch, when the resident's grandparent reported to her that staff snatched his/her arm on Saturday 3/8/25, before lunch. During an interview on 3/10/25 at 3:38 P.M., the Administrator viewed the footage and suspended the CNA. Review of CNA F's timecard, showed he/she worked on 3/8/25 until 2:31 P.M. Observation on 3/10/25 during the day shift, showed CNA F worked directly with the residents. 2. Review of Resident #7's medical record, showed the following: -Intact cognitive response; -Diagnoses include muscle weakness, functional quadriplegia, acquired absence of left leg below the knee and end stage kidney disease. Review of the resident's care plan, updated on 10/24/24, showed: -The resident was at risk for psychosocial well-being; -Interventions included: Allow the resident time to answer questions and to verbalize feeling, perceptions and fears; Inform DON/Administrator of alleged abuse/neglect. During an interview on 3/12/25 at 9:52 A.M., the resident said: -CNA G worked the night shift on his/her hall; (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She did not have a call light within reach and needed help with incontinence care; -He/She had to holler for help; -CNA G came into the room and told the resident he/she was too big for the CNA to move by him/herself; -CNA G scolded the resident, telling him/her not to holler because he/she would wake the other residents; -He/She tried to explain that he/she only hollered because the call light was not in reach; -CNA g left and came back with another CNA and provided care; -CNA G told the resident it was the last time he/she was going to care for the resident in bed before leaving the resident's room; -The resident was mad because he/she had to holler for the longest time and no one came to help him/her; -The resident's feelings were hurt and he/she felt disrespected; -He/She returned to the facility on Sunday around 7:40 P.M., after a birthday party; -He/She was waiting at the nurses station in his/her wheelchair to go back to his/her room; -CNA G came down the hall and passed the resident saying I'm not going to work with (him/her)! and called the resident a bad name, which he/she could not recall; -It made the resident feel mad and he/she did not want to tell anyone because he/she felt like all of the staff were up against him/her at that point and that they would not help the resident; -He/She did not want CNA G to provide care to him/her anymore. During an interview on 3/10/25 at 4:10 P.M., CNA G said: -Violation of resident rights was when a staff member used a threatening voice, refused to care for residents or refused to listen to residents' needs and/or wants; -He/She would notify the charge nurse or administrative staff of any violation of resident rights so they could investigate the incident; -He/She worked on 3/8/25 from approximately 2:45 P.M. until 8:59 P.M.; -He/She did not have any complaints from the resident regarding care; -He/She had a good relationship with the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/12/25 at 7:50 A.M., the DON said: -The resident reported to her on 3/11/25 that a CNA was talking badly about him/her on Sunday, after the resident had returned from a birthday party; -The CNA said I am not going to put (his/her) fat ass into the bed while he/she was pushing another resident in a wheelchair past the resident at the nurses' station; -The DON looked at the video that was taken around the time described by the resident and determined the CNA in question was CNA G; -The video shows CNA G pushing another resident in a wheelchair past the resident and CNA F was seen speaking to resident. There was no audio to the video; -She had not begun her investigation yet but would try to find out determine what happened and then make the determination of what was best for the residents in regards to psycho-social care; -She expected staff to report any verbal abuse to residents; -She was going to terminate CNA G after the investigation due to other allegations of resident rights violations; -She was educating staff on resident rights; -The resident did not report any incidents of staff rudeness to her.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete a thorough investigation of alleged abuse for one resident (Resident #11) per facility policy. Review of the facility investigation, provided during the onsite investigation, showed it did not include statements from staff or residents. The sample size was 17. The census was 86. Review of the abuse prevention policy, revised 9/16/24, showed: -Investigation: -When an incident or suspected incident of abuse or neglect is reported, the Administrator or designee investigates the incident with the assistance of appropriate personnel; -The investigation should be thorough with witness statements from staff, residents, family members who may be interviewable and have information regarding the allegation; -The investigation may consist of an interview with the person reporting the incident and witnesses, an interview with the resident if possible, a review of the resident's medical record, and interview with staff members having contact with the resident during the period of the alleged incident, interviews with the resident's roommate, family members and visitors, a review of all circumstances surrounding the incident; -The Administrator takes the following actions to ensure that the investigation is conducted effectively: -If the incident has resulted in an injury or was a sexual assault occurring within the last 48 hours, the resident may be transferred to a local emergency room; -In cases of sexual assault, the hospital staff or law officers determine if a rape examination should be conducted; -Conclusion must include whether the allegation was substantiated or not and what information supported the decision. The conclusion/summary must take into account an objective overview of the facts and a reason or basis for the decision to substantiate or not substantiate the allegation; -Reporting: -The results of a thorough investigation of the allegation will be reported to the Department of Health and Senior Services within five working days of the incident and in accordance with state and federal law. Review of Resident #11's significant change Minimum Data Set, (MDS) a federally required assessment instrument completed by facility staff, dated 1/29/25, showed: -Severe cognitive impairment; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Total staff assistance needed for hygiene and daily care; -Received hospice services; -Diagnoses included cancer, arthritis, aphasia (difficulty speaking), stroke and dementia. Review of the resident's care plan, updated on 3/3/25, showed: -Focus: at risk for psychosocial well-being related to residing in a facility. The resident's roommate made allegations about visitors; -Goal: no indications of psychosocial issues; -Interventions: allow the resident time to answer questions and verbalize feelings, staff report any allegations to facility management, and room changed. Review of Resident #26's quarterly MDS, dated [DATE], showed: -Able to make needs and wants known; -Minimal staff assistance needed in care needs; -Diagnoses included stroke, heart failure, anxiety, depression, and lung disease. Review of the resident's care plan, in use during the revisit, showed: -Focus: made accusation regarding roommate visitors; -Goal: no indications of psychosocial issues; -Interventions: allow the resident time to respond, report all allegations to administrator and room changed. Review of the Department of Health and Senior Services Self-Report form, dated 2/3/25 at 3:45 P.M., showed: -Reporter: Facility Administrator; -Resident involved: Resident #11; -Summary of incident: An outpatient counselor of Resident #26 notified the facility that Resident #26 had stated his/her roommate, Resident #11, had sex 2/2/25 with someone. Resident #26 added things were not good with the roommate. He/she stated Resident #11 did not like him/her, and Resident #11 was getting more visitors and he/she was lonely. Resident #26 does not like Resident #11 due to leaving feces on the toilet. Resident #26 has a history of attention seeking behavior, issues with previous roommates and was unable to describe persons or if any words were spoken. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/10/25 at 8:15 A.M., Resident #26 said he/she had been roommates with Resident #11 for several months. His/Her roommate received frequent visitors, and often needed staff to change him/her. Resident #26 said he/she did not like to have roommates and did not like to have staff in his/her room. He/She saw shadows through the room curtain and could not see what was happening clearly to Resident #11 during care. He/She had become suspicious and told his/her counselor that he/she suspected inappropriate sexual behavior had occurred. The Administrator spoke to him/her and the roommate was moved to a different room for several days. During an interview on 3/10/25 at 11:45 A.M., the Director of Nursing (DON) said the Administrator was responsible for the investigation. The DON did not assist or participate in the investigation process. During an interview on 3/10/25 at 3:05 P.M., the Administrator said he did not obtain written statements from staff or facility residents. The facility Social Worker (SW) also assisted with the investigation. The DON was not available to assist. He should have obtained written statements from staff, residents, or the reporting party. Resident #26's behavioral health counselor notified him of the resident's concern. He immediately started an investigation. Resident #26 had a history of false allegations against roommates. He/She wanted a private room. Resident #26's therapist told him he/she felt the resident made the allegations to obtain a private room. Resident #26 also said Resident #11 was incontinent and the room had odors. During an interview on 3/12/25 at 10:14 A.M., the facility SW said she was notified by the Administrator of the allegations on 2/3/25 around 3:30 P.M. She attempted to interview Resident #11. The resident is non-verbal and does not communicate. The nurse performed a skin assessment with no abnormal findings. Resident #26 had a history of behaviors related to roommates. He/She had been moved multiple times. Since Resident #11 admitted to hospice services, more visitors had arrived. Resident #26 said he/she did not like all of the people in the room. Resident #11 was moved to a private room during the investigation and moved back into the room once the investigation was completed. The SW interviewed several residents regarding the allegations. She did not obtain written statements from any of the staff or residents, and she did not have residents sign any statements. MO249008

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards for one out of three sampled residents (Resident #1) when staff failed to follow physician orders as written. A urine specimen was not collected until 8 days after ordered by the physician. Antibiotic treatment was also delayed. The census was 84. Review of the facility's Medication and Treatment Orders, revised July 2016, showed: -Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing; -Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state; -Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/03/24, showed: -admitted on [DATE]; -Severely cognitively impaired; -Required moderate assistance for toileting hygiene and bathing; -Occasionally incontinent of bladder and bowel; -Diagnoses included dementia, seizure disorder, myasthenia gravis (an autoimmune disease that causes muscle weakness), need for assistance with personal care and cognitive communication deficit. Review of the resident's progress notes, showed: -On 11/20/24 at 3:27 P.M., obtain the following labs: a complete blood count (CBC, determines general health status and screens for and monitors for a variety of disorders), a basic metabolic panel (BMP, blood test that measures sugar level, electrolyte and fluid balance and kidney function) and a urinalysis (UA, laboratory test of urine used to aid in diagnosis of disease or to detect the presence of infection) with culture and sensitivity (C&S, diagnostic laboratory test used to identify types of bacteria and to determine types of antibiotic that can be used to treat the bacteria). Review of the resident's lab report, dated 11/22/24, showed: -Blood samples were collected on 11/22/24 at 9:30 A.M., for a CBC and BMP; -The final results for CBC and BMP were obtained on 11/22/24 at 3:06 P.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Primary Care Physician (PCP) noted on the lab report that he saw the report on 11/28/24. Review of the resident's progress notes, showed: -On 11/28/24 at 7:45 P.M., Registered Nurse (RN) C documented a urine specimen was collected and placed in the refrigerator for lab to pick up in the morning. Review of the resident's lab report, dated 11/29/24, showed: -The urine specimen was collected on 11/29/24 at 1:45 P.M. for UA and C&S test; -The UA results were completed on 11/29/24 at 9:29 P.M.; -The C&S results were finalized on 12/3/24 at 5:08 P.M.; -A handwritten nurse's note on the lab report, showed the lab result report was faxed to the PCP on 12/4/24. Review of the resident's progress notes, showed: -On 12/3/24 at 9:26 A.M., RN C called to inform the PCP of the lab results.; -On 12/6/24 at 6:39 P.M., a call was placed to the PCP again and the nurse received orders for Levaquin (antibiotic) 250 milligrams (mg), give once a day for five days. The order was sent to the pharmacy and the resident's responsible party (RRP) was informed of the new orders; -On 12/6/24 at 6:47 P.M., the pharmacy system identified a possible drug allergy for the Levaquin 250 mg, give one time a day for urinary tract infection (UTI); -On 12/6/24 at 8:55 P.M., a nurse administered first dose of Levaquin 250 mg for UTI to the resident. There were no adverse reactions. Review of the resident's Medication Administration Record (MAR), dated December 2025, showed: -An order, dated 12/7/24, and discontinued on 12/7/24, for Levaquin 250 mg, give once a day for UTI; -There was no documentation of administered Levaquin 250 mg on 12/6/24 or 12/7/24. Review of the resident's progress notes, showed: -On 12/7/24 at 10:59 A.M., the pharmacy system identified a possible drug allergy for the Levaquin 250 mg, give one time a day for five days, for UTI; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/8/24 at 6:25 P.M., the nurse spoke with the pharmacy yesterday morning related to the Levaquin not sent out to the facility. The pharmacy representative said they needed a stop date. A stop date was given to the representative. The RRP was present and asking about the resident's medication, saying the resident had increased confusion since last month. The nurse placed a call out to the PCP both yesterday and today related to the RRP concerns without response. The Levaquin was still not available at time of note. Review of the resident's MAR, dated December 2025, showed: -An order dated 12/8/24, for Levaquin 250 mg, give once a day at 8:00 A.M., for five days, for UTI; -Documentation showed on 12/8/24 at 8:00 A.M. was marked as other/see progress notes; -Documentation showed the resident received the Levaquin as ordered on 12/9/24 at 8:00 A.M. Review of the resident's progress notes, showed: -On 12/9/24 at 6:29 P.M., the resident was on antibiotics for UTI, no adverse reaction noted; -On 12/9/24 at 7:19 P.M., a nurse called the pharmacy to follow up on Levaquin 250 mg being sent out to the facility. The pharmacy said the resident had an allergy to the medication. A call was placed to the PCP to make PCP aware. Waiting for return call from PCP; -On 12/9/24 at 8:58 P.M., the on-call physician returned call and wanted to continue medication as ordered and nursing staff directed to monitor for any anaphylaxis (a severe, potentially life-threatening allergic reaction). Review of the resident's care plan, revised on 12/10/24, showed: -Problem: The resident was at risk for adverse reactions related to allergic to Levaquin. On 12/8/24, the resident had a diagnosis of an UTI and Levaquin was ordered; -Interventions included: Monitor for anaphylaxis reactions; Inform pharmacy and PCP of allergens if in contact with allergens, follow PCP orders; Monitor for possible signs and symptoms of adverse drug reactions. Review of the resident's MAR, dated December 2025, showed: -An order dated 12/8/24, for Levaquin 250 mg, give once a day at 8:00 A.M., for five days, for UTI. -Documentation showed the resident received the Levaquin as ordered on 12/10/24 at 8:00 A.M. Review of the resident's progress notes on 12/10/24 at 9:35 A.M., showed the nurse called the pharmacy to inform them the physician wanted to continue medication as ordered and overrode the allergy. Pharmacy said they would send out the Levaquin later that day. Waiting for the medication arrival to the facility. Review of the resident's MAR, dated December 2025, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 12/8/24, for Levaquin 250 mg, give once a day at 8:00 A.M., for five days, for UTI. -Documentation showed the resident received the Levaquin as ordered at 8:00 A.M. on 12/11/24 and 12/12/24. Review of the resident's progress notes, showed: -On 12/13/24 at 6:09 A.M., the resident remained on antibiotic for UTI. No adverse reactions were noted; -On 12/13/24 at 2:00 P.M., the resident remained on antibiotic for UTI. No adverse reactions were noted. Review of the resident's MAR, dated December 2025, showed: -There was no documentation the resident received an antibiotic for UTI on 12/13/24. During interview on 1/22/25 at 2:02 P.M. and at 3:00 P.M., RN C said: -He/She would call the PCP if a resident had a suspected UTI to get orders for labs and a UA. He/She would also call the resident's RRP and write a progress note in the resident's EMR describing the resident's symptoms, who was notified and what orders were given; -He/She would put the all the PCP orders into the resident's EMR , including one to collect a urine sample for the UA; -He/She would get a urine sample from the resident, put it in a separate refrigerator meant for lab samples, call the lab to for pick up and fill out a lab requisition form informing lab staff to pick up the next time they were in the building; -The lab staff would come to pick up samples on Monday, Wednesdays and Fridays; -Urine samples were good for analysis for up to 24 hours after collection if kept in the refrigerator; -If the lab did not pick up the urine sample within 24 hours after collection, nursing staff would have to obtain a new urine sample and call the lab to pick it up; -He/She would document in the nursing 24 hour report sheet that the resident's urine sample was obtained; -He/She would not necessarily write a progress note in the resident's EMR showing he/she collected the urine sample; -He/She was not sure how other staff would know if the urine sample was collected; -He/She was not sure who was responsible for making sure the urine sample was collected; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expected nurses to document when a urine sample was picked up by the lab in the 24 hour report and maybe in the resident's progress notes in the EMR; -Residents were at higher risk of an increased infection and increased pain if their urine sample was not collected and processed in a timely manner; -Nurses were expected to put physician orders in as soon as possible, within their shift, and call the pharmacy so they were aware an antibiotic was needed; -Delayed antibiotic treatment could increase the risk of the resident's infection to decline, making it harder to kill and could cause the resident increased pain; -Nurses were expected to document in MAR only when they actually completed the task or administered the medication as ordered to ensure an accurate and complete medical record. During an interview on 1/28/25 at 12:20 P.M., the Director of Nursing (DON) said: -She expected nursing staff to have knowledge of and to follow facility policies; -She expected all physician written, verbal or telephone orders entered into residents' physician order sheet in the residents' EMR within their shift; -Residents' health could decline if orders were not put into the EMR in a timely manner; -She expected nurses to obtain a urine sample for a UA within 24 hours of the PCP order; -She expected nurses to document in progress notes if they were unable to obtain an urine sample so the next nurse was notified it was done and they still needed to obtain a urine sample; -She expected nurses to notify the PCP if they are not able to obtain a urine sample within eight hours of the given order; -It was not acceptable to wait eight days after the PCP order to obtain a urine sample; -Delayed lab work increased the risk of the infection to get worse, making it harder to treat and increased risk of pain to the resident; -She expected the nursing staff to document accurately in the EMR as it affects the plan of care; -She expected the pharmacy to deliver antibiotics the following day after they were notified of the order; -She expected the nursing staff to notify the PCP if they were not able to get the pharmacy to deliver the antibiotic so the PCP could suggest an alternative medication, so treatment for the infection was not delayed; -The residents were in danger of increased infection, possible sepsis (life-threatening condition that occurs when the body has an extreme reaction to an infection), possible hospitalization, and increased altered mental status when antibiotic treatment for an infection was delayed; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a danger to the resident's health and plan of care when nursing staff document antibiotics were given when there are conflicting notes that say the antibiotic was not available due to the pharmacy not sending it out and not available in the building; -Such conflicting documentation caused confusion on whether or not the resident actually received the antibiotic as ordered, for the full five days. MO00246949

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265883	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to provide the necessary care and services for feeding assistance at mealtime for nutrition and hydration for one of three sampled residents (Resident #2) who required assistance to perform activities of daily living (ADLs). The census was 84. Review of the facility's Assistance with Meals policy, revised July 2017, showed: -Policy statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident; -For residents requiring full assistance, nursing will remove food trays from the food cart and deliver the trays to each residents' room; -Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, Review of Resident #2's Registered Dietician note, dated 10/10/24 at 5:40 P.M., showed: -The resident was on regular - mechanical soft diet with thin liquids and was to receive health shakes three times a day (TID), fortified foods TID and was to receive Nutritional Supplement shakes for mid-day and night (HS) snacks; -The resident liked supplements and drank well when offered; -The resident was dependent on staff for meeting nutritional needs and was fed by an aide at the restorative table in the main dining room; -There was no other Registered Dietician documentation found. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/22/24, showed: -Severe cognitive deficiency; -Impairment on one side of upper body; -No mobility devices were used; -Total dependence on staff for all ADLs including bed mobility, transfers and eating; -Height of five feet and two inches; -Weight of 134 pounds (lbs); -Received a mechanically altered diet; -Received hospice care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included heart failure, diabetes mellitus, dementia, chronic kidney disease, dysphagia (difficulty swallowing), cognitive communication deficit and contracture of left and right hands. Review of the resident's care plan, dated 11/01/24, showed: -Problem: The resident was on hospice care as of 10/10/23; Interventions included provide comfort as needed; -Problem: The resident had an ADL self-care performance deficit related to confusion, disease process of dementia requires total care for all ADLs; Interventions included staff to spoon feed resident; -Problem: The resident had diabetes mellitus and was at risk for hypo/hyperglycemic (low or high blood sugar in the blood) reactions; Interventions included: Dietary consult for nutritional regimen and ongoing monitoring. Review of the resident's progress notes, dated 12/23/24 at 1:51 P.M., showed the resident had been eating mechanical soft diet well and was pocketing food in side of his/her mouth. The Primary Care Physician (PCP) was notified and a new order to downgrade diet to pureed diet was noted and implemented. Review of the resident's Physician Order Sheet (POS), dated 1/22/25, showed: -An order dated 2/9/24, for furosemide (diuretic) 20 milligrams (mg), take one a day for edema (swelling). -An order, dated 12/23/24, for regular diet, pureed texture, regular/thin consistency, Nutritional supplemental drink midday and at night and health shakes with meals. Review of the resident's Medication Administration Record (MAR), dated January 2025, showed: -An order, dated 2/10/24, for Furosemide 20 mg, give once a day for edema was documented as given every day as ordered; -There was no order found to give nutritional supplemental drink at midday and at night; -There was no order found to give health shakes with meals. Observations on 1/22/25 at 12:11 P.M., at 12:47 P.M. and at 1:07 P.M., showed: -The resident asleep in his/her bed, laying on his/her right side, on a low air loss mattress, covered with a blanket; -The resident's bed was in a lowered position and the bed had bilateral side rails in the raised position; -The resident had a cup of liquid on his/her bedside table, out of reach of the resident; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was not able to answer any questions, blinked and opened and closed his/her mouth when spoken to; -The resident's skin on his/her arms appeared dry with visible superficial cracks and the resident's lips appeared dry with flaky skin; -There was no meal tray seen in room. Observation on 1/22/25 at 1:18 P.M., showed Certified Nurse Assistant (CNA) A and CNA B passing meal trays to residents' rooms on the hall in which the resident resided. Observation on 1/22/25 at 1:22 A.M., at 1:33 A.M. and at 2:06 P.M., showed the resident in the same position, laying on his/her right side. There was no meal tray in the room. During an interview on 1/22/25 at 2:02 P.M., CNA D said: -He/She knew which residents required feeding and hydration assistance by personal observation of the residents, getting told in report from other staff or by looking in their medical record; -He/She was the resident's assigned CNA for the day; -He/She did not feed or give the resident any fluid that day. During an interview on 1/22/25 at 2:07 P.M., CNA A said he/she passed meal trays to the residents in their room on the resident's hall. He/She did not give the resident his/her meal tray and did not feed the resident his/her lunch or provide any liquid to the resident. During an interview on 1/22/25 at 2:10 P.M., CNA B said he/she passed meal trays to the residents in their room on the resident's hall. He/She did not give the resident his/her meal tray and did not feed the resident his/her lunch or provide any liquid to the resident. During an interview on 1/22/25 at 2:17 P.M., CNA A and CNA B said: -They were both assigned to pass meal trays out to the resident's hall and to give feeding assistance to those who needed it; -Neither CNA passed a meal tray to the resident; -Neither CNA fed or offered fluids to the resident during lunch; -Both of them assumed the other CNA fed the resident; -They knew which residents needed feeding assistance by report from fellow CNAs or the nurse or by reading the residents' meal tickets found on their trays; -Neither of them communicated with each other to make sure all residents received their meal trays and all who required feeding assistance were fed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Neither of them told the resident's nurse the resident did not receive his/her meal tray for lunch; -They were both responsible for checking the dining cart for any meal trays that were not given out to residents; -Neither of them noticed there was a full meal tray for the resident left on the dining cart; -All CNAs were responsible for charting ADLs for nutrition and amount eaten to show how residents were assisted and how much they ate during meal times; -The CNA who gave feeding assistance to the resident was also responsible for charting the amount the resident consumed when charting ADLs; -It was neglect when a resident who was totally dependent on staff for nutrition and hydration did not receive their food or drink. It could lead to the residents missing nutrients needed per their diet order and dehydration. During an interview on 1/22/24 at 2:32 P.M., Registered Nurse (RN) C said: -He/She was not aware the resident did not receive his/her meal tray or health shake at lunch time; -He/She expected whoever was assigned to pass out meal trays to residents in their rooms to assist residents with feeding if it was required; -He/She expected the CNAs to inform him/her if a resident was not fed, as well as how much they consumed; -He/She did not ask the CNAs if all residents who required feeding assistance were fed and how much did they consume; -He/She did not check to make sure CNAs were completing their duties, ensuring residents' needs were met. Review of the resident's ADL documentation for eating, dated 1/22/25 at 3:34 P.M., showed: -On 1/22/25 at 12:52 P.M., the resident was dependent on staff for feeding assistance. Review of the resident's ADL documentation for nutrition-amount eaten, dated 1/22/25 at 3:34 P.M., showed: -On 1/22/25 at 12:52 P.M., the resident ate 0 to 25 % of his/her meal. During an interview on 1/22/25 at 4:45 P.M., the Administrator said: -He expected CNAs to pass all meal trays to residents and to provide feeding assistance if needed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He expected nurses to follow up with CNAs to ensure residents received their meals and feeding assistance if required; -He expected CNAs to accurately document how much residents consumed. Review of the resident's meal tray ticket, dated 1/23/24, showed: -The resident needed feeding assistance; -The resident required a pureed regular diet with a fortified shake. During an interview on 1/28/25 at 12:20 P.M., the Director of Nursing (DON) said: -She expected staff to know how to access and follow facility policies; -She expected CNAs to provide feeding assistance to residents if required; -She expected nurses to follow up with their CNAs to make sure the residents received their meals and were provided feeding assistance if needed; -There was a risk of dehydration, malnutrition and other complications if residents did not receive their meals or hydration as ordered. MO00247227

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the Primary Care Physician and obtain orders for pressure ulcers (ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) when they were first identified for two residents (Resident #2 and #5) out of three sampled residents. The facility also failed to administer treatments as ordered and failed to have consistent documentation of the wounds. The census was 84. Review of the National Pressure Ulcer Advisory Panel (NPUAP), prevention and treatment of pressure ulcers: quick reference guide, Washington DC: National Pressure Ulcer Advisory Panel 2014 showed the following: -Assess the pressure ulcer initially and re-assess it at least weekly; -With each dressing change, observed the pressure ulcer for signs that indicate a change in treatments as required (e.g., Wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications); -Address the signs of deterioration immediately. Review of the Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Chapter 3, Section M, defines the different stages of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) as follows: -Stage I: an observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in skin temperature, tissue consistency, sensation, and/or a defined area of persistent redness; -Stage II: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue). May also present as an intact or open/ruptured blister; -Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining (destruction of tissue or ulceration extending under the skin edges) or tunneling (a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound); -Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color) may be present on some parts of the wound bed. Often includes undermining and tunneling; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Unstageable pressure ulcers (known but unstageable due to coverage the wound bed by slough (necrotic/avascular tissue in the process of separating from the viable portion of the body, usually light colored, soft, moist and stringy) and or eschar (thick leathery, frequently black or brown in color, necrotic tissue). Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined; -Deep tissue injury: Purple or maroon area of discolored intact skin due to damage of underlying soft tissue damage. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue; -Slough: necrotic/avascular tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist, and stringy; -Eschar: thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound. Review of the National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers; quick reference guide, Washington DC: National Pressure Ulcer Advisory Panel: 2009, showed ongoing assessment of the skin is necessary to detect early signs of pressure. Review of the facility's Pressure Ulcer/Skin Breakdown Policy, revised April 2018, showed: -The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers: for example, immobility, recent weight loss, and a history of pressure ulcer(s); -The nurse shall describe and document/report full assessment of the pressure ulcer and current treatments; -The physician will assist the staff to identify the type of ulcer; -The physician will order pertinent wound treatments; -The physician will evaluate and document the progress of wound healing. During an interview on 2/3/25 at 4:05 P.M., the Director of Nursing (DON) said the facility did not have a policy to Follow Physician Orders. 1. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/22/24, showed: -Severe cognitive impairment; -Impairment on one side of upper body; -No mobility devices were used; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Total dependence on staff for all activities of daily living (ADLs) including bed mobility, transfers, and eating; -Received hospice care; -At risk for pressure ulcers; -No unhealed pressure ulcers present; -Pressure reducing device for chair and bed were present; -Diagnoses included heart failure, diabetes mellitus, dementia, chronic kidney disease, dysphagia (difficulty swallowing), cognitive communication deficit and contracture of left and right hands. Review of the resident's care plan, undated, showed: -Problem: The resident was incontinent of bowel and bladder related to confusion and was at risk of skin break down. The resident had a Stage II Pressure Ulcer noted to his/her coccyx (a small triangular bone at the base of the spinal column) on 12/28/24. Interventions included: Resident to wear bilateral heel protectors; Assess skin weekly and as needed and inform resident's responsible party (RRP) and Primary Care Physician (PCP) of changes in skin integrity; Treat right foot and ankle as ordered; Treat calluses (hard, thickened skin) as ordered; Treat coccyx as ordered. Review of the hospice handwritten care notes, dated 11/06/24 through 12/3/24, showed there was no documentation found showing the resident had wounds. Review of the facility weekly wound report, dated Week One of December 2024, showed: -The resident had a wound (not specified) at his/her coccyx, measuring 4.5 centimeters (cm) by 3.5 cm by 0. 1 cm deep, with a treatment of Dakin's (an antiseptic cleanser) moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her right ankle, measuring 3.0 cm by 3.0 cm by 0.2 cm, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her left ankle, measuring 1.0 cm by 1.0 cm with no depth, with a treatment of Dakin's moist with gauze border dressing daily and as needed. Does the not specified statements above refer to the staff not documenting a stage for the wound? Who completes the weekly wound report? is it a designated wound nurse working at the facility? a nurse from a wound management co? I see the interview with the wound nurse below but couldn't tell if he/she was a facility employee. Review of resident's shower sheets, dated 12/3/24 through 12/15/24, showed there was no documentation found of any open areas or skin issues. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the hospice handwritten care notes, dated 12/3/24 through 12/15/24, showed there was no documentation found showing the resident had wounds. Review of the facility weekly wound report, dated Week Two of December 2024, showed: -The resident had a wound (not specified) at his/her coccyx, measuring 4.5 cm by 3.5 cm by 0.1 cm deep, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her right ankle, measuring 3.0 cm by 3.0 cm by 0.2 cm, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her left ankle, measuring 1.0 cm by 1.0 cm with no depth, with a treatment of Dakin's moist with gauze border dressing daily and as needed. Review of the resident's weekly skin assessment, dated 12/16/24 at 2:14 P.M., showed the resident's skin was intact with no open areas noted. Review of the facility weekly wound report, dated Week Three of December 2024, showed: -The resident had a wound (not specified) at his/her coccyx, measuring 4.5 cm by 3.5 cm by 0.1 cm deep, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her right ankle, measuring 3.0 cm by 3.0 cm by 0.2 cm, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her left ankle, measuring 1.0 cm by 1.0 cm with no depth, with a treatment of Dakin's moist with gauze border dressing daily and as needed. Review of the hospice handwritten care notes, dated 12/16/24 through 12/24/24, showed there was no documentation found showing the resident had wounds. Review of the resident's shower sheet, dated 12/24/24 with no time notes, showed the coccyx area was circled with a note saying new open area. Review of the facility weekly wound report, dated Week Four of December 2024, showed: -The resident had a wound (not specified) at his/her coccyx, measuring 4.5 cm by 3.5 cm by 0.1 cm deep, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her right ankle, measuring 3.0 cm by 3.0 cm by 0.2 cm, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her left ankle, measuring 1.0 cm by 1.0 cm with no depth, with a treatment of Dakin's moist with gauze border dressing daily and as needed. Review of the resident's weekly skin assessment, dated 12/26/24 at 9:46 A.M., showed: -A pressure ulcer at the resident's coccyx was present, measuring 4.5 cm by 3.5 cm by 0.1 cm deep; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A pressure ulcer at the resident's right ankle was present, measuring 3.0 cm by 3.0 cm by 0.2 cm deep; -A pressure ulcer at the resident's left ankle was present, measuring 1.0 cm by 1.0 cm with no depth noted. Review of the resident's progress notes, showed: -On 12/28/24 at 6:09 P.M., a family member reported the resident had an open area to his/her coccyx and an open area to his/her right ankle with multiple calloused areas on both heels and foot. A call was placed to the PCP for treatment orders for both pressure areas to cleanse the wounds with wound cleanser, apply Medihoney (antimicrobial to treat burns and wounds) and cover with bordered dressing (bandage) once a day and to apply skin prep (liquid film-forming dressing that forms a protective film over skin). There was no documentation found showing where to apply the skin prep; -On 12/28/24 at 6:49 P.M., showed the RRP was made aware of the new orders for the resident's wounds at his/her coccyx and right ankle; -There was no documentation found the facility notified the PCP or RRP of any wounds from 12/1/24 through 12/27/24. Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed: -An order, dated 5/17/24, to apply skin prep to the medial (inner edge that runs from the heel to the big toe) right foot once a day. Documentation showed the facility completed the treatment as ordered 15 out of 31 opportunities; -An order, dated 12/29/24 for Stage II pressure ulcer at right ankle, cleanse with wound cleanser, apply Medihoney and cover with bordered gauze dressing every day shift for wound healing. Documentation showed the facility completed the treatment as ordered two out of three opportunities; -An order, dated 12/29/24, for Stage II pressure injury at coccyx, cleanse with wound cleanser, apply Medihoney and cover with bordered gauze dressing every day shift for wound healing. Documentation showed the facility completed the treatment as ordered two out of three opportunities; Review of the resident's weekly skin assessment, dated 12/30/24 at 11:04 A.M., showed: -A pressure ulcer at the resident's coccyx was present, measuring 4.5 cm by 3.5 cm by 0.1 cm deep; -A pressure ulcer at the resident's right ankle was present, measuring 3.0 cm by 3.0 cm by 0.2 cm deep; -A pressure ulcer at the resident's left ankle was present, measuring 1.0 cm by 1.0 cm with no depth noted. Review of the resident's physician order sheets, dated December 2024, showed there was no order for a treatment to the resident's left ankle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the hospice handwritten care notes, dated 12/26/24 through 1/2/25, showed there was no documentation the resident had wounds. Review of the facility's weekly wound report, dated Week One of January 2025, showed: -The resident had a wound (not specified) at his/her coccyx, measuring 4.5 cm by 3.5 cm by 0.1 cm deep, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her right ankle, measuring 3.0 cm by 3.0 cm by 0.2 cm, with a treatment of Dakin's moist with gauze border dressing daily and as needed; -The resident had a wound (not specified) at his/her left ankle, measuring 1.0 cm by 1.0 cm with no depth, with a treatment of Dakin's moist with gauze border dressing daily and as needed. Review of the resident's weekly skin assessment, dated 1/2/25 at 2:16 P.M., showed: -A pressure ulcer, unstageable, at the resident's coccyx was present, measuring 4.5 cm by 3.5 cm by 0.1 cm deep; -A Stage II pressure ulcer at the resident's right ankle was present, measuring 3.0 cm by 3.0 cm by 0.2 cm deep; -A Stage II pressure ulcer at the resident's left ankle was present, measuring 1.0 cm by 1.0 cm with no depth noted. Review of the resident's weekly wound assessment, dated 1/2/25 at 4:32 P.M., showed: -A callous (hard thickened skin) located at the right ankle, acquired on 12/26/24, wound bed described as necrotic and dry, with no exudate, measuring 3 millimeters (mm) by 3 mm by .02 mm deep. Apply skin prep daily, with off-loading boot. Waiting on hospice measurements; -A Stage II pressure ulcer located at the coccyx, found on 12/26/24, wound bed described as necrotic and dry, measuring 45 mm by 35 mm by .01 mm deep. Apply border gauze daily; -A callous located at the left ankle, acquired on 12/26/24, wound bed described as necrotic and dry, measuring 1 mm by 1 mm by 0 mm deep. Apply skin prep daily, with off-loading boot. Waiting on hospice measurements. Review of the hospice handwritten care notes, dated 1/3/25, no time noted, showed the resident had wounds to his/her coccyx and right lateral ankle. Review of the facility's weekly wound report, dated Week Two of January 2025, showed there was no documentation on the resident's wounds. Review of the resident's progress note, dated 1/10/25 at 11:24 A.M., showed the RRP was called to confirm and educated the family on the resident's declining status and wound care. Review of the resident's weekly skin assessment, dated 1/9/25 at 2:16 P.M., showed: (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A pressure ulcer, unstageable, at the resident's coccyx was present, measuring 3.5 cm by 3.0 cm by 0.1 cm deep; -A Stage II pressure ulcer at the resident's right ankle was present, measuring 1.0 cm by 1.0 cm with no depth noted; -A Stage II pressure ulcer at the resident's left ankle was present, measuring 1.0 cm by 1.0 cm with no depth noted. Review of the resident's weekly wound assessment, dated 1/9/25 at 4:38 P.M., showed: -A callous located at the right ankle, acquired on 12/26/24, wound bed described as necrotic and dry, with no exudate, measuring 1 mm by 1 mm by 0 mm deep. Apply skin prep daily, with off-loading boot. Waiting on hospice measurements; -A Stage II pressure ulcer located at the coccyx, found on 12/26/24, wound bed described as necrotic and dry, measuring 35 mm by 30 mm by .01 mm deep. Apply border gauze daily; -A callous located at the left ankle, acquired on 12/26/24, wound bed described as necrotic and dry, measuring 1 mm by 1 mm by 0 mm deep Apply skin prep daily, with off-loading boot. Waiting on hospice measurements. Review of the Hospice Nurse Wound assessment, dated 1/10/25 at 9:24 A.M., showed: -Hospice assessed and treated the resident's wounds; This is the first time hospice assessed the wound? -A Stage II pressure ulcer at the right buttock, first assessed on 1/10/25, wound bed 50% granulation, 25% slough and 25% eschar, with small amount of serosanguineous, foul-smelling exudate (drainage) measuring 3.5 centimeters (cm) by 2.5 cm; -A Stage III pressure ulcer at the right ankle, first assessed on 1/10/25, wound bed of 100% slough, with moderate amount of serosanguineous exudate, measuring 2 cm by 2 cm by 0.1 cm deep. Review of the facility's weekly wound report, dated Week Three of January 2025, showed there was no documentation on the resident's wounds. Review of the Hospice Nurse Wound Assessment, dated 1/15/25 at 12:17 A.M., showed: -Hospice assessed and treated the resident's wounds; -A Stage III pressure ulcer at the right buttock, first assessed on 1/10/25, wound bed described as fragile, moist, necrotic and pink, with a small amount of tan exudate with a musty odor, no measurements found, wound status described as deteriorating. -A Stage III pressure ulcer at the right ankle, first assessed on 1/10/25, wound bed described as necrotic and pink with a small amount of exudate, no odor, no measurements found, wound status described as evolving; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A Stage III pressure ulcer at the left ankle, first assessed left blank, wound bed described as dry pink, with no exudate or odor, no documentation found regarding wound status. Review of the resident's weekly skin assessment, dated 1/16/25 at 10:18 A.M., showed: -A pressure ulcer, unstageable, at the resident's coccyx was present, measuring 8.5 cm by 3.5 cm by 0.1 cm deep; -A Stage II pressure ulcer at the resident's right ankle was present, measuring 2.0 cm by 2.0 cm by 0.2 cm deep; -A Stage II pressure ulcer at the resident's left ankle was present, measuring 1.5 cm by 1.5 cm with no depth noted Review of the resident's weekly wound assessment, dated 1/16/25 at 4:44 P.M., showed: -A callous located at the right ankle, acquired on 12/26/24, wound bed described as necrotic and dry, with no exudate, measuring 2 millimeters (MM) by 2 mm by .02 mm deep. Apply skin prep daily, with off-loading boot and border gauze (bandage) as needed. Waiting on hospice measurements; -A Stage II pressure ulcer located at the coccyx, found on 12/26/24, wound bed described as necrotic and dry, measuring 52 mm by 35 mm by .02 mm deep. Apply border gauze daily; -A callous located at the left ankle, acquired on 12/26/24, wound bed described as necrotic and dry, measuring 15 mm by 15 mm by .02 mm deep. Apply skin prep daily, with off-loading boot and border gauze (bandage) as needed. Waiting on hospice measurements. Review of the resident's progress note, dated 1/17/25 at 3:50 P.M., showed social services called the hospice four times to obtain their wound report and measurements for the wound nurse. The calls were not answered. Review of the resident's progress notes, showed there was no documentation found the RRP or PCP were notified of the Stage II pressure ulcer found on the resident's left ankle. Review of the resident's TAR, dated January 2025, showed: -An order, dated 5/17/24, to apply skin prep to the medial right foot once a day. Documentation showed the facility completed the treatment as ordered nine out of twenty one opportunities; -An order, dated 12/29/24, discontinue on 1/16/25, for Stage II pressure ulcer at right ankle, cleanse with wound cleanser, apply Medihoney and cover with bordered gauze dressing every day shift for wound healing. Documentation showed the facility completed the treatment as ordered seven out of sixteen opportunities; -An order, dated 1/17/25, for Stage II pressure ulcer at right ankle, cleanse with wound cleanser, apply Medihoney and cover with bordered gauze dressing every day shift for wound healing. Documentation showed the facility completed the treatment as ordered two out of five opportunities; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 12/29/24, for Stage II pressure injury at coccyx, cleanse with wound cleanser, apply Medihoney and cover with bordered gauze dressing every day shift for wound healing. Documentation showed the facility completed the treatment as ordered ten out of twenty one opportunities; -There was no treatment order for the resident's left ankle. Review of the resident's electronic medical record (EMR), showed there was no documentation of the resident's Braden score (test that scores resident's risk of pressure ulcers). Observations on 1/22/25 at 12:47 P.M. and at 1:22 P.M., showed: -The resident asleep in his/her bed, laying on his/her right side, on a low air loss mattress, covered with a blanket; -The resident's bed was in a lowered position and the bed had bilateral side rails in the raised position; -The resident had a cup of liquid on his/her bedside table, out of reach of the resident; -The resident was not able to answer any questions, blinked and opened and closed his/her mouth when spoken to; -The resident's skin on his/her arms appeared dry with visible superficial cracks and the resident's lips appeared dry with flaky skin; -There was a stack of wound supplies at bedside. During an interview on 1/22/25, at 1:27 P.M. the Wound Nurse said: -She was responsible for all wound reports, all weekly skin assessments, all wound treatments (unless they were for non open areas or skin tears) and to round with the Wound Doctor once a week; -She was also responsible for completing treatments on any hospice residents unless the hospice nurse completed them; -She expected hospice nurses to document when they completed treatments on residents and to give report to the nurse so they could track the wound's healing status; -She expected nurses who got report from the hospice nurse to write a progress note documenting what was done, by whom, when and the status of the wound during treatment; -She expected nursing staff to alert her when there was a new skin issue by telling her verbally or by putting a note in the wound nurse binder at the nurses station; -She was responsible for assessing resident's skin when she was alerted to a new skin issue, to document her findings on a skin assessment in the resident's EMR, then write a progress note what skin issue was found, the notification of the PCP for treatment orders and notification of the RRP. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-She was responsible for putting the physician orders into the resident's physician order sheets in the EMR; -She completed the resident's treatments to his/her right and left ankles and to his/her coccyx before the day shift nurse arrived; -Hospice nurses were responsible for completing weekly assessments on the hospice residents; -She expected hospice nurses to give their wound assessments on the day they were completed; -She was responsible for putting all wound assessments from both the Wound Physician and the hospice nurse into the residents' EMR and on the facility weekly wound report; Observation on 1/22/25 at 1:33 P.M., showed: -The Wound Nurse performed a skin assessment on the resident while the resident was in his/her bed; -The resident wore protective boots on both of his/her feet, had a pillow in between his/her knees and a pillow tucked under his/her right upper body as he/she lay on his/her right side; -The Wound Nurse exposed the resident's right ankle, showing a bandage which had exudate showing through to the surface of the bandage. The bandage was not dated or signed; -The Wound Nurse exposed the resident's left ankle, showing a bandage, which was not dated or signed; -The Wound Nurse exposed the resident's coccyx, showing a bandage was present, which was not dated or signed; -The Wound Nurse was not sure who changed the resident's bandages after she had completed the treatments earlier that morning and had dated and signed each bandage with the day's date and her initials. During an interview on 1/22/24 at 1:45 P.M., Registered Nurse (RN) C, said: -He/She did not administer any treatments to the resident that day; -He/She thought maybe a hospice nurse came and changed them after breakfast; -He/She expected the hospice nurse to document in the hospice binder when they visited, showing what they did during the visit; -He/She did not get a report from the hospice nurse today and would not document if he/she did get a report from hospice staff; -He/She was called to the resident's room a few weeks ago by the RRP; (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 B. Wing	01/28/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The RRP was upset because the resident had a wound at his/her coccyx for at least a week and a half and still staff had not done anything about it; -RN C assessed the resident's coccyx and found a new wound was present. He/She called the PCP, got an order, put in the resident's EMR and applied the treatment to the resident; -It was the first time the nurse was alerted to any wound located on the resident's coccyx; -If a Certified Nursing Assistant (CNA) told the nurse of a new skin issue, or if the nurse found a new skin issue, he/she would assess the wound, notify the PCP and RRP, obtain new treatment orders, put the treatment order in the resident EMR and apply the treatment, documenting all in a progress note; -He/She would also alert the Wound Nurse either verbally or by writing a note in the Wound Nurse binder found at the nurses station. Review of the handwritten Hospice Care notes, showed: -A note, dated 1/21/25, no time noted, showed the hospice nurse completed wound treatments on the resident; -There was no documentation they visited the resident on 1/22/24. During an interview on 1/28/25 at 12:20 P.M., the Director of Nursing (DON) said: -If a resident received hospice care, hospice nurses were responsible for changing the wound treatments when they are there and if they are not there, the Wound Nurse was responsible; -Hospice was also responsible for weekly wound assessments and if they didn't do it, the Wound Nurse was responsible or charge nurse in her absence; -If hospice changed a wound treatment and/or completed weekly wound assessments, the charge nurse or Wound Nurse would document that it was complete in the resident's progress notes and in the TAR with a note, saying hospice completed. 2. Review of Resident #5's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for toileting, showering, personal hygiene, bed mobility and transfers; -Wheelchair used for locomotion; -Always incontinent of bladder and bowel; -Diagnoses included kidney disease, diabetes mellitus, stroke, dementia and Parkinson's disease (disorder of central nervous system that affects movement). (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's current care plan, showed: -Problem: The resident was at risk for open areas related to decreased mobility and incontinence; -Interventions included: follow up with wound specialist as needed; Inform PCP and RRP of changes in skin integrity; Assess skin weekly and as needed and inform PCP and RRP of changes in skin integrity. Review of the resident's weekly skin assessment, dated 12/3/24 at 1:50 P.M., showed the resident had intact skin, no open areas, area to sacrum (was red), ointment applied. Review of the resident's shower sheet, dated 12/3/24, showed there were no areas circled or skin issues noted. Review of the resident's weekly wound assessment, dated 12/3/24, showed, Stage I pressure ulcer at the resident's coccyx, acquired on 12/3/24, wound bed had pink, moist tissue with no drainage, measuring at 5 mm by 5 mm with no depth, current treatment of collagen (used to absorb exudate) and border gauze daily. Review of the resident's weekly wound assessment, dated 12/5/24, showed: -The resident had a callus at his/her right heel, acquired on 12/3/24, with necrotic tissue present with no exudate, measuring 0 mm by 0 mm by 0 mm deep, with a treatment order to apply skin prep daily and as needed. Review of the facility's wound report, dated Week One of December 2024, showed: -The resident had an unspecified wound on his/her coccyx, measuring 1.5 cm by 0.5 cm by 0.1 cm with a treatment order of collagen and border gauze daily and as needed. Review of the resident's weekly skin assessment, dated 12/9/24, showed: -A pressure ulcer (stage not applicable) at the resident's right heel, with no measurements noted; -A Stage I pressure ulcer at the resident's sacrum, measuring 1.5 cm by 0.5 cm by 0.1 depth. Review of the resident's shower sheet, dated 12/10/24, showed there were no areas circled or skin issues listed. Review of the resident's weekly wound report, dated 12/12/24, showed: -The resident had a callus at his/her right heel, acquired on 12/3/24, with necrotic tissue present with no exudate, measuring 10 mm by 10 mm by 0 mm deep, with a treatment order to apply skin prep daily and as needed; -There was no documentation on the resident's coccyx. Review of the facility's wound report, dated Week Two of December 2024, showed: (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident had an unspecified wound on his/her coccyx, measuring 1.5 cm by 0.5 cm by 0.1 cm with a treatment order of collagen and border gauze daily and as needed. Review of the resident's weekly skin assessment, dated 12/16/24, showed: -A suspected deep tissue injury at the resident's right heel, measuring 1.0 cm by 1.0 cm by 0.1 depth; -A Stage I pressure ulcer at the resident's sacrum, measuring 0.5 cm by 0.5 cm by 0.1 cm deep. Review of the resident's shower sheet, dated 12/17/24, showed the resident's left buttock was circled with a note showing there was an open area present with a treatment in place. There was also a circle around both the right and left heels with a note saying skin prep to heels. Review of the resident's weekly wound report, dated 12/19/24, showed: -The resident had a callus at his/her right heel, acquired on 12/3/24, with necrotic tissue present with no exudate, measuring 10 mm by 10 mm by 0 mm deep, with a treatment order to apply skin prep daily and as needed; -There was no documentation on the resident's coccyx. Review of the facility's wound report, dated Week Three of December 2024, showed: -The resident had an unspecified wound on his/her coccyx, measuring 0.5 cm by 0.5 cm by 0.1 cm with a treatment order of collagen and border gauze daily and as needed; -The resident had an unspecified wound at his/her right heel, measuring 1.0 cm by 1.0 cm with no depth, with a treatment to apply skin prep daily and wear offloading boots. Review of the resident's weekly skin assessment, dated 12/23/24, showed: -A suspected deep tissue injury at the resident's right heel, measuring 1.0 cm by 1.0 cm by 0 depth; -A Stage I pressure ulcer at the resident's sacrum, measuring 0.5 cm by 0.5 cm by 0.1 cm deep. Review of the resident's shower sheet, dated 12/24/24, showed the resident's left buttock was circled with a note showing there was an open area present with a treatment in place. There was also a circle around both the right and left heels with a note saying skin prep to heels. Review of the resident's weekly wound report, dated 12/28/24, showed: -The resident had a callus at his/her right heel, acquired on 12/26/24, with necrotic tissue present with no exudate, measuring 10 mm by 10 mm by 0 mm deep, with a treatment order to apply skin prep daily and as needed; -There was no documentation found on the resident's coccyx. (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's wound report, dated Week Four of December 2024, showed: -The re

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	265883	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure staff maintained infection control and proper positioning of the tubing and reservoir bag, for one resident with an indwelling urinary catheter (Foley catheter (a thin, flexible tube inserted into the urethra (the tube that cares urine from the bladder to the outside of the body) to drain urine from the bladder into a collection bag) and recent history of urinary tract infection (Resident #15). The census was 86. Review of the facility's Catheter Care, Urinary policy, dated September 2014, showed: -Purpose: To prevent catheter-associated urinary tract infection (UTIs, infection of the urinary tract system); -Review the resident's care plan to assess for any special needs of the resident; -Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks; -The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder; -Be sure the catheter tubing and drainage bag are kept off the floor; -Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised; -Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.); -Observe the resident for complications associated with urinary catheters; -Check the urine for unusual appearance (i.e., color, blood, etc.); -Observe for other signs and symptoms of urinary tract infection or urinary retention. Review of Resident #15's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/12/25, showed: -Cognitively intact; -Dependent on help of staff for toileting, lower body dressing and transfers; -Indwelling catheter present; -Always incontinent of bowel; (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Care & Rehab Center	800 Chambers Road Ferguson, MO 63135

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included UTI within last thirty days, diabetes mellitus and acquired absence of right leg and left leg below the knee. Review of the resident's care plan, undated, showed: -Problem: The resident had an overactive balder with recurrent UTIs, urinary retention and urinary stricture (scarring that narrows the tube that carries urine out of the body) with a Foley catheter in place; -Interventions included: Change Foley catheter monthly and as needed; clean perineal (area between genitals and anus) with each incontinent episode; Foley care daily and as needed as ordered; keep drainage bag below the bladder; monitor/document for pain/discomfort due to catheters; Monitor for signs and symptoms of UTIs such as pain, deepening of urine color, no output, foul smelling urine and cloudiness. Review of the resident's Physician Order Sheet (POS), dated 3/10/25, showed: -There were no orders to clean the resident's catheter; -There were no orders to change the resident's catheter or the size of the Foley catheter. Observation on 3/10/25 at 8:05 A.M., showed the resident asleep in his/her bed. There was a catheter bag hooked to the frame on the left side of the bed. The catheter bag was visible and contained dark golden yellow urine. During an interview on 3/10/25 at 10:58 A.M. and at 11:04 A.M., the resident said: -Nursing staff were not cleaning his/her catheter, and he/she had pain in his/her genitalia, lower abdomen and groin; -He/She complained to the nursing staff but they did not do anything to care for his/her pain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/10/25 at 11:05 A.M., showed Registered Nurse (RN) C providing care for the resident while the resident lay in his/her bed. RN C pulled the resident's brief down and tucked it between the resident's legs. The resident's catheter tube was lodged underneath the resident's right below the knee amputation (BKA) leg, compressing the tube. There was urine visible in the catheter tube above the resident's right BKA leg and there was no urine visible in the tube below the resident's leg leading into the catheter bag. The catheter tube had dried dark matter on the outside of the tube extending from the point of insertion from the resident's urethra down to the resident's middle thighs. The catheter tube was not secured to the resident's leg and was visibly pulling from the resident's urinary tract when RN C cleaned the tube with a soapy cloth. The catheter tube was cloudy with visible urinary sediment (caused by the precipitation of calcium, phosphorous and magnesium minerals in the urine). RN C cleaned the catheter tube and then wiped the inside of the resident's inner thighs. The resident had dark brown, foul smelling matter in between his/her upper thighs and groin area. RN C put the catheter bag onto the resident's bed and turned the resident to his/her right side. Urine was flowing back up from the collection bag half way up the tube towards the resident's urethra. RN C wiped the back of the resident's thighs and wiped away a moderate amount of dark brown, foul smelling matter. There was dried foul smelling brown matter on the resident's buttocks. RN C rolled the resident to his/her back, took the catheter collection bag off of the resident's bed and emptied the contents into a urinal. The urine was foul smelling, dark yellow with visible white sediment present. RN C emptied the urine into the toilet and went back to care for the resident after washing his/her hands and donning gloves. Certified Nursing Assistant (CNA) E came into the room to assist RN C with dressing the resident and transferring him/her from the bed into the wheelchair. While dressing the resident, RN C and CNA E rolled the resident back and forth several times with the catheter bag hanging off of the side of the bed. The catheter bag would bounce from the floor and get pulled up the side of bed, almost to the mattress, each time the staff would turn the resident from the right side to the left. The tube was not secured to the resident's thighs and was visibly pulling up and down inside of the resident's urethra. After the resident was dressed in sweat pants, the catheter tube was again underneath the resident's right stump, compressed by the weight of the limb. RN C and CNA E transferred the resident to his/her wheelchair using a mechanical lift. While securing the resident to the mechanical lift, his/her catheter bag dangled off the side of the bed, lying a few inches off the floor. When moving the mechanical lift into position, CNA E hit the catheter bag with the legs of the machine and the CNA kicked the catheter bag out of the way with his/her foot. CNA E raised the resident out of his/her bed, using the mechanical lift, and placed the catheter bag on the resident's lap. The resident was lowered into his/her wheelchair, which was reclined back and had its footrest extended out. The resident's catheter tube was visible underneath his/her right stump, crossed to the left over the extended footrest and was placed inside of a pocket on the left side of the wheelchair by CNA E. There was visible urine in the tube right above where it was compressed by the resident's right stump. There was no urine visible below the compressed catheter tube. During an interview on 3/10/25 at 11:30 A.M., RN C said: -The dark brown, foul-smelling matter found on the resident's catheter, inner thighs and groin was stool; -Stool around or on the catheter tube could cause a bladder or kidney infection as the bacteria could travel into the resident's urethra; -The cloudy, dark yellow urine with visible sediment could be a sign of a UTI or kidney infection; (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 B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's catheter tube should be free of any object that could occlude the urine flow from the resident's bladder into the collection bag to avoid the risk of urine backing up into the bladder, causing infection. Observations on 3/10/25 at 1:37 P.M. and at 2:27 P.M., showed the resident sitting in his/her wheelchair, reclining back with the footrest extended. The resident's catheter tube was visible underneath the resident's right stump, extending out over the left side of the footrest and disappearing into the left pocket of the wheelchair. There was no urine visible in the catheter tube. During an interview on 3/12/25 at 8:11 A.M., the Director of Nursing (DON), said: -She expected nursing staff to have knowledge of and to follow facility policies; -She expected nursing staff to follow care plans; -She expected CNAs to clean resident's catheter tubes throughout their shift when providing perineal care at least a few times during their eight hour shift; -She expected nurses to clean residents' catheter tubes from the point of insertion, down towards the resident's legs once a shift to decrease the risk of infection and to monitor the Foley catheter system (the catheter tube and collection bag); -She expected residents' catheter tubes, inner thighs and groin to be free of stool, as it increased the risk of bacteria entering the resident's body through the urethra, causing infection; -She expected residents with catheters to have physician orders for cleaning and when to change the Foley catheter with the catheter size; -She expected nurses to follow up with the Primary Care Physician and get catheter care orders if they were missing on the physician order sheets; -A cloudy catheter tube could be a sign of infection or that the tube was dirty and needed changed; -She expected nursing staff to secure the catheter tube to the resident's leg so that it did not pull on the resident's urethra causing damage and trauma to the area; -Catheter tubes and collection bags should positioned hanging down below the resident's bladder at all times, without anything on top of the tube occluding the flow of urine; -Catheter bags should always be attached lower than the resident's bladder on the same side in which the resident was lying or on the same side the resident's leg the tube was positioned on; -Having the catheter collection bag move up and down the side to the mattress, on and off the floor, kicked by a staff member's foot was an infection control risk and could cause trauma to the resident's urethra; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Occlusion of the catheter tube could cause urine to stagnate in the bladder (as it can not flow freely out of the body), or to flow back into the bladder which increased the risk of bladder, urinary tract or kidney infections, damage to the urinary system and pain to the resident; -Cloudy dark yellow urine with sediment visible could be a sign of possible infection. MO00249022

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	265883	A. Building B. Wing	01/28/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to address an order of increased fluids from the Primary Care Physician (PCP) on 9/10/24 and again on 11/22/24 from the Registered Dietitian (RD) for a resident with diagnoses of severe malnutrition, renal (kidney) disease and abnormal lab values, for one out of three sampled residents (Resident #3). This resulted in the resident's hospitalization with the admitting diagnoses of renal failure, hypernatremia (high sodium levels in the blood) and altered mental status. The census was 84. Review of the facility's Nutrition and Hydration to Maintain Skin Integrity policy, revised October 2010, showed: -Purpose: The purpose of this procedure is to provide guidelines for the assessment of resident nutritional needs, to aid in the development of an individualized care plan for nutritional interventions, and to help support the integrity of the skin through nutrition and hydration; -When there is a decline in a resident's appetite, nutritional intake, weight, or overall condition, caregivers should first attempt to discover the factors compromising nutritional status and offer support with eating; -If intake continues to be inadequate, impractical or impossible, nutritional support must be implemented according to the plan of care; -Ensure that the resident's intake of fluid is sufficient. Sufficient fluid" means the amount of fluid needed to prevent dehydration and maintain health; -The Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition; -The specific amount of hydration needed is specific for each resident, and fluctuates as the resident's condition fluctuates; -Risk factors for dehydration include: fluid loss and increased fluid needs (e.g. uncontrolled diabetes), functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs, or dementia in which a resident forgets to drink or forgets how to drink; -Review supportive ancillary documentation that impacts the nutritional assessment, including, but not limited to, the food and fluid consumption record (Appetite Sheet), weight and height records, laboratory results, and nursing notes; -Implement nutritional support and interventions according to the plan or care. Review of Resident #3's Physician Order Sheet (POS), dated August 2024, showed: -An order, dated 6/14/24, for regular diet, mechanical soft texture, regular/thin consistency, a snack at night and Boost (a nutritional supplement for diabetics) three times a day. Use a divided plate; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 8/21/24, for labs, including a complete metabolic panel (CMP, measures 14 substances in the blood to assess metabolism, kidney and liver function and electrolyte and fluid balance). Review of resident's lab report, dated 8/30/24, showed: -On 8/30/24 at 2:30 A.M., the blood sample was collected; -On 8/30/24 at 9:34 A.M., the blood sample was received by the lab; -On 8/30/24 at 11:35 A.M., the final report for the CMP was completed; -Sodium (measures the amount of sodium in the blood. Normal ranges are between 136 milliequivalents per liter (mEq/L) and 145 mEq/L) measured within normal range at 142 mEq/L; -Creatine (measures how well kidneys are functioning, normal levels are between 0.7 milligrams per deciliter (mg/dL) and 1.3 mg/dL. High levels of creatine can show kidney disease or dehydration) measured high at 1. 4 mg/dL; -Blood urea nitrogen (BUN, measures the amount of urea nitrogen in blood, showing how well kidneys are functioning. Normal levels are between 10 mg/dL to 22 mg/dL. High BUN could indicate kidney problems) measured high at 30 mg/dL; -BUN to Creatine ratio (blood test that measures the levels of urea nitrogen and creatinine. Normal levels are between 8.6 to 16.7. A high BUN to creatinine ratio could indicate kidney problems or dehydration) measured high at 21.4286; -An order, dated 9/10/24, was handwritten by the PCP on the lab report to push fluids. Review of the resident's POS, dated September 2024, showed: -There was no order found to push fluids. Review of the PCP progress note, dated 11/11/24, showed: -The resident had generalized muscle weakness, was not well-looking, chronically ill and appeared poorly nourished; -The resident reported confusion, disorientation, memory lapse or loss, gait abnormality, difficulty with balance and poor coordination; -Plan of Care included to follow up with weight management; add Remeron (an appetite stimulant) 7.5 milligrams (mg) at night due to severe malnutrition. Review of the resident's Medication Administration Record (MAR), dated November 2024, showed: -An order, dated 11/11/24, discontinued on 11/19/24, for Remeron 7.5 mg, give once at bedtime for weight loss; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Documentation showed the facility administered the medication as ordered seven out of the eight opportunities. Review of the resident's progress notes, from 11/11/24 through 11/19/24, showed: -No documentation was found showing an order was given to discontinue the Remeron on 11/19/24. Review of the resident's Nutrition/Dietary Note, dated 11/22/24 at 12:23 P.M., showed: -The resident had a significant weight gain from 10/10/24 weight of 103.4 pounds (lbs) to 124.4 lbs on 11/8/24; -The resident height was 68 inches and current Body Mass Index (BMI, measured body fat based on height and weight) was 18.9, which was low for his/her age; -The RD believed the resident's October weight was inaccurate as there were no diagnoses or medications noted that could to contribute to weight fluctuation; -The resident was prescribed a mechanical soft diet with thin liquids, with special instructions to use a divided plate; -Supplements included Ensure (nutritional shake) three times a day (TID) and a snack at night; -Most recent labs from 8/30/24, showed creatine high at 1.4 mg/dL and BUN high at 30 mg/dL; -The PCP noted on the lab results to push fluids; -The RD recommended to update diet order to state push fluids 500 milliliters (ml)/2 cups at meals and 250 ml/1 cup in between; -The RD will continue to monitor weight, by mouth (PO) intake and labs as available; -The goal was to improve nutrition related labs and maintain weight plus four percent. Review of the resident's MAR, dated November 2024, showed there was no order to push fluids 500 ml at meals and 250 ml/1 cup between meals. Review of the resident's care plan, undated, showed: -Problem: The resident was at risk for unplanned/unexpected weight loss due to diagnosis of severe protein calorie malnutrition; -Interventions included: give supplements as ordered; give diet as ordered; push fluids 500 ml/2 cups at meals and 250 ml/1 cup in between meals, initiated on 11/22/24. Review of the resident's POS, dated December 2024, showed: (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 12/10/24, to push fluids 500 ml at meals and one cup in between meals, five times a day for hydration. Review of the resident's MAR, dated December 2024, showed: -An order, undated, to push fluids 500 ml at meals and 1 cup in between meals five times a day for hydration; -Documentation showed from 12/10/24 at 11:00 A.M. through 12/23/24 at 8:00 A.M., the facility documented they followed the order as written 15 times out of 65 opportunities; -Documentation showed the facility failed to follow the order three out of five opportunities on 12/19/24, 12/20/24 and on 12/21/24; -Documentation showed the facility failed to follow the order once out of five opportunities on 12/22/24. Review of the resident's progress note, showed: -A note, dated 12/16/24 at 2:34 P.M., an order was received from the PCP to obtain labs, including a CMP; -A note, dated 12/16/24 at 4:44 P.M., the nurse was informed by the RRP that while the resident was out having a computed tomography (CT scan, combines a series of x-ray images taken from different angles around the body), the office informed him/her that the resident's creatine level was high. The nurse reported the information to the PCP. Review of the resident's POS, dated December 2024, showed: -An order, dated 12/17/24, for labs, including CMP, one time only for creatinine level. Review of the resident's lab report, dated 12/18/24, showed: -On 12/18/24 at 4:26 A.M., the blood sample was collected; -On 12/18/24 at 11:11 A.M., the blood sample was received by the lab; -On 12/18/24 at 1:55 P.M., the final report for the CMP was completed; -Sodium measured high at 156 mEq/L; -Creatine measured high at 1.76 mg/dL; -BUN measured high at 43 mg/dL; -BUN to creatine ratio measured high at 24.4; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-A handwritten note, unsigned and undated, showed a call was placed to the PCP to ensure orders were verified, to encourage fluids and repeat CBC and CMP labs in one month. Review of the resident's POS, dated December 2024, showed: -There was no documentation found to repeat CBC and CMP labs in one month; Review of the resident's progress notes, showed: -A note, dated 12/18/24 at 2:41 P.M., the resident's lab results were still pending and the nurse will pass the information on in report; -A note, dated 12/19/24 at 4:59 P.M., the resident's responsible part (RRP) called concerned the resident was getting fluids, stating he/she put a sports drink and water in the resident's personal fridge. The RRP stated the resident had a CT scan on Monday (12/16/24) and iodinate will need to get flushed out. The writer informed the RRP the resident was offered fluids. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/21/24, showed: -Severe cognitive impairment; -Required moderate assistance with eating; -Height of 68 inches; -Weight of 120 pounds; -Risk for pressure ulcers (a localized area of damaged skin or tissue that occurs when pressure is applied to the skin for a prolonged period of time); -No pressure ulcers present; -Diagnoses included non-traumatic brain dysfunction, hypertension (high blood pressure), kidney disease, Diabetes Mellitus, Alzheimer's disease, stroke, dementia and severe protein-calorie malnutrition. Review of the resident's progress notes, showed: -A note, dated 12/23/24 at 9:45 A.M., the resident was leaving the building with a family member for a doctor appointment; -A note, dated 12/23/24 at 11:47 P.M., a call was made to the RRP asked when the resident would return to the facility. The RRP stated the resident was sent to the hospital emergency department for evaluation on an order from the doctor during their appointment; (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-A note, dated 12/24/24 at 12:09 A.M., the nurse called the hospital emergency department and was informed the resident was admitted to the hospital. Admitting diagnoses were hyponatremia (low sodium in the blood), dehydration and altered mental status. During an interview on 1/28/25 at 12:20 P.M., the Director of Nursing (DON) said: -She expected nursing staff to have knowledge of and to follow facility policies; -She expected staff to be aware of and to follow resident's care plans; -It was the charge nurses' responsibility to take physician written orders off of lab results and put them into the resident's physician order sheet in the electronic medical record (EMR); -The DON read the RD's nutritional recommendations after his/her visit to residents and was responsible for putting the RD's orders into the residents' physician order sheet in the EMR; -If the DON was not present on the days the RD came in to assess residents, the RD would email his/her report and the DON was responsible for putting the RD's orders into the residents' physician order sheet in the EMR; -She expected all written, verbal or telephone orders entered into residents' physician order sheet in the EMR within 48 hours; -Residents' health could decline if orders were not put into the EMR in a timely manner; -She expected nurses to document in a progress note when an order was discontinued; -Both she and the Assistant Director of Nursing (ADON) were responsible monthly for reviewing EMRs to review if orders were put in correctly; -Both she and the ADON would review MARs occasionally, especially if a resident complained they were not getting medications; -She was not aware of any issues regarding orders not implemented or followed per the plan of care or PCP; -When there was a blank in the documentation on a MAR, it meant the order was not done; -She expected staff to follow orders and offer fluids to dependent residents; -She expected nurses to follow up with Certified Nursing Assistants (CNA) to ensure the residents were given fluids as ordered; -The residents were at risk of complications to their health related to possible dehydration and/or malnutrition if nursing staff did not administer fluids as ordered. During an interview on 1/30/25 at 2:58 P.M., the hospital charge nurse said: (continued on next page)

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	265883	A. Building B. Wing	01/28/2025

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