STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 04351 Based on interview and record review, the facility failed to ensure residents and/or responsible parties were notified in a timely manner when a resident's account was within the $200 social security (SSI) limit. This affected seven of eight residents who were either over the SSI limit or within $200 of the SSI limit (Residents #500, #501, #502, #503, #504, #505 and #506). The census was 75. Review of the facility's policy regarding resident funds (RFMS), revised on 5/1/20, showed when the resident's account reaches within the $200 limit set by the state of Missouri, the business office manager (BOM) or designee will utilize the RFMS letter and send to appropriate party. The policy did not have a time of when the BOM should send the notification. 1. Review of Resident #500's trust account (a Medicaid recipient), showed the following: -In February 2021, his/her account had $5,108.79 in it; -In April 2021, his/her account had $6,214.82 in it. Review of the letter notification to the resident, dated 4/14/21, showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was signed by the responsible party. Further review of the resident's ledger, showed as of 5/6/21, he/she had $6265.45 in his/her account. 2. Review of Resident #501's trust account (a Medicaid recipient), showed the following; -On 4/30/21, his/her account had $5686.26 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $5686.30 in his/her account. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #502's trust account (a Medicaid recipient), showed the following; -On 1/31/21, his/her account had $5148.07 in it; -On 2/28/21, his/her account had $5198.19 in it; -On 3/31/21, his/her account had $5248.31 in it; -On 4/30/21, his/her account had $5298.31 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $5298.42 in his/her account. 4. Review of Resident #503's trust account (a Medicaid recipient), showed the following; -On 1/31/21, his/her account had $6947.56 in it; -On 2/28/21, his/her account had $6997.31 in it; -On 4/30/21, his/her account had $5466.73 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $5466.77 in his/her account. 5. Review of Resident #504's trust account (a Medicaid recipient), showed the following; -On 3/31/21, his/her account had $6141.36 in it; -On 4/30/21, his/her account had $6136.15 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $6186.21 in his/her account. 6. Review of Resident #505's trust account (a Medicaid recipient), showed the following; -On 3/31/21, his/her account had $6644.34 in it; (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/30/21, his/her account had $7479.38 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $7529.97 in his/her account. 7. Review of Resident #506's trust account (a Medicaid recipient), showed the following: -On 4/30/21, his/her account had $6217.12 in it. Review of the letter notification to the resident, dated 5/6/21 (the date of the survey), showed he/she was within $200 or exceeding what is allowable under medical assistance. The letter asked for the responsible party to respond within 7 days. The letter was not signed by the resident, responsible party or the facility representative. Further review of the resident's ledger, showed on 5/6/21, he/she had $6399.17 in his/her account. 8. During an interview on 5/6/21 at 1:10 P.M., the BOM said she was behind with sending out the letters. There are some residents who don't want to spend their money. She was not sure why some of the letters were not sent out on time. The company RFMS will send her a list of who is getting close to the SSI limit.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 04351 Based on interview and record review, the facility failed to ensure they maintained a surety bond for the resident trust fund account in the amount of one and one half times the average monthly balance for the past 12 months. The census was 75. Review of the facility's policy regarding resident funds (RFMS), revised on 5/1/20, showed no instructions on how to monitor the facility's surety bond to ensure it was sufficient. Review of the resident trust account for the past 12 months, from April 2020 to March 2021, showed an average monthly balance of $147,000. (This would yield a required bond in the amount of $220,500 (one and one half times the average monthly balance)). Review of the bond report for approved facility bonds by Department of Health and Senior Services (DHSS), showed an approved bond of $120,000, dated 1/30/15. Review of the ending balance for April 2021, showed an amount of $167,072.65. Review of the Surety Rider provided by the facility, showed an increase on 1/13/21 for $200,000. The Rider did not show it had been submitted to DHSS for approval. During an interview on 5/06/21 at 2:11 P.M., the business office manager said the corporate office is responsible for the oversight of the Rider.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure staff provided complete privacy for residents by failing to close the room door and pull a privacy curtain for one resident exposed during a skin assessment (Resident #45), and by failing to provide a privacy curtain for another resident a semi-private room (Resident# 224). The census was 75. 1. Review of Resident #45's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/12/21, showed: -admitted [DATE]; -Adequate hearing/vision; -Clear speech - distinct intelligible words; -Ability to express ideas and wants: Sometimes understood; -Ability to understand others: Sometimes understands; -Brief Interview for Mental Status (BIMS) score of 03 out of a possible 15 (a score of 0-07 indicates severe cognitive impairment); -Total dependence of two (+) persons required for transfers; -Total dependence of one person required for bed mobility, locomotion on/off the unit, dressing, eating, toilet use, personal hygiene and bathing; -Diagnoses of osteoporosis (weak bones), stroke, hemiplegia (paralysis of one side of the body) or hemiparesis (weakness of one side of the body) and multiple sclerosis (a chronic disease affecting the central nervous system (the brain and spinal cord)). Observation on 5/6/21 at 5:18 A.M., showed the resident lay in bed beneath covers, wearing a hospital gown and incontinence briefs. The resident's room was a semi-private room and his/her bed was closest to the door. Certified Nursing Assistant (CNA) R assisted with the resident's skin assessment. The CNA entered the resident's room. Without shutting the room door or pulling the privacy curtain around the resident's bed, the CNA pulled the resident's gown up, exposing the resident's chest, and removed the resident's incontinence brief, exposing the resident's genitalia and buttocks, as the resident was being positioned during the skin assessment. The resident was exposed to the hall during the assessment while other staff walked up and down the hallway in view of the room. 2. Review of Resident #224's medical record, showed: -admitted [DATE]; -Diagnoses included depression; (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A BIMS evaluation, dated 4/9/21, showed the resident with moderate cognitive impairment. Observations on 5/3/21 at 8:42 A.M., 9:09 A.M., 10:47 A.M., 11:45 A.M., 12:27 P.M. and 1:06 P.M., showed the resident lay in bed, dressed in a hospital gown. The resident's room was shared with a roommate, and his/her bed was closest to the door. A catheter bag hung on the resident's right side of the bed with pink-tinged urine and thick strings of mucus in the catheter tubing, visible from the doorway to the room. No privacy curtain hung by the resident's bed. At 2:38 P.M. the Assistant Director of Nurses (ADON) and wound nurse entered the resident's room and shut the door. At 3:12 P.M., the wound nurse exited the resident's room. As the resident's door was open, the resident lay on his/her right side in bed with the hospital gown pulled up, leaving his/her stomach and upper pubic area exposed, fully visible from the hallway. Observations on 5/4/21 at 7:02 A.M., 7:48 A.M., 9:11 A.M., 10:10 A.M. and 1:02 P.M., showed the resident lay on his/her back in bed, dressed in a hospital gown. A catheter bag hung on the resident's right side of the bed with pink-tinged urine and thick strings of mucus in the catheter tubing, visible from the doorway to the room. No privacy curtain hung by the resident's bed. Observations on 5/5/21 at 7:35 A.M., 9:47 A.M., 11:27 A.M. and 1:01 P.M., showed the resident lay in bed, dressed in a hospital gown. A catheter bag hung on the resident's right side of the bed with pink-tinged urine and thick strings of mucus in the catheter tubing, visible from the doorway to the room. No privacy curtain hung by the resident's bed. 3. During an interview on 5/14/21 at 12:01 P.M., the Director of Nurses (DON) and administrator said when a resident is receiving care or is going to be exposed, staff should pull the privacy curtain around the resident's bed and close the door to their room. All residents should have their own privacy curtain to maintain the resident's privacy. 40290

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to establish and implement a grievance policy to ensure the prompt resolution of all grievances, that included the grievance official receiving and tracking grievances through to their conclusion. The facility census was 75. Review of the facility's Resident/Patient/Family grievance policy, dated 1/14/19, showed the following: -Protocol: A resident/patient and/or family member has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; -The facility will provide residents/patients and their family members with prompt efforts to resolve grievances, including those with respect to the behavior of other residents/patient and/or staff; -Procedure: The facility has a grievance officer that is central to managing the grievance process and is the key contact for residents that wish to file a grievance. The grievance officer is the director of social services; -Residents will be notified of the grievance process and the grievance officer in person or by posting. They will be notified of their right to file the grievance orally or in written format, that they may file anonymously, the contact information of the grievance officer, the right to obtain a written decision regarding the grievance and the contact information of the pertinent state agencies such as state survey agency and Ombudsman office; -Encourage the resident to first notify the nurse manager, DON or administrator if they feel a need to express, file or otherwise communicate a concern and if the issue can be addressed immediately; -Any complaints that involve abuse, neglect, misappropriation and financial exploitation will be reported to the administrator and state authorities in accordance with federal and state guidelines; -Residents have the right to express grievances in a confidential manner, anonymously if desired, and have the grievance overseen by the director of social services who is also the resident advocate. If the resident requests, the local ombudsman may be also involved; -Grievances can be submitted to any nurse, manager, or directly to the director of social services and may be communicated in writing or verbally; -Grievance forms are available at each nursing station. Staff are also able to help provide a grievance form; -The forms may be submitted directly to the director of social services. If unavailable, the grievance can be submitted to the administrator, DON and manager on duty; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility will follow up on the grievance with the resident or family member in a reasonable timeframe, within three days and no later than five days; -The facility will keep grievances and the grievance log on file for three years; -The facility will maintain a log to track the grievance process, types of grievances and the process. Appropriate action will be taken to resolve the grievance; -Provide direction and information on how to contact other outside sources for assistance in filing complaints and/or grievances. This information will be provided in admissions, social services, and will be posted throughout the facility regarding how and where to contact such sources. 1. During an interview on 5/4/21 at 10:00 A.M., four of five residents who attended the resident council meeting said they received no responses to grievances they filled out or they did not know how to file one. Staff will take their grievances, and then no one gets back with them and they do not know what happens to the grievance. They do not like having to go to the nurse's station to get a grievance form because then staff know they are filling one out. Sometimes the social services director will come talk to them, but often they do not hear anything. They do not worry about retaliation because staff know no one is going to do anything about the grievance. 2. Review of Resident #525's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/26/21, showed: -admitted on [DATE]; -Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -Brief Interview for Mental Status score of 14 out of a possible 15 (a score of 13 - 15 indicates cognitively intact); -No behavioral symptoms. During an interview on 5/12/21 at 9:25 A.M., resident #525 said he/she did not know how to fill out a formal grievance. He/she complained to a nurse a couple of weeks prior about staff rudeness, and the nurse told him/her he/she would file a grievance for the resident, but the resident never heard anything back. He/she did not know where to get a grievance to fill out or who to talk to about filling out one. 3. Review of Resident #64's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -Brief Interview for Mental Status score of 15 (a score of 13 - 15 indicates cognitively intact); -No behavioral symptoms. During an interview on 5/12/21 at 11:15 A.M., resident #64 said he/she did not know how to fill out a grievance form or where they were kept. If if he/she had an issue, he/she would just have to report it to the nurse on duty. 4. During an interview on 5/12/21 at 8:15 A.M., the social services director said grievances are kept at the front desk and at the nurses stations. The residents would fill it out and bring it to her. Who responded to the grievance depended on the residents' concerns. She would give it to nursing if it was a nursing complaint, dietary if it was a food complaint and housekeeping if it was a housekeeping complaint. She would expect that person to get back with the resident and address the complaint. He/she did not check back with the staff or resident to see if the complaint was addressed. The problem was that staff did not always communicate well, so she might not be aware of how the grievance was handled. She did not always get a copy of the completed grievance. The grievances would be filled out by the person who addressed it, and then a copy would be kept in a book in the medical records office. Review of the grievances filed in the medical records office on 5/12/21 at 8:25 A.M., showed two completed grievances since 1/1/21. During an interview on 5/12/21 at 10:15 A.M., Certified Nurse's Aide F said he/she did not know where grievances were kept. He/she thought residents had to get them from the social services director. During an interview on 5/12/21 at 10:20 A.M., Licensed Practical Nurse (LPN) B said the grievances were kept at the nurse's station in a binder. If a resident filled one out, he/she would give it to the Assistant Director of Nursing, the Director of Nursing or the social services director. Once LPN B gave the form to the residents, he/she would not be expected to follow through with the residents to see if their concerns had been addressed. He/she had never been given a grievance to investigate. During an interview on 5/12/21 at 10:55 A.M., LPN A said he/she thought the grievances were kept at the nurse's station and the front desk. He/she would turn them in to the administrator or the social services director after residents filled them out. He/she had never been asked to investigate a grievance or talk to a resident about the results of one. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/21 at 1:30 P.M., the administrator said someone should get back with the resident with a response to all grievances filed. Grievances get turned into social services or him. They might assign someone to handle it but social services is supposed to get back with them to make sure it is resolved. The form would then go back to social services and be filed. He did not realize that residents did not feel comfortable getting grievance forms from the staff at the nursing stations. Residents should be informed at admission about the grievance procedure.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 27723 40290 Based on observation, interview and record review, the facility failed to ensure residents were free from physical restraints and when restraints were indicated, to document ongoing re-evaluation of the need for restraints for one resident (Resident #59). The sample was 18. The census was 75. Review of the facility's Restraint Alternatives policy, revised 6/3/19, showed: -Protocol: The purpose of the Restraint Alternatives Protocol is to implement individualized interventions for any resident/patient being assessed for or using a physical restraint. The goals of the Restraint Alternatives Protocol are to utilize restraint alternatives instead of or in conjunction with a restraint reduction plan, and optimize dignity and independence; -Procedure: -Review interdisciplinary assessments and documentation; -Include resident/patient/family and/or responsible party in the development of the interdisciplinary plan of care (IPOC); -Identify and implement immediate restraint alternatives. Alternatives include implementing seat belts for residents that are capable of taking or unbuckling; -Communicate interventions to staff on Kardex, individual resident care plan, and in clinical operations morning meeting; -Evaluate effectiveness of restraint alternatives such as each IPOC meeting and as needed (PRN); -Review and revise IPOC to reflect restraint alternative interventions; -Educate resident/patient/family and/or responsible party on restraint alternatives; -Restraint - Least Restrictive: -Protocol: The facility recognizes that a physical restraint may be required when resident/patient's medical symptoms lead to behaviors that threaten their safety or the safety of others, restraint alternatives are determined to be ineffective, or resident has medical conditions that may benefit from short-term use of physical restraints. Restraints include lap cushions, tap trays, or safety belts the resident/patient cannot remove; -Procedure: -Review and update all interdisciplinary documentation; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reevaluate and verify documentation on restraint alternative interventions used to treat the underlying causes of the medical sign/symptoms; -Complete and review the Assessment Tool; -Obtain physician's order for restraint, including medical symptoms requiring restraint use, type of restraint, length of time restraint is to be used, and plan for resident reduction/elimination; -Do accept orders for as needed (PRN) restraint use; -Provide the Physical Restraint Information sheet to the resident/patient or responsible party. If the resident/patient/family or responsible party refuses to the use of a restraint, document refusal in the medical record; -Check and release resident/patient at least every two hours and according to the IPOC; -Reassess resident/patient status at the IPOC meeting at least monthly and/or with any change in medical symptoms to evaluate effectiveness of restraint or enabler to treat identified medical symptoms, evaluate results of restraint reduction plan, and evaluate effectiveness of interventions to minimize or eliminate the medical symptoms being treated by the restraint. Review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/21, showed the following: -Diagnosis of multiple sclerosis (MS); -No short/long term memory loss; -Required total staff assistance for bed mobility, transfers, dressing, eating, toilet use, personal hygiene and bathing; -No trunk restraint used. Review of the resident's care plan, updated 4/8/21, showed the following: -Focus: Resident has an ADL self care performance deficit related to (r/t) MS. Requires total care from staff. Uses an electric wheelchair to navigate throughout the facility; -Interventions: Resident requires Hoyer Lift (machine used to transfer dependent residents) with two staff assistance for transfers; -No documentation regarding the use of a seat belt or trunk restraint. Observations and interviews, showed the following: -5/03/21 at 12:26 P.M.: Resident up in electric wheelchair with belt on. He/She couldn't remove it when asked by this surveyor; (continued on next page)

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Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/04/21 at 10:49 A.M.: Resident in his/her electric wheelchair. The resident stated he/she had a fall from the his/her electric wheelchair a while ago. That is when staff put the seat belt on; -5/05/21 at 11:05 A.M.: Resident outside in his/her electric wheelchair with the seatbelt attached, visiting with family; -5/12/21 at 12:30 P.M.: Resident in his/her electric wheelchair with his/her seat belt attached. Certified Medication Technician (CMT) AC in resident's room. This surveyor asked resident to remove his/her seat belt. He/She was unable to do so. During an interview on 5/14/21 at 7:35 A.M., the MDS coordinator said she was unaware the resident wore a seat belt. If she had known he/she was wearing a seat belt, she would have care planned it. Therapy assesses residents for seat belts and once assessed, they give their recommendations to the MDS Coordinator and he/she adds it to the resident's care plan. The MDS Coordinator is responsible for updating care plans. During an interview on 5/14/21 at 11:47 A.M., the Director of Nursing (DON) said residents should be assessed to determine if they can remove seat belts without assistance. If the resident is unable to remove it, it should be care planned as a restraint. The resident's seat belt was not assessed or care planned. It should have been. During interviews on 5/14/21 at 1:06 P.M. and 1:41 P.M., the DON said lap belts/seat belts should be assessed for use and the purpose of use should be documented in the resident's record. Once a resident is determined to need a lap belt, they should be reassessed for use of the device on an ongoing basis. The Therapy Screen Forms completed by the OT therapist, should include a detailed assessment for the use of a seat belt. Staff should also be checking lap belts routinely for safety.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04351 Based on interview and record review, the facility failed to follow their policy by failing to thoroughly investigate concerns made by family members on behalf of two residents regarding alleged mistreatment by staff members (Residents #15 and #379). In addition, the facility failed to ensure new employees did not have potential contact with residents prior to conducting criminal background and the employee disqualification check for three of nine sampled staff. The census was 75. Review of the facility's abuse prevention policy dated 2/19, showed: -Prevention and reporting: The administrator has primary responsibility in the facility for 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. Abuse shall include physical harm, pain, mental anguish, verbal abuse, sexual abuse or involuntary seclusion; -The facility encourages and supports all residents, staff and families in feeling free to report any suspected acts of abuse, neglect, misappropriation or injury of unknown origin. The facility takes all measures possible to ensure that residents, staff and families are free from fear of retribution if reports or incidents are filed with the facility; -Reports of abuse will be promptly reported and thoroughly investigated. Additionally the facility should immediately report all such allegations to administrator/designee and to the Department of Health and Senior Services. In cases where a crime is suspected staff should also report the same to local law enforcement; -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 facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property; -The facility has implemented the following processes in an effort to provide residents/patients and staff a safe and comfortable environment; -The shift supervisor (charge nurse, nurse manager or administrator) is identified as responsible for immediate initiation of the reporting process; -The administrator and Director of Nursing are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect and/or misappropriation of property standards and procedures: *Implementation; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Ongoing monitoring; *Reporting; *Investigation; *Tracking and trending; -Implementation and ongoing monitoring consist of the following: *Screening; *Training; *Prevention; *Identification; *Protection; *Investigation; *Reporting; -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; -Initiate the investigation, 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, and interview with the resident if possible, a review of the residents medical record, an interview with staff members having contact with the resident during the period of the alleged event, interviews with resident's roommate, family members and visitors, a review of all circumstances surrounding the incident; -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: Any person witnessing or having knowledge of alleged violation of involving abuse, neglect, misappropriation or injury of unknown origin are to notify the administrator or Director of Nursing immediately; -The administrator or Director of Nursing or designee to report to the regional clinical manager; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Notify the appropriate state agency(s) immediately of allegations or suspicious of abuse, neglect or injury of unknown injury by fax or telephone after identification of alleged/suspected incident. Allegations or suspicion of mistreatment of resident property or exploitation are to be reported to the state agency immediately and no later than 24 hours upon discovery; -Reports of abuse, neglect and injury of unknown origin are to be made to the state agency immediately, but no later than two hours from the allegation being made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hour if the event that cause the allegation do not involve abuse or result in bodily injury; -Follow reporting requirements as outlined by the state agency. 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/18/21, showed: -admitted [DATE]; -Adequate hearing/vision; -Clear speech - distinct intelligible words; -Ability to express ideas and wants: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others: Usually understands - misses some part/intent of message but comprehends most conversation; -Brief interview for Mental Status (an assessment used to determine cognitive status) score of 07 (a score of 0 -07 indicates severely impaired cognition); -No hallucinations or delusions; -No physical, verbal or other behaviors noted; -Wandering: Behavior not exhibited; -Rejection of care: Behavior not exhibited; -Limited assistance of one person required for bed mobility; -Extensive assistance on one person required for transfers, dressing, toilet use, personal hygiene and bathing; -Supervision - oversight, encouragement or cueing required for eating; -Independent for locomotion on/off the unit; -Functional limitation of both lower extremities; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mobility device: Wheelchair; -Diagnoses of renal (kidney) insufficiency, diabetes mellitus, stroke, hemiplegia (the complete loss or paralysis on one half of the body) or hemiparesis (minor to severe weakness of one half of the body) and manic depression (alternating moods of abnormal highs (mania) and lows (depression)). Review of a facility self-report to the DHSS, dated 5/12/21 at 10:22 P.M., showed: -Resident's family contacted the Admission Coordinator on 5/12/21 and stated the night shift staff (Night shift hours for Certified Nursing Assistants (CNAs) is 6:00 P.M. until 6:00 A.M.) had been rude to the resident. Administrator arrived on the night shift on 5/12/21 at approximately 7:30 P.M. and interviewed resident. Resident claimed that a staff member had been verbally rude, insulting him/her and had been physical with him/her. He/she claimed a Certified Nursing Assistant had pushed him/her on the night shift of 5/7/21. During an interview on 5/13/21 at 8:45 A.M., the Admission Coordinator (AC) said yesterday, 5/12/21 around 3:00 P.M., the resident's family contacted her by phone about sending the resident to another facility. During the conversation, the family member told her the resident was having problems with two Certified Nursing Assistants (CNAs) on the night shift. They threatened to throw the resident out of his/her wheelchair. The resident had fallen once and those same CNAs left him/her on the floor longer than he/she should have been. The AC said she was surprised as she speaks to the resident most every day and he/she had not mentioned that to her. She did not go and speak to the resident after the phone conversation because she went to the daily management meeting and told the Administrator what the family had said. During an interview on 5/13/21 at 9:13 A.M., the resident said an agency staff member, he/she was not sure if they were a CNA or a Nurse, but on the night shift was mean to him/her. The staff member hit him/her on his/her head around the mouth. This happened last Friday when he/she wanted to go into Resident #12's room to speak to him/her. Resident #12 was asleep in his/her recliner. The staff member came down the hall and would not allow him/her to go into the room. The staff member called him/her an ignorant bastard. The staff member hit him/her with his/her fist, then pulled Resident #12's door shut. Both he/she and the staff member left Resident #12's room at that time. The resident had no facial bruising noted during the interview. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/21 at 10:10 A.M., the administrator said the AC told him yesterday in their meeting around 3 o'clock. All he heard the AC say was Resident #15 said someone had been rude to him/her so he did not think it had anything to do with abuse at that time. He ended up leaving the facility and going home before returning between 6:00 P.M. and 6:30 P.M. to speak to the resident. He did not designate anyone to speak to the resident before he left to go home. It was not until he returned and spoke to the resident that he learned the resident claimed verbal abuse. He did not know what the facility policy showed in regards to initiating an abuse/neglect investigation although he did help write the policy. He said the resident did not tell him anything about being struck or threatened to be pushed out of his/her wheelchair. All the resident said was staff had verbally abused him/her. He reviewed the video of the resident and the CNA from 5/7/21, Friday evening. At that time the Administrator played the video that had no audio, and showed a CNA walking with Resident #15 towards Resident #12's room. Resident #15 was in his/her wheelchair. At the doorway of Resident #12's room, the CNA blocked the resident from entering by standing in the doorway. The CNA was not observed striking the resident. The CNA eventually stepped behind the resident, grabbed the handle bars on the back of the resident's wheelchair and pull the resident backwards a minimum of 4 or 5 feet away from Resident #12's door to the other side of the hall before letting go. The resident appeared to be upset by this and left the area at that time. The entire encounter lasted approximately two minutes. The administrator said the CNA should not have dragged Resident #15 backwards away from the door. The CNA should have asked Resident #12 if Resident #15 could come in. The CNA was suspended pending an investigation. During an interview on 5/13/21 at 10:40 A.M., Resident #12 said he/she liked Resident #15 and thought of Resident #15 like a son/daughter. Resident #15 is welcome to come in his/her room any time. Had the staff member woke him/her and asked if Resident #15 could come in he/she would have said yes. He/she had not heard what the staff member said to the resident and had not seen the resident hit by anyone. During a telephone interview on 5/13/21 at 10:48 A.M., the resident's family member confirmed what he/she had told the AC on 5/12/21. He/She added it was not the first time he/she had reported the resident had problems with two night shift staff. Approximately six months ago, he/she spoke to someone at the facility, but was not sure if it was the AC or the Social Service Director regarding the resident alleging two staff members threatened to throw him/her out of his/her bed or wheelchair. The family member said he/she never heard back from the facility after alerting them to his/her concerns. Review of DHSS complaints, showed no other complaint listed for Resident #15. Review of the resident's progress notes, including social service notes on 5/13/21, showed no documentation regarding a family member complaining about the resident's treatment by staff. During an interview on 5/13/21 at 1:49 P.M., the Social Service Director said she did not recall having any previous conversations with that family member, but did recall another family member telling her the resident was having trouble with the night shift staff. It was how they were approaching him/her. The way they were speaking to him/her. The family member did not know the names or titles of the staff. She could not recall how long ago that conversation took place and she did not document it. She did tell the Administrator and Director of Nurses (DON). She did not know if anyone followed up or not. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/21 at 2:15 P.M., the DON said she attended the meeting yesterday at 3:00 P.M. Everyone was talking at once and there was a lot of conversations going on. The AC was at the other end of the table from where she and the Administrator were sitting so she did not hear what the AC said. She did not recall the SSD telling her that the resident had a problem with two night staff a few months ago. She started at the facility in late February of this year. During an interview on 5/14/21 at 8:09 A.M., the Business Office Manager said she attended the management meeting on 5/13/21 at 3:00 P.M. She was sitting close to where the AC sat. She recalled the AC saying to everyone that the resident's family had called and said the resident was having problems with the night shift staff. She did not hear any specific details. The Administrator did not respond to AC after she announced it. She was not even sure the Administrator heard what AC had said as everyone was talking. During an interview on 5/14/21 at 8:59 A.M., the resident confirmed he/she had told his/her family that two night shift staff threatened to push him/her out of his/her wheelchair a few months ago. During an interview on 5/14/21 at 10:30 A.M. the Administrator denied being told by the SSD the resident had problems a few months ago with two night shift staff threatening to throw the resident out of his/her wheelchair. He was only aware of the problem the resident told him about on 5/12/21. 2. Review of Resident #379's admission MDS dated [DATE], showed: -Date of admission 8/15/19; -Diagnoses included cerebral palsy, malignant neoplasm of colon, sleep apnea and history of falling; -Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -Brief Interview for Mental Status score of 14 (a score of 13-15 indicates cognitively intact); -Extensive assistance of one person needed for bed mobility, transfers and dressing; -Total dependence needed for toilet use; -One person assistance needed for showers. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress notes dated 9/23/19 at 9:56 A.M., showed staff had a small care plan meeting with the resident's family member/power of attorney because of allegations at recent emergency room visit. The family member said he/she received calls from the hospital that residents were snotty and aides were too rough for showers. The family member wanted staff to be aware the resident could be manipulative and worried the resident acted like this because he/she wanted to return to a group home. The staff member assured the family member the transition was very difficult but they would work through it. The staff member explained the resident had been different since a visit from group home staff. He/she was more withdrawn and argumentative with residents but would apologize and move on when talked to by staff. The staff member assured the family member would educate staff on being extra gentle as the resident's diagnosis might make him/her perceive care differently. The staff member spoke to the resident and explained anytime he/she feels like residents are rude or staff are rough that he/she could talk to the staff member or social services so it could be addressed immediately. The family member was thankful for the meeting. Review of an investigative summary provided by the facility on 5/13/21, showed staff was informed of the allegation after the hospital called the family member on or about 9/22/19. The allegation was vague, the resident did not name any staff and simply claimed staff were rough in the shower. The resident had a diagnosis of cerebral palsy. He/she yelled during showers and when being transferred or walked. The resident was argumentative with behaviors after admission such as frequently arguing with other residents in the hallway. Staff who were interviewed had no issues with other staff, only concerns about the resident's behavior. The staff member who investigated supervised showers with the resident and noted the resident did not like water hitting his/her face. Staff would hold a washcloth at top of his/her head to avoid water striking his/her face. During an interview on 5/13/21 at 12:15 P.M., the administrator said he could not find documentation of an investigation. He called the former staff member who entered the information in the progress note and he/she provided the information in the investigative summary. The allegation should have been thoroughly investigated and documented. 3. Review of the new facility policy dated 2/2019 regarding new hire/employee screening showed: -The hiring process will include screening of all potential employees for criminal background history and history of abuse, neglect or mistreatment residents; -The following will be processed for new employees: -Criminal background checks must be completed; -Criminal background checks (CBC's) and decisions to hire must be done in accordance with state regulation as stated below; -Each facility shall, not later than two working days of the date an applicant for a position to have contact with residents hired, request a criminal background check; -Facility will not hire any person listed on the employee disqualification list (EDL); -The policy did not show that the facility would upon hire check the CBC's or EDL's on potential new employees. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Housekeeping EE's hire information, showed: -Date of hire 2/1/21; -Check of the Family Care Safety Registry (FCSR), a state registry which checks criminal history and the EDL) dated 3/2/21. 5. Review of Receptionist FF's hire information, showed: -Date of hire 7/17/20; -Check of the FCSR dated 7/21/20 . 6. Review of Occupational Therapy Assistant (OTA) GG's hire information, showed: -Date of hire 2/1/21; -Check of the FCSR dated 7/4/20. 7. During an interview on 5/6/21 at 1:10 P.M. human resource director HH said OTA GG was rehired on 1/29/21. He/she is a part time employee. She should have rechecked him/her. The date of hire is not necessarily when they are assigned to work the floor. However orientation, which is the date of hire, involves new employees going through the building at least three times going onto resident floors, observing residents, fire safety features and the layout of the building. She did not think about the potential of having resident contact. 8. Review of state statute 192.2495, for showed: - Prior to allowing any person who has been hired as a full-time, part-time or temporary position to have contact with any patient or resident the provider shall, or in the case of temporary employees hired through or contracted for an employment agency, the employment agency shall prior to sending a temporary employee to a provider: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Request a criminal background check as provided in section 43.540. Completion of an inquiry to the highway patrol for criminal records that are available for disclosure to a provider for the purpose of conducting an employee criminal records background check shall be deemed to fulfill the provider's duty to conduct employee criminal background checks pursuant to this section; except that, completing the inquiries pursuant to this subsection shall not be construed to exempt a provider from further inquiry pursuant to common law requirements governing due diligence. If an applicant has not resided in this state for five consecutive years prior to the date of his or her application for employment, the provider shall request a nationwide check for the purpose of determining if the applicant has a prior criminal history in other states. The fingerprint cards and any required fees shall be sent to the highway patrol's central repository. The fingerprints shall be used for searching the state repository of criminal history information. If no identification is made, fingerprints shall be forwarded to the Federal Bureau of Investigation for the searching of the federal criminal history files. The patrol shall notify the submitting state agency of any criminal history information or lack of criminal history information discovered on the individual. The provisions relating to applicants for employment who have not resided in this state for five consecutive years shall apply only to persons who have no employment history with a licensed Missouri facility during that five-year period. Notwithstanding the provisions of section 610.120, all records related to any criminal history information discovered shall be accessible and available to the provider making the record request; and - (2) Make an inquiry to the department of health and senior services whether the person is listed on the employee disqualification list as provided in section 192.2490. MO00185248 MO00182036 22409

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the Department of Health and Senior Services (DHSS) no later than two hours after an allegation was made by one resident's (Resident #15) family member to facility management, on two separate occasions. The census was 75. Review of the facility's abuse prevention policy dated 2/19, showed: -Prevention and reporting: The administrator has primary responsibility in the facility for 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. Abuse shall include physical harm, pain, mental anguish, verbal abuse, sexual abuse or involuntary seclusion; -The facility encourages and supports all residents, staff and families in feeling free to report any suspected acts of abuse, neglect, misappropriation or injury of unknown origin. The facility takes all measures possible to ensure that residents, staff and families are free from fear of retribution if reports or incidents are filed with the facility; -Reports of abuse will be promptly reported and thoroughly investigated. Additionally the facility should immediately report all such allegations to administrator/designee and to the Department of Health and Senior Services. In cases where a crime is suspected staff should also report the same to local law enforcement; -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 facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property; -The facility has implemented the following processes in an effort to provide residents/patients and staff a safe and comfortable environment; -The shift supervisor (charge nurse, nurse manager or administrator) is identified as responsible for immediate initiation of the reporting process; -The administrator and Director of Nursing are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect and/or misappropriation of property standards and procedures: *Implementation; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Ongoing monitoring; *Reporting; *Investigation; *Tracking and trending; -Implementation and ongoing monitoring consist of the following: *Screening; *Training; *Prevention; *Identification; *Protection; *Investigation; *Reporting; -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; -Initiate the investigation, 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, and interview with the resident if possible, a review of the residents medical record, an interview with staff members having contact with the resident during the period of the alleged event, interviews with resident's roommate, family members and visitors, a review of all circumstances surrounding the incident; -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: Any person witnessing or having knowledge of alleged violation of involving abuse, neglect, misappropriation or injury of unknown origin are to notify the administrator or Director of Nursing immediately; -The administrator or Director of Nursing or designee to report to the regional clinical manager; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notify the appropriate state agency(s) immediately of allegations or suspicious of abuse, neglect or injury of unknown injury by fax or telephone after identification of alleged/suspected incident. Allegations or suspicion of mistreatment of resident property or exploitation are to be reported to the state agency immediately and no later than 24 hours upon discovery; -Reports of abuse, neglect and injury of unknown origin are to be made to the state agency immediately, but no later than two hours from the allegation being made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hour if the event that cause the allegation do not involve abuse or result in bodily injury; -Follow reporting requirements as outlined by the state agency. 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/18/21, showed: -admitted [DATE]; -Adequate hearing/vision; -Clear speech - distinct intelligible words; -Ability to express ideas and wants: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others: Usually understands - misses some part/intent of message but comprehends most conversation; -Brief interview for Mental Status (an assessment used to determine cognitive status) score of 7 (a score of 0-7 indicates severely impaired cognition); -No hallucinations or delusions; -No physical, verbal or other behaviors noted; -Wandering: Behavior not exhibited; -Rejection of care: Behavior not exhibited; -Wandering: Behavior not exhibited; -Limited assistance of one person required for bed mobility; -Extensive assistance on one person required for transfers, dressing, toilet use, personal hygiene and bathing; -Supervision - oversight, encouragement or cueing required for eating; -Independent for locomotion on/off the unit; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Functional limitation of both lower extremities; -Mobility device: Wheelchair; -Diagnoses of renal (kidney) insufficiency, diabetes mellitus, stroke, hemiplegia (the complete loss or paralysis on one half of the body) or hemiparesis (minor to severe weakness of one half of the body) and manic depression (alternating moods of abnormal highs (mania) and lows (depression)). Review of a facility self-report to the DHSS, dated 5/12/21 at 10:22 P.M., showed: -Resident's family contacted the Admission Coordinator (AC) on 5/12/21 and stated the night shift staff (Night shift hours for Certified Nursing Assistants (CNAs) is 6:00 P.M. until 6:00 A.M.) had been rude to the resident. Administrator arrived on the night shift on 5/12/21 at approximately 7:30 P.M. and interviewed resident. Resident claimed that a staff member had been verbally rude, insulting him/her and had been physical with him/her. He/She claimed a Certified Nursing Assistant had pushed him/her on the night shift of 5/7/21. During an interview on 5/13/21 at 8:45 A.M., the AC said yesterday, 5/12/21 around 3:00 P.M., the resident's family contacted her by phone about sending the resident to another facility. During the conversation, the family member told her the resident stated two CNAs on the night shift threatened to throw the resident out of his/her wheelchair. The resident had fallen once and those same CNAs left him/her on the floor longer than he/she should have been. The AC said she was surprised as she speaks to the resident most every day and he/she had not mentioned that to her. She did not go and speak to the resident after the phone conversation because she went to the daily management meeting and told the Administrator what the family had said. During an interview on 5/13/21 at 9:13 A.M., the resident said an agency staff member, he/she was not sure if they were a CNA or a nurse, but on the night shift was mean to him/her. The staff member hit him/her on his/her head around the mouth. This happened last Friday when he/she wanted to go into Resident #12's room to speak to him/her. Resident #12 was asleep in his/her recliner. The staff member came down the hall and would not allow him/her to go into the room, The staff member called him/her an ignorant bastard. The staff member hit him/her with his/her fist, then pulled Resident #12's door shut. Both he/she and the staff member left Resident #12's room at that time. The resident had no facial bruising noted during the interview. During an interview on 5/13/21 at 10:10 A.M., the Administrator said the AC told him yesterday in their meeting around 3 o'clock. All he heard the AC say was Resident #15 said someone had been rude to him/her so he did not think it had anything to do with abuse at that time. He ended up leaving the facility and going home before returning between 6:00 P.M. and 6:30 P.M. to speak to the resident. He did not designate anyone to speak to the resident before he left to go home. It was not until he returned and spoke to the resident that he learned the resident claimed staff had verbally abused him/her. The resident did not tell him he/she had been struck by staff. He did not know what the facility policy showed in regards to initiating an abuse/neglect investigation, although he did help write the policy. He was aware of the two hour window to report an allegation of abuse to DHSS and acknowledged he failed to initiate an investigation immediately after the AC mentioned a problem in the management meeting and failed to report the resident's allegation of verbal abuse within the required two hour time frame. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/13/21 at 10:48 A.M., the resident's family member confirmed what he/she had told the AC on 5/12/21. He/She added it was not the first time he/she had reported the resident had problems with two night shift staff. Approximately six months ago, he/she spoke to someone at the facility, but was not sure if it was the AC or the Social Service Director regarding the resident alleging two staff members threatened to throw him/her out of his/her bed or wheelchair. The family member said he/she never heard back from the facility after alerting them to his/her concerns. Review of the resident's progress notes, including social service notes on 5/13/21, showed no documentation regarding a family member complaining about the resident's treatment by staff. During an interview on 5/13/21 at 1:49 P.M., the Social Service Director said she did not recall having any previous conversations with that family member, but did recall another family member telling her the resident was having trouble with the night shift staff. It was how they were approaching him/her. The way they were speaking to him/her. The family member did not know the names or titles of the staff. She could not recall how long ago that conversation took place and she did not document it. She did tell the Administrator and Director of Nurses (DON). She did not know if anyone followed up or not. Review of DHSS complaints, showed no other complaint listed for Resident #15. During an interview on 5/14/21 at 10:30 A.M., the Administrator denied being told by the SSD the resident had problems a few months ago with two night shift staff threatening to throw the resident out of his/her wheelchair. He was only aware of the problem the resident told him about on 5/12/21. MO00185248

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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** 22409 Based on observation, interview and record review, the facility failed to ensure one resident's (Resident #59) bilevel positive airway pressure machine (BiPap, a machine worn during sleep to maintain consistent breathing) was in working order for use during sleep. In addition, the facility failed to ensure staff documented they notified one resident's (Resident #51) physician for an order to remove the resident's indwelling urinary catheter or why it was necessary to remove the indwelling urinary catheter. The census was 75. 1. Review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/21, showed: -Diagnosis of multiple sclerosis (disease in which the immune system destroys the protective covering of nerves interrupting the nerve signals from the body to the spinal cord/brain); -No short/long term memory loss; -Required total staff assistance for bed mobility, transfers, dressing, eating, toilet use, personal hygiene and bathing; -BiPap not noted. Review of the resident's care plan, updated 4/8/21, showed: -Focus: Resident has altered respiratory status/difficulty breathing related to (r/t) sleep apnea (a potentially serious disorder in which breathing repeatedly stops and starts); -Intervention: BiPap Settings: 6-18 via mask, on at bedtime, off in morning. Elevate head of bed 30 degrees. Monitor for signs and symptoms of respiratory distress. Monitor/document/report abnormal breathing patterns to the physician. Review of the resident's physician's order sheet (POS), dated 5/21, showed an order dated 4/20/21, for an Auto BiPap machine (a device used for sleep apnea that uses two separate pressure settings for inhale and exhale), apply at bedtime and remove in the morning. During on observation and interview on 5/4/21 at 7:02 A.M., the resident said he/she did not sleep all night. There was no BiPap machine in the room. During an interview on 5/12/21 at 8:09 A.M., the resident said he/she has not worn the BiPap in approximately seven months. He/She said it needs to be serviced. Also, agency staff do not know how to put it on at night. It was frustrating, so he/she stopped asking the staff to put it on. During an interview on 5/13/21 at 1:29 P.M., the resident said he/she does not feel different since not wearing the BiPap. He/She asked Certified Nurse Aide W to tell Central Supply staff his/her Bi-pap needed servicing. He/she does not know where the BiPap machine is because he/she has not seen it for several months. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/21 at 1:36 P.M., Central Supply staff said the resident's BiPap machine was not in his/her room. His/Her job is to make sure the resident has one and that it is working properly. The resident has not spoken to him/her about the BiPap machine for about seven months. He/She will notify the Assistant Director of Nurses (ADON). During an interview on 5/13/21 at 1:42 P.M., the ADON said Central Supply staff reported the resident does not have his/her BiPap machine. He will have Central Supply order a new BiPap machine. He does not know what happened to it. The resident has an order to wear it at night. The nurse should apply the BiPap machine. He was unaware the resident was not wearing the BiPap machine. During an interview on 5/13/21 at 2:13 P.M., the Director of Nursing (DON), said she did not know the resident was not wearing his/her BiPap machine. She will contact the physician for an evaluation. 2. Review of Resident #51's admission MDS, dated [DATE], showed: -admitted [DATE]; -Adequate hearing/vision; -Clear speech - distinct intelligible words; -Ability to express ideas and wants: Understood; -Ability to understand others: Understands; -Brief Interview for Mental Status score of 15 out of a possible 15 (a score of 13-15 indicates cognitively intact); -Rejection of care: Behavior not exhibited; -Total dependence of one person required for bed mobility, toilet use and bathing; -Total dependence of two (+) persons required for transfers; -Extensive assistance of one person required for dressing and personal hygiene; -Functional limitation of both lower extremities (hip, knee, ankle, foot); -Indwelling urinary catheter (thin tube inserted through the urethra into the bladder to drain the bladder of urine); -Diagnoses of anemia (low number of red blood cells), septicemia (Systemic (bodywide) illness with toxicity due to invasion of the bloodstream by virulent bacteria coming from a local site of infection), urinary tract infection (last 30 days), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), anxiety and depression. Review of the resident's care plan, undated, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted with indwelling catheter; -Resident will show no signs and symptoms of urinary infection through next review; -Position catheter bag and tubing below the level of the bladder and away from entrance room door; -4/17/21: readmitted with UTI and sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues); -4/17/21: Continue to administer antibiotic therapy as ordered. Review of the resident's current POS, showed an order for the resident to have an indwelling urinary catheter. Observation on the following dates and times, showed: -5/4/21 at 6:50 A.M., 9:30 A.M., and 11:46 A.M., the resident had an indwelling urinary catheter; -5/5/21 at 7:25 A.M., 11:03 A.M. and 12:44 P.M., the resident had an indwelling urinary catheter; -5/6/21 at 7:59 A.M., the resident lay in bed sleeping. His/her indwelling urinary catheter had been removed; During an interview on 5/6/21 at 9:09 A.M., the resident said he/she asked Nurse H to remove his/her indwelling urinary catheter a couple of hours ago because he/she felt he/she had a urinary tract infection and he/she was becoming septic. During an interview on 5/6/21 at 11:40 A.M., Nurse H said earlier this morning, the resident asked him/her to remove the indwelling urinary catheter because he/she felt he/she was getting an infection. The nurse said he/she called the physician around 9:30 A.M. and received an order to remove the indwelling urinary catheter and begin oral antibiotics. Review of the resident's progress notes on 5/6/21 at 1230 P.M., and 5/10/21 at 7:30 A.M., showed no documentation regarding Nurse H contacting the resident's physician, removing the resident's indwelling urinary catheter, or why he/she removed the indwelling catheter. Observation on 5/10/21 at 7:00 A.M., showed the resident lay in bed without an indwelling urinary catheter. During an interview on 5/10/21 7:10 A.M., Nurse I said the resident had a 101.7 (normal 97.6 - 99.6) temperature and the physician ordered the resident to be evaluated at the hospital. During an interview on 5/11/21 at 9:46 A.M., the DON said the resident was admitted to the hospital on 5/10/21 with a diagnoses of sepsis and septic shock. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes on 5/13/21 at 7:45 A.M., showed no documentation regarding Nurse H contacting the resident's physician, removing the resident's indwelling urinary catheter, or why he/she removed the indwelling catheter. During an interview at that time, Nurse H said 5/6/21 was a hectic day, and he/she failed to document notifying the physician and removing the indwelling urinary catheter. Ideally, he/she should have documented that information in the resident's progress notes on 5/6/21 before leaving for the day. Review of the resident's progress notes on 5/14/21 at 12:00 P.M. showed no documentation regarding Nurse H contacting the resident's physician, removing the resident's indwelling urinary catheter, or why he/she removed the indwelling catheter. During an interview at that time, the DON said she would have expected Nurse H to have documented why the resident's indwelling urinary catheter was removed and contacting the resident's physician in the resident's progress notes. The resident was readmitted yesterday with a new indwelling urinary catheter. 27723 40290

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 Based on observation, interview and record review, the facility failed to ensure residents who are unable to carry out activities of daily living (ADLs) received services to maintain good personal hygiene and grooming. The facility failed to provide thorough perineal care (peri-care, cleansing from the front of the hips, between the legs and buttock and back of the hips) to one resident (Resident #55), the facility also failed to ensure one resident (Resident #22) maintained trimmed toenails, the facility also failed to ensure resident showers had been completed for two residents (Resident # 224 and Resident #69). The sample size was 18. The census was 75. 1. Review of the facility care of incontinent resident policy and procedure, reviewed 1/2020, showed: -Purpose: To keep residents clean and dry; -Policy: All residents who are identified as being incontinent will have incontinence care provided every two hours; -Procedure: -Explain procedure to the resident and bring the equipment to the bedside; -Remove excess feces and urine with diaper, pad or tissue as indicated; -Spray periwash (used for peri-care) on a wet washcloth and cleanse with the wet washcloth or cleanse with a wet, soapy washcloth; -Rinse washcloth (or turn washcloth to the clean side) and wipe the area clean. If cleaning feces, use a second washcloth; -For male residents: Cleanse moving from the tip of the penis to the base of the penis; -Dry the area well; -Apply protective ointment, lotion or cream and observe the skin closely for reddened or unusual areas. 2. Review of Resident #55's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 3/12/21, showed: -Severe cognitive impairment, unable to make needs and wants clearly known; -Extensive staff assistance needed with toileting, dressing, transfers and daily hygiene; -Frequently incontinent of bowel and bladder; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of Downs Syndrome (a genetic disorder causing developmental and intellectual delays), heart failure and depression. Review of the undated care plan, in use during the survey, showed: -Focus: The resident has self care deficit; -Goal: The resident will maintain current level of function in ADLs; -Interventions: The resident requires assistance with bathing, dressing, eating, transfers and personal hygiene. Staff provide incontinence care. Observation and interview on 5/10/21 at 6:48 A.M., showed Certified Nurse's Aide (CNA) R entered the resident's room, washed his/her hands and applied gloves. The resident slept in his/her recliner. CNA R said he/she last provided care to the resident at 4:30 A.M. CNA R obtained several wet wipes and placed the resident's wheel chair up next to the resident. He/She explained care to the resident and assisted the resident to stand with use of the wheel chair handles. CNA R lowered the resident's brief. A moderate amount of brown fecal material noted to the resident's buttocks and testes. CNA R used one wipe and wiped from the front of the groin to the buttocks. He/She repeated the motion with a second wipe. CNA R applied a clean brief and secured the brief into place. Multiple areas of brown stool remained on the resident's skin. The resident's buttocks appeared red, and CNA R did not apply cream to the buttocks. CNA R said the resident is incontinent of bowel and bladder. He/She had run out of wipes and had been scheduled to end the shift soon. He/She forgot to apply barrier ointment and would pass onto the next day shift aide about the resident needing ointment on his/her buttocks and more wipes in the room. During an interview on 5/10/21 at 11:05 A.M., the Director of Nursing (DON) said staff should always complete thorough perineal care. All areas should be cleaned and dried. There should be no visible stool on the resident before applying clean briefs or clothing. It is the aides' responsibility to ensure enough supplies are brought into the resident's room before providing care. Supplies are available for staff to use. 3. Review of Resident #22's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Extensive staff assistance for toileting, bathing and hygiene; -Diagnoses of stroke, Parkinson's (neurological disease causing uncontrollable tremors) and schizophrenia (mental disorder affecting reality, often causing delusions). Review of the undated care plan, in use during the survey, showed: -Focus: The resident has a self care deficit; -Goal: The resident will maintain current level of function in ADLs; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: The resident requires total staff assistance with bathing and dressing. During an observation and interview on 5/10/21 at 10:09 A.M., the wound care nurse examined the resident's toe nails and said Those are very long. Those toe nails need to be trimmed badly or they may start cutting into the skin. The toenails appeared approximately 1/2 inch to 3/4 inch long and jagged. The toenails had begun to curl and the jagged edges pressed into the sides of the opposing toes. The resident is not able to dress or bathe himself/herself and the aides are expected to tell the nurse when toe nails need to be trimmed. The facility has a podiatrist that comes to see residents. The resident's toe nails are long enough that he/she should be seen by podiatry. During an interview on 5/10/21 at 11:05 A.M., the DON said toe nails and finger nails should be trimmed during the shower or bath. Long nails can cause discomfort or get caught on socks and tear. There should be no long toe nails on residents. Resident #22 will need to be seen by podiatry due to the length of the toe nails. As aides assist a resident to dress or bathe, the aide can also notify the nurse for nail trimming. 4. Review of Resident #224's medical record, showed: -admitted [DATE]; -Diagnoses included depression; -Moderate cognitive impairment. Review of the resident's care plan, undated and in use at the time of survey, showed no documentation of the resident's preferences for bathing or grooming. Review of the facility's 200 hall shower schedule, undated and posted at the 200 hall nurse's station, showed the resident scheduled for showers on Tuesday and Friday nights. Review of the resident's shower sheets from April and May 2021, showed one bed bath documented as completed on 4/13/21. Observations of the resident, showed: -On 5/3/21 at 8:42 A.M., 9:09 A.M., 10:47 A.M., 11:45 A.M., 12:27 P.M. and 1:06 P.M., the resident lay in bed, dressed in a hospital gown; -On 5/4/21 at 7:02 A.M., 7:48 A.M., 9:11 A.M., 10:10 A.M. and 1:02 P.M., the resident lay in bed, dressed in a hospital gown; -On 5/5/21 at 7:35 A.M., 9:47 A.M., 11:27 A.M. and 1:01 P.M., the resident lay in bed, dressed in a hospital gown. His/her shoulder-length hair disheveled and stringy; -On 5/6/21 at 7:53 A.M. and 11:14 A.M., the resident lay in bed, dressed in a hospital gown. His/her shoulder-length hair stringy; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 5/12/21 at 8:44 A.M., the resident lay in bed, dressed in a hospital gown. His/her face greasy and hair stringy; -On 5/13/21 at 8:49 A.M. and 12:38 P.M., the resident lay in bed, dressed in a hospital gown. His/her hair combed back and stringy. During an interview on 5/10/21 at 9:33 A.M., Certified Nurse Aide (CNA) BB said Resident #224 spends all day in bed and never really gets up. He/She seems like he/she is tired, worn out, but doesn't refuse care. The resident gets bed baths and the CNA has provided one to the resident before. When CNAs provide bed baths or assist residents with bathing, they should document completion of a bed bath or shower on a shower sheet, and turn it in at the nurse's station. During an interview on 5/12/21 at 8:05 A.M., CNA P said Resident #224 has been in bed since admitted to the facility a month ago. He/she never comes out of his/her room and sleeps all day, but does allow staff to provide care and does not refuse it. Residents should be bathed or showered at least twice a week or more if needed, but residents are probably not getting bathed that often. The facility used to have a shower aide, but they do not anymore. Ensuring residents are clean is important because being soiled all day leads to skin breakdown. 4. Review of Resident #69's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Severe cognitive impairment; -Rejection of care not exhibited; -Total dependence of one staff physical assist required for personal hygiene and bathing; -Upper and lower extremity impaired on one side; -Diagnoses included stroke, dysphagia (swallowing disorder), unsteadiness on feet and depression. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: The resident has a behavior problem, tends to place his/her hand in soiled undergarment before and during changing. Refuses medication, showers and care at times; -Interventions included: Explain all procedures to resident before starting and allow resident to adjust to changes, come back and approach later if necessary; -Focus: Resident requires assistance with all ADLs related to stroke with right sided weakness. The resident has limited mobility and refuses care at times; -Interventions included the resident is totally dependent on one staff to provide bath/shower two times weekly and as necessary, and the resident requires total care by one staff with personal hygiene and oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's 200 hall shower schedule, undated and posted at the 200 hall nurse's station, showed the resident scheduled for showers on Wednesday and Saturday nights. Review of the resident's shower sheets from March through May 2021, showed one shower sheet, dated 4/27/21, with bed bath or shower not specified. Observations of the resident, showed: -On 5/3/21 at 11:04 A.M. and 5/4/21 at 7:43 A.M., the resident lay in bed with stringy hair and greasy face; -On 5/10/21 at 12:25 P.M. and 5/13/21 at 8:54 A.M. and 1:02 P.M., the resident lay in bed, dressed in a hospital gown, with stringy hair and greasy face. 6. During an interview on 5/11/21 at 7:43 A.M., Nurse I said all residents should receive bed baths or showers at least twice a week. Residents have the right to refuse care and if this occurs, staff should ask them again later. Any resident refusals should be documented in the resident's medical record. The intervention is to ask the resident again later, and if they continue to refuse, they should document it in the medical record. During an interview on 5/14/21 at 1:06 P.M., the Director of Nursing said showers or baths should be done twice a week and as needed. Bed baths and showers should be documented on shower sheets when offered. She was not aware they had not been done as often as expected. MO00182036 MO00182550 40290

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to notify one resident's (Resident #374) physician of a critical lab result and that resident was later admitted to the hospital for a related condition. The facility failed to administer medications per facility policy for one resident (Resident #46) and obtain orders to maintain one resident's peripherally inserted central catheter (PICC, a thin flexible tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of heart. Used to give IV fluids and medications) (Resident #51). The sample was 18. The census was 75. 1. Review of the facility's Notification of Resident Change in Condition policy, updated 8/1/18, showed: -Protocol: The facility's clinician's will notify the physician and family or legal representative if there is a change in the resident's condition; -Procedure: 1. Notify the physician and family or legal representative at the earliest possible time, during waking hours, if there is a change in condition (unless requested to do otherwise). 2. Notify the physician and family or legal representative if there is a significant change in condition regardless of the time. If the resident's change in condition merits immediate attention the nurse will provide immediate assistance and will call 911 for medical intervention. If the attending physician is not available (does not respond) to physician notification and there is no physician on call. The nurse can call the facility's Medical Director regarding the resident change in condition with follow up with attending physician. 3. Document in the nurses notes the time the notification was made, the names of the persons to whom they spoke to, and sign the entry. Review of Resident #374's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/6/20, showed: -Diagnoses of high blood pressure, diabetes, stroke and seizure; -Short/long term memory loss; -Extensive staff assistance for bed mobility and dressing; -Total staff assistance for transfers, dressing, toileting, personal hygiene and bathing; -No oxygen use. Review of the resident's progress notes, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-9/28/20 at 1:03 P.M.: At approximately 11:50 A.M., a certified nursing assistant (CNA) came to the nurse's station to report the resident had complaints of shortness of breath (SOB) and that he/she seemed to struggle to breathe. He/She was breathing rapidly and was wheezing slightly when staff got him/her up to a chair. Nursing assessment showed his/her lungs sounds had respiratory wheezes in upper lobes. O2 (oxygen) Saturation (SATs) (normal range is 95 - 100%) was 80% initially, heart rate was 90 (normal range is 60 - 100 beats per minute). Encouraged him/her to cough. Cough was productive and his/her O2 SATs increased quickly to 89%. He/She was placed on 2 L (liters) of oxygen per nasal cannula. The physician was notified and new orders were received for chest x-ray, Mucinex (an expectorant, helps thin mucus and loosen congestion) and Duoneb (a combination medication relax muscles in the airways and increase airflow to the lungs) treatment. O2 SATs remain at greater than 95% on 2 L of oxygen. Will continue to monitor. Blood pressure (BP) is 150/90 (normal is 120/80), taken manually, sitting upright in chair; -9/28/2020 at 4:30 P.M.: X-ray here at this time, resident has refused x-ray. Combative with staff and x-ray technician. Will try again tomorrow; -No further documentation regarding resident's condition until 9/29/20. Review of the resident's chest x-ray results, dated 9/29/21 at 7:29 A.M., showed the the findings most consistent with congestive heart failure (CHF) and pulmonary edema. Review of the resident's progress notes, showed: -9/29/2020 at 9:53 A.M.: Spoke with the physician's nurse practitioner (NP) regarding chest x-ray results. New order received for STAT (immediate) BMP (Basic Metabolic Panel, a blood test used to give information about the body's fluid balance), BNP (Brain Natriuretic Peptide, a blood test which measures cardiac function), CBC (Complete Blood Count, blood test that evaluates blood cells), Daily weights x 5 days (If 2-3 pound increase in 1 day or 5 pound increase in 5 days, notify the physician office), give 20 milligram (mg) of Lasix (diuretic) now, cardiology consultation, and obtain speech evaluation all related to (r/t) CHF findings on chest x-ray results. STAT labs ordered; -9/29/2020 at 3:19 P.M.: Resident is scheduled at hospital on October 5, 2020 at 2:30 P.M., for new cardiology consult r/t CHF findings upon x-rays. Order and all necessary paper-work have been faxed to office; -9/29/2020 at 5:24 P.M.: Late Entry Note: Stat CH (Critical High) BNP lab results of 808 (normal is less than 100 picograms per milliliter (ml) of blood) called to the physician's office. Messages left. No one answered or responded this shift; -9/29/2020 no time noted, late entry documented on 9/30/21 at 9:46 P.M.: Resident alert but resting in bed. O2 on at 2 L per nasal cannula. Refused his/her bedtime medication, accucheck and insulin. O2 Sat was 100%. Resting quietly in bed most of the night with eyes closed. No distress noted; -No further documentation regarding the resident's condition until 9/30/20; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-9/30/2020 at 8:52 A.M.: SBAR (Situation, Background, Assessment and Recommendation) Summary for Providers Situation: The Change In Condition/reported were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Shortness of breath. At the time of evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: BP 154/82 Position: Sitting left/arm, Pulse (heart rate): (P) 66 Regular, Respirations R 22 (normal range is 12 - 20 breaths per minute), Temp: T 98.2 (normal is 98.6), Forehead (non-contact), Pulse Oximetry: O2 89%, Oxygen via Nasal Cannula, Blood Glucose: BS 173 (normal range is less than 140), Resident in the facility for: Long Term Care, Code Status: Full code; -Resident had the following medication changes in the past week: Lasix 20 mg x 1; -Nursing observations, evaluation, and recommendations are: resident needs to be sent to hospital; -Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: send to ER; -9/30/2020 at 9:08 A.M.: Resident currently in bed with O2 on at 4 liters per nasal cannula. Respirations at 22 per minute. Resident lab work BNP 808. NP notified and order received to send resident to ER. VS 154/82, 66, 22, O2 Sat 89% and Temp: 98.2. Respirations are labored at times. Ambulance called and waiting for transfer to hospital; -9/30/2020 at 9:17 A.M.: POA notified of transfer to hospital. Review of the resident's Hospital History and Physical dated 9/30/20, showed: -admitted d of 9/30/20; -Reason for admission: Bilateral Pleural Effusion (fluid buildup on the lungs), pulmonary edema (excess fluid in the lungs usually caused by a heart condition); -BNP elevated on admission. Review of the resident's Hospital Discharge/Transfer papers, dated 10/4/20, showed the following: -Discharge Diagnosis: Acute hypoxemic respiratory failure (low oxygen level in blood with close to normal carbon dioxide level) secondary to mild diastolic Congestive Heart Failure (CHF) (a condition in which the heart doesn't pump blood as well as it should) ; -History of presenting illness: Presents to the emergency room with acute onset of shortness of breath, lived at the nursing home since his/her stroke and did not required oxygen. That morning he/she was found severely short of breath, required eight liters of oxygen and was transported to the emergeny room; -In the emergency room , chest xray showed bilateral interstitial infiltrates (double pneumonia) and pulmonary edema (excess fluid in the lungs) and given IV (intravenous) Lasix (medication used to treat fluid retention); -Labs: elevated BNP in the 700's; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-admitted for further management; -Hospital Course: He/she was admitted to Cardiology. He/she was found to be in sinus bradycardia (slow heart rhythm), medications amiodarone (used to treat heart rhythm problems) and a beta blocker (medication used to treat high blood pressure) were held. He/she was diuresed (increased fluid removal) with improvement in oxygenation. He/she did not require oxygen at the time of discharge; - Resident was discharged back to facility on 10/4/20. During an interview on 5/14/21 at 10:22 A.M., the Director of Nurses (DON) said after review of the resident's record, staff failed to notify the physician of a critical lab. She would have expected staff to make her aware of the critical lab. She would have given the staff instructions to send the resident to the hospital. Staff should have continued to try to call the physician to notify him/her of the critical lab. She also would expect staff to notify the Medical Director if they unable to reach the primary physician. 2. Review of facility's medication administration policy, last revised on 5/1/11, showed: -Purpose: To administer the following: Right medication; Right dose; Right dosage form; Right route; Right resident; Right time; -Read the medication administration record (MAR) for the ordered medication, dose, dosage form, route, and time; -Verify the correct medication, dose, dosage form, route, and time again by comparing to MAR before administering; -Document the following as applicable: -Administration of medication on the MAR as soon as medications are given; -Omitted dose by circling your initials in the appropriate block on the medication MAR; -Reason for omission in the Nursing Progress Notes or on the back of the MAR; -As needed (PRN) medication, reason for administration, and effectiveness in the nursing progress notes or on the back of the MAR; -When medication has been discontinued by writing D/C (discontinued) next to the last dose of the medication on the MAR; block out the rest of the days that month; -Notify physician of changes in resident or with refusal of medication. Review of Resident #46's medical record, showed: -Diagnoses included methicillin resistant staphylococcus aureus infection (MRSA, an infection that is difficult to treat because of resistance to some antibiotics) and heart failure; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 3/10/21 and discontinued on 3/17/21, for vancomycin hydrochloride (HCL) solution (antibiotic used to treat infections) 1000 mg, Use 1000 mg intravenously (IV, administer through the veins) every 12 hours for infection. Review of the resident's MAR, dated 3/1/21 through 3/31/21, showed documentation for vancomycin HCL 1000 mg intravenous (IV) was left blank on the following days: -3/13/21 at 8:00 A.M. medication pass; -3/14/21 at 8:00 A.M. medication pass. Further review of the resident's medical record, showed no documentation staff had administered the medications. There was no documentation that staff alerted the physician of failure to administer the medication. Further review of the resident's medical record, showed an order, dated 4/7/21 and discontinued on 4/21/21, for vancomycin HCL 1000 mg/200 ml of normal saline (NS), Use 1000 mg IV every 12 hours for infection. Review of the resident's MAR, dated 4/1/21 through 4/30/21, showed documentation for vancomycin HCL 1000 mg/200 ml was left blank on the following days: -4/9/21 at 9:00 P.M. medication pass; -4/18/21 at 9:00 P.M. medication pass. Further review of the resident's medical record, showed no documentation that staff had administered the medications. There was no documentation staff alerted the physician of failure to administer the medication. Further review of the resident's medical record, showed: -An order, dated 5/1/21, for vancomycin HCL 1000 mg/200 ml NS, Use 1000 mg IV one time a day for abscess (an infection that causes a confined pocket of pus that collects in tissues, organs, or spaces inside the body); -A progress note, dated 5/3/21 at 10:38 A.M., showed vancomycin IV was discontinued per physician. The resident would follow up at a later time with infectious disease physician but the resident had already completed months of IV antibiotic and his/her abscess was not seen on scans. Observation on 5/4/21 at 8:25 A.M., showed Nurse A prepared a bag of vancomycin HCL 1000 mg/250 ml of NS, with the directions to administer over 90 minutes or 167 ml/hour. The nurse entered the resident's room, hung the bag of vancomycin on the resident's IV medication pump and programmed the pump to run the medication at 167 ml/hr. The nurse then attached the IV tubing from the vancomycin to the resident's PICC located at the resident's right arm. Nurse A then turned the IV medication pump on and medication was seen flowing from the bag of vancomycin into the resident's PICC. During an interview on 5/4/21, at 12:53 P.M., Nurse A said: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Each medication must have a physician's order in the resident's medical record before nursing staff could administer medications to residents; -Nursing staff were expected to administer medications exactly as the physician ordered; -If he/she had any questions regarding the medication, he/she would clarify the order with the physician before administering the medication; -When a medication was discontinued, it would show up in the resident's MAR, lit up in white, and labeled D/C; -He/she was unaware the vancomycin was discontinued. Further review of the resident's medical record, on 5/6/21 at 8:00 A.M., showed no documentation staff alerted the physician of the administration of the vancomycin on 5/4/21. During an interview on 5/6/21, at 9:00 A.M., the DON said: -She expected staff to follow manufacturer's instructions and physician's orders when administering medications to residents; -Administering discontinued medications, such as vancomycin, could cause significant harm to residents; -She expected staff to report a medication error to the physician, the DON, the resident or the resident's responsible party; -She expected staff to document medication errors in resident progress notes, detailing what occurred, who was notified and when, if there were new orders, and what follow up occurred; -She expected staff to administer all doses of antibiotics; -Missed doses of antibiotics could cause significant harm to residents as it could delay healing, bacteria could render resistance to the antibiotic causing the infection to deteriorate; -Missed doses of antibiotics was a medication error; -She expected staff to fill out MARs completely; -If there was a blank in a resident's MAR, other staff would not know if the medication was administered, not administered, not available, or refused and could affect patient care; -She expected staff to follow facility policies. 3. Review of the facility Care of Peripherally Inserted Central Catheters policy, dated 2004 and last revised in 2013, showed: Introduction: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Brief Interview for Mental Status score of 15 out of a possible 15 (a score of 13-15 indicates cognitively intact); -Rejection of care: Behavior not exhibited; -Total dependence of one person required for bed mobility, toilet use and bathing; -Total dependence of two (+) persons required for transfers; -Extensive assistance of one person required for dressing and personal hygiene; -Functional limitation of both lower extremities (hip, knee, ankle, foot); -Indwelling urinary catheter (inserted through the urethra into the bladder to drain the bladder of urine); -Diagnoses of anemia (low number of red blood cells), septicemia (Systemic (bodywide) illness with toxicity due to invasion of the bloodstream by virulent bacteria coming from a local site of infection), urinary tract infection (last 30 days), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), anxiety and depression. Review of the resident's progress notes, showed: -4/13/21 at 10:26 A.M.: Upon assessment the resident presented with a temperature of 101.2 orally and a pulse of 151. The resident also presented with a productive cough that produced a moderate amount of thick yellow mucous. The resident's bladder was also distended and the indwelling urinary catheter was not draining. The catheter was removed and the bladder did empty a large amount of urine. The resident was also vomiting and did vomit 350 ml. Emergency medical services was called and the resident has been taken to the hospital; -On 4/17/21 the resident was discharged from the hospital and readmitted to the facility; -4/17/21 at 2:38 P.M.: Ceftazidime (IV antibiotic) and dextrose solution (sugar/water mixture) reconstitute, 2 grams (gm) (ceftazidime) and 50 ml (dextrose solution). Use 2 gm IV every 12 hours to infection for 11 days. Medication will start the evening of 4/17/21. Review of the resident's POS, on 5/3/21, showed: -4/17/21: Ceftazidime and dextrose solution, 2 gm every 12 hours per IV for 11 days; -No order to flush the PICC line after the antibiotics finished in 11 days; -No orders to routinely change the PICC line adaptor or dressings. Review of the resident's care plan, showed: -No information about the resident receiving IV antibiotics or why; (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	-No information about maintenance of the resident's PICC line, including dressing changes, cap and adapter changes, and flushes. Review of the resident's MAR and treatment administration record (TAR), dated 4/1/21 thru 4/30/21, showed: -4/17/21: Ceftazidime 2 mg/50 ml IV every 12 hours (8:00 A.M. and 9:00 P.M.) for 11 days. Last dose received documented on 4/28/21 at 8:00 A.M.; -No orders to change the PICC dressing, and adapter changes; -No order to flush the PICC line after the antibiotic therapy was completed in 11 days. Observation on 5/4/21 at 6:50 A.M., showed the resident lay in bed. A single lumen PICC line was noted in the resident's right upper arm. A dressing with rolled up edges and several pieces of tape covered the PICC insertion site. The resident's skin could not be clearly seen through the pieces of tape. The dressing covering the PICC insertion site was dated 4/16/21. The resident said the dressing was put on at the hospital when the PICC line was inserted. No one at the facility had changed the dressing. The edges of the dressing keeps rolling up. CNA W told the nurse's the dressing needs changed and brought him/her tape to tape the dressing down. Observation and interview on 5/5/21 at 11:03 A.M., showed the resident lay in bed. The resident said last night he/she told the 100 hall night nurse (his/her nurse) about the PICC dressing needing to be changed. The 100 hall night nurse looked at the PICC dressing in his/her right upper arm. The 200 hall night nurse got a PICC dressing change kit for the 100 hall night nurse who laid it on his/her bed table and it is still laying there. Observation at that time, showed a PICC dressing kit laid on the resident's bed table and the current dressing covering the resident's PICC insertion site was dated 4/16/21. Observation on 5/5/21 at 12:43 P.M., showed the resident's PICC dressing had been changed. During an interview on 5/5/21 at 12:44 P.M., Nurse B said he/she usually works on the 200 hall but was filling in that day on the 100 hall. He/she changed the resident's PICC dressing and adaptor. He/she reviewed the resident's orders in the electronic medical records and could not find orders for the PICC line dressing and adaptor changes or routine flushes. He/she looked for hospital discharge orders in the resident's hard chart and could not find any dated 4/17/21. He/she could not find documentation the dressing or adaptors had been changed or the PICC had been flushed since the antibiotics had finished on 4/28/21. He/She said he/she would assume all of those things should be done at least weekly. He/She would call the physician for orders. The facility wound nurse, present at the time of the interview, stated she had looked in the resident's records and found no order to discontinue the PICC line, no order for a PICC dressing change and no orders for flushes after the antibiotics had finished. Review of the resident's POS and TAR on 5/6/21, showed an order for maintenance of the resident's PICC, including flushes and dressing changes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/5/21 at 1:00 P.M., CNA W said he/she recalled giving the resident tape for the PICC dressing. The resident told him/her the area at the PICC insertion site was sore and he/she (CNA W) told the nurse. He/She also told the nurse the resident was applying tape to the current PICC dressing because the dressing was peeling off. He/she did not recall the day or what nurse he/she had told. During an interview on 5/10/21 at 10:40 A.M., the DON said if orders are not received on admission for the maintenance of a PICC line, she would expect the nurse's to contact the resident's physician for orders within 24 hours after admission. The IV antibiotics, PICC line and the maintenance of the PICC line should have been documented on the care plan. The facility has a pharmacy policy for PICC lines and she expects staff to follow that policy. 27723 37672 41061

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 27723 Based on observation, interview and record review, the facility failed to have a process to ensure Certified Nurse Aides (CNAs) reported new or worsening skin conditions and soiled or missing dressings to the nurse when identified. In addition the facility failed to ensure nurses applied treatments to wounds with soiled or missing dressings timely, completed weekly skin assessments and ensure treatments were applied as ordered. The facility identified 13 residents with pressure ulcers. Of those 13, six were included in the sample and problems were found with all six. In addition, the survey team identified three residents with new pressure ulcers, not identified by the facility. (Residents #19, #224, #46, #63, #51, #45, #3, #22 and #55). The census was 75. The administrator was notified on 5/11/21 at 3:09 P.M., of an immediate jeopardy (IJ) which began on 5/3/21. The IJ was removed on 5/12/21, as confirmed by surveyor onsite verification. Review of the facility's pressure ulcer policy, updated 5/28/19, showed; -Pressure Ulcer Prevention included: Reposition at least every two hours. Use pillows, foam wedges, etc to keep bony prominences from direct contact. Use devices that reduce pressure on the heels. If indicated. Place on pressure redistribution mattress. Use pressure redistribution devices for seating surfaces. Inspect skin during care and report and changes; -Measuring Skin Ulcers Policy and Procedure: All residents with skin ulcers will have measurements taken weekly or PRN (as needed) to chart increase or decrease in ulcer size; -Best Practices included: Daily skin inspection, reposition at least every 2 hours, float heels in bed, protect bony prominences with positioning devices, complete bath sheets/eval as scheduled, complete weekly measurements/documentation, notify family and physician weekly of progress and document, for all wound care always follow MD orders. Refer to wound MD/wound clinic if applicable; The policy failed to show what staff should do when a dressing is found soiled or off. Review of the facility's Wound Care Education for all New Hires policy, undated, showed: -CNAs: Upon finding any area/skin issue, report to charge nurse immediately. If a dressing is saturated or has fallen off, report to nurse immediately. During care/bathing, never wash a wound with a wash cloth, and only pat dry if not covered with dressing. Shower sheets must be completed noting any area found; -Nurses: When skin issue, if found, is reported, immediately obtain order from the physician. Notify the Director of Nurses (DON)/designee to add to weekly wound rounds. Skin assessments must be completed weekly, when scheduled, and entered under assessments. 1. Review of Resident #19's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/1/21, showed: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Diagnoses of quadriplegia (paralysis of all four limbs), diabetes and depression; -Short/long term memory loss; -Required total staff assistance for all activities of daily living (ADLs); -Has an indwelling urinary catheter (hollow tube inserted through the urethra into the bladder to drain the bladder of urine); -Has a colostomy (a piece of the colon is diverted to an artificially created opening in the abdominal wall for stool to pass and be collected into a bag outside of the body); -Stage I (Intact skin with nonblanchable (blood flow does not return when pressure is applied and then released, redness of a localized area usually over a bony prominence) pressure ulcer; -Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) pressure ulcer; -Two Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mutinous) or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, maybe softer or harder than surrounding skin, may be present on some parts of the wound bed) pressure ulcers. Review of the resident's care plan, updated 4/13/21, showed: -Focus: Stage IV on buttock, Stage II (Partial thickness loss of dermis (top layer of skin) presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) on right knee, Stage III healing ulcer right calf, Unstageable (Known but not stageable due to coverage of wound bed by slough and or eschar) pressure ulcer; -Interventions: Continue treatments as ordered. Continue treatments to pressure ulcers. Continue weekly assessment and documentation. Continue low air loss (LAL, reduces the contact pressure at the skin-mattress contact) mattress, heel float and wedges. (3/28/19) Educated CNAs upon finding any areas/skin issues, report to the charge nurse immediately. If dressing is saturated or fallen off, report to the nurse immediately. During care never wash a wound with a wash cloth and only pat dry if not covered with dressing. Nurse education: When skin issue is reported, immediately obtain physician order. Notify DON/designee to add to weekly rounds. Skin assessments must be completed weekly -Focus: Resident has a history of osteomyelitis (an infection of the bone) of the buttock, sacral and hip wounds; -Interventions: Maintain universal precautions when providing resident care. Monitor sites for infection and report to physician. Resident remains on long term antibiotic related to osteomyelitis. Review of the facility's Wound Report, dated 4/26/21 through 4/30/21, showed: -Location: Sacral (area located at the base of the spine, just above the coccyx (tailbone), Stage IV, start date: 5/9/19, acquired, size: 12.5 centimeter (cm) by 14.0 cm by 6.0 cm; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Location: Left hip, Stage IV, start date: 5/16/19, acquired, size: 4.0 cm by 2.5 cm by 0.5 cm; -Location: Right inner knee, Stage II, start date: 2/1/20, acquired, size: 4.5 cm by 3.0 cm by 0.2 cm; -Location: Left heel, Unstageable, start dated: 1/11/21, acquired, size: 2.5 cm by 4.0 cm by 0.2 cm; -Location: Right calf, Stage III, start date: 7/3/20, acquired, size: 0.5 cm by 0.3 cm by 0.5 cm; -Location: Coccyx, Unstageable, start date: 4/27/21, new acquired, size: 4.5 cm by 2.0 cm by 0.2 cm; -Location: Right under knee, Stage II, start date: 4/10/21, acquired, size: 1.0 cm by 0.7 cm by 0.2 cm. Review of the resident's progress notes, dated 4/30/21, at 3:15 P.M., showed: -Resident was seen by outside Wound Company on 4/27/21; -The resident's physician watched dressing changes on Thursday, 4/29/21; -Agreed with all orders from outside Wound Company; -Left hip Stage IV measures 4.0 cm x 2.5 cm x 0.5 cm. Wound bed 50% pink, 50% yellow. Undermining (occurs when tissue under the wound's edge becomes eroded resulting in a pocket) 8 - 10 (o'clock) with a depth of 3.3 cm; -Right hip/ischium/scrotal wound area measures 12.5 cm x 14.0 cm x 6.0 cm. Depth is at two open areas that connect around the hip joint. Wound bed 20% purple, 20% hypergranulation (excessive tissue growth above the wound surface), 30% pink, 20% epithelial; -Coccyx Unstageable measures 4.5 cm x 2.0 cm x 0.2 cm. Wound bed 50% pink, 50% yellow; -Right lateral (outer) knee measures 1.0 cm x 0.7 cm x 0.2 cm. 100% yellow wound bed; -Right medial (inner) knee measures 4.5 cm x 3.0 cm x 0.2 cm. 80% hypergranulation and 20% pink. Stage 2; -Right lateral LE (lower extremity) 0.5 cm x 0.3 cm x 0.5 cm. 100% pink wound bed. Some fungal dermatitis to periwound area; -Left heel Unstageable measures 2.5 cm x 4.0 cm x 0.2 cm. Wound was debrided by NP (nurse practitioner). 30% pink, 70% unstable eschar; -Right anterior thigh measures 1.5 cm x 0.7 cm x 0.2 cm; -LAL mattress, protein supplements, wedges and heel float, long term antibiotic for osteomyelitis. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's physician's order sheet (POS), dated 5/21, showed: -Dated 4/29/21: Cleanse pressure ulcer to left buttock, right and left of the scrotum, with Dakin's solution (a diluted bleach solution used as an antiseptic), apply gentamicin (antibiotic) cream, xerofoam gauze (petroleum jelly impregnated gauze) to wound bed and cover with foam dressing once a day; -Dated 4/30/21: Cleanse pressure ulcer to coccyx, right lateral lower extremity and left heel with Dakin's solution, apply gentamicin cream, calcium alginate (a dressing that absorbs wound drainage (exudate)) and cover with bordered foam once a day; -Dated 4/29/21: Cleanse pressure ulcer to right hip/right ischium, under scrotum, with Dakin's solution, apply gentamicin cream and crushed Flagyl (antibiotic) tablet to wound bed, pack lightly with Dakin's soaked roll, cover with alginate and large pad dressing daily and as needed; -Dated 4/30/21: Cleanse pressure ulcer to left hip with 1/4 strength Dakin's solution soaked gauze, apply gentamicin cream, alginate and cover with bordered foam dressing every Monday, Wednesday and Friday. Observation on 5/3/21, showed: -At 9:03 A.M.: During the facility tour, the resident lay on a low air loss mattress with his/her side rails up on both sides of the bed. The resident appeared disheveled, the pad appeared soiled, and the bed linens were wrinkled and dirty. The dressing on his/her right inner knee was dated 4/30/21; -At 12:32 P.M.: The resident lay on his/her back, with bolster under legs to lift feet, heels remain on bed, undated dressing coming off left heel; -At 2:03 P.M.: During a skin assessment, the resident lay in bed on a low air loss mattress. The Wound Nurse and unknown staff member, removed the positioning device under the resident's legs and turned him/her to his/her right side, revealing saturated dressings dated 4/30/21. All dressings were saturated with a large amount of strong, foul smelling drainage. The disposable pad and draw sheet were saturated with the same drainage. The odor from the dressing permeated the room. The Wound Nurse removed the saturated dressings revealing large pressure ulcers to the resident's coccyx, buttocks, hips and ischials, with slough and drainage noted. The Wound Nurse said all dressings on the resident's buttocks should be changed daily. They should have been changed over the weekend. She last changed the resident's dressings on Friday, 4/30/21. The wound nurse said frequently on Monday after the weekend, he/she observes staff has failed to change the dressings. This has occurred frequently. She said it's frustrating because she works on the wounds all week to heal them. Review of the resident's progress notes, dated 5/9/21 at 5:52 P.M., showed: -Seen by outside wound company this week; -Treatment discontinued to right lateral knee, healed; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Right ischium, Stage IV, treated by NP for excessive bleeding with silver nitrate (used to cauterize infected tissues. Also used to help stop bleeding), measured: 11.5 cm by 15.5 cm by 6.0 cm, wound bed 40% pink 60% yellow; -Left of scrotum: 1.0 cm by 0.5 cm by 0.2 cm, wound bed 100% pink; -Coccyx: Unstageable, measured 3.5 cm by 2.4 cm by 0.2 cm, 50% pink, 50% yellow; -Right buttock: New, unstageable, measured 2.4 cm by 1.8 cm by 0.2 cm, 50% pink, 50% yellow; -Left buttock: Has an opened draining area that has developed a wound bed surrounding: 2.0 cm by 0.7 cm by 0.5 cm, 50% pink, 50% yellow; -Left heel: unstageable, was debrided by NP, measured 2.5 cm by 3.0 cm by 0.2 cm, 70% pink, 30% yellow/brown; -Right lower extremity: Stage III, nearly healed, measured 0.6 cm by 0.2 cm by 0.1 cm with 100% pink wound bed; -Right anterior thigh: 0.5 cm by 0.5 cm by 0.1 cm; -Right medial knee: 4.5 cm by 3.0 cm by hypergranulation; -Left hip: Stage IV, measured 5.0 cm by 3.5 cm by 1.0 cm, 40% pink, 40% yellow; -Resident's physician assessed the wounds this week, updated about new orders, and agreed with treatment orders. During an interview on 5/11/21 at 6:10 A.M., CNA Y (agency staff) said he/she works the night shift at the facility. He/She took care of the resident approximately two weeks ago. Prior to that he/she hadn't taken care of the resident for several weeks. When he/she turned the resident on his/her side, the dressings on his/her buttocks were saturated and some of them had fallen off. The CNA said the appearance of the resident's buttocks frightened him/her because he/she didn't know what to do. He/She asked a facility CNA to help him/her. He/She doesn't know the staff member's name. The facility CNA said the facility was aware of the wounds on the resident's buttocks. He/She cleaned the wound and applied a clean dressing. CNA Y said he/she has reported when dressings have come off in the past, but the charge nurses say they would report it to the day shift nurse. Most of the time they won't replace the dressing. During an interview on 5/11/21 at 4:56 P.M., CNA Z said he/she is employed by the facility. He/She has taken care of the resident on the day shift. He/She has found the resident's dressings to be soaked and soiled. On two prior occasions he/she has changed the resident's dressings because the agency nurse said they would apply a clean dressing when they get to it, but they don't do it. The resident also has a large oozing wound which he/she feels the nurse should address. He/she has squeezed it on occasion to make the pus come out. He/she has also applied antibiotic powder to the resident's groin area because it was red. The nurse has opened the treatment cart so he/she can get supplies. He/she had a recent in-service regarding wounds and knows he/she should report it to the nurse when a dressing comes off or is soiled. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/12/21, the outside wound company Nurse Practitioner said she has evaluated the resident's pressure ulcer twice, 4/27/21 and today, 5/12/21. She found the Unstageable coccyx wound on the initial visit on 4/27/21. She said it would impact the healing of the wounds if staff aren't consistently changing the dressings as ordered. She would expect staff to complete the treatments as ordered and replace dressings when soiled or when they come off. Review of the resident's progress notes, dated 5/13/21 at 10:12 A.M., showed: -An outside wound company assessed pressure ulcers and treated this week; -Right medial knee: Stage II, measured 5.2 cm by 3.0 cm by hypergranulation, wound bed fragile, sliver nitrate applied; -Right anterior (front) thigh: Draining area from abscess, measured 0.5 cm by 0.5 cm by 0.1 cm, 100% pink; -Right lower extremity: Healing Stage III, wound has split wound bed, distal (away from the center of the body) area measured 0.8 cm by 0.5 cm by 0.1 cm with 100% pink wound bed, proximal (closer to the center of the body) area measured 1.2 cm by 0.2 cm by 0.1 cm, 10% pink, 90% yellow; -Left hip: Stage IV, measured 4.5 cm by 3.5 cm by 1.0 cm, undermining 8 - 10 (o'clock) at 2.5 cm, wound bed 50% pink, 50% yellow; -Coccyx: Unstageable, measured 3.5 cm by 2.4 cm by 0.2 cm, wound bed 40% pink and 60% yellow; -Left buttock: Has small draining area, 0.7 cm by 0.5 cm by 0.2 cm, 100% pink; -Left of scrotum: Stage II; -Right buttock: Unstageable, measured 1.8 cm by 1.8 cm by 0.2 cm with 100% yellow wound bed; -Right hip/ischium/scrotum: measured: 15 cm by 15 cm by 6.0 cm, depth around hip joint. Measures through two tunneling (are channels that extend from the wound into surrounding tissue). holes to either side of joint, top opening 2.0 cm by 0.8 cm, lower opening 3.0 cm by 1.0 cm, wound bed beefy red with sanguineous (bloody) drainage. 2. Review of Resident #224's POS, dated 4/9/21, showed: -admitted d of 4/9/21; -Order date: 4/9/21: NPWT (Negative Pressure Wound Therapy (wound vac) is a method of drawing out fluid and infection from a wound to help it heal) to sacrum, Change Monday and Thursday; -Order date: 4/9/21: Ensure NPWT is sealed and functioning every shift. Change canister if full; -Order date: 4/27/21: Left iliac crest (top of hip) of hip, treat with wound gel, gauze and dry dressing once a day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's treatment administration record (TAR), showed: -April: Order dated 4/9/21: Ensure NPWT is sealed and functioning every shift. Change canister if full. A.M.: Staff initialed as complete: 4/11 - 4/21, 4/23, 4/25 - 4/30. No staff initials on: 4/10, 4/22 and 4/24/21. P.M.: Staff initialed as complete: 4/9 - 4/25, 4/27 - 4/29/21. No staff initials: 4/26 and 4/30/21. -April: Order dated 4/27/21: Left iliac crest of hip, treat with wound gel, gauze and dry dressing once a day. Staff initialed as complete: A.M.: 4/27 - 4/30/21. Review of the facility's Wound Report, dated 4/26/21 through 4/30/21, showed: -Location: Sacral: Stage IV, start date 4/9/21, admitted with, measured 6.9 cm by 7.9 cm by 0.8 cm; -Location: Left Hip: Stage II, start date 4/26/21, new acquired, measured 0.9 cm by 0.3 cm by 0.2 cm. Review of the resident's TAR, dated 5/1/21 through 5/31/21, showed: -Order dated 4/9/21: Ensure NPWT is sealed and functioning every shift. Change canister if full. A.M.: May: A.M.: Staff initialed as complete: 5/1 and 5/2/21. P.M.: 5/1 and 5/2/21; -Order dated 4/27/21: Left iliac crest of hip, treat with wound gel, gauze and dry dressing once a day. Staff initialed as complete: A.M.: May: 5/1 and 5/2/21. Observation on 5/3/21 (Monday), showed: -At 8:42 A.M., during the tour of the facility, the resident lay on his/her back in bed, on a pressure-reducing mattress, dressed in a hospital gown. No boots or socks on the resident's feet; -At 9:21 A.M., the resident lay on his/her back in bed. A NPWT (wound vac) to the left of the resident's bed beeped and flashed Full. The wound vac canister was full of red, yellow, and white secretions; -At 10:47 A.M. and 11:45 A.M., and 12:01 P.M., the resident lay on his/her back in bed. A flat sheet covered his/her legs. The wound vac beeped and flashed Full. The wound vac canister full of red, yellow, and white secretions. The beeping could be heard from the hall; -At 12:13 P.M., CNA N entered the resident's room and shut the door. He/She exited the room at 12:25 P.M. The resident remained on his/her back in bed with eyes closed. The wound vac was off and canister was full; -At 1:06 P.M., the resident lay on his/her back in bed. The wound vac was off and canister was full; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-At 2:20 P.M., during care, the resident lay in bed. CNA CC turned the resident to his/her right side revealing a dressing to the left hip dated, 4/26/21 (Monday). Below the wound vac dressing was a pressure ulcer, with yellow slough covering the wound bed, approximately 3 cm in size. The wound vac remained off and was full of secretions. CNA CC covered the resident and left the room. He/She did not indicate he/she would report the pressure ulcer to the nurse; -At 2:38 P.M.: During a skin assessment: The Assistant Director of Nurses (ADON) and Wound Nurse entered the room. The Wound Nurse acknowledged the resident's wound vac was off and full of secretions. She said she did a recent in-service with nurses on how to change a full wound vac canister. She was sure that's the reason the wound vac was off, or it was turned off because it was beeping. She removed wound vac dressing, and packing from the pressure ulcer. The pressure ulcer measured 7.4 cm by 8 cm, the undermining measured 5 cm to 8 cm. She said the wound vac is changed on Monday and Thursday. The left hip dressing should be changed every 3 days. It should have been changed on 4/29/21. The Wound Nurse said pressure ulcer on the coccyx was new and was not there on Thursday, 4/29/21, when she checked the resident's wound vac dressing. No one reported the new pressure ulcer or that the wound vac was off. She was pulled to work as a charge nurse that day, 5/3/21. The coccyx pressure ulcer was Unstageable and measured 2.2 cm by 3.2 cm with 50% slough and 50% pink tissue. She removed the left hip dressing, dated 4/26/21, revealing a hole in the left hip, with a large amount of dark brown drainage on the dressing. She said the physician said he/she believes the wound is tunneling. The treatment nurse said she would call the physician and obtain a treatment order for the coccyx pressure ulcer. Review of the resident's progress note, dated 5/3/21, showed: -New pressure ulcer noted during dressing change to NPWT; -Unstageable coccyx pressure ulcer noted; -50% pink, 50% slough; -New per physician: Comfort foam (a dressing used to provide a moist wound environment, used for wounds with moderate to heavy exudate) every two days. Review of the resident's POS, dated 5/1/21, showed an order dated 5/3/21, for Comfort foam dressing to coccyx every two days. Review of the resident's TAR, dated 5/1/21 - 5/31/21, showed: -Comfort foam to coccyx every two days; -Staff initialed as complete: 5/4, 5/6 and 5/8. Review of the resident's progress note, dated 5/9/21, showed: -At 3:48 P.M.: Physician updated: Left hip treatment changed to every two days; -At 6:07 P.M.: Stage IV pressure ulcer to sacral area measured 6.9 cm by 6.8 cm by 0.8 cm, undermining from 5 - 7 o'clock with a depth of 6 cm. NPWT applied at -120 mmhg, change Monday and Thursday; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Left hip: Stage II, measured 0.4 cm by 0.1 cm by 0.1 cm, mild serous (thin watery) drainage. Do not use or leave brief open to prevent pressure to the area; -Coccyx Unstageable pressure ulcer, below NPWT, measured 1.0 cm by 1.0 cm, 100% yellow. It appears the sacral pressure ulcer wound has tunneled under the coccyx pressure ulcer and expects the area to open; -The physician has been updated, orders to continue the NPWT. Observation on 5/10/21, showed: -At 7:00 A.M.: During a skin assessment, the resident lay in bed on a pressure relief mattress. CNA DD positioned the resident on the right side, the left hip dressing was dated 5/9/21, the dressing above the coccyx was intact, attached to the wound vac and dated 5/9/21. The pressure ulcer, to the right of the coccyx had no dressing. To the left of the coccyx was a small pressure ulcer with slough covering the wound bed, approximately 1 cm in size. CNA DD made no acknowledgement of the pressure ulcers. He/she said he/she didn't take care of the resident last night; -At 9:45 A.M.: During a skin assessment the Wound Nurse, turned the resident to the right side and said no one reported the dressing was off the pressure ulcer to the right of the coccyx. She said the pressure ulcer looked visibly worse. She was worried about the pressure ulcer tunneling when she saw it on Friday, 5/7/21. She said the pressure ulcer to the left of the coccyx was new. No one reported it to her. It was not there on Friday 5/7/21, when she last did the resident's treatment. She would have expected staff to report the new pressure ulcer on the left of the coccyx. In addition she would have expected the night nurse to replace the dressing to the pressure ulcer to the right of the coccyx During an interview on 5/10/21 at 10:09 A.M. The Wound Nurse said the pressure ulcer to the right the right of the coccyx measured 2.5 cm by 1.4 cm, and was Unstageable. The new pressure ulcer to the left of the coccyx measured 0.5 cm by 0.4 cm with yellow slough. It is Unstageable. She said it looked as if staff failed to turn the resident and he/she laid on his/her buttocks over the weekend. 3. Review of Resident #46's admission MDS, dated [DATE], showed: -Diagnoses of heart failure, multi drug resistant organism and diabetes; -Short/long term memory loss; -Required total staff assistance for bed mobility, transfers, dressing, toilet, personal hygiene and bathing; -Required extensive assistance of staff for eating; -Incontinent of bowel and bladder; -admitted with two Unstageable pressure ulcers. Review of the facility's Wound Report, dated 3/29/21, showed: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Wound: Coccyx; -Stage: Unstageable; -Start date: 2/19/21; -admitted with; -Size: 8.0 cm by 3.2 cm. Review of the resident's care plan updated 4/1/21, showed: -Focus: Resident admitted with Unstageable pressure ulcer to coccyx; -Goal: Pressure will show signs of healing and free from infection; -Intervention: Pressure foam mattress and cushion when in chair. Out of chair as tolerated. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of the facility's Wound Report, showed: -Date: 4/5 through 4/9/21: Wound: Coccyx, Stage: Unstageable, start date: 2/19/21, admitted with, size: 7.8 cm by 4.1 cm; -Date: 4/12 through 4/16/21: Wound: Coccyx, Stage: Unstageable, start date: 2/19/21, admitted with, size: 7.5 cm by 4.0 cm; -Date: 4/26 through 4/30/21: Wound: Coccyx, Stage: Unstageable, start date: 2/19/21, admitted with, size: 7.5 cm by 4.1 cm. Review of the outside wound company's Initial Visit Case Report, dated 4/27/21, showed: -Physical Exam: Skin: Pressure ulcer to coccyx covered with soft eschar and yellow around the edges; -Wound location: Coccyx, Stage: Unstageable, Measurement: 7.5 cm by 4.0 cm, mild pain, moderate serosanguineous (fluid that contains blood and serum) drainage, Necrotic tissue: 100% yellow and black eschar. Review of the resident's POS, dated 5/1/21 through 5/31/21, showed: -Order dated 4/28/21; -Cleanse coccyx pressure ulcer with Dakin's 1/4 strength solution soaked gauze, apply Bactroban (antibiotic cream) 2% cream and alginate to wound bed and cover with foam dressing on Monday, Wednesday and Friday. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's TAR, dated 5/1/21 through 5/31/21, showed: -Cleanse coccyx pressure ulcer with Dakin's 1/4 strength solution soaked gauze, apply Bactroban 2% cream and alginate to wound bed and cover with foam dressing on Monday, Wednesday and Friday; -Staff initialed as complete 5/3/21. Observations on 5/3/21, showed: -At 8:51 A.M., during the initial tour of the facility, the resident lay on a low air loss mattress with a fall mat to the left side of the bed. During an interview at that time, the resident said he/she had a sore on his/her buttocks, but staff aren't changing the dressings. He/she pointed to his/her buttocks and said there wasn't a dressing on his/her buttocks. She doesn't understand how the wounds would heal if they don't change the dressings; -At 12:37 P.M., the resident lay in bed. The resident said staff came in to dry him/her, but they did not put a dressing on his/her buttocks. CNA F and CNA X entered at that time and positioned the resident in bed; -At 1:44 P.M., during a skin assessment, the resident lay in bed. The Wound Nurse turned the resident to the right side, removed the brief and revealed a large pressure ulcer covered with eschar to the resident's coccyx. The Wound Nurse said no one reported the resident's dressing was off. She would have expected the staff to report whenever a resident's dressing comes off so it can be reapplied. Review of the resident's progress note, dated 5/9/21 at 6:03 P.M., showed: -Resident seen by outside wound company; -The resident's physician assessed the resident's pressure ulcer during dressing change; -Coccyx: 7.5 cm by 3.5 cm, wound bed: soft eschar: 20% yellow, 80% dark eschar; -Pressure ulcers to be debrided (the removal of unhealthy/damaged/dead tissue from a wound to promote wound healing). Observations on 5/10/21, showed: -At 6:50 A.M., the resident lay in bed. The resident said there wasn't a dressing on his/her buttocks. He/she said the dressing was off during the night; -At 9:56 A.M., the resident lay in bed. Observation during a skin assessment with the Wound Nurse showed there was no dressing on the resident's coccyx. The Wound Nurse said no one reported the resident's dressing was off. She was not aware the resident's dressing was off last night. She would expect staff to report it to the charge nurse so he/she could replace it. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/10/21 at 7:05 A.M., CNA NN (agency staff) said he/she worked last night. The CNA who took care of the resident left at 5:00 A.M., which left the floor with two CNAs. When asked what he/she would do if dressings were soiled, the CNA said he/she would remove the soiled dressing and report it to the charge nurse. The charge nurse usually records the information in the report book that the dressings need to be replaced or that they are off. The night nurse usually notifies the day nurse that a dressing was off and report it to the Wound Nurse. Most of the agency nurses will not replace the dressing if it is soiled or comes off. Review of the resident's progress notes, dated 5/13/21 at 10:29 A.M., showed: -Resident see by Outside Wound Company; -Coccyx pressure ulcer: 8.0 cm by 4.0 cm by 0.2 cm; -Wound bed: 20% yellow slough, 80% soft brown eschar; -Erythema (redness and inflammation) to periwound (area surrounding the wound); -Drainage: green; -NP suggest antibiotic. The resident's physician declined antibiotic. 4. Review of Resident #63's quarterly MDS, dated [DATE], showed: -Cognitively intact, able to make needs and wants known; -No behaviors; -Total staff assistance needed for hygiene, bed mobility, transfers and eating; -Diagnoses of cancer, diabetes, quadriplegia, multiple sclerosis (disease in which the immune system destroys the protective covering of nerves interrupting the nerve signals from the body to the spinal cord/brain) and depression; -Used urinary catheter and a colostomy; -At risk to develop pressure ulcer or pressure injury; -No unhealed wounds; -Used a pressure reducing device on the bed and chair; -Used a turn and reposition program; -Staff applied dressings other than to the resident's feet. Review of the resident's undated care plan, in use during the survey, showed: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Focus: The resident is at risk for skin breakdown. He/she has a history of skin breakdown and requires total care from staff; -Goal: The resident will have intact skin, free of redness, blisters or discoloration; -Interventions: Staff administer treatments as ordered and monitor for effectiveness, assess skin routinely, ensure pressure relief mattress on bed and cushion in the wheelchair, the resident should be placed back in bed after four hours in the wheelchair, staff use wedge or pillows to reduce pressure to ankles and heels, place a donut in between the knees and the resident should wear soft boots at all times. Review of the resident's POS, showed an undated order, to avoid pressure to the right ankle. Turn the resident to the left side or turn the right leg to the left side or up. Avoid the right side down during every day and night shift. Review of the resident's Comprehensive CNA shower sheets, showed: -On 3/27/21: No irregular skin concerns, signed by the aide and no nurse signature; -On 3/30/21: The resident received a bed bath, no irregular skin concerns, signed by the aide and the nurse; -On 3/31/21: The resident received a bed bath, no irregular skin concerns, signed by the aide and the nurse; -On 4/4/21: No irregular skin concerns, signed by the aide and no nurse signature; -No further shower sheets available after 4/4/21. Review of the resident's weekly skin assessment, dated 4/17/21, showed no skin concerns. No further weekly skin assessments available or located. Observations and interviews, showed: -On 5/3/21 at 9:17 A.M., 11:51 A.M., 12:45 P.M., and 2:13 P.M., the resident lay in bed on his/her back with a blue wedge under his/her lower legs. The wedge was in direct contact with the resident's lower leg skin. The resident said he/she needed staff to move him/her in bed and provide all care needs. Staff do not turn him/her very often in bed and he/she often lay on his/her back for long periods of time. The wedge is always under his/her lower legs to keep his/her feet off of the bed. He/She cannot feel pain or discomfort well because of his/her MS. He/She is unable to reposition himself/herself. He/She

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure staff implemented interventions consistent with a resident's individual needs in accordance with their care plan to eliminate the risk and/or reduce the risk of an accident, and to ensure staff performed neurological assessments and fall investigations in accordance with the facility's policy, for five residents (Residents #37, #69, #15, #20 and #384). The sample was 18. The census was 75. Review of the facility's Falls Programs Policy and Procedure, reviewed January 2020, showed: -Purpose: To identify all residents who have a high risk for falls and to ensure adequate interventions are in place to prevent a major injury; -Policy: All residents will be evaluated to assess for fall risk on admission/readmission. An investigation of all falls will be completed by the DON/designee and submitted to the interdisciplinary team (IDT) committee for review; -Procedure: -The Fall Risk Evaluation will be completed on every resident upon admission/readmission by the nurse on the shift that the resident is admitted on ; -When a resident is identified as being at a high risk for falls, an Initial Plan of Care must be implemented upon admission and the fall risk interventions noted on the Kardex; -When a resident within the facility falls, the nurse will assess/evaluate the resident and document in the electronic medical record (EMR). Neuro checks (neurological assessments) will be initiated for all unwitnessed falls, residents on anticoagulant or antiplatelet medication or hit their head and as ordered by the physician/practitioner; -The nurse will complete a new Fall Risk Evaluation in the EMR; -The nurses document post fall for 72 hours completing the Fall Follow Up 72 Hour in the EMR; -The DON/designee will complete the Post Fall Evaluation within 24 hours and/or the next business day in the EMR; -Fall tracking/incident reports are completed in the electronic Risk Management Program; -Fall tracking is reviewed during monthly Quality Assurance Performance Improvement (QAPI) for patterns and trends. 1. Review of Resident #37's medical record, showed: -admitted on [DATE]; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included heart failure, high blood pressure, dementia, history of falling and history of healed traumatic fracture; -A Fall Risk Evaluation, dated 6/25/20 identified the resident as At Risk for falls with a score of 14. Review of the resident's progress notes and assessments, showed: -An incident note, dated 6/25/20 at 1:55 A.M., in which staff documented the resident found laying on the floor in the doorway of his/her room. Resident stated he/she was trying to get dressed. Resident assessed and vitals taken; blood pressure was 196/81. Resident had some complaint of pain on right side hip and leg. Resident stayed up in chair next to certified nurse's aide (CNA) and did not want to go to bed at this time. Resident was able to communicate needs; -No documentation regarding Neurological checks (neuro checks, assessments include (at a minimum) pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength, including assessment of range of motion); -A situation-background-assessment-recommendation (SBAR), dated 6/25/20 at 2:25 A.M., in which staff documented the resident's vitals obtained at 2:29 A.M. Neurological Status Evaluation: Resident was laying on the floor in the doorway, stated he/she was getting dressed for work. Primary Care Provider feedback; no recommendations; -No documentation regarding assessment of range of motion; -A transfer to hospital note, dated 6/25/20 at 4:57 A.M., in which staff documented the resident complained of pain on the right side hip and leg. Nurse assessed resident and called physician. Resident is being sent out to the hospital. -No Post Fall evaluation or fall investigation documented. Review of the resident's hospital record, showed the resident admitted to the hospital on 6/25/20 and diagnosed with right femur fracture. Resident underwent surgery and returned to the facility on [DATE]. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/26/21, showed: -Severe cognitive impairment; -Required limited assistance of one person for transfers; -Balance not steady when moving from seated to standing position, or surface-to-surface transfer; -One fall without injury since last assessment. Review of the resident's Kardex, printed on 5/11/21, showed guidance for safety included ensuring resident wears a seat belt and the bed is to remain in the lowest position with fall mat next to bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's undated care plan, showed: -Focus: Resident at risk for falls related to gait/balance problems. Unaware of safety needs. Diagnoses of dementia and femur fracture in May (year not specified). 6/29/20 readmitted after fall on 6/25/20 and sustained hip fracture; -Interventions included ensure nonskid footwear and bed in lowest position with fall mat next to bed; -Focus: The resident has had an actual fall related to poor balance, and unsteady gait; -11/8/20 removed seat belt and attempted to stand in dining room, sustained hematoma to right temple and laceration to right wrist and hand; -3/3/21 resident slid out of wheelchair; -3/11/21 resident slid from wheelchair and sustained abrasion to right elbow; -4/6/21 resident stood from wheelchair in courtyard and fell ; -4/7/21 fall transferring himself/herself to a recliner; -Interventions included ensure resident wears seat belt and keep bed in lowest position. Observations on 5/3/21, showed: -At 8:39 A.M., the resident lay in bed with head of bed elevated 45 degrees. Bed positioned at regular height. No fall mats on floor next to bed; -At 1:10 P.M., the resident seated in his/her wheelchair in the dining room. He/she unbuckled his/her seat belt, pulled off his/her nonskid socks, and stood up. Two staff seated in the dining room did not acknowledge or redirect the resident. He/she sat back in his/her wheelchair and socks remained off; -At 3:14 P.M., the resident lay in the bed, positioned at regular height. No fall mats on floor next to bed. Observation on 5/5/21 at 9:45 A.M., showed the resident lay in bed with eyes closed. Bed positioned at regular height. No fall mats on floor next to bed. Observation on 5/12/21 at 8:04 A.M., showed the resident seated at the foot of his/her bed, facing the left side of the bed and visible from the doorway to the room. The resident was alert and confused, talking nonsensically. He/she wore a brief and long-sleeved shirt without footwear. The bed was in the low position. No fall mats were on the floor next to the bed. 2. Review of Resident #69's medical record, showed: -admitted on [DATE]; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included heart failure, unsteadiness on feet, stroke, traumatic brain bleed with loss of consciousness for unspecified duration, dysphagia following stroke (difficulty swallowing), attention and concentration deficit following stroke and depression; -A physician's order, dated 1/31/20, for floor mats down while resident is in bed. Review of the facility's incident/accident report, dated 2/3/21 through 5/3/21, showed the resident had one unwitnessed fall, which occurred 3/31/21 at 9:20 A.M. Review of the resident's Fall Risk Evaluation, dated 3/1/21, showed the resident identified as At Risk for falls with a score of 11. Review of the resident's medical record, showed: -A nurse's note, dated 3/25/21 at 11:00 A.M., the resident fell forward out of his/her wheelchair and had a large hematoma to left side of the forehead, complaints of head pain. Physician notified, received order to send to hospital; -A Neurological Focused Evaluation, dated 3/25/21 at 11:46 A.M., in which staff documented vital signs obtained at 11:22 A.M. and within normal limits. Resident complains of generalized pain, rated as a 5 and constant. Cool compress applied. Neurologic: Pupils with sluggish response. Mood/Behavior: Resident is disoriented, confused. Oriented to person. Current disorientation is baseline for resident. As needed (PRN) medication administered. Pain/discomfort: Yes. Additional vital signs obtained at 12:18 P.M.; -A nurse's note, dated 3/25/21 at 6:52 P.M., resident returned from emergency room with no new orders. Continue with neuro checks; -No documentation of additional neuro checks or Fall Follow Up 72 Hour completed on 3/26/21 or 3/27/21; -No new Fall Risk Evaluation completed; -A nurse's note, dated 3/31/21, showed a loud thud heard from the resident's room. Upon entering the room, the resident found on the floor next to his/her bed, in front of his/her wheelchair. No injuries noted and range of motion performed without difficulty. Vitals documented. Physician notified; -A Fall Risk Evaluation, dated 3/31/21, the resident identified as At Risk for falls with a score of 18; -A Neurologic Focused Evaluation, dated 3/31/21 at 11:46 A.M., resident complained of head pain at a 10 and PRN medication administered. Vitals within normal limits; -Neuro check evaluations completed 3/31/21 and 4/1/21; -No neuro checks documentation of neuro checks or Fall Follow Up 72 Hour completed on 4/2/21. Review of the resident's quarterly MDS, dated [DATE], showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -Total dependence of one person physical assist for bed mobility; -Total dependence of two (+) person physical assist for transfers; -Upper and lower extremity impaired on one side; -One fall with injury and one fall without injury since prior assessment. Review of the resident's Kardex, printed 5/11/21, showed guidance for safety included keep bed in low position and blue mat on floor next to bed. Review of the resident's undated care plan, showed: -Focus: The resident is at risk for falls related to stroke with hemiplegia (paralysis to one side of the body). Resident is in new surroundings with overall decline in functioning ability. Falls on 3/25/21 and 3/31/21 documented; -Interventions included keep bed in low position and blue mat on floor next to bed. Observations of the resident, showed: -On 5/3/21 at 11:47 A.M., the resident lay in bed with eyes closed. Bed at regular height, not in low position. No fall mats on floor; -On 5/3/21 at 1:03 P.M., the resident seated in bed with eyes open, alert. Bed at regular height, not in low position. No fall mats on floor next to bed; -On 5/4/21 at 9:04 and 10:10 A.M., the resident lay in bed with eyes closed. Bed at regular height, not in low position. No fall mats on floor; -On 5/4/21 at 1:02 P.M., the resident seated in bed, with head of bed elevated 45 degrees. The resident slouched down so his/her lower back lay on the flat part of the bed, while he/she ate lunch. Bed at regular height, not in low position. No fall mat on floor; -On 5/5/21 at 12:58 P.M., the resident lay in bed with eyes closed. Bed in low position. No fall mat on floor; -On 5/6/21 at 7:53 A.M. and 11:14 A.M., the resident seated in bed with head of bed elevated 45 degrees. Bed at regular height, not in low position. No fall mat on floor; -On 5/10/21 at 8:47 A.M., the resident lay in bed. Bed in low position. No fall mat on floor; -On 5/13/21 at 8:54 A.M. and 12:35 P.M., the resident seated in bed with eyes open, alert. Head of bed elevated. Bed at regular height, not in low position. No fall mat on floor. 3. Review of Resident #15's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -Adequate hearing/vision; -Ability to express ideas and wants: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others: Usually understands - misses some part/intent of message but comprehends most conversation; -Brief interview for Mental Status (an assessment used to determine cognitive status) score of 7 out of a possible 15 (severely impaired cognition); -Required limited assistance of one person for bed mobility; -Required extensive assistance on one person for transfers, dressing, toilet use, personal hygiene and bathing; -Independent for locomotion on/off the unit; -Functional limitation of both lower extremities; -Mobility device: Wheelchair; -Diagnoses of renal (kidney) insufficiency, diabetes mellitus, stroke, hemiplegia (the complete loss or paralysis on one half of the body) or hemiparesis (minor to severe weakness of one half of the body) and manic depression (alternating moods of abnormal highs (mania) and lows (depression)); -No falls since admission or prior assessment. Review of the resident's care plan, showed: -At risk for falls related to bilateral lower extremity amputation and new surroundings; -The resident had actual falls on: -10/18/20: Found on floor next to bed; -10/25/20: Fall, slid out of wheelchair attempting to transfer unassisted; -10/31/20: Resident found on floor next to bed; -1/26/21: Fall transferring self from bed; -1/26/21: Another fall attempting to transfer, complained of right wrist pain; -1/27/21: Observed on floor next to bed; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2/10/21: Fall attempting to transfer from bed to wheelchair; -2/13/21: Fall attempting to transfer self without assistance; -2/23/21: Found on floor between wall and bed; -2/26/21: Fall transferring self to wheelchair unassisted; -3/4/21: Found on floor next to bed on fall mat; -4/8/21: Found on floor in front of toilet in his/her bathroom; -4/29/21: Fall transferring self from bed to wheelchair; Further review of the care plan, showed interventions included: -10/18/20: Remind resident to use call light to transfer safely; -10/31/20: Continue education. Bed in low position and fall mat next to bed' -1/27/21: Resident states understanding that it is unsafe to transfer self, will wait for assistance; -No date: Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed; -No date: The resident needs a safe environment, even floors, free from spills and/or clutter, reachable call light, the bed in lowest position at night with fall mat; -2/22/21: Ensure bed in lowest position and fall mat next to bed; -3/4/21: Continue to keep bed in lowest position with fall mat next to bed. Observations of the resident on 5/4/21 at 6:59 A.M. and 11:34 A.M., 5/5/21 at 7:07 A.M. and 7:37 A.M., 5/6/21 at 5:13 A.M., 7:50 A.M. and 8:17 A.M. and on 5/10/21 at 6:45 A.M., showed the resident lay in bed, his/her bed against the wall and the fall mat underneath the bed. Review of the 100 Hall Key Interventions form, kept in the Kardex report book (used by CNAs), showed: -Remind resident to use call light to transfer for safety, wait for staff assist, stand by assistance for transfers. Fall risk, check on resident's needs such as toileting. Review of the resident's Kardex report, showed the same interventions as listed on the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/21 at 12:00 P.M., the Director of Nursing (DON) said the resident's fall mat is an intervention used to prevent or limit injuries to the resident from falls. When the resident is in bed, the fall mat should be positioned on the floor next to the bed and not underneath it. 4. Review of Resident #20's annual MDS, dated [DATE], showed: -admitted on [DATE]; -Severe cognitive impairment; -Required extensive assistance of one person physical assist for transfers; -Balance not steady when moving from seated to standing position, or surface-to-surface transfer; -Diagnoses included heart disease, dementia, non-traumatic brain dysfunction, and peripheral vertigo (problem with inner ear affecting balance); -Two or more falls since last assessment. Review of the resident's Fall Risk Evaluation, dated 3/17/21, showed: -Disoriented at all times; -Three or more falls in past three months; -Chair bound; -Balance problem while standing and walking; -Decreased muscular coordination; -At Risk of falls with a score of 20. Review of the resident's undated care plan, showed: -Focus: The resident is at risk for falls. Resident has history of falls. Resident can be impulsive and stands from wheelchair. Resident has dementia and decreased safety awareness. -2/5/21: fall to floor attempting to transfer self from bed; -3/17/21: fall from wheelchair in room; -3/21/21: fall transferring self from couch in lobby; -4/13/21: fall transferring self from wheelchair to couch; -5/4/21: removed seat belt and slid to floor from wheelchair; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions included properly fitting footwear, and ensure bed is in lowest position and blue mat next to bed. Review of the resident's Kardex, printed on 5/11/21, showed guidance for safety included ensure bed is in lowest position and blue mat is next to bed, and properly fitting footwear. Observations on 5/3/21, showed: -At 8:35 A.M. and 10:39 A.M., the resident lay on his/her right side in bed, positioned low. A thin, gray fall mat on the floor, half underneath the bed with approximately 6 inches of the mat exposed on the left side of the bed. No fall mat on the right side of the bed; -At 10:59 A.M., the Assistant Director of Nurses (ADON) entered the room and exited within a few minutes; -At 11:07 A.M. and 12:19 P.M., the resident lay on his/her right side in bed with the fall mat unchanged in position, half underneath the bed; -At 12:28 P.M., CNA N entered the resident's room and left a lunch tray on his/her bedside table; -At 12:42 P.M., 1:12 P.M., and 3:11 P.M., the resident lay on his/her right side in bed, with the fall mat unchanged in position, half underneath the bed with approximately 6 inches of the mat exposed on the left side of the bed. Observations on 5/4/21, showed: -At 7:23 A.M., the resident seated in his/her wheelchair in the dining room, wearing regular socks and no shoes. No pedals on the wheelchair; -At 10:10 A.M., the resident lay on his/her right side in bed, positioned low. A thin, gray fall mat on the floor, mostly underneath the bed with several inches of the mat exposed on the left side of the bed. No fall mat on the right side of the bed. Observation on 5/11/21 at 4:51 P.M., showed the resident lay on his/her back in bed, positioned low. A thin, gray fall mat on the floor, completely underneath the bed. Observation on 5/13/21 at 8:34 A.M., showed the resident lay on his/her back in bed, positioned low. A thin, gray fall mat on the floor, completely underneath the bed. Observation on 5/14/21 at 9:26 A.m., showed the resident lay in bed with a cover over his/her head. Bed positioned low and a thin, gray fall mat on the floor, half underneath the bed with approximately 6 inches of the mat exposed on the left side of the bed. No fall mat on the right side of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/11/21 at 7:43 A.M., Nurse I said the resident has frequent falls and tries to transfer himself/herself all the time. The resident can unlock his/her wheelchair brake, unfasten his/her seat belt, and transfers himself/herself without assistance. His/Her bed should be in the low position, but ideally, his/her bed would be directly on the floor because more often, the resident falls when transferring to and from the bed. He/She has a fall mat that should be next to his/her bed, not underneath it; however, this might not be an effective intervention because he/she falls during transfers. 5. During an interview on 5/10/21 at 9:33 A.M., CNA BB said residents who have histories of falls should be wearing shoes and/or nonskid socks, and should be positioned correctly in their wheelchairs or if in bed, the bed should be low to the ground. He/She did not know how to identify which residents were a fall risk or which resident required specific fall interventions. Sometimes the back of a resident's wheelchair will show if they are a fall risk. To his/her knowledge, Residents #37, 69, and #20 have not had any recent falls. None of them have fall mats. If an aide comes across a resident who has fallen, they have to notify the nurse as soon as possible and the nurse will assess the resident. During an interview on 5/11/21 at 6:03 A.M., Nurse Q said if an aide comes across a resident who has fallen, they should notify the nurse right away. A resident should not be moved until the nurse completes a full assessment. The nurse should assess the resident's vitals, pain level, and range of motion. Neuro check protocol is initiated for all unwitnessed falls and any fall with a head injury. Neuro checks are performed to assess for head injury and should be completed every 15 minutes for an hour, then every 30 minutes, every hour, and every shift until 72 hours has passed. Neuro checks should be documented in the resident's EMR. During an interview on 5/11/21 at 7:58 A.M., Nurse I said neuro checks are initiated for all unwitnessed falls and falls with head injury. Neuro checks must be performed by the nurse, who assess a resident's cognition and range of motion. Neuro checks are done every 15 minutes, every 30 minutes, every hour, and every shift for 72 hours following a fall. They are documented in the resident's electronic medical record. It is not acceptable to stop neuro checks a day or so after the fall because they must be completed until 72 hours have passed in order to ensure there is no brain bleed or delayed injury. During an interview on 5/11/21 at 11:24 A.M. and 4:58 P.M., the DON said neuro checks should be initiated for unwitnessed falls and any fall with head injury, suspected head injury, or altered level of consciousness. If a fall is unwitnessed and the resident can tell staff what happened, then there is no need for neuro checks. Neuro checks should be performed by the nurse every 15 minutes, every hour, and every shift for the 72 hours following a resident's fall. They are performed to see if there are any neurological issues or injury, and should be documented in the resident's EMR. The circumstances of a fall should be investigated and documented in the resident's record. Falls are discussed in the daily clinical meetings, at which time staff discusses what interventions should be put in place. Falls are also discussed in the monthly Quality Assurance/Performance Improvement (QAPI) meetings. Fall interventions are added to the resident's care plan and Kardex. The Kardex is used by CNAs to determine what interventions they should implement. Fall mats should not be positioned under a resident's bed. They need to be on each side of the bed to be effective. Residents who are at risk of falls should be wearing nonskid socks or footwear, and when in bed, their bed should be positioned low. All staff, including housekeeping, are responsible for ensuring beds in the low position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #384's face sheet, showed the following: -admitted [DATE]; -Diagnoses of abscess of the buttock, diabetes, high blood pressure and chronic kidney disease. Review of the resident's initial care plan, dated 5/6/21, showed the following: -Focus: Resident has an ADL deficit; -Intervention: Required moderate assistance of staff for bathing/showering two times per week. Required minimal assistance with bed mobility, dressing, personal hygiene and transfers. Review of the resident's progress note dated 5/21/21, showed the following: -9:55 A.M.: Resident complained of being tired and doesn't feel like him/herself. Resident's physician assessed him/her. New order received for urinalysis, Complete Blood Count (CBC, Laboratory test used to evaluate the cells that circulate in the blood), Basic Metabolic Profile (BMP, blood test used to check kidney function); -10:03 A.M.: Notified resident's significant family member of the physician's orders; -10:51 A.M.: Resident had a change of condition. New order received to send to the hospital for evaluation and treatment; -11:00 A.M.: Resident had a change of condition, very loose stools, change in mental status. During an interview on 5/21/21 at 6:15 P.M., Nurse TT, agency nurse, said he/she worked 5/20/21 from 6:00 P.M. until 6:30 A.M., on the 200 hall. During report, he/she asked how the resident was because when he/she last worked the floor, the resident had a cough. The nurse reported the resident slept most of the day but nothing unusual. When he/she made rounds on the hall, he/she saw the resident lay in the bed sleeping. During rounds, CNA UU reported the resident had diarrhea and was fussing about getting cleaned. He/She went into the room and spoke to the resident. He/She told the resident his/her bed was soiled and for him/her to allow CNA UU to clean him/her. He/She instructed CNA UU to clean the stool off the floor in the bathroom and clean the resident. He/She left the room. Not more than five minutes later, CNA UU reported the resident was on the floor. He/She reentered the room, observed the resident was on the floor and a skin tear to his/her hand close to the wrist. He/She asked CNA how the skin tear occurred. CNA UU reported the resident pulled away from him/her and lay on the floor when he/she tried to get him/her up so he/she could change the bed. He/She and CNA UU assisted the resident off the floor. He/she applied triple antibiotic ointment and a dressing. After CNA UU cleaned the resident's bed, the resident slept the rest of the night without further complaints. When asked why she failed to document the skin tear in the process note, Nurse TT said he/she became busy and forgot to document. He/she did not notify the oncoming shift regarding the skin tear or the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/21 at 4:40 P.M., Nurse I said he/she was one of the nurses who worked the day shift on the 200 hall. He/she started the shift at 6:00 A.M., this morning, 5/21/21. During rounds, he/she noticed a change in the resident's mental status and he/she was having diarrhea. This was not his/her normal behavior. They notified the physician and received an order to send him/her to the hospital for evaluation. He/she did see the dressing on the resident's right wrist. He/She didn't remove the dressing. The was nothing documented in the report regarding the resident's dressing, diarrhea or a fall. During an interview on 5/21/21 at 5:00 P.M., Nurse VV said he/she arrived to start the shift at 6:00 A.M. He/she received report from Nurse TT. Nurse TT did not report any concerns regarding the resident. Nothing was reported about a fall or a skin tear. The resident did not report anything unusual to him/her. During an interview on 5/24/21 at 1:10 P.M., the ADON said he was unaware the resident fell or had a skin tear until this surveyor asked about it on 5/21/21. He would have expected Nurse TT to complete the Risk Management/Incident Report in the electronic record, notify the DON/ADON regarding the incident, notify the physician, obtain a treatment order and document it in the resident's progress note. MO00171991 27723 37672 40290

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 27723 40290 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services to prevent urinary tract infections (UTIs) by failing to adequately assess and report changes regarding an indwelling urinary catheter (a tube inserted into the bladder for the purpose of continual urine drainage) for one resident (Resident #224), and by failing to provide appropriate indwelling urinary catheter positioning for three residents (Residents #51, #19 and #59). The facility identified four residents as having indwelling urinary catheters. All four residents were chosen for the sample and problems were found with all four. The sample was 18. The census was 75. Review of the facility's indwelling urinary catheter care policy, dated January 2020, showed: -Procedure: -Provide perineal care (peri-care) first prior to catheter care; -Check catheter to make sure positioning promotes proper flow of urine, no pulling present, and catheter bag is below level of bladder; -Notify physician of any concerns; -Document all changes. 1. Review of Resident #224's face sheet, showed: -admitted on [DATE]; -Diagnoses included degenerative disease of nervous system, heart disease, heart attack, diabetes, and major depressive disorder. Review of the resident's discharge orders from his/her previous facility, printed 4/9/21, showed a physician's order, dated 4/6/21 through 4/11/21, for ciprofloxacin (Cipro, an antibiotic) 500 milligrams (mg) one tab every 12 hours for five days for a UTI. Review of the resident's primary care physician's (PCP) progress note, dated 4/9/21, showed: -Medication list included Cipro 500 mg every 12 hours for 5 days; -Assessment/Plan: UTI, treatment Cipro for 5 days, Enterobacter (a gram-negative bacteria). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician order sheet (POS) and medication administration record (MAR) for April 2021, showed no orders for ciprofloxacin, or documentation of the medication as administered. Review of the resident's clinical admission evaluation, dated 4/9/21, showed: -Body System Baselines: Resident continent of bladder. Urine clear yellow. Denies urinary complaints; -Mental status: Alert and oriented x 3. -General note: Resident came from another facility. He/she has a urinary catheter size 18 French (fr) with 30 cubic centimeter (cc) balloon draining amber urine. Further review of the resident's POS, showed: -An order, dated 4/22/21, to change urinary catheter with 18 fr with a 30 cc balloon every morning on the 15th for UTI, starting on 5/15/21; -No physician's orders for catheter care or catheter changes as needed (PRN). Review of the resident's care plan, undated and in use at the time of survey, showed no documentation regarding the resident's indwelling urinary catheter. Review of the resident's progress notes, from 4/22/21 through 5/3/21, showed no documentation of the resident experiencing a decline in his/her health status. No documentation of the resident experiencing hallucinations or increased lethargy, or issues with his/her catheter. Observations on 5/3/21, showed: -At 8:42 A.M., 9:21 A.M., 10:47 A.M., 11:45 A.M., and 12:01 P.M., the resident lay on his/her back in bed with eyes closed, dressed in a hospital gown with his/her lower legs uncovered. A catheter bag hung on the right side of the resident's bed, visible from the doorway to the room, with pink-tinged urine and thick strings of mucus in the catheter tubing; -At 12:13 P.M., Certified Nurse Aide (CNA) N entered the resident's room and shut the door; -At 12:25 P.M., CNA N exited the resident's room. The resident remained on his/her back in bed with eyes closed and his/her catheter tubing remained full of pink-tinged urine and thick strings of mucus, visible from the doorway to the resident's room; -At 12:34 P.M., Certified Medication Technician (CMT) C delivered a lunch tray to the resident's room. He/She uncovered the resident's lunch plate and opened his/her cup of fruit, then left the resident's room. The resident remained in bed with his/her eyes closed and food untouched. His/Her catheter tubing remained full of pink-tinged urine and thick strings of mucus, visible from the doorway to his/her room; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 1:06 P.M., CNA N entered the resident's room and called the resident's name. The resident opened his/her eyes and took several bites of potato salad and watermelon. His/her catheter bag remained hanging on the right side of the bed, and the catheter tubing remained full of pink-tinged urine and thick strings of mucus, visible from the doorway to the resident's room. Observations on 5/4/21, showed; -At 7:02 A.M., the resident lay on his/her back in bed. A catheter bag hung on the right side of the resident's bed, visible from the doorway to the room, with pink-tinged urine and thick strings of mucus in the catheter tubing; -At 7:32 A.M., staff delivered a breakfast tray to the resident's room and the resident pushed food around on his/her plate; -At 9:12 A.M., the resident lay on his/her back in bed with eyes closed. CNA P entered the resident's room and exited a minute later. The resident remained on his/her back in bed. His/her catheter bag remained hanging on the right side of the bed, and the catheter tubing was full of pink-tinged urine and thick strings of mucus, visible from the doorway to the resident's room; -At 10:10 A.M. and 1:02 P.M., the resident lay on his/her back in bed with eyes closed. His/her catheter bag remained hanging on the right side of the bed, and the catheter tubing was full of pink-tinged urine and thick strings of mucus, visible from the doorway to the resident's room. Observations on 5/5/21, showed: -At 7:35 A.M., the resident lay on his/her right side in bed. A catheter bag hung on the right side of the bed, and the catheter tubing was full of pink-tinged urine and thick strings of mucus, visible from the doorway to the resident's room; -At 7:47 A.M., the resident remained on his/her back in bed with his/her catheter bag hanging on the right side of the bed. CNA O sat in a chair next to the resident's catheter tubing, while he/she fed the resident breakfast; -At 9:47 A. M, 11:27 A.M., and 1:01 P.M., the resident lay in bed with eyes closed. His/Her catheter bag remained hanging on the right side of the bed, visible from the doorway to the room, with pink-tinged urine and think strings of mucus in the catheter tubing. Observations on 5/6/21, showed: -At 7:53 A.M., the resident lay on his/her back in bed. His/er catheter bag hung on the right side of the bed with pink-tinged urine and thick strings of mucus in the catheter tubing. A staff member sat in a chair next to the resident's catheter tubing, while he/she fed the resident breakfast; -At 11:14 A.M., the resident remained on his/her back in bed. His/Her catheter bag remained hanging on the right side of the bed, visible from the doorway to the room, with pink-tinged urine and think strings of mucus in the catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress notes, from 5/3/21 through 5/6/21, showed no documentation of the resident experiencing a decline in his/her health status. No documentation of the resident experiencing hallucinations, increased lethargy, or issues with his/her catheter. Review of the resident's psychiatrist's note, dated 5/7/21, showed: -History: Patient seen, chart reviewed, obtained verbal update from staff. Nursing notes reviewed, no report regarding mood since last visit. Verbally, nursing reported patient has been declining, has not been eating. Primary physician started antidepressant medication trial on 4/22/21. Staff also reported patient has been hallucinating, appears to be talking to people and calling them by name. Further reported to be intermittently sleeping more and not eating very well; -Assessment and Plan: Given presence of active hallucinations, recommend decreasing sedating medications. Discontinue one antidepressant medication and decrease anticonvulsant medication for five days, then discontinue. Requesting to rule out UTI. Review of the resident's handwritten physician orders, showed on 5/7/21, the psychiatrist documented his/her recommendation to discontinue medications as indicated in his/her progress note, and to obtain a urinalysis with culture and sensitivity (a test to determine if there is infection and if so to identify what the organism is and what medication will treat it) if necessary for diagnoses of acute hallucinations. No documentation staff communicated the psychiatrist's recommendation to the PCP. Review of the resident's progress note, dated 5/10/21 at 8:30 A.M., showed staff documented the resident was lethargic, responds to verbal and physical stimuli. Urinary catheter intact with some mucus in tubing. Unable to make needs known. Will continue to monitor. No documentation staff notified the PCP of the resident's condition. Observations on 5/10/21 at 8:46 A.M. and 12:25 P.M., showed the resident lay on his/her back in bed with eyes closed. His/Her catheter bag hung on the right side of the bed, visible from the doorway to the room, with pink tinged urine and thick strings of mucus in the catheter tubing. Observation on 5/11/21 at 6:03 A.M., showed the resident lay on his/her back in bed with eyes closed. His/her catheter bag hung on the right side of the bed, with pink-tinged urine and thick strings of mucus in the catheter tubing. Nurse Q entered the resident's room and observed the catheter tubing. During an interview, Nurse Q, said he/she was the nurse assigned to the resident's hall that night. He/she had not noticed the pink-tinged urine and mucus in the catheter tubing until now. The catheter tubing appeared to contain blood-tinged sediment. The resident might have hematuria (blood in the urine). If one of the CNAs noticed this before, they should have reported it to the nurse right away. The nurse would have to assess the resident, obtain his/her vitals, and see if the resident had a fever. This should be reported to the physician. The resident could have a UTI or the hematuria could be from his/her catheter getting yanked. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/11/21 at 7:58 A.M., Nurse I said he/she saw the resident's catheter tubing earlier that morning and it looked full of sediment, but he/she has not made his/her way to the resident to pass medication yet, and has not checked the resident's catheter bag. The resident might be on a medication that causes his/her urine to have a pink tinge. He/she reviewed the resident's POS in the electronic medical record (EMR) and noted the resident was not prescribed medication that would cause his/her urine to have a pink tinge. The POS showed orders to change the resident's catheter on 5/15/21, but there were no orders to change the catheter on an as needed (PRN) basis. Nurse I said the resident's urine might have a pink tinge because he/she drinks cranberry juice. Observation showed, Nurse I entered the resident's room, donned gloves, and pulled the resident's catheter bag out of the protective covering. He/she said there is sediment in the bottom of the bag, and pink-tinged sediment in the catheter tubing. The pink-tinged sediment does not appear to be hematuria (blood in the urine). The catheter might need to be irrigated and the bag should be changed. He/she will have to assess the resident and notify the physician. The resident should have physician's orders for PRN catheter changes and flushes. CNAs should be looking at catheter tubing when they provide care, and if they notice a pink tinge, they should notify the nurse right away. The resident does not usually complain of pain. He/she sleeps all the time. During an interview on 5/11/21 at 11:24 A.M., the Director of Nurses (DON) said no one told her about issues with the resident's catheter. If the nurse notices a resident's catheter tubing is filled with pink-tinged sediment or mucus, they should notify the physician and change the catheter. The nurse should assess the resident for signs and symptoms of a UTI, get a current temperature on him/her, and document any increased confusion, lethargy, or changes to level of consciousness. The resident has been tired since admitted to the facility. Staff need to follow up about his/her catheter. If there are only orders to change his/her catheter once a month, the nurse should notify the physician to get orders for PRN catheter changes. Review of the residents' medical record, showed: -A nurse's note entered on 5/11/21 at 11:53 A.M., in which staff documented the resident is experiencing altered mental status. PCP notified and an order was given to obtain a urinalysis with culture if indicated; -No temperature documented on 5/11/21. Observation on 5/11/21 at 12:39 P.M., showed the resident on his/her back in bed. His/her catheter bag hung on the right side of the bed with clear catheter tubing, draining yellow urine. During an interview, Nurse I said the physician was notified of the resident's pink-tinged urine and orders were received to obtain labs to check for a UTI. At 12:44 P.M., CNA K began feeding the resident lunch. The resident laughed to him/herself, and talked nonsensically. During an interview on 5/12/21 at 8:05 A.M., CNA P said the resident never comes out of his/her room and sleeps all day. He/She does not refuse care from staff, and allows them to provide peri-care as needed. CNAs are supposed to clean catheters when they provide peri-care. The resident is still incontinent of bowel, so it is important to make sure and clean his/her catheter after a bowel movement. If CNAs notice issues with catheter tubing, such as it looking clogged, they must report it to the nurse. CNA P noticed mucus and sediment in the resident's catheter tubing last week and discussed it with the other nursing staff, but they didn't know what the cause was. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 5/12/21, showed: -At 8:44 A.M., the resident sat upright in bed, eating breakfast. His/her catheter bag hung on the right side of the bed, with yellow urine in the catheter tubing; -At 10:01 A.M., the resident sat upright in bed, talking and laughing to him/herself. His/her catheter bag hung on the right side of the bed, with yellow urine in the catheter tubing. Observation on 5/13/21 at 8:49 A.M., showed Nurse I sat in a chair next to the right side of the resident's bed, next to the resident's catheter bag. Pink-tinged urine and thick strings of mucus were in the catheter tubing. The resident talked nonsensically and laughed to him/herself. During an interview, Nurse I said the resident had red in his/her urine again. His/her urine was collected and sent to the lab, and the results were pending. Review of the resident's partial lab results, collected on 5/11/21 and reported to the facility on [DATE], showed: -Blood: 3+, abnormal (normal range: negative); -Leukocytes: 2+, abnormal (normal range: negative); -White blood count: 21-50, abnormal (normal range: less than 6); -Bacteria: Many, abnormal (normal range: negative); -Mucous: Present, abnormal (normal range: absent); -Results met criteria to perform urine culture. During an interview on 5/14/21 at 12:01 P.M., the DON said CNAs are the front line staff and should be keeping their eyes on resident catheters. If they notice any issues, they need to report it to the nurse right away. All residents with catheters should have orders for nurses to be able to change catheters and tubing PRN. The resident's labs were received, and showed abnormal values with culture indicated. Staff should have notified the nurse about the resident's catheter issues sooner than they did. Review of the resident's medical record, showed the urinalysis with culture and sensitivity, collected on 5/11/21 and reported on 5/15/21, was reported to the physician. The physician said the counts were low, likely due to colonization (there is bacteria in the urine, but there are no signs or symptom and it is not causing illness), and no new orders were received. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/21 at 2:25 P.M., the DON said the resident's urinalysis culture was reviewed by the PCP, who determined the culture was colonized. No new orders were received. Prior to the resident's admission to the facility, he/she was prescribed Cipro for a UTI. The medication was ordered on 4/6/21 and should have been administered through 4/11/21. When admitted to the facility, it doesn't look like his/her orders for Cipro carried over and she does not see documentation of the medication as administered by the facility in April 2021. The physician should have been notified to obtain approval for transferring physician's orders and the resident should have received his/her full course of the antibiotic. During the survey from 5/3/21 though 5/13/21, 31 licensed nursing staff worked on the resident's hall. 2. Review of Resident #51's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/22/21, showed: -admitted [DATE]; -Total dependence of one person for bed mobility, toilet use and bathing; -Total dependence of two (+) persons for transfers; -Extensive assistance of one person for dressing and personal hygiene; -Indwelling urinary catheter; -Diagnoses of septicemia (body wide bacterial infection), UTI in the past 30 days, paraplegia (paralysis of the legs and lower body) and anxiety; -Special treatments and programs: IV (intravenous) medications while not a resident. Review of the resident's care plan, undated, showed: -admitted with indwelling catheter; -Resident will show no signs and symptoms of urinary infection through next review; -Position catheter bag and tubing below the level of the bladder and away from entrance room door; -4/17/21: readmitted with UTI and sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues); -4/17/21: Continue to administer antibiotic therapy as ordered. Observation on 5/4/21 from 6:50 A.M. until 9:14 A.M., showed the resident lay in bed sleeping. His/her catheter bag was full of urine and laying on the floor between the bed and the window. At 9:30 A.M., the resident lay in bed sleeping, his/her catheter bag remained on the floor full of urine. At 11:46 A.M., the resident's catheter bag had been emptied and was off the floor hanging from the bed frame. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/10/21 at 7:10 A.M., Nurse I said the resident had a fever of 101.7 and was being sent to the hospital. Review of the resident's hospital emergency room notes, dated 5/10/21 at 9:27 A.M., showed he/she was admitted with diagnoses that included severe sepsis with septic shock and UTI associated with indwelling urinary catheter. During an interview on 5/14/21 at 12:00 P.M., the DON said catheter bags should not be on the floor for infection control reasons. The resident was readmitted to the facility that day with a new urinary catheter. 3. Review of Resident #19's annual MDS, dated [DATE], showed: -Diagnoses of quadriplegia, diabetes and depression; -Short/long term memory loss; -Required total assistance of staff for all activities of daily living; -Urinary catheter into the bladder. Review of the resident's care plan, updated 4/21/21, showed: -Focus: Indwelling catheter; -Goal: Will be/remain free from catheter-related trauma; -Intervention: Check tubing for kinks routinely. Change catheter as ordered. Provide privacy bag. Ensure catheter bag is below the bladder. Provide catheter care each shift. Review of the resident's POS, dated 5/21, showed an order to change the catheter every month on the 24th. Observation on 5/3/21 showed: -At 9:03 A.M., the resident lay in bed on a low air loss mattress with the catheter drainage bag on the floor on the right side of the bed, without a cover over the bag; -At 12:32 P.M., the resident lay on his/her back. The catheter bag remained on the floor without a cover over the bag. 4. Review of Resident #59's quarterly MDS, dated [DATE], showed: -Diagnosis of Multiple Sclerosis; -No short/long term memory loss; -Required total staff assistance for all activities of daily living; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Suprapubic catheter (a tube placed surgically through the abdomen into the bladder, used to drain urine). Review of the resident's care plan, undated, showed: -Focus: Resident has a Suprapubic Catheter. Resident has a diagnosis of Neurogenic Bladder (lack of bladder control due to brain, spinal cord or nerve problem); -Resident will remain free from catheter-related trauma; -Intervention: Position catheter bag below the the level of the bladder and away from the entry room door. Monitor and document output as ordered. Monitor/record/report to physician for signs and symptoms of UTI, pain, burning, blood tinged urine, cloudiness, no out put, increased temperature, foul smelling urine, fever, chills, altered mental status and change in behavior. Observation on 5/12/21 at 9:43 A.M., during a transfer, showed the resident lay in bed with a full bulging catheter drainage bag. CNA F and CNA K positioned the lift pad under the resident and attached the drainage bag to the Hoyer Lift (a machine used to lift and transfer dependent residents). The resident asked CNA F whether he/she would empty his/her catheter drainage bag prior to transfer. CNA F replied CNA K would empty it. During the transfer, urine flowed backward (up toward the bladder) in the tubing. CNA K emptied the drainage bag of 1000 cc of urine. 5. During an interview on 5/14/21 at 11:47 A.M., the DON said she would expect staff to empty the drainage bag prior to transferring the resident to the wheelchair. Draining the urine from the bag will prevent a backflow of urine in the tubing. Urinary catheters tubing and bags should be kept off the floor for infection control. In addition, catheter bags should be place in a privacy bag.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 40290 Based on observation, interview, and record review, the facility failed to monitor and implement resident-specific interventions, including the provision of nutritional supplements, to maintain acceptable parameters of nutritional status for two residents identified with recent weight loss (Residents #69 and #20.). The sample was 18. The census was 75. 1. Review of Resident #69's medical record, showed -admitted [DATE]; -Diagnoses included heart failure, diabetes with diabetic chronic kidney disease, stroke, attention and concentration deficit following stroke, dysphagia (swallowing disorder) following stroke, vitamin B deficiency, vitamin D deficiency, and depression. Review of the resident's active physician order sheet (POS), showed: -An order, dated 6/4/20, to add ice cream daily at lunch; -An order, dated 6/22/20, for med pass (fortified nutritional shake), 120 milliliters (mL) three times a day, four times a day for supplement; -An order, dated 8/4/20, for no added salt (NAS), regular texture diet; -No orders for a nutritional health shake. Review of the resident's weights, showed: -On 12/8/20, weighed 139.2 pounds (lbs); -On 1/13/21, weighed 120.8 lbs; -On 2/11/21, weighed 123.4 lbs; -On 3/5/21, weighed 111 lbs. Review of the resident's nutrition/dietary note, dated 3/16/21, showed staff documented the resident's current weight as 111 lbs. Significant weight loss over 1-6 months. Diet orders: regular NAS, ice cream daily, 120 mL med pass three times daily. No orders for Ensure nutritional health shake. Review of the resident's medication administration record (MAR) for April 2021, showed staff documented administration of 120 mL med pass four times daily. Review of the resident's meal consumption log for April 2021, showed: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Task for staff to document the resident's percentage of meal eaten in morning, afternoon, and evening, for a total of 90 meals in the month; -Staff documented the resident consumed 0-25% of 10 meals; -Staff documented the resident consumed 26-50% of 3 meals; -Staff documented the resident consumed 51-75% of 8 meals; -Staff documented the resident consumed 76-100% of 23 meals; -Staff failed to document the amount of food eaten for 46 meals. Review of the resident's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/21/21, showed: -Severe cognitive impairment; -Rejection of care not exhibited; -Supervision with one person physical assist required for eating; -Upper extremity impaired on one side; -Weight loss of 5% or more in the last month, or 10% or more in the last 6 months. Not on a physician prescribed weight loss regimen; -Weight: 116 lbs. Review of the resident's nutrition/dietary note, dated 4/22/21, showed staff documented the resident with significant weight gain over 1 month after undesired weight loss. Weight stability is desired at this time. Diet orders included: Regular NAS, ice cream daily at lunch. No recommendation for nutritional health shake. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: The resident has a mood problem related to stroke with hemiplegia (paralysis to one side of the body). 4/28/21 Resident remains with weight loss over quarter; -Interventions included: ice cream at lunch and dinner each meal; -Focus: The resident has a swallowing problem related to dysphagia. Note: Spitting out food and only drinking. Resident with weight loss. 4/28/21 weight loss over quarter; -Interventions included: add ice cream daily at lunch. Add nutritional shakes with each meal. Resident will be assisted with eating at each meal. Resident needs to be up in chair at mealtime. Document consumption after each meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's breakfast diet card, undated, showed Ensure supplement listed under Physician Order. Observation on 5/6/21 at 7:53 A.M., showed the resident sat in bed, feeding him/herself breakfast from a divided plate. A container of Ensure and several beverages sat on the resident's over-the-bed table. Review of the resident's lunch diet card, undated, showed no documentation regarding ice cream. Ensure listed under Likes. Observations of the resident during lunch, showed: -On 5/3/21 at 12:38 P.M., the resident sat in bed, with certified nurse aide (CNA) N seated in a chair to the resident's right side. He/she was served chicken, potato salad, and watermelon, and fed him/herself. No ice cream or Ensure was served during the meal; -On 5/4/21 at 1:02 P.M., the resident sat in bed, with staff seated in a chair to the resident's right side. The resident fed him/herself. A carton of whole milk and a container of Ensure sat on the resident's over-the-bed table. No ice cream served during the meal; -On 5/10/21 at 12:25 P.M., the resident sat in bed. He/she was served pork, corn, potato salad, and strawberry shortcake. The resident fed him/herself without staff in the room to assist. No ice cream or Ensure served during the meal; -On 5/12/21 at 12:35 P.M., the resident sat in bed. Staff served served chicken wings, creamed spinach, stuffing, and cake. No ice cream or Ensure served during meal. 2. Review of Resident #20's medical record, showed -admitted [DATE]; -Diagnoses included heart disease, dementia without behavioral disturbance, vitamin deficiency, vitamin B12 deficiency, vitamin D deficiency anemia, folate deficiency anemia, anemia, and depression. Review of the resident's active POS, showed: -An order, revised 4/10/20, for regular diet, mechanical soft texture; -An order, dated 10/21/20, for ice cream at lunch; -An order, dated 3/31/21, for med pass 120 mL, four times a day for weight management; -No orders for an additional nutritional health shake. Review of the resident's weights, showed: -On 12/8/20, weighed 135.8 lbs; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/13/21, weighed 124.6 lbs. Review of the resident's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Rejection of care exhibited 1-3 days; -Supervision with one person physical assist required for eating; -Weight loss of 5% or more in the last month, or 10% or more in the last 6 months. Not on a physician prescribed weight loss regimen; -Weight: 117 lbs. Review of the resident's nutrition/dietary note, dated 4/22/21, showed the resident's current weight as 113 lbs. Underweight and stable over one month after significant weight loss. Weight stability or health, gradual weight gain is desired at this time related to underweight status. Diet orders included: mechanical soft, 120 mL med pass four times daily, and ice cream at lunch. Review of the resident's meal consumption log for April 2021, showed: -Task for staff to document the resident's percentage of meal eaten in morning, afternoon, and evening, for a total of 90 meals in the month; -Staff documented the resident refused 2 meals; -Staff documented the resident consumed 0-25% of 8 meals; -Staff documented the resident consumed 26-50% of 5 meals; -Staff documented the resident consumed 51-75% of 8 meals; -Staff documented the resident consumed 76-100% of 26 meals; -Staff failed to document the amount of food eaten for 41 meals. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: The resident has an ADL self-care performance deficit related to dementia; -Interventions included resident will refuse to get out of bed, resident hard of hearing and needs a positive approach, approach calmly and speak face to face; -Focus: The resident may be at risk for weight loss related to dementia. 2/12/21 resident remains with weight loss; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: add health shake, fortified nutritional shake as ordered. Ice cream at lunch. Mechanical diet. Monitor at mealtime in dining room. Document consumption after each meal-report meal refusal. Must get out of bed and go to dining room for breakfast. 8/24/20 resident must go to the dining room in his/her wheelchair for every meal. Review of the resident's breakfast diet card, undated, showed Ensure supplement listed under Physician's Order. Review of the resident's lunch diet card, undated, showed no documentation regarding ice cream per physician order and no documentation to provide Ensure supplement. Observations on 5/3/21, showed: -At 12:19 P.M., the resident lay in bed on his/her right side, with a blanket over his/her head; -At 12:28 P.M., CNA N delivered a lunch tray to the resident's room, called the resident's name several times, and said he/she would be back to check on him/her later; -At 12:42 P.M., the resident remained in bed on his/her right side with the blanket no longer covering his/her head. A plate of uncovered mechanical soft food, sat on the resident's bedside table. Staff did not serve ice cream or Ensure with the resident's meal. CNA N reentered the resident's room and attempted to wake the resident, who did not verbally respond. The CNA exited the room and told the nurse the resident was not eating; -At 1:12 P.M., the resident remained in bed on his/her right side with food on bedside table, untouched. Observation on 5/5/21 at 7:35 A.M., showed the resident sat in his/her wheelchair in the dining room, feeding him/herself without staff assistance. Staff did not provide Ensure. Ten minutes later, the resident had consumed all of his/her breakfast. Observation on 5/12/21 at 12:40 P.M., showed the resident sat in his/her wheelchair in the dining room, staff served a mechanical diet of soft meat, mashed potatoes, creamed spinach, cake, and Ensure supplement. No ice cream was provided. Observation on 5/13/21 at 8:34 A.M., showed the resident lay in bed with a blanket over his/her head. No food on his/her bedside table. During an interview, the CNA II said the resident did not eat breakfast that morning, but did drink half an Ensure. He/she is not a morning person and does not like to get up to eat breakfast. 3. During an interview on 5/13/21 at approximately 7:19 A.M., cook QQ and dietary aide (DA) RR said the Dietary Director (DD) types up the diet cards for all residents, for each meal. She gets her orders from nursing and adds them to the diet cards. Supplemental items, such as ice cream, are ordered for residents who need to gain weight or do not eat as much as they should for whatever reason. Supplemental items, including Ensure, are added to resident meal trays by dietary staff. If a resident is supposed to get these items or other supplements, it should be on their diet card. If an item is not listed on the diet card, dietary staff do not put it on the meal tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/21 at 2:27 P.M., the Registered Dietician (RD) said nutritional assessments are completed by the dietician upon a resident's admission, readmission, and on a quarterly basis. Some residents are assessed more frequently based on their condition, such as having weight variances. Upon assessment, the dietician might make recommendations for supplemental items, such as ice cream with meals, med pass, or Ensure. She submits her recommendations to the facility's administrator, Director of Nurses (DON), and DD. Recommended supplements should be implemented by the facility. Health shakes like Ensure require an order. Residents #69 and #20 should be getting med pass, as well as ice cream with lunch. She reviewed the physician orders for both residents and observed the recommendation for ice cream under other, instead of dietary, which is probably why the DD did not pull the recommendations over to the resident's diet cards. During an interview on 5/14/21 at 9:51 A.M., the RD and DD said diet cards are generated by information from a program in the electronic medical record, and from diet communication sheets obtained from nursing staff. If a resident requests an item that is not on their diet card, it is acceptable to give them the item unless it is a change in consistency from what they should receive, or Ensure. Ensure must have physician orders. Until today, Ensure was on the resident's diet cards and dietary staff was responsible for putting the Ensure on the resident's meal tray. Now Ensure has been removed from the diet cards and nursing staff will be responsible for providing it to residents. The DD was not aware residents had not been provided with supplemental items as ordered, or that they had been getting Ensure when not ordered. If an item is not on a resident's diet card, dietary staff won't know to put it on the resident's meal tray. During an interview on 5/14/21 at 6:40 A.M., the DON said staff should monitor resident's meal consumption and document their intake in the resident's medical record. She expects staff to notify her if a resident is not eating. All residents should receive the correct meals as ordered by the physician and dietician, and she expects residents to be served supplements as ordered by physician and dietician. During an interview on 5/14/21 at 12:01 P.M., the administrator said residents should be receiving diets in accordance with their physician orders. All staff should reference a resident's diet card during meal service to ensure residents get what they are supposed to. Staff should not pass out other items that are not on the resident's diet card.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure one resident received tube feeding (a tube inserted through the abdomen into the stomach to provide medication, nutrition and hydration) as ordered on a consistent basis. The facility identified two residents with tube feeding, one was sampled and problems were identified (Resident #27). The sample was 18. The census was 75. Review of Resident #27's quarterly Minimum Data Set, a federally mandated assessment instrument completed by facility staff, dated 2/15/21, showed: -admitted [DATE]; -Makes Self Understood: Sometimes understood - responds adequately to simple, direct communication only; -Ability to understand others: Sometimes understands - responds adequately to simple, direct communication only; -Brief Interview for Mental Status score of 00 out of a possible 15 (a score of 00 - 07 indicates severe cognitive impairment); -Total dependence of two (+) persons required for transfers; -Total dependence of one person required for bed mobility, locomotion on/off the unit, dressing, eating, toilet use, personal hygiene and bathing; -Diagnoses of renal (kidney) insufficiency and stroke; -Weight of 141 pounds; -Weight loss: No; -Weight gain: No; -Feeding tube; -Proportion of total calories the resident received through tube feeding: 51% or more. Review of the resident's physician's order sheet, showed: -12/7/19: Jevity 1.5 (liquid nutritional supplement) 50 milliliters (ml) an hour for 21 hours a day; -Tube feeding off from 12:00 A.M. until 3:00 A.M. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, showed: Activity of daily living deficit due to diagnoses of stroke and dementia. Resident has overall decline in functioning ability and is totally dependent on staff; Requires continuous tube feeding related to dysphagia (difficulty swallowing) and history of malnutrition: -Registered Dietician (RD) to evaluate quarterly and as necessary. Monitor caloric intake, estimate needs. Make recommendations for tube feeding as necessary; -Jevity 1.5 at 50 ml and hour for 21 hours a day. Tube feeding off from 12:00 A.M. until 3:00 A.M. Observation on 5/3/21 at 9:25 A.M., showed the resident lay in bed. The tube feeding pump was on and showing Feed Error, but was not audibly alarming. The date a staff member hung the now empty bottle of Jevity (not Jevity 1.5) was dated 5/2/21 at 3:00 A.M. At 10:03 A.M. the tube feeding bottle remained empty and the tube feeding pump had an auditory alarm sounding. At 10:55 A.M. the tube feeding bottle was still empty. At 12:08 P.M., a new bottle of Jevity 1.5 was infusing at 50 ml and hour. Observation on 5/6/21 at 5:15 A.M., showed the resident lay in bed. A 1000 ml bottle of Jevity (not Jevity 1.5) with 950 ml remaining in the bottle was hanging, but the tube feeding pump had been turned off. At 5:26 A.M. during a skin assessment of the resident, the tube feeding pump remained turned off with 950 ml remaining in the bottle. At 9:48 A.M., the tube feeding pump remained turned off with 950 ml remaining in the bottle. Review of the resident's progress notes at that time, show no documentation as to why the tube feeding pump was off. At 11:14 A.M., the tube feeding pump remained turned off with 950 ml remaining in the bottle. During an interview at 11:18 A.M., Certified Nursing Assistant X said he/she helped give the resident a bed bath around 9:00 A.M. that morning and the tube feeding was off. He/she did not know why the tube feeding was off. Nurse PP, said no one had told him/her the resident's tube feeding had been off all morning. There was no reason that he/she knew of for it to be turned off. Nurse PP turned the resident's tube feeding of Jevity back on at that time. During an interview on 5/14/212 at 10:13 A.M., the Director of Nurses said she expects staff to follow the physician's order by providing the resident with Jevity 1.5, not Jevity and to ensure the tube feeding is infusing unless there is a reason which should be documented in the progress notes. The RD, present during the interview stated the difference between Jevity and Jevity 1.5 in a 1000 ml bottle is Jevity is 500 calories less than Jevity 1.5.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to follow their policy for hemodialysis (dialysis, the mechanical treatment of blood to clean it of impurities and excess fluids when the body's kidneys are not working properly) by failing to consistently assess residents' shunts (the connection from a hemodialysis access point to a major artery) and/or fistulas (a surgical connection made between an artery and a vein used for hemodialysis), failing to consistently communicate with the dialysis units and failing to ensure residents wore an identification bracelet showing in which arm the shunt/fistula was located. The facility identified two residents as receiving dialysis. One resident (Resident #15) was sampled, one resident was selected as an expanded sample (Resident #382) and problems were identified with both residents' care. The sample was 18. The census was 75. Review of the facility Clinical Management Hemodialysis policy, last revised on 5/1/2018, showed: Protocol: -The facility has designed and implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis residents; Procedure: -Contractual agreement will include, but may not be limited to, the following: Medical and non-medical emergencies, development and implementation of resident's care plan, and interchange of information useful/necessary for the care of the resident; -Obtain a clear understanding of roles and responsibilities between the facility and the dialysis center and define in writing. This will include: Responsibility of monitoring lab values, how physician's orders will be validated and how physician's orders will be communicated between the nursing staff; -Assure assessment and documentation of fistula or graft (type of access used for hemodialysis and usually placed in the arm) site; -Manage special dietary regime and dietary restrictions as ordered. Review of the facility's Dialysis Policy for facility staff, undated, showed: -Dialysis patients must not have their blood pressure taken in the arm where the shunt/fistula is located; -An alert bracelet will be placed on the arm with the fistula/shunt to assist with identifying the arm with the fistula/shunt; -Dialysis patients must have a pre/post assessment on dialysis days; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility will maintain ongoing communication with the dialysis centers. Review of the facility's Dialysis Communication Form, showed the following information to be communicated to, and received from, the dialysis centers: Information to be completed by the facility: -Attending physician; -Facility nurse or contact person; -Care plan meeting and update information; -Medications administered; -Meal provision; -Condition alert; Information to be completed by the dialysis center: -Pre-weight; -Post-weight; -Dialysis completed without incident?; -Problem with access graft/catheter?; -Lab work completed?; -Medications given at dialysis; -Recommendations. 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/18/21, showed: -admitted [DATE]; -Ability to express ideas and wants: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to understand others: Usually understands - misses some part/intent of message but comprehends most conversation; -Brief interview for Mental Status ((BIMS), an assessment used to determine cognitive status) score of 7 out of a possible 15 (severely impaired cognition); (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required limited assistance of one person for bed mobility; -Required extensive assistance of one person for transfers, dressing, toilet use, personal hygiene and bathing; -Independent for locomotion on/off the unit; -Functional limitation of both lower extremities; -Mobility device: Wheelchair; -Diagnoses of renal (kidney) insufficiency, diabetes mellitus, stroke, hemiplegia (the complete loss or paralysis on one half of the body) or hemiparesis (minor to severe weakness of one half of the body) and manic depression (alternating moods of abnormal highs (mania) and lows (depression)); -Dialysis. Review of the resident's undated care plan, in use during the survey, showed: -Receives dialysis on Tuesday, Thursday and Saturday.; -Assist with transfer needs when going to dialysis; -Shunt in left forearm; -Check for bruit (a rumbling sound that you can hear) and thrill (a rumbling sensation that you can feel) and notify the dialysis center if not present;; -Check for new orders upon return from dialysis; -Maintain communication with dialysis center staff; -No blood pressures or blood draws in left arm. Review of the resident's medical record for Dialysis Communication Forms, showed the forms were completed and sent to the resident's dialysis unit on the following dates: -10/26/20, 10/29/20, 11/3/20, 11/23/20, 11/28/20, 12/1/20, 4/20/21 and 4/29/21; -The facility could not provide any other dialysis communication forms. Review of the resident's physician's order sheet (POS), showed an order, dated 11/12/21, for staff to check fistula on left arm for bruit and thrill each shift. Review of the resident's treatment administration record (TAR) for 3/2021, 4/2021 and 5/1/21 through 5/10/21, showed the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/12/20: An order dated 11/12/20 for staff to check fistula site left arm for bruit and thrill each shift (there are two shifts a day for nurses); -Staff did not initial the bruit and thrill was checked two of 62 times for March, seven out of 60 times for April and six out of 20 times from 5/1/21 through 5/10/21. Review of the resident's Kardex report book (kept at the nurse's station for certified nurses aides (CNAs) to refer to regarding residents' care) on 5/5/21 at 10:00 A.M., showed the same interventions as those on the care plan. Observations of the resident on the following dates and times, showed the resident had no identification bracelet on his/her left arm: -5/3/21 at 10:15 A.M.; -5/4/21 at 6:59 A.M., 7:48 A.M. and 11:34 A.M.; -5/5/21 at 7:07 A.M., 8:42 A.M. and 10:59 A.M.; -5/6/21 at 5:13 A.M., 7:50 A.M. and 9:06 A.M.; -5/12/21 at 7:58 A.M. During an interview on 5/13/21 at 7:52 A.M.,, the Assistant Director of Nurses (ADON) said he was not aware their policy showed a dialysis resident would wear an identification bracelet on the arm with a shunt or fistula. He was not aware the resident did not have an identification bracelet. 2. Review of Resident #382's admission face sheet, showed: -An admitted [DATE]; -Diagnoses of end stage renal disease, anemia (low red blood cells) and diabetes mellitus. Review of the resident's undated care plan, in use during the survey, showed: -Receives dialysis on Monday, Wednesday and Friday at 8:30 A.M.; -Assist with transfers as needed when going to dialysis; -Check for new orders upon return from dialysis; -Maintain communication with dialysis center staff; -Dialysis pre/post assessment to include vitals and description of site and bruit and thrill; -Limb alert bracelet placed on arm where new fistula is placed; -No blood pressure or lab draw in arm with fistula. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's current POS, in use during the survey, showed no order for staff to check the fistula on the right forearm. Review of the resident's TAR, dated 5/1/21 through 5/11/21, showed: -From 5/1/21 through 5/10/21, no order for staff to check the fistula on the right forearm; -5/11/21: An order for staff to check the fistula on the right forearm for bruit and thrill each shift. Observation of the resident on 5/13/21 at 7:52 A.M., showed the resident sitting on the side of his/her bed, eating breakfast. The fistula and dressing on his/her right forearm were visible. The ADON was in the room. The resident was not wearing an identification bracelet on his/her right wrist. During an interview on 5/13/21 at 7:52 A.M.,, the resident showed his/her fistula, which was located on his/her right forearm. The ADON, who was present during the interview, said he was not aware their policy showed a dialysis resident would wear an identification bracelet on the arm with a shunt or fistula. Review of the resident's medical record, showed facility staff had not sent any Dialysis Communication Forms with the resident to dialysis. 3. During an interview on 5/11/21 at 6:55 A.M., Agency Nurses Q and OO said they thought there was a dialysis book kept at the nurse's station, but neither one knew what was in them. They had not been inserviced to document on dialysis patients' fistula/shunt sites or bruit and thrill. Neither nurse knew dialysis residents should wear an identification bracelet on the fistula/shunt arm and neither were aware of the Dialysis Communication Forms. During an interview on 5/11/21 at 7:35 A.M., the Director of Nurses said she expected staff to document an assessment of the fistula/shunt site every shift. Staff should document bruit and thrill and what the fistula/shunt site looked like (bleeding, infections, etc.). It has been difficult for the facility to get information from the dialysis units. She had been at the facility since February, 2021 and did not know the facility had communication forms to send with residents on their dialysis days. During an interview on 5/11/21 at 10:16 A.M., the ADON stated he could not find any more dialysis communication forms for Resident #15 and Resident #382 and said the nurses are not good about sending the dialysis communication forms like they should.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure residents using bed/side rails, had adequate assessments to determine the side rails were appropriate and safe to be used and/or had physician's orders. The facility identified 17 residents that utilize side rails. Four residents were sampled for the use of side rails (Residents #13, #19, #69, and #224), two identified by the facility as using side rails (Residents #19 and #224) and two who had side rails but not identified by the facility as having side rails (Residents #13 and #69). The sample was 18. The census was 75. Review of the facility's Bed Rails policy, dated 11/27/19, showed: -The facility will attempt to use appropriate alternatives prior to installing a side rail or bed rail. If a bed/side rail is used the facility will verify correct installation, use, and maintenance of bedrails; -Protocols: -Assess the resident for risk of entrapment from bed rails prior to installation; -Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; -Ensure that the bed's dimensions are appropriate for resident's size and weight; -Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails; -Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars; -In the event that bedrails are necessary the facility will adhere to the following policies: -A physician's order must be present which clarifies the exact type of bed rail to be utilized, duration, and medical symptoms present secondary to diagnosis; -Bed rails are to be checked every shift and as needed (PRN). This is to be documented on the treatment administration record (TAR); -If a resident has an order for bed rails the nurse will complete the Bed rail Evaluation/Assessment; -The Bed rail Evaluation/Assessment will be completed initially, quarterly, significant change, annually, and PRN; (continued on next page)

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	265130	A. Building B. Wing	05/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed rails will be checked by Maintenance monthly to verify they are secured/installed properly to the resident's bed frame. 1. Review of Resident #13's medical record, showed: -admitted to facility on 10/6/20; -Diagnoses included stroke, dementia, and dysphagia (swallowing disorder) following stroke; -A physician's order, dated 10/6/20, for side rail assessment to be done on admission and quarterly every three months, starting on the 7th; -No active physician's orders for use of side rails. Review of the resident's Bed Rail Evaluation, dated 10/6/20, showed: -Cognition: Current cognitive status includes poor short term memory, poor long term memory, safety impairment, fall risk. Dementia may affect resident's safety awareness. Can resident communicate needs: No; -Medical: Diagnoses include stroke, dysphagia, dementia. Total dependence with two (+) person physical assist needed for bed mobility; -History/alternatives attempted: Previous intervention of high-low bed. Describe why these alternatives did not work, prompting need for bed rails: Resident can't follow direction; -Type of mattress used: Low air loss; -Bed rail information: Half-length rail requested. Power of Attorney requested bed rail for safety. Physician order obtained 10/6/20; -Risks of bed rail use discussed with resident/legal representative: Immobility, increased confusion, and incontinence. Staff did not indicate discussing risk of entrapment, temporary/permanent bodily injury, increased falls, strangulation/asphyxiation, or death; -Reason for recommendation/use: Safety; -Determination: The bed rail use impedes the resident's freedom of movement. Review of the resident's incident notes, showed: -On 11/24/20 at 5:57 A.M., staff documented certified nurse aide (CNA) reported that he/she just finished rounds around 1:30 A.M., on the resident. When the CNA checked on resident, he/she was found with his/her neck between the side rails and the bed. Nurse assessed resident and no injuries observed, no signs of pain. Vitals obtained. Physician was notified of the incident; -On 11/24/20 at 2:53 P.M., staff documented as per the employee's statement, the resident's head was between the bed rail and mattress. Side rails have been taken off. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation, submitted to the Department of Health and Senior Services within the required timeframe, showed statements regarding the incident were obtained from staff. The CNA demonstrated how the resident was found during rounds, with his/her head between the mattress and bed rail. The IDT (interdisciplinary team) decided that residents with dementia and poor mobility should be assessed to have bed rails removed. Review of the resident's Bed Rail Evaluation, dated 11/24/20, showed: -Cognition: Current cognitive status includes able to retain safety information and safety impairment. Resident totally dependent for bed mobility and transfers, also unable to communicate needs; -History/alternatives attempted: High-low bed, and anticipating hunger, pain, heat, and cold. Describe why these alternatives did not work, prompting need for bed rails: Resident cannot follow direction or communicate needs; -Reason for recommendation/use: Not recommended; -Determination: The bedrail use impendes the resident's freedom of movement. Resident does not use side rails. Review of the resident's incomplete Bed Rail Evaluation, dated 12/4/20, showed: -Cognition: Current cognitive status includes able to retain safety information. How this may affect the resident's safety awareness: Getting his/her head stuck; -Type of bedrail requested: None; -Reason for recommendation/use: None; -Determination: blank. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/11/21, showed: -Severe cognitive impairment; -Extensive assistance of one person physical assist required for bed mobility; -Total dependence of two (+) person physical assist required for transfers; -Upper and lower extremities impaired on both sides; -Bed rails not used. Review of the resident's care plan, undated and in use at the time of survey, showed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: The resident has an activities of daily living (ADL) self-care performance deficit related to overall decline in functioning ability related to stroke. Resident totally dependent with bed mobility. At risk for entrapment; -Interventions included the resident is totally dependent on one staff for repositioning and turning in bed; -No documentation regarding the use of side rails. Further review of the resident's medical record, showed no Bed Rail Evaluations completed after 12/4/20. Observations on 5/3/21 at 8:45 A.M. and 10:51 A.M., 5/4/21 at 7:17 A.M. and 9:04 A.M., 5/5/21 at 7:40 A.M. and 9:45 A.M., and 5/6/21 at 7:53 A.M. and 11:14 A.M., showed the resident lay in bed, on a pressure reducing mattress, with U-shaped side rails raised on both sides, at the head of the bed. During an interview on 5/13/21 at 9:59 A.M., the Assistant Director of Nurses (ADON) said in November 2020, the resident was able to hold onto side rails for repositioning. Certified medication technician (CMT) C said when the CNA did rounds one night that month, he/she found the resident on the side of his/her bed with his/her knee on the floor and head against the quarter-length rail on the side of his/her bed. CMT C was called to the room, observed the resident, and notified the nurse. The nurse assessed the resident, who did not have any injuries or complaints of pain. After this incident, the quarter-length rails were removed from his/her bed. The ADON said the resident was given U-shaped side rails he/she could hold onto to maintain positioning when receiving care. He/she has since declined and can no longer use the side rails. The side rails should have been removed a while ago. 2. Review of Resident #19's annual MDS, dated [DATE], showed: -admitted to facility on 11/21/13; -Moderate cognitive impairment; -Total dependence of one person physical assist required for bed mobility, and two (+) person physical assist required for transfers; -Upper and lower extremities impaired on both sides; -Diagnoses included quadriplegia (paralysis of all four limbs), muscle spasms, and depression; -Bed rails not used. Review of the resident's physician's order sheet (POS), showed: -An order, dated 5/8/19, for may have side rails per resident request. Type of side rail not specified; -An order, dated 3/9/21, for side rail assessment to be done on admission and quarterly every three months, starting on the 15th. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Bed Rail Evaluation, dated 4/6/21, showed: -Cognition: Current cognitive status includes alert and able to follow instructions; -Medical: Diagnoses include quadriplegia. Total dependence with two (+) person physical assist needed for bed mobility; -History/alternatives attempted: Previous intervention of high-low bed. Describe why these alternatives did not work, prompting need for bedrails: Resident has fear and requests bed rails. Family representative agrees; -Type of mattress: Standard; -Bed rail information: Quarter-length rail requested. Physician requested bed rail. Physician order for four quarter-length bed rails obtained 3/28/17; -Risks of bed rail use discussed with resident/legal representative: Loss of independence. Staff did not indicate discussing risk of entrapment, temporary/permanent bodily injury, increased falls, strangulation/asphyxiation, or death; -Reason for recommendation/use: Resident requested. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: The resident has an ADL self-care performance deficit related to quadriplegia with spinal cord injury, contracture right elbow and hand. Resident requires total care from staff. On 7/15/20, resident found with head resting against bed rail causing abrasion; -Interventions included: -The resident is totally dependent on one staff for repositioning and turning in bed as necessary. Resident may have four side rails for bed mobility and positioning as needed. On 7/15/20, resident must be positioned using wedges and pillows to keep body away from bed rails. 8/25/20, bed rails requested to remain and padded with pillows (discontinued 5/11/21). Observation on 5/3/21 at 9:03 A.M. and 5/4/21 at 9:26 A.M., showed the resident lay in bed, on a low air loss mattress, with one quarter-length side rail raised on both sides, at the head of the bed. 3. Review of Resident #69's medical record, showed: -admitted to facility on 1/30/20; -Diagnoses included unsteadiness on feet, stroke, traumatic brain bleed with loss of consciousness for unspecified duration, dysphagia following stroke, attention and concentration deficit following stroke, and depression; -A physician's order, dated 1/31/20, for side rail assessment to be done on admission and quarterly every three months, starting on the 1st; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No active physician orders for use of side rails. Review of the resident's Bed Rail Evaluation, dated 2/1/21, showed: -Cognition: Current cognitive status includes poor short term memory, poor long term memory, delirium. How above areas may affect resident's safety awareness: Difficult to follow instructions; -Medical: Diagnoses not listed. Extensive assistance of two (+) person physical assist needed for bed mobility; -History/alternatives attempted: Previous intervention of family companion. Describe why these alternatives did not work, prompting need for bedrails: not applicable; -Resident's height and weight not documented; -Bed rail information: Quarter-length rail requested. Doctor requested bed rail for repositioning/transfers. Physician order obtained 1/31/20; -Risks of bed rail use discussed with resident/legal representative: Immobility. Staff did not indicate discussing risk of entrapment, temporary/permanent bodily injury, increased falls, increased confusion/agitation, loss of independence, strangulation/asphyxiation, or death; -Reason for recommendation/use: Transfers/repositioning. Review of the resident's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Total dependence of one staff physical assist for bed mobility; -Extensive assistance of two person physical assist required for transfers; -Upper and lower extremities impaired on one side; -One fall without injury and one fall with injury occurred during review period; -Bed rails not used. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: Requires assist with all ADLs related to stroke and right sided weakness. Resident has limited mobility; -Interventions included the resident requires total assist by one staff to turn and reposition in bed; -No documentation regarding the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 5/3/21 at 11:04 A.M. and 1:03 P.M., 5/4/21 at 9:04 A.M. and 1:02 P.M., 5/5/21 at 12:58 P.M. , 5/6/21 at 7:53 A.M. and 11:14 A.M., 5/10/21 at 8:47 A.M. and 12:25 P.M., and 5/13/21 at 8:54 A.M., showed the resident lay in bed, with the bed's left side next to the wall. A quarter-length rail raised on the left side, at the head of the bed, with a gap of approximately 4 inches in between the rail and the wall. 4. Review of Resident #224's medical record, showed: -admitted to facility on 4/9/21; -Diagnoses included degenerative disease of nervous system and depression; -A physician's order, dated 4/9/21, for side rail assessment to be done on admission and quarterly every three months, starting on the 9th; -No active physician's orders for use of side rails. Review of the resident's assessments, showed no documentation of a Bed Rail Evaluation completed. Review of the resident's care plan, undated and in use at the time for survey, showed no documentation regarding the use of side rails. Observations on 5/3/21 at 8:42 A.M. and 12:27 P.M., 5/4/21 at 7:02 A.M. and 1:02 P.M., 5/5/21 at 7:35 A.M. and 11:27 A.M., 5/6/21 at 7:53 A.M. and 11:14 A.M., 5/10/21 at 8:46 A.M. and 12:25 P.M., 5/11/21 at 6:03 A. M., and 5/13/21 at 8:49 A.M. and 12:38 P.M., showed the resident lay in bed with quarter-length side rails raised on both sides, at the head of the bed. 5. During an interview on 5/10/21 at 11:37 A.M., the Maintenance Director said therapy assesses residents for the use of side rails and they let him know which type of side rail should be installed on the bed. Some of the beds have side rails with controls built into them; the ADON inspects these and measures the space in between the rails and the bed. The Maintenance Director is responsible for inspecting all side rails in the building to make sure they are secure, but he does not have a routine schedule of inspections or documentation of any inspections completed within the past year. During interviews on 5/10/21 at 11:40 A.M. and 5/11/21 at 4:58 P.M., the ADON said the facility is transitioning to the use of U-bars, which are the U-shaped rails on some of the residents' beds, instead of the bed rails they have used in the past. Bed/side rail assessments are completed upon admission and quarterly. All fields of the side rail assessments should be accurate and completed. He is responsible for completing the side rail assessments, but there is also a spot on the resident's administration record to notify other nurses if the assessment is due. Side rails are installed by him or the Maintenance Director. He has not been assessing the gaps in between the rail and the bed, but understands the gap should be measured to assess for entrapment. Any resident who should have side rails is included on the list of residents with side rails, and if a resident is not listed, they should not have side rails on their beds. Residents #19 and #69 do not have a need for side rails and should not have them. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/11/21 at 11:24 A.M., the Director of Nurses said assessments for the use of side rails should be completed upon admission and quarterly. The ADON assesses residents for the use of side rails, and the assessment is listed on the resident administration records for all nurses. All fields of the side rail assessment should be completed and staff should assess the risk of entrapment. If side rails are used, physician's orders for them should be obtained and it should be documented on the resident's care plan. MO00178524

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 37672 Based on observation, interview and record review, the facility failed to ensure nursing staff with the appropriate competencies and skill sets were used to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident. The facility failed to ensure that nursing staff are able to demonstrate competency in skills and techniques necessary to care for residents, by failing to conduct weekly skin assessments, report discovery of new wounds in a timely manner, and provide appropriate wound care. In addition, the facility failed to ensure all staff, including contracted agency staff, were adequately trained and informed of facility policies and expectations per acceptable nursing standards. The census was 75. 1. Review of the facility assessment tool, reviewed [DATE], showed: -Staff: -Registered Nurse (RN); -Licensed Practical Nurse (LPN); -Direct Care Staff: utilize Certified Nurse Aides (CNA) agency staff on day and night shift; -Nurse Consultant; -Staff training/education and competencies: -Describe the staff members training/education and competencies that are necessary to provide the level and types of support and care needed for the resident population. Include staff member certification requirements. Potential data sources include hiring, education, training, competency, instruction and testing policies: Agency staff are provided orientation using agency staff orientation packet. This education packet to include education provided to regular staff as need arises such as cardiopulmonary resuscitation (CPR) education, elopement education and other regulatory needs. The assessment did not expand on staff or agency competencies, testing or inservicing. The assessment did did not address frequency of inservicing, training or testing; -Consider the following training topics: communication for direct staff members, behavior management, resident rights, abuse, neglect and exploitation training and infection control; -Required in-servicing training for nurse aides must be sufficient to ensure the continuing competence of nurse aides, but no less than 12 hours per year. No further documentation in the assessment for the training used; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Consider the following competencies: Activities of daily living, resident assessments and examinations such as skin assessment, pressure injury assessment, wound care/dressings, dialysis care, tube feedings. No further documentation in the assessment for the competencies were addressed. 2. Review of the undated agency orientation packet showed: -Wound Care education for all new nursing hires: -CNAs: Upon finding any area/skin issue, report the finding to the charge nurse immediately. If a dressing is saturated or has fallen off, report it to the nurse immediately. When bathing/showering a resident, never wash a wound with a wash cloth, and only pat the area dry if uncovered. Shower sheets must be completed noting any area found; -Nurses: When a skin issue is found or reported to you, immediately obtain an order from the physician. Notify the Director of Nurses (DON)/designee for the resident to be added to the weekly wound rounds. Skin assessments must be completed weekly when scheduled and entered into the system. 3. During an interview during the entrance conference on [DATE] at 8:23 A.M., the administrator said the facility used nursing agency staff to fill staffing needs. The facility did not have many hired staff and had been working on continuing to hire more staff in nursing. 4. Observations during the survey, showed: -The facility failed to ensure residents received care to prevent pressure ulcers (injury to the skin and/or underlying tissues, as a result of pressure or friction) and ensure residents with pressure ulcers received necessary treatments and services to promote healing. The facility identified 13 residents with pressure ulcers. Of those, eight were included in the sample (Residents #19, #224, #46, #45, #51, #55, #3 and #22). and issues were discovered with all eight of these sampled residents regarding pressure ulcers. The facility failed to assess wounds and skin per facility policy and standards of practice and provide treatments as ordered: -Resident #19: The staff failed to apply wound treatment as ordered daily. This failure resulted in the wound becoming foul smelling. Interviewed agency staff had been unsure on the procedure when a wound is discovered and untreated. The facility staff aide applied a treatment, and practiced outside of the scope of practice; -Resident #224: The staff failed to maintain the functionality of an ordered wound vacuum (used to promote wound healing) for extended hours. Interviews with staff, showed in-servicing regarding wounds had recently been conducted prior to the observation. Staff also failed to ensure dressings were changed as ordered. Also, soiled dressings remained in place for several days; -Resident #46: The facility staff failed to report unstageable pressure areas to the feet upon discovery for several days. Interviewed staff said if aides observe a soiled dressing, the aides remove the dressing and report the finding to the nurse. Staff added that agency nurses do not apply dressings to wounds; -Resident #45: The staff failed to ensure ordered dressing treatments were changed as the physician ordered; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #51: The staff failed to report and identify unstageable wounds timely to the nurse for several days. -Resident #55: The staff failed to ensure an ordered wound treatment remained in place, and when the dressing had been identified as missing and in conjunction with the observation of a new bleeding pressure injury, the staff failed to report the wound; -Resident #3: The staff failed to ensure ordered wound treatments remained in place. When discovered while dressing the resident, staff did not report the uncovered wound to the nurse; -Resident #22: The staff failed to report an identified unstageable outer foot wound to the nurse upon discovery. The agency staff also said they had been unsure if the area had already been reported to the nurse. The staff did not report the findings. 5. Staff interviews on [DATE], showed: -At 2:14 P.M., Nurse S said that nurses are supposed to perform skin assessments weekly. The facility had recently started to discuss the facility wound care nurse to conduct all the skin assessments, Nurse S added he/she had been uncertain if that had begun. There had been no clear direction from management whether the charge nurses or the wound care nurse conducted weekly skin assessments. The facility used several different nursing agency staff aides and nurses. The agency staff do not seem to get an orientation and do not report concerns or issues to the facility nurses. He/She had not received in-servicing or return demonstration practices in a long time. Staffing has been an issue, and he/she felt there was no time from management to train staff right now. The facility is attempting to hire more staff, but the facility used many agency staff; -At 2:15 P.M., CNA T said he/she had not worked at the facility before. He/She was an agency staff member. He/She reported to the facility staffing coordinator office and received a very fast orientation and a paper packet had been handed to him/her. He/She had been shown to the floor of scheduled assignment. He/She did not get to review the agency packet forms, and did not have time to ask questions. No facility staff educated him/her on what to do if he/she discovered a wound, and no policies or procedures had been reviewed in person with him/her. Facility staff did not provide him/her with a resident report. He/She did not review the agency packet with the staffing coordinator; -At 2:29 P.M., Nurse U said he/she had been unsure of the facility's policy and procedure regarding wounds. He/She had not received in-servicing for several months and there had been a lot of staff turnover. The facility used agency nurses and CNAs. The agency staff seemed confused as what is expected. The facility CNAs should give report to the agency CNAs. If no facility CNA is on shift, the agency CNA should get report from the charge nurse. If a wound had been reported to him/her, he/she would notify the wound nurse so he/she could treat the wound. If the wound nurse was not available, he/she may have attempted to apply the ordered dressing. Nurse U said Wound care is a speciality, and that is the wound care nurse's speciality. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on [DATE] at 2:01 P.M., the DON and Certified Medication Technician (CMT) C said that CMT C had been asked to take over the staff training from the former DON in February 2021. He/She assisted with training the aides. The DON trains the nurses. The current DON started at the facility , d+[DATE] and had not been able to conduct many trainings. CMT C said staffing at the facility has been difficult, and he/she worked the floor many times. It is hard to get the training program organized. The facility had not offered any training with return demonstration. Staff training has been difficult to get done and a lot of agency staff are working at the facility as well. MO00182036

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 22409 37672 Based on interview and record review, the facility failed to ensure eight out of nine randomly selected certified nurse aides (CNA), who worked at the facility for more than one year, had the total required annual 12 hours of resident care training. The census was 75. Review of the facility assessment, last reviewed 8/27/20, showed: -Staff education/training and competencies: -Required in-service training for nurse aides training must: -Be sufficient to ensure the continuing competence of nurse aides, but be no less than 12 hours per year; -Include dementia management training and resident abuse prevention training; -Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff members; -Care for cognitively impaired residents; -Identification of resident change in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of interventions; -Consider the following competencies: -Person centered care; -Activities of daily living (ADLs); -Infection control; -Resident assessment and examinations, skin assessments, pressure ulcer assessments. Review of the annual CNA training sheets, showed: -CNA JJ: hired on 11/9/17, total hours listed for the past year: 6.25 hours; -Certified medication technician (CMT)/CNA E: hired on 9/18/19, total hours listed for the past year: 6.5 hours; -CNA KK: hired on 2/7/20, total hours listed for the past year: 8 hours; (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA MM: hired on 3/19/01, total hours listed for the past year: 8.5 hours; -CNA N: hired on 11/21/17, total hours listed for the past year: 8.5 hours; -CNA II: hired on 10/1/04, total hours listed for the past year: 8.75 hours; -CNA/CMT AA: hired on 1/7/20, total hours listed for the past year: 9.5 hours; -CNA LL: hired on 3/1/2018, total hours listed for the past year: 11 hours. Interviews on 5/13/21, showed the following: -At 1:46 P.M., the Assistant Director of Nursing (ADON) said CMT C had been asked to oversee the CNA annual training from the former Director of Nursing (DON). The former DON left around 2/2021. CMT C can train the aides and other CMTs, but not the nurses. CMT C is often assigned to work on the floor as an aide or CMT. The facility has been short staffed and had been using agency staff as well. Training has been forgotten about many times; -At 2:01 P.M., CMT C said he/she was asked to take over the training from the former DON as she was leaving in February 2021. The old education binder did not have dates or accurate staff names. Staffing at the facility has been difficult and he/she worked the floor many times. It had been difficult to get the CNA/CMT training organized. CMT C had been unaware the annual training had specific training the aides needed, involving resident care. No one had explained to him/her what needed to be in the training. He/She said the program needed to be improved and no training had occurred with return demonstration; Training has been difficult to get done, and there are a lot of agency there as well; -At 2:19 P.M., the DON said CMT C took over the CNA/CMT training from the former DON before he/she left 2/21. CMT C worked the floor several times and it had been difficult for him/her to train staff as well. The nurses are trained by the DON. The training/in-servicing program needed improvement. The DON is responsible to ensure all CNAs have the required annual 12 hour training. If needed for staffing, CMTs are used as CNAs on the floor and are expected to participate in the annual CNA training requirements. Staff in-servicing is attempted at shift change at the nurse station, or at times on paydays the facility attempted additional trainings. Training and in-servicing had not been done on a routine basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The controlled substance shift change count check sheets were missing documentation for four of the four facility medication carts. The facility also failed to secure narcotics in two out of two medication rooms. The census was 75. Review of the facility's controlled substances policy, dated May 2019, showed the following: -Policy: Medications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage, and record keeping; -Only authorized nursing personnel and pharmacy personnel have access to medication. The Director of Nursing is responsible for the control of these medications; -All controlled substances will be dispensed in tamper resistant containers designed for easy counting of contents; -All control substances will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: -Inspect both the drug package and the corresponding count sheet to verify the accuracy of the amount remaining; -Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count sheet; -Both the nurses will count the controlled substances count sheets and verify the accuracy of the number of remaining count sheets; -Both nurses will sign the Shift Controlled Substance Count sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented; -Any discrepancy in the count of controlled substances shall be reported in writing to the responsible supervisor and a signed entry shall be recorded on the page where the discrepancy is found; -The supervisor shall institute an investigation to determine the reason for the discrepancy. The record shall then be updated; -The consultant pharmacist shall be notified if any discrepancy in the count is detected for any controlled substances regardless of the classification. The pharmacist shall make regular checks of the handling, storage, and recording of controlled substances. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review on 5/3/21 at 8:27 A.M., of the facility's Controlled Substance Shift Change Check Sheet for the rooms 101 through 112 hall medication cart, dated March 2021, showed the following: -31 out of 127 shifts with one nurse documented; -34 out of 127 shifts without count of narcotics or nurse documentation. 2. Review on 5/3/21 at 8:28 A.M., of the facility's Controlled Substance Shift Change Check Sheet for the rooms 113 through 126 medication cart, dated April 20, 2021, showed the following: -Four out of 25 shifts with one nurse documented; -Four out of 25 shifts without count of narcotics or nurse documentation. 3. Review on 5/3/21 at 8:29 A.M., of the facility's Controlled Substance Shift Change Check Sheet for the rooms 201 through 213 medication cart, dated March 30, 2021, showed the following: -30 out of 69 shifts with one nurse documented; -17 out of 69 shifts without count of narcotics; -13 out of 69 shifts without count of narcotics or nurse documentation. 4. Review on 5/3/21 at 8:30 A.M., of the facility's Controlled Substance Shift Change Check Sheet for the room [ROOM NUMBER] through 226 medication cart, dated April 15, 2021, showed the following: -18 out of 35 shifts with one nurse documented; -12 out of 35 shifts without count of narcotics; -Seven out of 35 shifts without count of narcotics or nurse documentation. 5. Observation on 5/3/21 at 9:10 A.M., of the 100 hall medication room, showed the following: -Unlocked refrigerator containing three bottles of Ativan (a controlled substance used to treat symptoms of anxiety disorders). Two were opened. During an interview on 5/3/21 at 9:30 A.M., the Infection Preventionist/Wound Nurse said narcotics should be locked in the refrigerator to deter theft. 6. Observation on 5/3/21 at 10:29 A.M., of the 200 hall medication room, showed the following: -Unlocked medication refrigerator containing one opened bottle of Lorazepam (a sedative used to treat anxiety and seizures) and one bottle of Vimpat (controlled substance used to treat seizures). During an interview on 5/3/21 at 10:29 A.M., Nurse D said the narcotics should be under a secondary lock in the refrigerator to deter theft. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Observation on 5/3/21 at 10:41 A.M., of the medication cart for room [ROOM NUMBER] through 226 hall, showed the following: -One packet of Alprazolam (sedative used to treat anxiety and panic disorder) 0.25 milligrams (mg) containing three pills, loose in the bottom of locked narcotic medication box, without name and dosing instructions for a resident; -One packet of Zolpidem (sedative used to treat insomnia) 5 mg containing four pills, loose in the bottom of locked narcotic medication box, without pharmacy label, without resident name and without dosing instructions for resident; -The room [ROOM NUMBER] through 226 hall narcotic book did not contain a narcotic report sheet for the Alprazolam 0.25 mg, three pills. During an interview on 5/3/21 at 11:06 A.M., certified medication technician (CMT) E said the following: -He/she pulled the packet of Alprazolam 0.25 mg containing three pills, from the facility's automatic pill dispenser this morning and put them in the locked medication drawer on the cart; -He/she did not create a new narcotic sheet to for the packet of Alprazolam 0.25 mg containing three pills from the facility's automatic pill dispenser. 8. During an interview on 5/3/21 at 11:25 A.M., the Director of Nursing (DON) said the following: -Staff were expected to follow the facility's policies; -Refrigerated narcotics were expected to be in a locked refrigerator to deter theft; -Staff were expected to create a new narcotic report sheet when they pulled out multiple doses of narcotics which showed the resident's name, physician order, and how many pills were in the locked narcotic box; -Staff were expected to put loose pills from the automatic pill dispenser in an envelope or baggy labeled with resident's name, the name and dose of the medication, and the physician's order for administration; -Nursing staff were expected to count narcotics with every shift change; -Both the offgoing and oncoming nursing staff were expected to count narcotics together and completely fill out the Controlled Substance Shift Change Check Sheet -The facility would know if narcotics were missing from shift to shift if the count was wrong on the controlled substance shift change count check sheets; -Given the examples of missing documentation on the controlled substance shift change count check sheet, they were not sufficient to obtain accurate reconciliation of narcotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41061

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41061 Based on observation, interview and record review, the facility failed to administer medications with a less than five percent medication error rate. Out of 26 opportunities for error, three errors occurred, resulting in an 8.66% medication error rate for two of six sampled residents (Residents #12 and #59). The facility census was 75. Review of facility's medication administration policy, last revised on 5/1/11, showed the following: -Purpose: To administer the following: Right medication; Right dose; Right dosage form; Right route; Right resident; Right time; -Read the Medication Administration Record (MAR) for the ordered medication, dose, dosage form, route, and time; -Verify the correct medication, dose, dosage form, route, and time again by comparing to MAR before administering; -Document the following as applicable: -Administration of medication on the MAR as soon as medications are given; -Omitted dose by circling your initials in the appropriate block on the MAR; -Reason for omission in the Nursing Progress Notes or on the back of the MAR; -As needed (PRN) medication, reason for administration, and effectiveness in the nursing progress notes or on the back of the MAR; -When medication has been discontinued by writing D/C (discontinued) next to the last dose of the medication on the MAR; block out the rest of the days that month; -Notify physician of changes in resident or with refusal of medication. 1. Review of Resident #12's physician order sheet (POS), dated 5/4/21, showed the following: -An order dated 5/18/20, for Fluticasone Propionate Suspension (a nasal spray used to relieve allergy symptoms) 50 micrograms (mcg/act) per spray, two sprays in each nostril one time a day for allergies; -An order dated 10/21/20, for Pazeo Solution 0.7% (antihistamine used to treat eye itching caused by allergic conjunctivitis (pink eye, inflammation of the white area of the eye), instill one drop in both eyes one time a day for allergic conjunctivitis; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included Guillain-Barre syndrome (a condition in which the immune system attacks the nerves), human immunodeficiency virus/acquired immunodeficiency syndrome (virus that interferes with the body's ability to fight infections). Observation on 5/4/21 at 8:16 A.M., showed Nurse A gathered the resident's medications and entered the resident's room. The resident lay on his/her bed. The nurse took his/her gloved finger and lowered the resident's left eyelid. Nurse A then administered one drop of Pazeo 0.7% eye drops into the pocket of the resident's eyelid. The nurse did not hold the resident's left inner eye for two to three minutes while instructing the resident to keep his/her eye closed. Nurse A then took his/her gloved finger and lowered the resident's right eyelid. The nurse administered one drop of the Pazeo eye drops into the pocket of the resident's left eyelid. Nurse A did not hold the resident's right inner eye for two to three minutes while instructing the resident to keep his/her eye closed. Nurse A asked the resident to sit up. Further observation on 5/4/21 at 8:18 A.M., showed the resident sat on the edge of his/her bed. Nurse A gave the resident his/her bottle of Flonase. The resident put the tip of the Flonase bottle into his/her right nostril and administered one spray. The resident then took the tip of the Flonase bottle, inserted it into his/her left nostril and administered one spray. The nurse did not educate the resident to administer two sprays into each nostril. Review of the Pazeo manufacturer's directions for use, showed the following: -Remove cap. Hold bottle upside down between thumb and index finger; -Tilt the head back slightly and pull the lower eyelid down with the index finger of the opposite hand to create a pocket between the eye and the lower eyelid; -With the bottle positioned above the eye, gently squeeze the side of the bottle to dispense one drop; -Keep head tilted backwards and close eyes for two to three minutes while gently pressing index finger on the inside corner of the eye. 2. Review of Resident #59's POS, dated 5/4/21, showed the following: -An order, dated 11/10/19, for Flonase Suspension 50 mcg/act, give two spray in both nostrils one time a day for sinus allergies; -Diagnosis included nasal congestion. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/4/21 at 7:45 A.M., showed Nurse A gathered all of the resident's medications and brought them into the resident's room. The resident lay on his/her bed. Nurse A raised the resident's head of bed to 90 degrees, and straightened the resident into an upright position. Nurse A washed his/her hands, donned gloves and removed the cap from a new, unused bottle of Flonase. The nurse primed the bottle of Flonase by spraying two sprays into the air and then placed the tip of the Flonase bottle into the resident's right nostril, counted out loud to three and then sprayed one dose. The resident inhaled the medication through his/her nose. Nurse A repeated the process spraying one dose of the medication into the resident's left nostril. The nurse did not give an additional spray of Flonase into the resident's right or left nares. 3. During an interview on 5/4/21 at 12:53 P.M., Nurse A said the following: -Each medication must have a physician's order in the resident's medical record before nursing staff could administer medications to residents; -Nursing staff were expected to administer medications exactly as the physician ordered; -If he/she had any questions regarding the medication, he/she would clarify the order with the physician before administering the medication; -He/she did not know if there were any special instructions when administering Pazeo eye drops. During an interview on 5/6/21, at 9:00 A.M., the Director of Nursing (DON) said the following: -She expected staff to follow manufacturer's instructions and physician orders when administering medications to residents; -She expected staff to report a medication error to the physician, the DON, the resident or the resident's responsible party; -She expected staff to document medication errors in resident progress notes, detailing what occurred, who was notified and when, if there were new orders, and what follow up occurred; -Staff were expected to follow all policies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41061 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional standards in two out of two medication rooms, two out of two treatment carts, one out of one insulin cart and four out of four medication carts. The census was 75. Review of the facility's medication storage in the facility policy, dated [DATE], showed the following: -Policy: Medications and biologicals are stored safely, securely, and properly, following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -Medications are not to be transferred medications in containers in which they were received; -Drugs used for internal use are kept separate from externally used medications; -Eye drops, ointments, drops, and inhalers are kept separate from externally used medications; -Medication rooms, carts, and medication supplies are locked or attended by person with authorized access; -All drugs classified as Schedule H of the Controlled Substances Act will be stored under double locks. Schedule II-V medications must be maintained in separately locked, permanently affixed compartments and cannot be stored with other nonscheduled medications; -Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closure will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists; -Medication storage areas are kept clean, well lit, and free of clutter -Facility staff will assure that the multiple dose vial is stored following manufacturer's suggested storage conditions and that aseptic technique is used by staff accessing the drug product. 1. Observation on [DATE] at 8:31 A.M., of the insulin cart on 200 hall, showed the following: -Two vials of Novolog insulin (a rapid acting insulin used to treat diabetes mellitus (DM)) opened used and undated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on [DATE] at 8:42 A.M., of the medication cart for 201 through 213 hall, showed the following: -One vial of Novolin insulin (a short acting insulin used to treat DM) used, undated, without a pharmacy label rolling around loose in the top drawer of the cart. 3. Observation on [DATE] at 8:48 A.M., of the medication cart for 101 through 112 hall, showed the following: -One Tresiba insulin pen (a long acting insulin used to treat DM), used and undated; -One Basaglar insulin pen (a long acting insulin used to treat DM) new and undated; -Dirty fork with dried food on it mixed in with over the counter medications (OTC); -One vial of ipratropium bromide (used to treat and symptoms (wheezing and shortness of breath) caused by lung disease) loose in top drawer without pharmacy label; -Two open bags of ipratropium bromide, open without pharmacy label; -One bottle of fluconazole propionate nose spray (Flonase, used to treat symptoms caused by allergies) loose in drawer, without pharmacy label, without name. 4. During an interview on [DATE] at 8:50 A.M., the Infection Preventionist/Wound Nurse said the following: -Insulin should have a date on it as soon as it comes to room temperature; -Insulin was only stable for 30 days after it comes to room temperature; -Dirty forks should not be in a medication cart next to OTC medications due to infection control; -Medications should be in pharmacy bag or have pharmacy label on them so nursing staff could correctly administer the correct medication to the resident; -Each medication was specific to a resident and if medication was unlabeled or not in pharmacy packaging, staff should throw it away. 5. Observation on [DATE] at 8:59 A.M., of treatment cart for the 100 hall, showed the following: -Three used, opened tubes of Santyl (a prescription medication used to remove dead tissue from wounds so they can start to heal) without pharmacy labels, loose in drawer; -One tube of Nystatin (antifungal medicine used to treat or prevent infections), without pharmacy label, loose in drawer; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One used tube of Medihoney (an ointment used to remove dead tissue and aid in wound healing), without a pharmacy label located in a small box with alcohol pads, tubes of lotion, packets of plastic cutlery, leaking its contents into the box; -Two pharmacy cards of unidentifiable pills, without pharmacy label; -One opened package of alginate wound dressing (used to cover wounds to absorb exudate), with a piece cut out of it, without a label. During an interview on [DATE] at 9:05 A.M., the Infection Preventionist/Wound Nurse, said the following: -Medications should be in pharmacy box or have pharmacy label so staff uses the medication as prescribed on the correct resident; -It was not appropriate to use medications on more than one resident due to infection control; -It was important to keep treatment carts clean and free of debris for infection control and to ensure residents are receiving the correct medications; -Once packets for wound dressings were opened, and left open to air, they were no longer sterile and could introduce new bacteria into a wound if used. 6. Observation on [DATE] at 9:10 A.M., of the 100 hall medication room, showed the following: -Unlocked refrigerator containing three bottles of Ativan (a controlled substance used to treat symptoms of anxiety disorders) two opened; -A bag of staff's personal belongings on counter located next two four bags of Vancomycin (antibiotic used intravenously (in the veins); -Four thermal cups, two filled with fluid on the countertop; -One packet of Albuterol Sulfate vials (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing and chest tightness caused by lung diseases) without pharmacy label, not in pharmacy bag, loose in upper cabinet; -A cosmetic bag full of toothpaste, toothbrush, mints, mouthwash, lotions, located in upper cabinet with a box of hot chocolate, dirty blue nightgown, used hairbrush full of hair; -One box of Narcan (used to treat narcotic overdose in an emergency situation) located in upper cabinet, shoved behind a wound vacuum, with rolls of bandages, and one tube of used nystatin cream; -A grocery bag with an open bag of sunflower seeds and a bottle of water located on the countertop next to the sink; -One packet of trazadone (an antidepressant and sedative used to treat depression, anxiety and insomnia), unlabeled, loose in a drawer with a can of tea and several packets of foam border bandages. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:30 A.M., the Infection Preventionist/Wound Nurse said the following: -He/she did not know there was Narcan located in the upper cabinet and it would have been difficult to find in an emergency situation; -Narcotics should be locked in the refrigerate to deter theft; -Food and personal belongings should not be kept in medication rooms due to infection control; -Medication rooms should be neat and clean so staff can quickly find what they need and for infection control; -All medications should be in pharmacy packaging or labeled for infection control and to ensure medications were used on the correct resident as the physician ordered. 7. Observation on [DATE] at 9:34 A.M., of the medication cart for ,d+[DATE], showed the following: -An open, uncapped bottle of Omeprazole (used to treat heart burn and acid reflux) with four unidentifiable capsules inside; -An open packet of Restasis (used to reduce inflammation in the tear ducts) eye drops, not in pharmacy package, not labeled. During an interview on [DATE] at 9:34 A.M., Certified Medication Technician (CMT) C, said the following: -It was not appropriate to have opened bottles of medications due to infection control and staff would not know if the correct medication was in the bottle; -The Restasis eye drops should be in the pharmacy package to prevent any medication errors; -Without medication properly labeled, nursing staff would not know if they were administering the correct medication to the right resident per physician orders. 8. Observation on [DATE] at 10:29 A.M., of the 200 hall medication room, showed the following: -Unlocked medication refrigerator containing one opened bottle of Lorazepam (a sedative used to treat anxiety and seizures) and one bottle of Vimpat (controlled substance used to treat seizures). During an interview on [DATE] at 10:29 A.M., Nurse D said the following: -The narcotics should be under a secondary lock in the refrigerator to deter theft. 9. Observation on [DATE] at 10:36 A.M., of the 200 hall treatment cart, showed the following: -An opened bag filled with a roll of material coated in a white substance, open to air, without a label; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two opened packages of Xeroform gauze dressings (used to cover and protect low to non-fluid producing wounds), loose in a drawer, without labels; -Three open packets of dermal collagen powder (a wound filler dressing applied to wounds to aid in wound healing) each leaking powder into the bottom of the drawer, without labels. 10. Observation on [DATE] at 10:41 A.M., of the medication cart for 214 through 226 hall, showed the following: -One packet of Alprazolam (sedative used to treat anxiety and panic disorder) 0.25 milligrams (mg) containing three pills, loose in bottom of locked narcotic medication box, without name and dosing instructions for a resident; -One packet of Zolpidem (sedative used to treat insomnia) 5 mg containing four pills, loose in bottom of locked narcotic medication box, without pharmacy label without resident name and dosing instructions for resident; -The 214 through 226 hall narcotic book did not contain a narcotic report sheet for the Alprazolam 0.25 mg, three pills. During an interview on [DATE] at 11:06 A.M., CMT E said the following: -He/she pulled the packet of Alprazolam 0.25 mg containing three pills, from the facility's automatic pill dispenser this morning and put them in the locked medication drawer on the cart; -He/she did not create a new narcotic sheet to for the packet of Alprazolam 0.25 mg containing three pills from the facility's automatic pill dispenser. 11. During an interview on [DATE] at 11:25 A.M., the Director of Nursing (DON) said the following: -Staff were expected to follow the facility's policies; -Refrigerated narcotics were expected to be in a locked refrigerator to deter theft; -Staff were expected to create a new narcotic report sheet when they pulled out multiple doses of narcotics which showed the resident's name, physician order, and how many pills were in the locked narcotic box; -Staff were expected to put loose pills from the automatic pill dispenser in an envelope or baggy labeled with resident's name, the name and dose of the medication, and the physician's order for administration; -Nursing staff were expected to count narcotics with every shift change; -Both the off going and oncoming nursing staff were expected to count narcotics together and completely fill out the Controlled Substance Shift Change Check Sheet; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility would know if narcotics were missing from shift to shift if the count was wrong on the controlled substance shift change count check sheets; -Given the examples of missing documentation on the controlled substance shift change count check sheet they were not sufficient to obtain accurate reconciliation of narcotics. During an interview on [DATE] at 11:28 A.M., the DON said the following: -Charge nurses were ultimately responsible for maintaining medication storage rooms and medication/treatment carts; -It was important to maintain cleanliness and order in storage rooms and carts for infection control, to prevent cross contamination, and so staff could find items when needed; -Staff should store their personal belongings and food in lockers or in the break room; -It was not appropriate for staff to store personal belongings or food in medication storage rooms or medication/treatment carts due to infection control. It brought in filth, food borne illness, and could contaminate sterile supplies and medications; -Medications were stored in their pharmacy packaging. It was not appropriate to store medications in a plastic cup, without a label; if not labeled or in pharmacy package, staff would not know who they belong to or what the order was specifically; -Insulin should be dated when up to room temperature per manufacture's recommendation and according to standard procedure; -Staff should discard expired, used medications or medical supplies according to procedure; -Medication carts, treatment carts and refrigerators with narcotics are to be locked when not in use; -Expected nursing staff to date insulin pens and vials when they were first used, or when brought up to room temperature; -She expected staff to follow all policies.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40290 Based on interview, and record review, the facility failed to ensure all meals met the needs of residents in accordance with established national guidelines, by providing an alternative menu not reviewed or approved by the registered dietician (RD). The census was 75. Review of the menus and recipes, prepared by the Registered Dietician (RD), dated 5/3/21 through 5/13/21, showed the meals met recommended dietary requirements. No alternative menu options were documented by the dietician. Review of the facility's menus, prepared by the Dietary Director (DD), dated 5/3/21 through 5/13/21, showed the RD's prepared menu available for lunch and dinner. An alternative meal option available for lunch and dinner, not approved by the RD. Review of the dinner menus for 5/5/21, showed: -RD menu: cup of soup, egg salad on croissant, pickled beets, and chilled peaches; -DD menu: chicken and cheese wrap, pasta chips, chilled peaches, and tomato, pickles, and lettuce. Alternate option of beef gravy over noodles, whipped potatoes/gravy, and corn. Observation of dinner on 5/5/21 at 5:45 P.M., showed residents served a burrito, cheese puffs, and side salad, or a sandwich with chips. During an interview on 5/4/21 at approximately 10:30 A.M., the DD said the menu provided by the RD does not list alternatives, so she designed her own alternative menu options based on nutritional guidelines. The menus posted in the kitchen and provided to residents, include the RD's recommended menu and the DD's alternative menu. During an interview on 5/14/21 at 9:51 A.M., the DD said she created the alternate menu based on information she had from the previous DD. She did not consult with the dietician before providing the alternative menu, but should have. Alternative menus need to be reviewed by the dietician to make sure they are nutritionally sound. During an interview on 5/13/21 at 2:27 P.M., the RD said she creates a menu for the facility twice a year. Menus are given to the DD and come with production sheets, which tell dietary staff exactly what should be served at each meal. If something on the menu cannot be served for whatever reason, an appropriate substitution should be made. The RD was unaware that the DD created her own alternative menu. An alternative menu should meet nutritional guidelines, and should be reviewed and approved by the dietician before implemented.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41061 Based on observation, interview, and record review, the facility failed to ensure one resident's medical records were accurate, kept confidential and secure in accordance with accepted professional standards and practices for one out of six sampled residents (Resident #19). This had the potential to affect all residents. The census was 75. Review of the facility's Confidentiality and Non-disclose Agreement, undated, showed the following: -The facility's information systems contained confidential records pertaining to the business operations, the residents, business associates, health care professionals and employees; -Employees were expected to protect data in accordance with current Health Insurances Portability and Accountability Act (HIPPA) regulations and facility policies governing the access, use and disclosure of protected health or facility information; -Employees were expected to respect the privacy and confidentiality of any information they have access through the computer system or network and would only access or use that information necessary to perform their job; -Employees would safeguard and not disclose their password or user identification (ID) code that allowed access to protected information; -Employees accepted responsibility for all entries and actions recorder using their password and user ID code; -Employees would immediately report to the HIPPA Compliance Officer any suspicions that their password and user ID code had been compromised; -Employees would not permit others to access the facility's computer system or network using their password or ID code. 1. Review of Resident #19's medical record, showed the following: -An order dated 11/12/19, for Baclofen (a muscle relaxant) suspension, give 1 milliliter (ml), 6 milligrams (mg) per 1 ml, via gastrostomy tube (g-tube, surgically placed device used to give direct access to the stomach) three times a day related to muscle spasm; -An order dated 11/13/19, for Acetaminophen (treats mild to moderate pain) liquid, give 20 ml via g-tube for pain; -Diagnoses included chronic pain and muscle spasms. During an interview on 5/5/21 at 8:14 A.M., Certified Medication Technician (CMT) C, said the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she was responsible for administering medications to the residents on the 101 through 112 hall; -He/she could not administer medications to residents with g-tubes because it was out of his/her scope of practice; -Nurse B would administer medications to Resident #19 using the 101 through 112 medication cart. Observation on 5/5/21 at 8:28 A.M., showed Nurse B administered medications, including Baclofen and Acetaminophen, to Resident #19 via his/her g-tube. Before preparing the resident's medications, the nurse pulled up the resident's current physician orders in the electronic medical record and verified the medications against the physician orders before dispensing medications to administer to the resident. As the nurse prepared each medication, he/she signed the Medication Administration Record (MAR) signifying he/she administered the medication. While preparing the medications, Nurse B said he/she accidentally logged in as CMT C when accessing the resident's medical record. Nurse B logged out and then logged back in to the resident's medical record and completed the medication pass. Review of the resident's MAR, dated 5/1/21 through 5/31/21, showed the following: -On 5/3/21 at 8:00 A.M., CMT C's initials indicating he/she administered Acetaminophen 20 ml via g-tube; -On 5/3/21 at 8:00 A.M., CMT C's initials indicating he/she administered Baclofen Suspension 1 ml via g-tube. During an interview 5/5/21 at 10:19 A.M., CMT C said the following: -He/she would not sign off on a resident's MAR if he/she did not administer the medication because it was falsification of information on a legal document; -The facility's electronic medical record program did not erase log in names and passwords after staff logs out of the program, so anyone could open up a resident's medical record under someone else's electronic signature; -He/she did not administer medications to Resident #19; -Nurse B used CMT C's tablet when he/she was administering medications to the resident and accidentally logged in under CMT C's name. During an interview on 5/5/21 at 10:33 A.M., the Director of Nursing (DON) said the following: -Anyone could sign into a resident's medical record because the system did not erase staff members' log in information; -The facility's medical records could easily contain falsified information regarding notes, administration of medication, and possible theft of controlled substances because they were not secure; -All agency staff were given the same log in user names and passwords; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no way to verify which agency staff documented in the medical records, even with staffing records. During an interview on 5/5/21 at 10:53 A.M., the Administrator said the following: -He noticed that the facility's electronic medical record program saved his sign-in information after he logged out of the system; -All agency staff were given the same user name and passwords to access electronic medical records. Although staffing sheets showed what assignments agency staff were responsible for during their shift, the facility would not be able to prove no one else signed in a resident's medical record because they all had the same electronic signature. During an interview on 5/6/21 at 10:00 A.M., the DON said the following: -The facility used the document named Confidentiality and Non-disclosure Agreement as a policy regarding compliance to HIPPA regulations for medical records; -Employees were trained on HIPPA confidentiality requirements for resident medical records using the Confidentiality and Non-Disclosure Agreement in the orientation packet and requiring signature of receipt; -The facility did not have an additional policy outlining their expectations of how electronic records were maintained, secured, or how staff were assigned individualized electronic signatures.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22409 Based on observation, interview and record review, the facility failed to develop and implement an appropriate plan through the facility's Quality Assurance and Performance Improvement (QAPI) committee to correct problems they had identified with pressure ulcer assessments, monitoring and treatments. The census was 75. Review of the facility QAPI Plan, undated, showed: Overall description of QAPI Plan: -The QAPI Plan is based upon person centered care with the goal of providing a home like environment where residents can become more independent. We will develop processes to better enable staff to assist residents in becoming independent and living the best quality life possible. The purpose of the QAPI Plan is to improve Quality of Care and services provided to generate to highest quality of life for our residents; -Our QAPI plan is on-going, with continual monitoring and efforts at process and performance improvement; Guiding Principles: -The goal of QAPI in our organization is to improve the quality of care and the quality of life of our residents; -The QAPI process is focused on system and process improvement along with employee development; -The QAPI program addresses all departments, the development of all services provided, and the development of all staff in the vision and mission of the organization; -With the QAPI program, we make decisions utilizing available data including feedback from caregivers, residents, health care practitioners, and families; -Our home sets measurable goals for performance improvement and we track our progress toward those goals; The facility QAPI Plan is a pro-active approach to improving residents' quality of life; -QAPI design and scope: Designed to be on-going and comprehensive. Its purpose is to correct deficiencies in quality of service and put processes in place to consistently improve performance; -Clinical care services are centered on individualized care plans and resident choice. These services include: Individualized care plans, skilled nursing care, fall and pressure sore management, medication management, treatments, reduction in urinary tract infections and weight loss, physician communication, pharmacy consultations and dietician consultations; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Person-centered quality of life focuses on plans to improve resident care tailored to individual needs: Establishment of goals for each resident, assistance with activities of daily living, dining experiences and dietary choices and social services; -The leadership team including the administrator, Director of Nurses (DON) and department heads are responsible for implementing the QAPI program. There will be weekly review of QAPI progress, monthly QAPI team meetings and quarterly meetings; -The coordinator of the QAPI program is the administrator who has the ultimate responsibility to ensure all department heads are aware of their responsibilities and following through with their part of the QAPI Plan; Feedback, Data Systems and Monitoring: -We use data from all available sources such as auditing efforts, data gathered through Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, and from feedback provided by staff, residents and others; Performance Improvement Projects (PIPs): -PIPs establish projects that address a particular concern by investigating, putting into place education and process changes, auditing performance and gathering data on the concern; Systemic Analysis: -The facility will utilize available data and Root Cause Analysis methods to determine the cause(s) behind problems that have been identified. The focus will be on identifying systemic problems and focus on process improvement performance improvement. All staff involved in QAPI PIPs will be trained in Root Cause Analysis. During the survey process, multiple problems associated with the monitoring, assessment, and treatment of pressure ulcers were discovered, including the following: -Unstageable pressure ulcers identified by the survey team; -Treatments not completed as ordered; -Weekly skin assessments not completed by nurses per facility policy; -Bath/shower sheets not completed by Certified Nursing Assistants (CNAs) and co-signed by nurses in accordance with the facility's policy; -Residents not turned and repositioned every two hours in accordance with the facility's policy; -Resident left soiled for prolonged periods; -A lack of staff inservicing for the identification, assessment, reporting and treatment of pressure ulcers; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Due to the significance of the above concerns, the facility was issued an immediate jeopardy citation at F686 for pressure ulcers during the survey process. During an interview on 5/10/21 at 8:32 A.M., the facility wound nurse said she was hired last July and became the wound nurse in November. She works Monday through Friday. She does the treatments Monday through Friday. She does pressure ulcer and wound measurements on Thursdays. The problems the survey team have discovered are not new. Basically, since the time she became the wound nurse, she has had problems getting staff to complete residents' treatments on Saturdays and Sundays. She has even placed each resident's treatment in plastic bags with their names and times the treatments should be done and left them in the medication rooms so the nurses would not forget to do the treatments over the weekends. That did not work out well, as she continued to have the same problems. She does not think staff are turning and repositioning the residents timely and that is a problem. She is aware skin assessments and bath/shower sheets are not being completed per facility policy. It is really frustrating trying to get everyone to do what they are supposed to do. She has discussed all of these problems with the previous director of nursing (DON) as well as the new DON. During an interview on 5/10/21 at 10:46 A.M., the DON said she had been at the facility since late February of this year. She first noticed the nurses had not been completing their weekly skin assessments a few weeks ago. It is a concern because there is no consistency. Over the past two to three weeks, she asked the wound nurse to do the weekly skin assessments and document the findings in the medical records. The same is true for the CNA bath/shower sheets which should be completed two times a week. They are not being completed consistently. The CNAs are supposed to notify the charge nurses immediately if there is any bruising or wounds and the charge nurse should sign off on the shower sheet before his/her shift is over. If a new area or concern is identified, the nurse is responsible to assess the area and notify the physician. Both the nurse's weekly skin assessment and the CNA bath/shower sheets are meant to identify skin problems before they get worse. She expected treatments to be completed as ordered. If a dressing is soiled or has come off, she expected the CNAs to notify the nurses, and the nurses to replace the dressing as soon as possible. During an interview on 5/11/21 at 11:43 A.M., the facility Medical Director answered the survey team's questions regarding the problems that had been identified with pressure ulcers. The Medical Director said she attends the QAPI meetings and she had not been informed of the problems identified by the survey team. During an interview on 5/14/21 at 6:40 A.M., the DON said the QAPI team meets the third Thursday of every month. As far as she can recall, they had not addressed the issues they were having regarding pressure ulcers at the QAPI meetings. The facility Medical Director, along with the facility management team, attend the QAPI meetings. During an interview on 5/21/21 at 10:50 A.M., the administrator said the DON worked with the wound nurse on a process to implement improvements. At the April QAPI meeting, the wound nurse reviewed the existing wounds, the wound company and the progress notes with wounds in the past couple of weeks. It was briefly mentioned that the assessments and treatments on the weekends needed to be done more consistently and the DON and wound nurse were working on an action plan. The action plan developed in the two weeks following the QAPI meeting included turning over skin assessments to the wound nurse and for the weekend nurses, including nurse management, to follow-up.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure staff completed routine inspection of bed frames, mattresses and bed/side rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #13, #19, #69, and #224) with side rails to reduce the risks of accidents. The facility identified 17 residents with side rails in use. Residents #13 and #69 were not identified by the facility as having side rails. The sample was 18. The census was 75. Review of the FDA (Federal Drug Administration) documents, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, showed bed rails, also called side rails, may be used as a restraint, reminder, or assistive device. Evaluating the gaps in hospital beds is one component of a mitigation strategy to reduce entrapment. Hospital beds have seven potential entrapment zones. The neck, head, and chest are the key body parts at risk for life-threatening entrapment. Elderly residents are among the most vulnerable for entrapment, particularly those who are frail, confused, restless, or who have uncontrolled body movement. Review of the facility's Bed Rails policy, dated 11/27/19, showed: -The facility will attempt to use appropriate alternatives prior to installing a side rail or bed rail. If a bed/side rail is used the facility will verify correct installation, use, and maintenance of bed rails; -Protocols: -Assess the resident for risk of entrapment from bed rails prior to installation -Ensure that the bed's dimensions are appropriate for resident's size and weight; -Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails; -Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars; -In the event that bed rails are necessary the facility will adhere to the following policies: -A physician's order must be present which clarifies the exact type of bed rail to be utilized, duration, and medical symptoms present secondary to diagnosis; -Bed rails are to be checked every shift and as needed (PRN). This is to be documented on the treatment administration record (TAR); -If a resident has an order for bed rails the nurse will complete the Bed rail Evaluation/Assessment; (continued on next page)

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Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed rails will be checked by Maintenance monthly to verify they are secured/installed properly to the resident's bed frame. 1. Review of Resident #13's medical record, showed: -admitted to facility on 10/6/20; -Diagnoses included stroke, dementia, and dysphagia (swallowing disorder) following stroke; -A physician's order, dated 10/6/20, for side rail assessment to be done on admission and quarterly every three months, starting on the 7th; -No active physician orders for use of side rails; -No documentation of a maintenance inspection to include an entrapment assessment for the use of side rails. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/11/21, showed: -Severe cognitive impairment; -Extensive assistance of one person physical assist required for bed mobility; -Total dependence of two (+) person physical assist required for transfers; -Upper and lower extremities impaired on both sides; -Bed rails not used. Review of the resident's care plan, undated and in use at the time of survey, showed: -No documentation regarding the use of side rails. Observations on 5/3/21 at 8:45 A.M. and 10:51 A.M., 5/4/21 at 7:17 A.M. and 9:04 A.M., 5/5/21 at 7:40 A.M. and 9:45 A.M., and 5/6/21 at 7:53 A.M. and 11:14 A.M., showed the resident lay in bed with U-shaped side rails raised on both sides, at the head of the bed. 2. Review of Resident #19's annual MDS, dated [DATE], showed: -admitted to facility on 11/21/13; -Moderate cognitive impairment; -Total dependence of one person physical assist required for bed mobility, and two (+) person physical assist required for transfers; -Upper and lower extremities impaired on both sides; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included quadriplegia (paralysis of all four limbs), muscle spasms, and depression; -Bed rails not used. Review of the resident's physician order sheet (POS), showed: -An order, dated 5/8/19, for may have side rails per resident request. Type of side rail not specified; -An order, dated 3/9/21, for side rail assessment to be done on admission and quarterly every three months, starting on the 15th. Review of the resident's Bed Rail Evaluation, dated 4/6/21, showed: -Type of mattress used: Standard; -Bed rail information: Quarter-length rail requested. Physician requested bed rail. Physician order for four quarter-length bed rails obtained 3/28/17. Review of the resident's care plan, undated and in use at the time of survey, showed: -The resident is totally dependent on 1 staff for repositioning and turning in bed as necessary. Resident may have 4 side rails for bed mobility and positioning as needed. 7/15/20 - Resident must be positioned using wedges and pillows to keep body away from bed rails. 8/25/20 - Bedrails requested to remain and padded with pillows (discontinued 5/11/21). Observation on 5/3/21 at 9:03 A.M. and 5/4/21 at 9:26 A.M., showed the resident lay in bed with quarter-length side rails raised on both sides, at the head of the bed. Review of the resident's medical record, showed no documentation of a maintenance inspection to include an entrapment assessment for the use of side rails. 3. Review of Resident #69's medical record, showed: -admitted to facility on 1/30/20; -Diagnoses included unsteadiness on feet, stroke, traumatic brain bleed with loss of consciousness for unspecified duration, dysphagia following stroke, attention and concentration deficit following stroke, and depression; -A physician's order, dated 1/31/20, for side rail assessment to be done on admission and quarterly every three months, starting on the 1st. Review of the resident's Bed Rail Evaluation, dated 2/1/21, showed: -Resident's height and weight not documented; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed rail information: Quarter-length rail requested. Doctor requested bed rail for repositioning/transfers. Physician order obtained 1/31/20. Review of the resident's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Total dependence of one staff physical assist for bed mobility; -Extensive assistance of two person physical assist required for transfers; -Upper and lower extremities impaired on one side; -One fall without injury and one fall with injury occurred during review period; -Bed rails not used. Further review of the resident's medical record, showed: -No active physician orders for the use of side rails. -No documentation of a maintenance inspection to include an entrapment assessment for the use of side rails. Review of the resident's care plan, undated and in use at the time of survey, showed: -No documentation regarding the use of side rails. Observations on 5/3/21 at 11:04 A.M. and 1:03 P.M., 5/4/21 at 9:04 A.M. and 1:02 P.M., 5/5/21 at 12:58 P.M. , 5/6/21 at 7:53 A.M. and 11:14 A.M., 5/10/21 at 8:47 A.M. and 12:25 P.M., and 5/13/21 at 8:54 A.M., showed the resident lay in bed, with the bed's left side next to the wall. A quarter-length rail raised on the left side, at the head of the bed. 4. Review of Resident #224's medical record, showed: -admitted to facility on 4/9/21; -Diagnoses included degenerative disease of nervous system and depression; -A physician's order, dated 4/9/21, for side rail assessment to be done on admission and quarterly every three months, starting on the 9th; -No active physician orders for use of side rails; -No documentation of a maintenance inspection to include an entrapment assessment for the use of side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, undated and in use at the time for survey, showed no documentation regarding the use of side rails. Observations on 5/3/21 at 8:42 A.M. and 12:27 P.M., 5/4/21 at 7:02 A.M. and 1:02 P.M., 5/5/21 at 7:35 A.M. and 11:27 A.M., 5/6/21 at 7:53 A.M. and 11:14 A.M., 5/10/21 at 8:46 A.M. and 12:25 P.M., 5/11/21 at 6:03 A.M., and 5/13/21 at 8:49 A.M. and 12:38 P.M., showed the resident lay in bed with quarter-length side rails raised on both sides, at the head of the bed. During an interview on 5/10/21 at 11:37 A.M., the Maintenance Director said therapy assesses residents for the use of side rails and they let him know which type of side rail should be installed on the bed. Some of the beds have side rails with controls built into them; the ADON inspects these and measures the space in between the rails and the bed. The Maintenance Director is responsible for inspecting all side rails in the building to make sure they are secure, but he does not have a routine schedule of inspections or documentation of any inspections completed within the past year. During interviews on 5/10/21 at 11:40 A.M. and 5/11/21 at 4:58 P.M., the ADON said side rails are installed by him or the Maintenance Director. He has not been assessing the gaps in between the rail and the bed, but understands the gap should be measured to assess for entrapment. Any resident who should have side rails is included on the list of residents with side rails, and if a resident is not listed, they should not have side rails on their beds. Residents #19 and #69 do not have a need for side rails and should not have them. During an interview on 5/14/21 at 12:01 P.M., the administrator said he used to perform routine inspections of side rails in the past, and turned this task over to Maintenance over a year ago. They have discussed assessing side rails for the risk of entrapment and obtaining gap measurements. He will try to locate documentation of side rail inspections completed over the past year. (As of the exit date, no additional information was provided.)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 Based on observation, interview and record review, the facility failed to ensure staff answered one resident's call light timely. The resident was observed with their call light on as several staff stood by the nurse's station or walked by the resident's room without answering the call light and/or assisting the resident (Resident #51). Five additional residents complained that it sometimes took staff one to three hours to answer their call lights. (Residents #14, #22, #64, #60 and #16). The census was 75. 1. Review of Resident #51's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/22/21, showed: -admitted [DATE]; -Adequate hearing/vision; -Clear speech, distinct intelligible words; -Ability to express ideas and wants: Understood; -Ability to understand others: Understands; -Brief Interview for Mental Status (BIMS, a brief screener of cognition) score of 15 (cognitively intact); -Total dependence of one person required for bed mobility, toilet use and bathing; -Total dependence of two (+) persons required for transfers; -Required extensive assistance of one person for dressing and personal hygiene; -Functional limitation of both lower extremities (hip, knee, ankle, foot); -Mobility device: Wheelchair; -Indwelling urinary catheter (inserted through the urethra into the bladder to drain the bladder of urine); -Diagnoses of anemia (low number of red blood cells), septicemia (systemic (body wide) illness with toxicity due to invasion of the bloodstream by virulent bacteria coming from a local site of infection), urinary tract infection (last 30 days), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), anxiety and depression. Review of the resident's current care plan, showed: -Activities of daily living performance deficit: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Encourage resident to use call light for assistance; -Chronic pain; -The resident is able to call for assistance when in pain, reposition self, ask for medication, tell how much pain he/she is experiencing. Observation on 5/3/21 at 12:50 P.M., showed the resident turned on his/her call light. Staff were in the hall, passing his/her room and at the nurse's station. At 1:15 P.M., a staff member answered the resident's call light. During an interview on 5/4/21 at 6:50 A.M., the resident said his/her back hurt the previous day when he/she had his/her call light on. He/she needed pain medication. Sometimes it took up to three hours for staff to answer his/her call light. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -BIMS score of 15; -No behavioral symptoms. During the group interview on 5/4/21 at 10:00 A.M., five of five residents said it took a long time for staff to answer call lights. Resident #14 said it could take over an hour for staff to respond to a light. 3. Review of Resident #22's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Required extensive staff assistance for dressing, toileting and hygiene; -Diagnoses of dementia, Parkinson's (a neurological disease affecting nerve signals to the brain, often cause tremors), disease, stroke history and schizophrenia (affects the perception of reality often symptoms include hallucinations). Review of the undated care plan, in use during the survey, showed: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: The resident has a self-care performance deficit related to dementia; -Goal: The resident will improve current level of function; -Interventions: Staff encourage the resident to participate in care as much as possible to increase his/her strength and mobility, assist with bathing, dressing, and toileting. The resident requires maximum assistance with daily care. During an observation and interview on 5/3/21: -At 10:14 A.M., the call light for room [ROOM NUMBER] noted to be sounding and lit above the doorway. The resident's roommate said Resident #22 wanted to get out of bed, but had some difficulty activating the call light. The roommate activated his/her own. He/she added the call light had been activated for 30 minutes and no staff had responded. He/she saw multiple staff walk past the open doorway. From the hallway, a nurse sat at the nurses station. The call light was noted to be audible and the room lit on the call light board at the nurses station; -At 10:30 A.M., two additional staff walked past the resident's room as the call light sounded and did not enter the resident's room; -At 10:45 A.M., the room call light was answered by staff. During a group interview on 5/4/21 at 10:00 A.M., five of five residents said it took a long time for staff to answer call lights. Resident #22 said the night staff were the worst. It regularly took over an hour for staff to respond and when they did they were rude about it. 4. Review of Resident #64's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -BIMS score of 15; -No behavioral symptoms. During an interview on 5/4/21 at 12:25 P.M., the resident said it would take up to an hour for staff to answer his/her call light. 5. Review of Resident #60's admission MDS, dated [DATE], showed: -admitted on [DATE]; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -BIMS score of 12 (severely cognitively intact); -No behavioral symptoms. During an interview on 5/10/21 at 1:00 P.M., the resident said it could take up to three hours for staff to answer call lights. Sometimes staff would come into their rooms, turn off the light, say they would be right back and would not come back. It was worse in the evenings and at night. 6. Review of Resident #16's admission MDS, dated [DATE], showed: -admitted on [DATE]; -Adequate hearing and vision; -Clear speech; -Ability to express ideas and wants: Understood; -Ability to understand others: Understood; -BIMS score of 15; -No behavioral symptoms. During an interview on 5/13/21 at 9:15 A.M., the resident said he/she has had to wait up to an hour for staff to answer his/her call light. It happened a lot. The longest was four hours when they left him/her in his/her wheelchair when he/she wanted to go back to bed, so he/she would not get up in his/her wheelchair anymore. 7. During an interview on 5/14/21 at 12:00 P.M., the Director of Nurses (DON) said she expected staff to answer resident call lights within five minutes and no longer than 15 minutes. Any staff member can answer a call light, it does not have to be a nursing staff member. There are times when a resident's need does not require a nurse such as pushing a bed table closer to the bed or turning on a light on/off. 37672