STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265118	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN POINT HEALTH AND REHABILITATION	2840 WEST CLAY ST SAINT CHARLES, MO 63301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #26 and #4), in a review of 17 sampled residents, had call lights within reach. The facility census was 56. Review of the facility policy, Call Lights: Accessibility and Timely Response, last revised September 2021, showed the following: -The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow resident to call for assistance; -All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light; -All residents will be educated on how to call for help by using the resident call system; -Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system; -Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly (Examples include touch pads, larger buttons, bright colors, etc.);	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 3/28/25

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.

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F 558	Continued From page 1 -With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. 1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 11/16/24, showed the following: -Cognition was severely impaired; -Required partial to moderate assistance from lying to sitting on side of bed; -Required partial to moderate assistance with transfers; -Required substantial to maximal assistance with walking 10 feet - once standing, the ability to walk at least 10 feet in a room, corridor, or similar space; -Used a manual wheelchair. Review of the resident's care plan, last revised 02/10/25, showed the following: -He/She had an activities of daily living (ADL) self-care performance deficit; -He/She was blind and required guidance; -He/She was impulsive and had a history of falls/at risk for falls related to confusion, decreased balance, and blindness; -Be sure his/her call light is within reach or attached to his/her person; -Staff to do frequent rounds and to toilet and lay down after meals; -Anticipate and meet his/her needs; -He/She was to be laid down after meals. Observation on 2/24/25 at 12:50 P.M., showed the following: -The resident sat on the side of the bed with his/her meal tray on the over-bed-table in front of	F 558		

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him/her. There were no staff in the resident's room;
-The resident said he/she was blind and asked multiple times what food items were on his/her tray;
-The resident touched around his/her tray feeling for the food and for his/her drink glass with juice;
-The resident said he/she could not find the juice and asked for assistance to find it on his/her tray;
-The resident asked for more chips and called out, "Hello. More chips. Hello, nurse.";
-The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

During interview on 2/24/25 at 1:05 P.M., the resident said he/she had no way to ask for help. He/She did not have a call light, or if he/she had one, he/she didn't know where it was. He/She was blind, so staff would have to put the call light somewhere he/she could find it and access. He/She couldn't call for help and would like for someone to come by his/her room periodically and ask if he/she needed something.

Observation on 2/24/25 at 1:42 P.M., showed the resident lay in bed. The resident called out, "Nurse. Nurse. Hello!" No staff was in the hallway. The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/24/25 at 2:04 P.M., showed the resident lay in bed. The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/24/25 at 2:55 P.M. showed the

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following:
-The resident lay awake in bed;
-The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

During an interview on 2/24/25 at 2:55 P.M., the resident said the following:
-He/She never had a call light to use;
-He/She asked where the call light was located;
-He/She wished he/she had a call light;
-He/She thought there ought to be a way to get a hold of someone when he/she needed something.

Observation on 2/25/25 at 11:40 A.M. showed the following:
-The resident lay awake in bed;
-The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/25/25 at 12:17 P.M. showed the following:
-The resident was in bed;
-The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/25/25 at 2:30 P.M. showed the following:
-Certified Medication Technician (CMT) F and the Social Services Director (SSD) assisted the resident to the bathroom and then back into his/her wheelchair;
-The resident wore a t-shirt and an incontinence brief and did not wear any pants;
-The resident said he/she was very cold and

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would like a blanket and would like to lay back down;
-CMT F covered the resident with a blanket and told him/her that he/she would have to get his/her pants from the shower room and left the room;
-CMT F left the room around 2:40 P.M. and did not return with the resident's pants;
-The resident sat in his/her wheelchair near the middle of the room with a blanket. The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

During an interview on 2/25/25 at 3:05 P.M., the resident said he/she would like to go to bed.

Observation on 2/25/25 at 3:05 P.M. showed the resident called out, "Hello, can I please go to bed now?" The SSD talked to the resident and said she was working on getting the resident's belongings moved to his/her new room and staff would lay him/her down once they got his/her bed cleaned and made. The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/25/25 at 3:35 P.M. showed the resident still slumped down in his/her wheelchair. The resident was not wearing pants and was covered with a blanket. The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/25/25 at 4:50 P.M. showed the resident remained slumped down in his/her wheelchair. The resident's legs were stretched out in front of him/her, and he/she was covered with a blanket. The resident's call light hung on

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the wall between the two beds in the room and was not within the resident's reach.

Observation on 2/25/25 at 5:15 P.M. showed the following:
-The resident lay on the floor in front of his/her wheelchair;
-His/Her blanket lay behind him/her on the floor;
-The resident was curled up on his/her left side. The resident was not wearing pants and his/her t-shift was pulled over his/her knees.

During an interview on 2/25/25 at 5:15 P.M., the resident said he/she had been asking to lay down, so he/she put one knee down and then the next to lay himself/herself down (on the floor).

During an interview on 2/27/25 at 1:30 P.M., the resident's family member and power of attorney (POA) said the resident could use the call light to call for help if he/she remembered.

During an interview on 2/27/25 at 2:10 P.M., Registered Nurse (RN) J said the following:
-The resident was blind so he/she usually hollered if he/she needed anything;
-He/She thought the resident had a call light, but he/she was not sure;
-He/She expected for the resident's call light to be within the resident's reach at all times.

During an interview on 2/27/25 at 2:20 P.M., CMT L said the resident's call light should be within reach at all times.

During an interview on 2/27/25 at 10:00 A.M., the Assistant Director of Nursing (ADON) said resident should have his/her call light within

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reach at all times.

During an interview on 2/27/25 at 3:15 P.M., the Director of Nursing (DON) said she expected the resident's call light to be within reach at all times.

During an interview on 2/27/25 at 4:00 P.M., the Administrator said she expected all residents' call lights to be within reach.

2. Review of Resident #4's Care Plan, last revised 11/18/24, showed the following:
-He/She has an ADL performance deficit and impaired vision and required assistance with all care;
-Encourage him/her to use bell to call for assistance;
-He/She was at risk for falls, gait/balance problems, was legally blind and had decreased safety awareness:
-Be sure his/her call light is within reach and encourage him/her to use it for assistance as needed;
-He/She has a communication problem;
-He/She sometimes had a hard time making his/her needs known.

Review of the resident's quarterly MDS, dated 12/21/24, showed the following:
-Cognition severely impaired;
-Required substantial/maximal assistance for transfers;
-Frequently incontinent of urine.

Observation on 2/24/25 at 2:55 P.M. showed the following:
-The resident sat awake on his/her bed;
-The resident's call light hung on the wall in

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F 558	Continued From page 7 between the beds in the room and was not within the resident's reach. During an interview on 2/24/25 at 3:00 P.M., the resident said the following: -When asked if he/she was able to use the call light, the resident said, "Yes, yes, yes"; -He/She shook his/her head back and forth, side to side when asked if he/she knew where the call light was. Observation on 2/26/25 at 5:55 A.M., showed the following: -The resident lay on his/her back in bed. The resident was awake and made screaming noises; -The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach. Observation on 2/26/25 at 7:23 A.M., showed the following: -The resident sat in bed; -The resident's call light hung on the wall between the two beds in the room and was not within the resident's reach. During an interview on 2/26/25 at 8:40 A.M., Certified Nurse Assistant (CNA) B said the resident was able to use the call light. During an interview on 2/27/25 at 3:15 P.M., the DON said she expected the resident to have his/her call light within reach at all times. During an interview on 2/27/25 at 4:00 P.M., the Administrator said she expected the resident to have his/her call light within reach at all times.	F 558		
F 583	Personal Privacy/Confidentiality of Records	F 583		

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F 583 SS=G	Continued From page 8 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 583		

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review, the facility failed to ensure staff provided personal privacy and treated one resident (Resident #4), in a review of 17 sampled residents, with dignity and respect when providing personal care. Staff provided a bed bath to the resident with the resident's privacy curtain and door open while talking to other residents in the hallway. The facility census was 56.

Review of the facility policy, Promoting/Maintaining Resident Dignity, last revised 10/01/23, showed the following:
-It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality;
-All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights;
-The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences;
-When interacting with a resident, pay attention to the resident as an individual;
-Explain care or procedures to the resident before initiating the activity;
-Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused and resident centered;
-Groom and dress residents according to resident preferences:
-Speak respectfully to residents; avoid discussions about residents that may be

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overheard;
-Maintain resident privacy;
-Each resident will be provided equal access to quality of care regardless of diagnosis, severity of condition or payment source.

1. Review of Resident #4's Care Plan, last revised 11/18/24, showed the following:
-The resident's autonomy and dignity will be honored;
-The resident has the right to be treated with consideration, respect, and dignity;
-He/She had an activities of daily living (ADL) performance deficit and impaired vision and required assistance with all care;
-He/She was dependent on staff for personal hygiene, showering/bathing, toileting hygiene and dressing;
-He/She had a communication problem;
-He/She sometimes had a hard time making his/her needs known.
-Request clarification from him/her to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise,

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 12/21/24, showed the following:
-Cognition severely impaired;
-Dependent on staff for toilet hygiene and upper/lower body dressing;
-Dependent on staff for showering/bathing.

Observation on 2/26/25 at 7:23 A.M., showed the following:
-Certified Medication Technician (CMT) L entered

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the resident's room and did not knock, introduce himself/herself, or pull the privacy curtain or bedroom door closed;
-The resident did not wear any clothing or undergarments and sat fully exposed on his/her bed with his/her legs bent and crossed in front of him/her;
-The resident sat in the middle of his/her bed facing the hallway. The door to the room was open and the privacy curtain was not pulled to provide privacy to the resident from the hallway;
-Another resident was outside of the resident's room in the hallway. The entire front side of the resident's body was exposed to the resident in the hallway as the other resident looked in and talked to CMT L, who was in the resident's room;
-CMT L filled a plastic tub with soapy water and sat it on the bedside table near the resident's bed;
-CMT L provided a bed bath for the resident. The door to the resident's room remained open and the privacy curtain was not pulled. Another resident walked in the hallway by the resident's doorway. CMT L said, "What's up?" to the other resident and began having a conversation with the resident in the hallway as he/she provided the bed bath for Resident #4;
-The resident was left completely exposed with no covering during the entire bed bath;
-CMT L saw another resident in a wheelchair in the hallway and said, "What are you doing?";
-CMT L completed the bed bath, removed his/her gloves, left the resident exposed in the bed when he/she went over to the resident's sink to wash his/her hands and put on new gloves;
-CMT L assisted the resident to dress in an incontinence brief, shorts, socks, and shirt, exposing all of the resident's body and genitalia

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F 583	Continued From page 12 to anyone in the hall. During an interview on 2/27/25 at 2:15 P.M., CMT L said the following: -He/She did not recall having the curtain/door open while providing care for the resident (on 2/26/25); -He/She did not recall having conversations with other residents walking by the resident's room while providing care; -He/She felt this would have been an invasion of the resident's privacy. During an interview on 2/27/25 at 2:10 P.M., Registered Nurse J said he/she expected staff to close the privacy curtain and the resident's room door to provide privacy when providing care. During an interview on 2/27/25 at 3:15 P.M., the Director of Nursing said she expected staff to ensure privacy for the resident or any other resident when providing personal care by closing the door, pulling the privacy curtain, and only exposing the area of the resident that they are working with. During an interview on 2/27/25 at 4:00 P.M., the Administrator said the following: -She expected staff to treat residents with dignity and respect; -She expected staff to provide residents with privacy.	F 583		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		

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F 655	Continued From page 13 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 14 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a baseline care plan, consistent with the resident's specific conditions, needs and risks that provide effective person-centered care that met professional standards of quality of care within 48 hours of admission to the facility for two residents (Residents #405 and #102), in a review of 17 sampled residents. The facility census was 56. Review of the facility's policy, Baseline Care Plans, last reviewed 09/01/21, showed the following: -The facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care; -A baseline care plan would be developed within 48 hours of a resident's admission; -The admitting nurse, or supervising nurse on duty, should gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable; -Interventions should be initiated that addressed the resident's current needs that may include, but not limited to any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk; any identified needs for supervision, behavioral interventions, and assistance with activities of daily living; -Once established, goals and interventions should be documented in the designated form;	F 655		

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F 655	Continued From page 15 -The summary should include the initial goals of the resident, a summary of the resident's medication and dietary instructions, and any services and treatments to be administered by the facility and personnel acting on behalf of the facility. 1. Review of Resident #405's hospital medical records, dated 2/10/25, showed the following: -The resident had an unstageable pressure injury (obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (non-viable tissue that accumulates on the surface of a wound) or eschar (dead tissue within a wound)) to the sacrum (the large, triangle shaped bone at the base of the spine that connects the spine to the pelvis); -The resident had an unstageable pressure injury to the right hip; -The resident had an unstageable pressure injury to the right elbow. Review of the resident's undated face sheet showed the following: -Admitted on 2/13/25; -Diagnosis included metabolic encephalopathy (a change in how the brain works due to an underlying condition). Review of the resident's Progress Notes, dated 2/13/25 at 1:36 P.M., showed the Director of Nursing (DON) documented the resident arrived on a stretcher, with a surgical dressing in place from a pacemaker placement. The resident had a wound on this/her sacrum that measured 14 x 8 x 0.1 (no unit of measure provided), with the	F 655		

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wound bed comprised of less than 3% slough. Both of the resident's legs were contracted.

Review of the resident's Physician Order Sheet, dated February 2025, showed the following:
-No added salt diet, mechanical soft texture, regular/thin liquids consistency (original order dated 2/13/25);
-Right hip superior, clean with normal saline, pat dry, apply Santyl (an ointment that removes dead tissue from a wound), every day shift for unstageable wound (original order dated 2/13/25);
-Weekly skin assessment, every day shift, every Friday, if there are any new skin issues, identify on skin assessment (original order dated 2/13/25)
-Weekly weights for four weeks from admission, then monthly weights (original order dated 2/13/25).
-Clean with normal saline, pat dry, apply dry dressing daily, one time a day for sacrum (original order dated 2/14/25);
-Clean with normal saline, pat dry, apply Santyl right hip one time a day for unstageable wound (original order dated 2/14/25).

Review of the resident's Care Plan, dated 2/14/25, showed the care plan included the resident's rights. The care plan did not include the type of assistance the resident required for activities of daily living (ADLs), his/her diet, pressure ulcers present on admission, weekly weights, incontinence, or any refusal of care.

Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility

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staff, dated 2/15/25, showed the following:
-Cognitively intact;
-No behaviors or rejection of care;
-Impairment of both lower extremities;
-Required set up and clean up assistance with eating;
-Required maximum assistance with toileting, showering/bathing, lower body dressing, and personal hygiene;
-Required supervision/touching assistance with upper body dressing;
-Was dependent on staff for putting on/taking off footwear and all mobility (rolling in bed, sitting up, lying down, standing, and all transfers);
-Was always incontinent of bowel and bladder;
-Had two stage III pressure ulcers (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may also occur) and one unstageable pressure ulcer on admission;
-Was on a mechanically altered diet.

Review of the resident's Physician Order Sheet, dated February 2025, showed the following:
-Right hip, clean with normal saline/wound cleanser, pat dry, apply calcium alginate once daily, abdominal (ABD) pad and cover site dressing, every day shift for right hip (original order dated 2/19/25);
-Sacrum, clean with wound cleanser/normal saline, pat dry, apply calcium alginate, ABD pad and cover site dressing, every day shift (original order dated 2/19/25).

Review of the resident's care plan, dated 2/21/25,

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showed staff added the following to the resident's care plan:
-The resident required enhanced barrier precautions for chronic wounds;
-The resident had a stage III pressure ulcer on his/her right hip, a stage III pressure ulcer on his/her sacrum and an unstageable pressure ulcers on his/her left heel related to his/her impaired mobility.
-Staff did not updated the care plan to include the type of assistance the resident required for ADLs, his/her diet, weekly weights, incontinence, or any refusal of care.

Observation on 2/25/25 at 12:16 P.M., showed the Corporate Registered Nurse (RN) delivered the resident's meal tray and asked if the resident wanted help to eat. The resident initially refused, but then agreed. Certified Medication Technician (CMT) F attempted to feed resident.

Observation on 2/25/25 at 12:21 P.M., showed CMT F left the resident's room. CMT F said the resident refused to eat any of his/her meal.

Observation on 2/26/25 at 5:57 A.M., showed Certified Nurse Assistant (CNA) O and CNA P provided incontinence care to the resident.

Observation on 2/26/25 at 7:53 A.M. showed CMT L assisted the resident to eat his/her breakfast.

Observation on 2/26/25 at 9:19 A.M. showed the Assistant Director of Nursing (ADON) attempted to provide wound care to the resident, who refused.

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During interviews on 2/26/25 at 3:02 P.M. and 2/27/25 at 12:41 P.M., RN J said the following:
-The resident had been refusing most cares, including getting out of bed, since his/her arrival to the facility;
-The resident had been refusing to get up since he/she admitted, so staff had not been able to obtain an accurate weight;
-Today was the first day he/she had seen the resident out of bed and in a wheelchair;
-The resident required a mechanical lift for transfers;
-The resident required assistance from staff to eat, but could drink on his/her own.

Observation on 2/27/25 at 12:19 P.M., showed CNA B assisted the resident to eat his/her lunch

During an interview on 2/27/25 at 1:01 P.M., CNA B said the resident had been refusing most of his/her cares since arriving to the facility.

During an interview on 2/27/25 at 1:04 P.M., the Physician Assistant said the following:
-He/She was not aware staff did not obtain the resident's weight, but they likely did not weigh the resident due to the resident's refusal and resistance to cares;
-He/She would have expected staff to obtain and document the resident's weights. In the case the resident refused, he/she would have expected the staff to document the refusal make other attempts to obtain the resident's weight.

During an interview on 2/27/25 at 3:16 P.M., the Director of Nursing (DON) said if the resident refused, she would expect staff to properly document and provide education to the resident.

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2. Review of Resident #102's face sheet showed the following:
-He/She was admitted to the facility on 02/20/25;
-Diagnoses included stroke, dysphagia (difficulty swallowing), and anxiety.

Review of a nursing progress note, dated 02/26/25 at 2:44 P.M., showed the resident admitted to the facility on 2/20/25 after he/she suffered a cerebral infarction (stroke) with left side (dominant) paresis (inability to move one side of the body). His/Her arm was in a brace and he/she worked with physical therapy, occupational therapy, and speech therapy.

During an interview on 02/24/25 at 2:49 P.M., the resident said the following:
-He/She was unable to move his/her dominant left hand and needed assistance with oral hygiene;
-He/She required assistance with transfers.

Observation on 02/24/25 at 2:49 P.M., showed the resident was unable to move his/her left arm. The resident wore a brace on his/her left arm/wrist.

Observation on 02/26/27 at 7:30 A.M., showed two staff transferred the resident from the bed to the wheelchair with a gait belt.

Review of the resident's care plan, completed on 2/23/25, showed the facility did not address the resident's care needs including transfer status, assistance needed for oral care, use of a left arm/hand brace, or therapy services.

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F 655	Continued From page 21 During an interview on 2/27/25 at 9:15 A.M., RN H said the nurse who completed a resident's admission should complete an initial/baseline care plan. The care plan should be based on the nurse's initial assessment and the resident's initial care needs should be included on the baseline care plan. He/She was unsure why the baseline care plan was not completed for Resident #102. 3. During interviews on 02/27/25 at 11:30 A.M. and 3:16 P.M., the DON said completion of a baseline care plan had always been an expectation of the admitting nurse, but was not included on the checklist to ensure it was completed. She was unsure of the time frame requirement for a baseline care plan to be completed. During an interview on 2/27/25 at 4:02 P.M., the Administrator said she would expect baseline care plans to be done following guidelines and regulations and completed within 48 hours of a resident's admission.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff followed physician orders for three residents (Residents #5, #14, and #30), in a review of 17 sampled	F 658		

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residents. Staff failed to follow physician's orders for oxygen therapy and immunizations/vaccinations for Resident #5, failed to pack a wound as ordered for Resident #14, and failed to apply a soft hand splint for Resident #30. The facility census was 56.

Review of the facility policy, Medical Provider Orders, revised 4/7/22, showed the following:
-The facility shall use uniform guidelines for the ordering and following of medical provider orders;
-Medical provider orders should be reviewed prior to administration of medication and/or treatment to validate the orders contains all required elements;
-Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order;
-If an order does not contain all the required elements staff should contact the ordering provider for clarification of the order prior to implementation of the order.

1. Review of Resident #30's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 01/10/25, showed the following:
-His/Her cognition was severely impaired;
-He/She had impaired range of motion (ROM) in both his/her upper and lower extremities;
-He/She was dependent on staff for activities of daily living (ADLs), including dressing.

Review of the resident's Physician's Orders, dated February 2025, showed the following:
-Nursing to apply soft palm splint to right hand as tolerated;

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-On 01/29/25, an order was obtained to administer Tdap (vaccine protects against tetanus (infection of the nervous system), diphtheria (serious bacterial infection), and pertussis/whooping cough (highly contagious respiratory infection), Prevnar 20, and a COVID booster.

Review of the resident's medical record showed no evidence staff administered the Tdap vaccination, Prevnar 20, or COVID booster as ordered.

Review of the resident's care plan, last reviewed on 02/23/25, showed the following:
-His/Her cognitive function was impaired related to dementia;
-He/She was dependent on staff with dressing;
-He/She required a soft palm splint related to contracture of his/her right hand.

Observation on 02/24/25 at 12:00 P.M., showed the following:
-The resident's right hand was contracted;
-He/She sat at the dining room table in his/her Broda (special tilt in space seating) chair with no soft palm guard on his/her right hand.

Observation on 02/25/25 at 12:00 P.M., showed the following:
-The resident's right hand was contracted;
-He/She sat at the dining room table in his/her Broda chair with no soft palm guard on his/her right hand.

Observation on 02/25/25 at 3:35 P.M., showed the following:
-The resident lay in his/her bed without a soft

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palm guard on his/her contracted right hand;
-No palm guard was visible in the resident's room.

Observation on 02/26/25 at 6:00 A.M., showed the following:
-The resident lay in his/her bed with no soft palm guard on his/her contracted right hand;
-No palm guard was visible in the resident's room.

Observation on 02/26/25 at 7:30 A.M. showed the following:
-The resident's right hand was contracted;
-Staff assisted the resident to the dining room for breakfast. Staff did not put a soft palm guard on the resident's contracted right hand;
-No palm guard was visible in the resident's room.

During an interview on 02/26/25 at 3:40 P.M., the Therapy Director said the following:
-The resident should have a soft palm splint on the right hand to avoid his/her nails digging into the palm of the resident's contracted right hand;
-She had educated staff and placed the palm guards in the resident's room prior to survey;
-She was not aware staff did not use the soft palm guard.

During an interview on 02/26/25 at 4:30 P.M., Certified Nurse Assistant (CNA) B said the resident had a soft hand guard that was suppose to be used on the contracted right hand, but he/she didn't know where it was.

During an interview on 02/27/25 at 11:30 A.M., the Corporate Registered Nurse (RN) said the

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physician entered the orders for the vaccinations (Tdap, Pertussis, Prevnar 20, and COVID booster) as a routine order, therefore, the order did not generate into the nurse administration record to be given, and consequently staff did not administer the vaccinations. Administrative staff should have discovered the order in the chart review, but did not.

2. Review of Resident #14's quarterly MDS, dated 12/18/24, showed the following:
-One or more unhealed pressure ulcers;
-Three stage IV (full thickness, tissue loss with exposed bone, tendon or muscle, slough or eschar may be present on some parts of the wound bed, often includes undermining and tunneling) pressure ulcers;
-Received application of non-surgical dressings.

Review of the resident's Physician Order, dated February 2025, showed the following:
-Right ischial (lower half of the hip bone) wound: Cleanse with normal saline, skin prep (a film-forming skin protectant) to peri wound, lightly pack wounds with Vashe (wound cleanser solution) soaked one solid length of gauze roll, cover with bordered foam, change twice a day and as needed if removed or soiled. Do not use multiple pieces of gauze. Every day and evening shift;
-Coccyx (tailbone): Cleanse with normal saline, skin prep to peri wound, lightly pack wounds with Vashe soaked one solid length of gauze roll, cover with bordered foam, change twice a day and as needed if removed or soiled. Do not use multiple pieces of gauze. Every day and every evening shift.

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Review of the resident's Treatment Administration Record (TAR), dated 2/25/25, showed Licensed Practical Nurse (LPN) N provided the treatment to the resident's right ischium and coccyx on the evening shift.

During an interview on 2/26/25 at 3:20 P.M., LPN N said the following:
-The resident's wounds should be packed with gauze;
-Last night (2/25/25), the wounds had some drainage so he/she just used a 4x4 gauze to cover the wounds to stop the drainage and covered them with the bordered foam dressing.

Observation on 2/26/25 at 1:45 P.M., showed the Assistant Director of Nursing (ADON) entered the resident's room to perform treatment to the resident's pressure ulcers. The ADON removed bordered foam dressings from the resident's right ischium and coccyx. There was no packing in either of the resident's wounds.

During an interview on 2/26/25 at 1:45 P.M., the ADON said there was an order for the pressure ulcers to be packed twice daily, so she was not sure why staff (LPN N) did not pack the pressure ulcers last night.

During an interview on 2/27/25 a 10:10 A.M., the Physician Assistant said the following:
-He expected staff to follow the physician orders;
-The wound could worsen if staff did not pack the wound and follow the orders.

During an interview on 2/27/25 at 3:15 P.M., the Director of Nursing (DON) said she expected staff to pack the wound packed as ordered.

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3. Review of Resident #5's Care Plan, last reviewed/revised on 01/08/25, showed the following:
-He/She required oxygen therapy as needed while in bed;
-Administer oxygen as ordered.

Review of the resident's quarterly MDS, dated 01/22/25, showed the following:
-Cognition was intact;
-Diagnoses included heart failure, stroke, hemiplegia (inability to move one side of the body), and anxiety;
-No evidence to show the resident used oxygen during the previous seven-day look back period.

Review of resident's Physician's Orders, dated February 2025, showed the following:
-Apply oxygen at 2 liters (L) per nasal cannula continuously while in bed;
-May titrate up oxygen to 3 liters to keep oxygen saturation level above 90% every shift (original order dated 12/18/24).

Observation on 02/26/25 at 5:50 A.M., showed the resident lay in bed with oxygen via nasal cannula in place in his/her nostrils. The resident's oxygen concentrator was set to deliver 4.5 liters of oxygen per minute.

Observation on 02/26/25 at 4:20 P.M., showed the resident lay in bed with oxygen nasal cannula in place in his/her nostrils. The resident's oxygen concentrator was set to deliver 4.5 liters of oxygen per minute.

During an interview on 02/26/25 at 2:00 P.M.,

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F 658	Continued From page 28 CNA B said the following: -CNAs were allowed to place oxygen on residents; -He/She applied the resident's oxygen and turned on the machine (on 2/26/25); -He/She knew what the resident's oxygen was supposed to be set at because he/she had worked with this resident a long time. Review of resident's progress notes, dated 02/26/25, showed no documentation the resident complained of shortness of breath and/or any other respiratory symptoms that warranted an increase in the resident's oxygen level. Observation on 02/27/25 at 9:00 A.M., showed the resident lay in bed with oxygen nasal cannula in place in the resident's nostrils. The resident's oxygen concentrator was set to deliver 4.5 liters per minute. During an interview on 02/27/25 at 9:15 A.M., RN H said the following: -The resident's oxygen was supposed to be set on 2 liters at night and as needed for shortness of breath or decreased oxygen saturation; -Licensed nurses were responsible for applying oxygen. He/She did not receive report that the resident required an increase in oxygen level; -The resident should not have oxygen set on 4.5 liters per minute. Review of resident's progress notes, dated 02/27/25, showed no documentation the resident complained of shortness of breath and/or any other respiratory symptoms that warranted an increase in the resident's oxygen level.	F 658		

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F 658	Continued From page 29 During an interview on 02/27/25 at 11:20 A.M., the DON said the following: -Licensed nursing staff were responsible for applying oxygen on the residents; -CNAs could monitor and ensure oxygen was properly placed in the nose, but they were not to apply oxygen; -She expected staff to follow physician's orders as written. During an interview on 2/27/25 at 2:15 P.M., the resident's Physician's Assistant said the following: -He expected staff to follow orders as written and/or be notified if any changes were needed; -The resident's oxygen was ordered for 2 liters; -He expected staff to follow the resident's physician order, because 4.5 liters per minute was too much; -He consistently educated staff that more oxygen was not always better, and they should follow the orders and titrate as needed; -He was not notified that the resident required more oxygen than what was ordered. During an interview on 02/27/25 at 4:02 P.M., the Administrator said she expected staff to follow physician orders as written.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 677		

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review, the facility failed to provide three residents (Residents #102, #14, and #12), who relied on staff to assist with their activities of daily living (ADLs), in a review of 17 sampled residents, the necessary care to maintain good personal hygiene. The facility census was 56.

Review of the facility's policy, Oral Care, last reviewed/revised 09/01/21, showed it was the practice of the facility to provide oral care to residents in order to prevent and control plaque associated oral diseases. (The policy did not address how often staff were to provide assistance with oral care.)

Review of the facility's policy, Providing Nail Care, reviewed/revised 9/1/21, showed the following:
-Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care;
-Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis;
-Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises.

1. Review of the Resident #102's Face Sheet showed the following:
-He/She admitted to the facility on 02/20/25;
-His/Her diagnoses included stroke and dysphagia (difficulty swallowing).

Review of the resident's Care Plan, dated 02/24/25, showed no documentation related to the type of assistance the resident required for

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F 677	Continued From page 31 oral hygiene. Observation on 02/24/25 at 2:49 P.M., showed the resident's left (dominant) hand/arm was flaccid (inability to move) and was in a brace. The resident's breath was odorous and there was a white substance around his/her mouth. The resident had his/her natural teeth. There were no oral hygiene products (toothpaste, toothbrush) located in the resident's room. During an interview on 02/24/25 at 2:49 P.M., the resident said the following: -He/She was unable to move his/her dominant left hand and needed assistance with oral hygiene; -None of the staff had assisted him/her with oral hygiene since he/she admitted to the facility on 02/20/25. During an interview on 02/26/25 at 7:10 A.M., the resident said none of the staff helped him/her with oral care since he/she was admitted and his/her mouth was starting to taste pretty bad. Observation on 02/26/25 at 7:10 A.M., showed the resident's mouth was dry with a white substance around his/her gum line. Observation on 02/26/25 at 7:25 A.M., showed Certified Nurse Assistant (CNA) B did not assist the resident with oral hygiene as part of morning care before assisting the resident to the dining room for breakfast. There were no oral hygiene products located in the resident's room. During an interview on 02/26/25 at 7:30 A.M., CNA B said he/she did not assist the resident	F 677		

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with oral hygiene, because the resident did not have any oral care supplies in his/her room as the resident was recently admitted. He/She had not worked for a few days and did not know why there were no supplies in the resident's room. Staff was supposed to provide oral care every morning.

During an interview on 02/27/25 at 9:15 A.M., Registered Nurse (RN) H said CNAs and/or the nurse should provide oral care for residents, including residents with no teeth, every eight hours and/or shiftly.

During an interview on 02/27/25 at 11:30 A.M., the Director of Nursing (DON) said CNAs should assist residents with oral care at a minimum with morning care.

During an interview on 2/27/25 at 4:00 P.M., the Administrator said she expected staff to provide oral care in the morning, in the evenings, and as needed.

2. Review of Resident #14's quarterly MDS, dated 12/18/24, showed the following:
-Cognition intact;
-No rejection of care;
-Dependent on staff for all ADLs.

Review of the resident's Care Plan, revised on 2/24/25, showed the following:
-He/She was dependent on staff for all ADLs;
-He/She was able to make his/her needs known and wanted to make care decisions;
-Check nail length and trim and clean on bath day and as necessary.

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Observation on 2/24/25 at 3:05 P.M. showed the resident lay awake in bed. The resident's fingernails were very long.

During an interview on 2/24/25 at 3:05 P.M., the resident said the following:
-His/Her nails were way too long and needed to be cut;
-Staff usually cut his/her nails; they had not done this though for a while.

Observation on 2/25/25 at 2:45 P.M. showed the resident lay in bed. The resident's fingernails were very long.

3. Review of the Resident #12's Face Sheet showed the resident's diagnoses included stroke, cognitive communication deficit, disorganized schizophrenia (mental disorder characterized by hallucinations, delusions, and disorganized thinking and behavior), Parkinson's disease (neurodegenerative disease affecting both motor and non-motor systems), and need for assistance with personal cares.

Review of the resident's admission MDS, dated 02/01/25, showed the following:
-He/She was cognitively intact;
-He/She required supervision or touch assistance with personal hygiene and bathing.

Review of the resident's Care Plan, revised 10/30/24, showed the following:
-Required supervision/cues with cares due to diagnosis of schizophrenia, to ensure he/she had completed ADLs appropriately;
-Staff to check nail length, trim and clean them on bath day and as necessary.

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F 677	Continued From page 34 Observation on 2/24/25 at 1:15 P.M., showed some of the resident's fingernails were long, jagged, and had brown debris under the nails. Observation on 2/25/25 at 11:27 A.M., showed some of the resident's fingernails were long, jagged, and had brown debris under the nails. Observation on 2/26/25 at 5:53 A.M., showed some of the resident's fingernails were long, jagged and had brown debris under the nails. Observation on 2/26/25 at 12:50 P.M., showed some of the resident's fingernails were long, jagged and had brown debris under the nails. Observation on 2/27/25 at 9:00 A.M., showed some of the resident's fingernails were long, jagged and had brown debris under the nails. During an interview on 2/27/25 at 11:15 A.M., CNA D said the following: -All staff were responsible for providing nail care; -CNAs should check residents' nails on shower days; -The resident does his/her own showers with staff supervision; -CNA D checked residents' nails on shower days and cleaned and cut them if needed. During an interview on 2/27/25 at 2:20 P.M., CNA B said the following: -A typical shower consisted of checking residents' nails; -He/She gave the resident a shower on 2/26/25 and did not notice the resident's nails needed to be cut.	F 677		

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F 677	Continued From page 35 4. During an interview on 2/27/25 at 2:10 P.M., RN J said he/she expected the aides to provide nail care with shower at least twice a week. During an interview on 2/27/25 at 10:00 A.M., the Assistant Director of Nursing (ADON) said aides should provide nail care on shower days and as needed. During an interview on 2/27/25 at 3:16 P.M., the DON said the following: -CNAs should complete nail care or at least check the residents' nails with showers; -Staff should completed nail care when needed and when the nails are soiled, broken or uneven. During an interview on 2/27/25 at 4:00 P.M., the Administrator said she expected staff to clean and trim/file nails on shower days and as needed.	F 677		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		

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F 692	Continued From page 36 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently implement, evaluate, and modify interventions to prevent unintended weight loss for one resident (Resident #26), in a review of 17 sample residents, who had a 8.61% weight loss in one month. The facility census was 56. Review of the facility policy, Weight Monitoring, last revised 9/1/22, showed the following: -Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; -Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem; -The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors; b. Evaluating/analyzing the assessment	F 692		

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information;
c. Developing and consistently implementing pertinent approaches;
d. Monitoring the effectiveness of interventions and revising them as necessary.
-Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible:
a. Identified causes of impaired nutritional status
b. Reflect the resident's personal goals and preferences
c. Identify resident-specific interventions
d. Time frame and parameters for monitoring
e. Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or a new causes of nutrition-related problems are identified.
f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate.
g. The resident and/or resident representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences.
-Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.
-Weight Analysis: The newly recorded resident weight should be compared to the previous

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F 692	Continued From page 38 recorded weight. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days) -Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss. c. If the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietitian, Dietary Manager, or the nursing department may initiate this process. d. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes. e. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate. f. The interdisciplinary plan of care communicates care instructions to staff. 1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 11/16/24, showed the following: -Cognition was severely impaired; -Understood others and was able to make himself/herself understood; -Severely impaired vision; -Required supervision or touch assist for eating;	F 692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 39 -Height was 68 inches; weight was 159 pounds; -No weight loss. Review of the resident's Care Plan, revised on 11/13/24, showed the following: -The resident had an activities of daily living (ADL) self-care performance deficit, he/she was blind, and required guidance; -When the resident was eating, explain placement of items and feed if necessary; -The resident was able to feed himself/herself with tray set up due to him/her being blind; -He/She repeatedly asks for food and drink; -He/She would eat either in his/her room or in the main dining area. -Instruct him/her to eat in an upright position, to eat slowly, and to chew each bite thoroughly. (The resident's care plan did not address weight loss or identify interventions to prevent weight loss.) Review of the resident's weight record, dated 1/08/25, showed the resident weighed 159.1 pounds. Review of the resident's Physician Progress Note, dated 1/21/25, showed the following: -Protein calorie malnutrition (an individual does not eat enough protein and calories to meet nutritional needs); -Encourage increased oral intake; -On house supplement (a fortified nutritional shake that provides calories and protein) and Remeron 15 milligrams (mg) at bedtime for appetite stimulant. Review of the resident's Physician Progress Note, dated 1/24/25, showed the following:	F 692		

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F 692	Continued From page 40 -The resident gets up readily for snacks; -The resident had a very good appetite and seemed to always want to eat. Review of the resident's weight record, dated 02/06/25, showed the resident weighed 145.4 pounds (a weight loss of 13.7 pounds; a 8.61% weight loss in one month). Review of the resident's nutritional assessment, dated 02/10/25, showed the Registered Dietician (RD) documented the following: -Regular diet with regular consistency; -Nectar thickened liquids; -Meal intake 50-100%; -Weight on 02/06/25 was 145 pounds; -Loss of 5% or more in the last month or loss of 10% in the last six months; -Nutritional requirements: 1848 kilocalories (kcal), 66 grams of protein, and 1980 ml fluids; -The resident with fair to good oral intake with meals. Significant weight loss noted. Will add 60 milliliter (ml) med pass supplement (house supplement) three times a day to support nutritional needs and promote weight gain. Review of the resident's Physician's Orders, dated February 2025, showed the following: -Mirtazapine (Remeron) 15 mg, take one tablet my mouth at bedtime for depression, obsessive compulsive disorder, and anxiety (original order dated 8/17/24); -2.0 House Supplement (nursing), give 60 ml three times a day for weight loss (original order dated 2/10/25). Review of the resident's Care Plan, revised on 2/10/25, showed no documentation the facility	F 692		

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developed a care plan to address the resident's weight loss. The care plan did not include documentation the resident had weight loss and did not include listed interventions to prevent further weight loss and promote weight gain.

Review of the resident's Medication Administration Record (MAR), dated February 2025, showed the following:
-On 02/13/25 at 2:00 P.M., staff documented 0 mls of the 2.0 House Supplement was administered;
-On 02/14/25 at 9:00 A.M., staff documented 0 mls of the 2.0 House Supplement was administered;
-On 02/14/25 at 2:00 P.M., staff documented 0 mls of the 2.0 House Supplement was administered.

Review of the resident's annual MDS, dated 2/16/25, showed the following:
-Cognition was moderately impaired;
-Understood others and was able to make himself/herself understood;
-Severely impaired vision;
-Required supervision or touch assist for eating;
-It was very important to the resident to have snacks in between meals;
-Height was 68 inches; weight was 145 pounds. (Based on this information, the resident's calculated body mass index (BMI; a calculated measure of weight relative to height) was 22. Normal/healthy BMI is 18.5 to 24.9);
-Weight loss of 5% or more in last month or loss of 10% or more in last six months;
-On physician prescribed weight loss program.
(Note: The physician's progress notes, dated 1/21/25, identified the resident had protein calorie

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malnutrition. Staff was to increase the resident's oral intake and provide supplements/medications to increase appetite. The resident was not on a prescribed weight loss program.)

Review of the resident's MAR, dated February 2025, showed the following:
-On 02/24/25 at 9:00 A.M., staff documented 0 mls of the 2.0 House Supplement was administered;
-On 02/24/25 at 2:00 P.M., staff documented 0 mls of the 2.0 House Supplement was administered.

Review of the resident's MAR, dated 02/27/25 at 9:00 A.M., showed Registered Nurse (RN) J charted 0 mls of the 2.0 House Supplement was administered.

During an interview on 02/27/25 at 2:10 P.M., RN J said the following:
-The resident sometimes refused his/her house supplement;
-The resident didn't like the taste of the house supplement;
-He/She charted it as 0 mls administered if the resident didn't drink the supplement.

During an interview on 2/27/25 at 2:15 P.M., the resident said the following:
-He/She did not refuse a milkshake this morning;
-He/She would like to have a milkshake.

Observation on 2/24/25 at 12:50 P.M., showed the following:
-The resident sat on the side of the bed with his/her meal tray on the over-the-bed table in front of him/her. There were no staff in the

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resident's room;
-The resident said he/she was blind and asked multiple times what food items were on his/her tray. The resident's tray included chicken strips, mixed vegetables, a cup of tortilla chips, a cup of fruit cocktail, a glass of thickened water and a glass of thickened juice.
-The resident touched around his/her tray feeling for the food and for his/her drink glass with juice.
-The resident said he/she could not find the juice and asked for assistance to find it on his/her tray.
-The resident said he/she liked chicken but could not see it to enjoy it;
-The resident ate 100% of the fruit cocktail and chips with his/her hands. The resident did not eat any of his/her chicken or mixed vegetables;
-The resident asked for more chips and called out, "Hello. More chips. Hello, nurse."

Observation on 2/24/25 at 1:05 P.M., showed the resident lay in bed. His/Her meal tray sat on the over-the-bed table next to his/her bed. The chicken and the mixed vegetables remained on the resident's tray. The resident called out, "hello."

During interview on 2/24/25 at 1:05 P.M., the resident said he/she had no way to ask for help. He/She did not have a call light, or if he/she had one, he/she didn't know where it was. He/She couldn't call for help and would like for someone to come by his/her room periodically and ask if he/she needed something. He/She wished he/she had a menu of the items served for the meals so he/she could pick out his/her own food. He/She would like a choice in what he/she ate, but no one had asked him/her what he/she would like. He/She would like peanut butter and jelly

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sandwiches and grilled cheese. (These items were listed as an alternate the residents could request on the resident's meal ticket, however, the resident was blind and could not read the ticket).

Observation on 2/24/25 at 1:30 P.M., showed CMT F took the resident's tray from his/her room and told the resident he/she would get the resident a snack. The resident lay in bed.

Observation on 2/24/25 at 1:39 P.M., showed the resident lay in bed. The resident did not have any food or drink in his/her room. The resident said he/she would like more chips and something to drink.

Observation on 2/24/25 at 1:42 P.M., showed the resident lay in bed. The resident called out, "Nurse. Nurse. Hello." The resident did not have any food or drink in his/her room. No staff was in the hallway to respond to the resident.

Observation on 2/24/25 at 2:55 P.M. showed the following:
-The resident lay awake in bed;
-No cup or fluids were available for the resident in his/her room.

During an interview on 2/24/25 at 2:55 P.M., the resident said the following:
-He/She thought there ought to be a way to get a hold of someone when he/she needed something;
-He/She would like more food;
-He/She was thirsty and would like something to drink.

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F 692	Continued From page 45 Observation on 2/25/25 at 11:40 A.M., showed the following: -The resident lay awake in bed; -The resident's water pitcher, which contained regular water (not thickened) was on the bedside table, and not within his/her reach. A small bendable straw was down inside the pitcher. During an interview on 2/25/25 at 11:40 A.M., the resident said the following: -He/She was hungry and thirsty; -He/She would like a milkshake. Observation on 2/25/25 at 11:45 A.M., showed CMT E poured a 4 ounce mighty milkshake (a fortified, frozen shake, used to add calories and protein to the diet) into a clear cup with a straw and handed it to the resident. (The mighty milkshake was not the same as the house supplement.) During an interview on 2/25/25 at 11:45 A.M., the resident said the straw was broken and he/she was not getting anything out through the straw. Observation on 2/25/25 at 11:45 A.M. showed CMT E told the resident he/she would get him/her a new straw and left the room. CMT E did not return with a new straw. Observation on 2/25/25 at 11:45 A.M. showed the following: -The resident repeatedly sucked through the straw and continued to say, "This isn't working. This is broken"; -The resident consumed approximately 50% of the shake before giving up on the broken straw and lying back down on the bed.	F 692		

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F 692	Continued From page 46 Observation on 2/26/25 at 7:00 A.M. showed the resident called out, "Hello, can I have some food please? Hello, can I have something to drink please?" During an interview on 2/26/25 at 7:00 A.M., the resident said he/she would like something to eat and drink. Observation on 2/26/25 at 7:05 A.M., showed the following: -Licensed Practical Nurse (LPN) N brought the resident a small cup of koolaide and the resident drank it very quickly and asked where the food was; -LPN N told the resident he/she would bring it as soon as he/she got it. Review of the resident's dietary tray card for breakfast on 2/26/25 at 8:00 A.M., showed the following: -Regular, Finger Foods; -No pork; -Nectar thick liquids; -Provide assistance at meals; -Wants peanut butter and jelly for breakfast; -The resident was to receive corn flakes, French toast sticks, sausage links, juice of choice, coffee or hot tea, and milk of choice. Observation on 2/26/25 at 7:50 A.M., showed the following: -CMT F brought the resident's breakfast tray to the resident's room and sat it down on his/her bedside table; -The resident's breakfast tray included French toast, a bowl of oatmeal, a sausage patty, and	F 692		

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F 692	Continued From page 47 juice. (The resident did not receive a peanut butter and jelly sandwich, corn flakes, milk, or coffee with his/her breakfast meal.); -The resident asked where his/her food and drink were and grabbed all around the plate and tray to find his/her food and drink; -He/She found his/her juice and drank it quickly, spilling it all over the blanket; -CMT F poured the syrup on the resident's French toast but did not explain where things were on the resident's tray; -CMT F left the room; -The resident felt around the plate to locate his/her food and got syrup all over his/her hands; -He/She ate his/her food very quickly; -He/She consumed 100% of the meal. Observation on 2/26/25 at 8:12 A.M., showed the following: -The resident was in bed; -The resident said, "Nurse, can I get some more food? Can I get some toast and coffee?" -CMT L was in the room assisting the resident's roommate. He/She went to the resident, removed the resident's tray, and said, "You ate it all!"; -The resident said, "Nurse, can I get some coffee, please? Where can I get some coffee? Hello? Nurse, can I get some coffee?"; -CMT L told the resident that he/she would get him/her some coffee when he/she was finished feeding the resident's roommate some grapes; -The resident asked, "Can I get some grapes? Where is the food at? I'm so hungry!"; -CMT L said, "You just finished breakfast"; -The resident said, "Well, I'm still hungry!" -CMT L said, "Let's get up and I'll see about getting you a snack";	F 692		

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F 692	Continued From page 48 -The resident said, "Can I get some coffee? I don't want to get up"; -CMT L finished assisting the resident to get dressed; the resident continued to say, "I'm hungry. Can I get some food?"; -CMT L assisted the resident to transfer into his/her wheelchair and pushed the resident to the dining room; -The resident said, "I'd like breakfast and coffee"; -CMT L said, "You already ate"; -The resident said, "I'd like some more"; -CMT L got the resident some coffee with cream and sugar from the dining room area and sat it in front of him/her on the table; -CMT L did not get the resident anything to eat. Observation on 2/26/25 at 8:34 A.M., showed the following: -The resident sat at the dining room table and said, "Nurse, can I get something to eat or drink? I'm hungry"; -The resident did not have any food in front of him/her; -Housekeeper M told the resident that he/she would get him/her a peanut butter and jelly sandwich; -Corporate RN delivered a peanut butter and jelly sandwich to the resident's old room (resident moved rooms during the survey) and sat it on a bedside table; -Staff did not bring any food to the resident who was in the dining room. Observation on 2/26/25 at 8:45 A.M., showed the following: -Corporate RN walked up to the resident in the dining room and asked how he/she was doing; -The resident asked for food;	F 692		

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F 692	Continued From page 49 -Corporate RN told the resident the kitchen staff would get food for him/her; -The Registered Dietician (RD) brought the resident a cookie. Observation on 2/26/25 at 8:55 A.M., showed the following: -The resident ate all of his/her cookie and asked for another snack; -Corporate RN asked kitchen staff to get the resident another snack. Observation on 2/26/25 at 9:00 A.M., showed the following: -The resident ate cheese crackers off of a small saucer at the dining room table; -Crackers were scattered all around the outside of the plate. Observation on 2/26/25 at 1:45 P.M., showed the following: -The resident lay in bed awake and said, "Nurse, I'm hungry. I'd like something to eat. Is there anymore food?"; -The Assistant Director of Nursing (ADON) was in the resident's room providing a treatment for the resident's roommate. The ADON said, "Wait, I'm helping your roommate"; -The resident said, "I've been waiting for quite some time"; -The ADON said, "How about some popcorn"; -The resident said, "Where is it?"; -The ADON said, "I'll have to get it"; -Housekeeping M brought the resident some popcorn (no drink). The resident shoved the popcorn into his/her mouth one bite after the other very quickly; -The resident ate all of his/her popcorn and	F 692		

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F 692	Continued From page 50 asked for more to eat. During an interview on 2/26/25 at 2:30 P.M., the resident said he/she would like a snack and a drink. Observation on 2/26/25 at 2:40 P.M., showed the RD brought the resident thickened water and a fig newton bar for a snack. During an interview on 2/27/25 at 1:30 P.M., the resident's family member and power of attorney (POA) said the resident was thinner and had lost weight. During an interview on 3/11/25 at 9:40 A.M., the RD said the following: -She was not aware the resident was constantly asking for food and drink; -The resident asked her for a snack every once in a while, and she would get the resident whatever he/she asked for, which was usually something sweet like a danish or an alternate like an oatmeal cream pie; -The resident would also ask her for juice or coffee, and she would make sure it was thickened (nectar thick liquids); -She expected staff to give the resident food and drink that he/she liked, like sweets, to promote weight gain related to his/her weight loss; -She looked at her notes and the resident's weight was documented on 2/6/25; -Once the weight was put into the system, it triggered a list that she printed out, then made recommendations, and gave it to the Administrator and Director of Nursing; -She added a note on 2/10/25 and recommended a House Supplement three times daily for the	F 692		

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F 692	Continued From page 51 resident; -She did not recall discussing the resident or his/her weight loss with the interdisciplinary team (IDT); -The IDT met every morning and discussed anyone on the list, so she was sure they discussed the resident at that time; -She did not recall the last time the IDT discussed the resident; -She was not aware staff were documenting that the resident did not consume his/her house supplement; -She could not see the resident refusing or not consuming his/her house supplement unless he/she was not feeling well that day; -She followed up monthly to ensure interventions were effective. During interview on 3/12/25 at 9:26 A.M., the Director of Nursing said the following: -She was not aware the resident asked for more food and drinks. She knew the the resident frequently said, "Nurse, nurse" but she was not aware of anything else; -She was not aware staff documented the resident did not consume all of his/her house supplement. She would have expected staff to have notified her; -She looked at the resident's medical record and was seeing now that the resident had a 14 pound weight loss. She would have expected staff to notify her of the resident's weight loss; -The IDT met daily and weekly to discuss interventions and to determine if interventions were successful. She did not recall discussing the resident's weight loss in the IDT meetings.	F 692		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 52 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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	265118	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 883	Continued From page 53 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide evidence the facility offered the pneumococcal vaccination to three residents (Residents #5, #29, and #36), in a review of 17 sampled residents, and failed to provide education to each resident or resident representative regarding the benefits and potential side effects of the pneumococcal vaccination. The facility census was 56. Review of the facility policy, Pneumococcal Vaccine, dated 9/1/21, showed the following: -It is the facility policy to offer residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with Centers for Disease Control and Prevention (CDC) guidelines and recommendations; -Each resident will be assessed for pneumococcal immunization upon admission, self-report of immunization shall be accepted, any additional efforts to obtain information shall	F 883		

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F 883	Continued From page 54 documented, including efforts to determine date of immunization or type of vaccine received; -Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized, following assessment for any medical contraindications the immunization may be administered in accordance with physician-approved "standing orders"; -Prior to offering the pneumococcal immunization, each resident or the resident's representative will received education regarding the benefits and potential side effects of the immunization; -The individual receiving the immunization, or the resident's representative, will be provided with a copy of the CDC's current vaccine information statement relative to that vaccine; -If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding; -The resident/representative retains the rights to refuse the immunization, a consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record; -The type of pneumococcal vaccine offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations; -Usually only one pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime, however, based on an assessment and practitioner recommendation, additional vaccines may be provided; -The resident's medical record shall include documentation that indicates at a minimum, the following:	F 883		

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F 883	Continued From page 55 A. The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; B. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. Review of the CDC's recommendations for pneumococcal vaccine timing, dated 04/01/22, showed the following: -CDC recommends pneumococcal vaccination for adults 65 years old or older; -For adults who have never received a pneumococcal vaccine, or those with unknown vaccination history, one dose of PCV 15 (15-valent pneumococcal conjugate vaccine) or PCV 20 (20-valent pneumococcal conjugate vaccine) should be administered; -If PCV 20 is used, their pneumococcal vaccinations are complete; -If PCV 15 is used, follow with one dose of PPSV 23 (23-valent pneumococcal polysaccharide vaccine) with a recommended interval of at least one year; -For adults who have previously received PPSV 23 but who have not received any pneumococcal conjugate vaccine (PCV), one does of PCV 15 or PCV 20 may be administered with an interval of at least one year; -For adults 65 years or older without an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant, who have previously received PCV13 at any age, it is recommended to receive one dose of PPSV 23 at or after 65 years of age (at least one year after PCV13 was received). Their pneumococcal vaccinations are complete;	F 883		

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F 883	Continued From page 56 -For adults 19 years or older with an immunocompromising condition who have previously received a PCV13 at any age, CDC recommends two doses of PPSV 23 before age 65 years and one dose of PPSV 23 at the age of 65 or older. Administer a single dose of PPSV23 at least 8 weeks after the PCV13 was received. -If the patient was younger than 65 years old when the first dose of PPSV23 was given and has not turned 65 years old yet, administer a second dose of PPSV23 at least five years after the first dose of PPSV23. This is the last dose of PPSV23 that should be given prior to 65 years of age. -Once the patient turns 65 years old and at least five years have passed since PPSV23 was last given, administer a final dose of PPSV23 to complete their pneumococcal vaccinations. 1. Review of Resident #5's face sheet showed the following: -He/She admitted to the facility on 07/05/24; -He/She was over 65 years old; -His/Her diagnoses included unspecified organ and tissue transplant with rejection. Review of the resident's vaccination record showed the following: -The resident received PPSV 23 on 02/05/22; -There was no documentation to show the resident received any other pneumococcal vaccinations prior to or after administration of PPSV 23; -There was no documentation to show the facility offered the PCV 20 vaccination to the resident per CDC guidelines. Review of the resident's quarterly Minimum Data	F 883		

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F 883	Continued From page 57	F 883		

Set (MDS), a federally mandated assessment instrument completed by the facility, dated 01/22/25, showed the resident was up to date with pneumococcal vaccinations.

Review of the resident's medical record showed no documentation the facility offered the resident the pneumococcal vaccination, and no documentation the facility provided education to the resident regarding the benefits and potential side effects of the vaccination.

2. Review of Resident #29's face sheet showed the following:
-Admitted on 11/4/24;
-Diagnoses included cancer of the hypopharynx (the lower part of the throat) and chronic obstructive pulmonary disease (COPD);

Review of the resident's admission MDS, dated 11/8/24, showed the resident was not up to date on his/her pneumococcal vaccinations. Staff documented the reason the resident did not receive the vaccination was because it was not offered.

Review of the resident's Medication Administration Record (MAR), dated 11/15/24, showed the resident was to receive the PPSV23 vaccine. There was no documentation staff administered the vaccine.

Review of the resident's significant change in status MDS, dated 1/27/25, showed the resident was not up to date on his/her pneumococcal vaccinations. Staff documented the reason the resident did not receive the vaccination was because it was not offered.

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F 883	Continued From page 58	F 883		

Review of the resident's immunization record, located in the electronic medical record, showed no documentation the resident received a pneumococcal vaccine prior to or after admission to the facility.

Review of the resident's medical record showed no documentation the facility offered the resident the pneumococcal vaccination, and no documentation the facility provided education to the resident regarding the benefits and potential side effects of the vaccination.

During an interview on 2/27/25 at 2:59 P.M., the Corporate Registered Nurse (RN) said he could not locate any documentation staff administered the PPSV23 vaccine to the resident.

During an interview on 2/27/25 at 3:16 P.M., the Director of Nursing (DON) said she was not aware the resident had not received the pneumococcal vaccine.

3. Review of Resident #36's Face Sheet showed the following:
-Admitted to the facility on 09/09/22;
-He/She was over 65 years old;
-His/Her diagnoses included adult failure to thrive.

Review of the resident's vaccination record showed the following:
-The resident received Prevnar 13 (PCV13) on 12/12/14;
-There was no documentation to show the resident received any other pneumococcal vaccinations prior to or after administration of the

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F 883	Continued From page 59 PCV13 vaccination. Review of the resident's quarterly MDS, dated 12/18/24, showed the resident was up to date with pneumococcal vaccinations. Review of the resident's medical record showed no documentation the facility offered the resident the pneumococcal vaccination, and no documentation the facility provided education to the resident regarding the benefits and potential side effects of the vaccination. 4. During an interview on 2/27/25 at 4:02 P.M., the Administrator said she expected staff to follow the Centers for Disease Control and Prevention (CDC) guidelines for determining the administration of pneumococcal vaccines.	F 883		

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A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure Tuberculin Skin Tests (TST) were completed and documented in accordance with the requirements for Tuberculosis (TB; a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) testing for long-term care employees for four employees, in a review of eight employees, when the facility did not ensure the first-step TST was read on or prior to the employee's start date (first date of compensation). The facility census was 56. Review of the facility policy, Employee Tuberculosis Testing, implemented 09/01/21, showed the following: -Tuberculosis (TB) screening and testing is conducted in this facility for the purpose of early identification, evaluation, and treatment of employees with latent TB infection or TB disease; -Follow state or local requirements regarding TB screening and testing of employees. In the absence of state or local requirements, follow Centers for Disease Control and Prevention	A4031		

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A4031	Continued From page 1 (CDC) recommendations below; - New Staff Screening: -a. At the time of employment, all new staff shall undergo pre-placement screening for TB, including an individual risk assessment, TB symptom screen and a TB test; -b. All new staff shall receive two Mantoux TB Skin Tests given two weeks apart ("two-step testing") unless: i. A previously positive TB skin test reaction or positive TB blood test is reported, OR ii. Evidence of completion of adequate therapy for active TB is reported, OR iii. Two negative TB skin tests within the past 12 months, the more recent within the last three months, can be documented, OR iv. The employee has previously received the BCG vaccine (a live, weakened vaccine used to prevent tuberculosis). In this case, the employee shall be tested using a blood test (i.e. IGRA); -c. All initial and follow-up TB tests shall be administered and interpreted (48-72 hours for skin tests) by a trained healthcare provider on our staff or any licensed physician. Review of the Department of Health and Senior Services Tuberculosis Screening for Long-Term Care Facility Employees Flowchart (based on the requirements identified in the state regulation for administering TB testing), updated 03/11/14, showed the following: -Administer first-step TST prior to employment. Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date; -Read results of first-step TST within 48-72 hours of administration. The results must be read and documented in millimeters (mm) induration prior to or on the employee start date;	A4031		

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A4031	Continued From page 2 -The employee cannot start work for compensation until the first-step TST is administered and read. 1. Review of Certified Medication Technician (CMT) F's employee file showed the following: -First time card punch (first date of paid compensation) was on 12/04/24; -First-step TST administered on 12/04/24; -First-step TST read on 12/06/24; -The employee's first step TST was not administered and read before his/her first day of compensation. 2. Review of Cook G's employee file showed the following: -First-step TST administered on 10/22/24; -First time card punch was on 10/23/24; -First-step TST read on 10/25/24; -The employee's first step TST was not administered and read before his/her first day of compensation. 3. Review of the Human Resources Staff's employee file showed the following: -First time card punch was on 10/30/24; -First-step TST administered on 10/30/24; -First-step TST read on 11/01/24; -The employee's first step TST was not administered and read before his/her first day of compensation. 4. Review of the Occupational Therapist (OT)'s employee file showed the following: -First time card punch was 01/15/25; -First-step TST administered on 01/15/25; -First-step TST read on 01/17/25; -The employee's first step TST was not administered and read before his/her first day of compensation.	A4031		

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A4031	Continued From page 3 During an interview on 02/27/25 at 4:02 P.M., the Administrator said she thought TB testing was to be done prior to any resident contact and did not realize it was to be done prior to first day of paid compensation.	A4031		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II* Refer to F658. *The higher classification merited due to the violation's effect on the residents.	A4075		
A4076	19 CSR 30-85.042(67) Clean, Dry, Odor Free Each resident shall be clean, dry, and free of body and mouth odor that is offensive to others. I/II This regulation is not met as evidenced by: Class II Refer to F677.	A4076		
A4079	19 CSR 30-85.042(70) Sufficient Fluids/Hydration The facility must provide each resident the opportunity to access sufficient fluids to maintain proper hydration in accordance with the resident's	A4079		

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A4079	Continued From page 4 medical condition and goals of treatment as documented in the medical record. I/II This regulation is not met as evidenced by: Class II Refer to F692.	A4079		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Refer to F883.	A4086		
A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Each resident shall be served nutritious food, properly prepared and appropriately seasoned, taking into consideration resident food preferences, to provide an adequate diet in accordance with the physician ' s order and as recommended by the National Research Council. Nutritional needs of residents shall be met and shall be based on the individual ' s circumstances, medical condition and goals of	A5001		

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A5001	Continued From page 5 treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly assess these needs and shall keep the physician informed of the nutritional status of the resident. I/II This regulation is not met as evidenced by: Class II Refer to F692.	A5001		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* Refer to F583. *The higher classification merited due to the violation's effect on residents.	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Aspen Point Health & Rehabilitation
Street Address, City, Zip:	2840 West Clay St, St. Charles, MO 63301
Date of Survey:	02/24/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265118

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	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F558 / SS = D	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 4 - Call light placed within reach. Therapy assessment to determine cognitive status. Resident 26 - Call Light placed within reach. Therapy assessment to determine cognitive status. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Administrator/Designee will educate facility staff on the Call Lights: Accessibility and Timely Response policy to ensure call lights are within reach of residents. Ongoing education has been scheduled with QIPMO to be completed April 3rd-April 4th.	3/25/25

	How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure call lights are within reach. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	

F583 / A8030 SS = G	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 4 remains in the facility. Trauma informed care assessment was completed with no negative findings. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Administrator/Designee will educate facility staff on the Promoting and Maintaining Resident Dignity Policy to ensure residents are provided with privacy with cares. Education will include closing doors/privacy curtains during cares and knocking and waiting for permission to enter the resident room. Ongoing education has been scheduled with QIPMO to be completed April 3rd-April 4th. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Administrator/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure residents are provided privacy during cares. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	3/25/25

F655 / SS = D	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 405 – Resident's care plan will be reviewed and updated with the information regarding the resident's ADL needs, diet, pressure ulcer admission history and current skin integrity status, weights, continence vs. Incontinence status and history of refusals of care. Resident 102 – Resident's care plan will be reviewed and updated with the information regarding the resident's needs for transfer status, assistance for oral care, need for left arm/hand brace, and therapy services. The Facility Admission Checklist audit has been updated to include an audit of the baseline care plan during the morning clinical meeting. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Newly admitted residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Regional Nurse Consultant/Designee will educate the DON on the requirement for baseline care plan completion within 48 hours of admission. The DON/Designee will educate licensed nurses on initiation & completion of the baseline care plans within 48 hours of admission. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will complete random audits during morning clinical meeting weekly x 4 weeks and then monthly x 2 months to ensure baseline care plans are completed within 48 hours of admissions. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to	3/25/25

	remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	

F658 / A4075 SS=E	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 5 - Resident was assessed by the DON with no negative outcomes noted. Resident's oxygen was applied as per physician's orders. Resident received immunizations per physician orders. Resident 14 –Resident was assessed by the DON with no negative outcomes noted. Resident's wound has been dressed according to physician orders. Resident 30 – Resident was assessed by the DON with no negative outcomes noted. Resident's hand splint was applied per physician's orders. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The DON/Designee will educate Licensed Nurses on the Medical Providers Order Policy to include oxygen, wound, and splint orders. The DON/Designee will educate CNAs, CMTs, LPNs, & RNs on the CNA scope of practice for administering oxygen. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure physician orders are followed. Audits will include review of oxygen administration, wound care, and splints. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	3/25/25

F677 / A4076 SS= E	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 102 – Resident was provided oral hygiene and supplies are present in room. Resident 14 – Resident was provided nail care. Resident 12 – Resident was provided nail care. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. Residents were provided with supplies for oral hygiene. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The DON/Designee will educate the nursing staff and activity staff on the policy for oral care and nail care to include frequency of oral/nail care and ensuring residents are provided with the appropriate supplies. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure residents are provided with oral care and nail care. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	3/25/25

F692 / A4079 A5001 SS = G	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Interventions are in place for R#26. R#26's weight was obtained and is increasing as per most recent weights obtained. Resident #26 will be assessed by speech therapy and will make recommendations as indicated by their assessment. Resident #26's care plan will be reviewed and information regarding nutritional interventions and weight loss will be added as appropriate. The facility's dietician and/or dietary manager will review food preferences with residents and make any changes needed. The facility dietician will review residents for appropriateness of supplements and identify if additional weights are required. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Residents identified by facility dietician to be experiencing weight loss will be reviewed with care plan's updated as needed. The Director of Nursing and Care Plan Nurse are responsible to ensure resident care plans are updated as needed to address interventions to prevent weight loss. Residents identified by facility dietician to be experiencing weight loss will be reviewed for recommendations and/or if a re-weight is indicated. Dietician's recommendations will be reviewed for existing and new admission recommendations during the morning clinical meeting. The Director of Nursing & the Dietician are responsible to ensure dietary recommendations are followed.	3/25/25

	The administration record will be reviewed in the morning clinical meeting to ensure dietary supplements are administered as ordered. The DON/Designee will educate facility staff on diet orders, obtaining & recording weights, weight loss interventions to include following and care planning RD recommendations. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will review the items detailed above during morning clinical meeting weekly x 4 weeks and then monthly x 2 months to ensure residents who experience weight loss have interventions in place. Any issues identified will have corrective action taken. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	

F883 / A4086 SS = E	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident's #5,#29, & #36 will have informed consent/declination obtained with the resident/responsible party and will be immunized according to their wishes. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. The facility completed a 100% audit of pneumococcal vaccines to ensure all residents were educated and received the pneumococcal vaccine per their preference. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Regional Nurse Consultant will educate the DON, ADON/Infection Preventionist on vaccinations schedules to include administration schedule, monitoring physician orders, and documentation of administration or declination. The Infection Preventionist/Director of Nursing is responsible to ensure immunizations are administered as ordered. Admissions & re-admissions will be reviewed during the morning clinical meeting to ensure residents are up to date on the pneumococcal vaccine per their preference. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure residents are receiving pneumococcal vaccines per the vaccination schedule and/or physician orders. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	3/25/25

A4031 – Class II	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit was completed of the employee tuberculosis record to ensure facility staff are current on tuberculosis screening/testing. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrence include:** The Regional Nurse Consultant educated the NHA, DON, ADON/Infection Preventionist on the policy of Employee Tuberculosis Testing and the DHSS Tuberculosis Screening for Long Term Care Facility Employees Flowchart. Education included that the first step Tuberculosis test must be administered and read prior to the first day of compensation. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Administrator/Designee will complete random audits weekly x 4 weeks and then monthly x 2 months to ensure 1st step tuberculosis testing for employees will be completed prior to their first day of compensation. The results of the audits will be presented to the QAPI committee monthly to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months. In addition, the facility is engaging a temporary external quality assurance consultant to monitor the improvements and progress towards a good faith effort to remain in substantial compliance with the program rules of participation for Medicare and Medicaid.	3/25/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.