Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31404	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD SENIOR LIVING OF WENTZVILLE	120 PERRY CATE BOULEVARD WENTZVILLE, MO 63385

(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) COMPLETE DATE
A4507	19 CSR 30-86.045(3)(A)(6)(B) Individual Evacuation Plan- Interventions General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 6. At a minimum the evacuation plan shall include the following components: B. The fire protection interventions needed to ensure the safety of the resident; II This regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the individual evacuation plan included the intervention when two staff were needed to ensure the safety of three residents (Residents #4, #6, and #7) out of 12 residents sampled. The facility census was 57. 1. Record review of Resident #4's face sheet showed the following: -Admission date of 4/7/22; -Diagnoses included anxiety disorder (mental illness characterized by persistent fears), hypothyroidism (hormonal disorder), vascular dementia (disorder causing limitations with memory), and cerebrovascular disease (disorder effecting blood flow in the brain). Review of the resident's Individualized Evacuation Plan (IEP) dated 12/19/23 showed the following: - Resident required the assistance of two staff members to transfer the resident into a wheelchair utilizing a mechanical lift; - Resident required the assistance of one staff member to propel the resident in a wheelchair to the nearest exit or area of refuge;	A4507		

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A4507	Continued From page 1 - Staff assigned to assist resident with notification, transfer, and evacuation on Day Shift was identified as Position I with no second staff position assigned for Day Shift; - Staff assigned to assist resident with notification, transfer, and evacuation on Evening Shift was identified as Position K with no second staff position assigned for Evening Shift; - Staff assigned to assist resident with notification, transfer, and evacuation on Night Shift was identified as Position M. 2. Record review of Resident #6's face sheet showed the following: -Admission date of 8/29/22; -Diagnoses included benign prostatic hyperplasia (enlarged prostate gland), diabetes mellitus type 2 (blood sugar disorder), major depressive disorder (mental illness characterized by persistent sadness), congestive heart failure (disorder in which the heart does not efficiently pump blood), gastroesophageal reflux disease (digestive disorder), cerebral infarction (disorder which limits blood flow in the brain), gait and mobility abnormalities, and unspecified lack of coordination. Review of the resident's IEP dated 12/14/23 showed the following: - Resident required the assistance of two staff members to transfer the resident into a motorized wheelchair utilizing a mechanical lift; - Resident would self-propel the motorized wheelchair to the nearest exit or area of refuge; - Staff assigned to assist resident with notification, transfer, and evacuation on Day Shift, 7 AM to 7 PM, was identified as Position D with no second staff position assigned for Day Shift; - Staff assigned to assist resident with notification, transfer, and evacuation on Night	A4507		

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A4507	Continued From page 2 Shift, 7 PM to 7 AM, was identified as Position H 3. Record review of Resident #7's face sheet showed the following: -Admission date of 11/11/21; -Diagnoses included hypothyroidism, Parkinson's Disease (disorder characterized by muscle weakness and tremors), glaucoma (vision disorder), and other amnesia (memory disorder). Review of Resident the resident's IEP dated 2/23/24 showed the following: -Resident required the assistance of two staff members to transfer the resident into a high-backed wheelchair utilizing a mechanical lift; -Resident required the assistance of one staff members to proper the high-back wheelchair to the nearest exit or area of refuge; -Staff assigned to resident with notification, transfer, and evacuation on Day Shift, 7 AM to 7 PM, was identified as Position B with no second staff position assigned for Day Shift; -Staff assigned to assist resident with notification, transfer, and evacuation on Night Staff, 7 PM to 7 AM, was identified as Position F 4. Observation on 3/14/24 of the binder on medication carts on Assisted Living (east and west) and Memory Care showed the following: -A list of current residents identified as requiring an IEP for each unit; -No documentation in the binder of the specific interventions required by each resident on the list. Observation on 3/14/24 at 2:40 P.M. of the nurses office accessible to all care staff in the assisted living unit showed the following: - No binder listing the specific evacuation and assistance needs of the residents assessed to require IEPs; and	A4507		

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A4507	Continued From page 3 - A list of the residents in the assisted living unit and memory care unit who had been assessed to require an IEP without documentation indicating the evacuation and assistance needs of those residents. 5. During interview on 3/27/24 at 3:50 P.M., the administrator said the following: -The resident IEP information, including the particular interventions needed to safely evacuate the residents assessed to need IEPs, was kept in electronic form in the resident's electronic medical records; - It was her expectation that the IEP information would be accurately maintained and kept up-to-date electronically and in all the designated binders; - It was the responsibility of the director of nursing to make sure resident IEP information was accurately maintained and kept up-to-date electronically and in the designated binders.	A4507		
A4511	19 CSR 30-86.045(3)(A)(9) Resident Evacuation Plan - Readily Available General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 9. A copy of the resident ' s evacuation plan shall be readily available to all staff; II This regulation is not met as evidenced by: Class II Based on observation, interview, and record	A4511		

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A4511	Continued From page 4 review, the facility failed to have a copy of the resident's individualized evacuation plan readily available to all staff for three residents (Residents #4, #6, and #7) out of 12 residents sampled. The facility census was 57. 1. Record review of Resident #4's face sheet showed the following: - Admission date of 4/7/22; - Diagnoses included anxiety disorder (mental illness characterized by persistent fears), vascular dementia (disorder causing limitations with memory), and cerebrovascular disease (disorder effecting blood flow in the brain). Review of the resident's Individualized Evacuation Plan (IEP) in the electronic medical records dated 12/19/23 showed the resident required the assistance of two staff members to transfer the resident into a wheelchair utilizing a mechanical lift. 2. Record review of Resident #6's face sheet showed the following: - Admission date of 8/29/22; - Diagnoses included major depressive disorder (mental illness characterized by persistent sadness), congestive heart failure (disorder in which the heart does not efficiently pump blood), cerebral infarction (disorder which limits blood flow in the brain), gait and mobility abnormalities, and unspecified lack of coordination. Review of the resident's IEP in the electronic medical record dated 12/14/23 showed the resident required the assistance of two staff members to transfer the resident into a motorized wheelchair utilizing a mechanical lift. 3. Record review of Resident #7's face sheet	A4511		

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A4511	Continued From page 5 showed the following: - Admission date of 11/11/21; - Diagnoses included Parkinson's Disease (disorder characterized by muscle weakness and tremors), glaucoma (vision disorder), and other amnesia (memory disorder). Review of the resident's in the electronic medical record dated 2/23/24, showed the resident required the assistance of two staff members to transfer the resident into a high-backed wheelchair utilizing a mechanical lift. 4. Record review on 3/13/24 at 4:15 P.M., of the binder on the Memory Care medication cart showed the following: - A list of residents in the assisted living and memory care units who had been assessed to require IEPs; - No documentation in the binder showing the specific evacuation and assistance needs for the residents identified as requiring an IEP. Record review on 3/13/24 at 4:23 P.M. of the binder on the assisted living north medication cart showed the following: - A list of residents in the assisted living and memory care units who had been assessed to require IEPs; - No documentation in the binder showing the specific evacuation and assistance needs for the residents identified as requiring an IEP. Record review on 3/14/24 at 2:32 P.M. of the binder on the assisted living south medication cart showed the following: - A list of residents in the assisted living and memory care units who had been assessed to require IEPs; and - No documentation in the binder showing the	A4511		

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A4511	Continued From page 6 specific evacuation and assistance needs for the residents identified as requiring an IEP. Observation on 3/14/24 at 2:40 P.M. showed the following: - A list of residents in the assisted living and memory care units who had been assessed to require IEPs; - No binder in the nurse's station containing the documentation showing the specific evacuation and assistance needs for the residents identified as requiring an IEP. 5. During interview on 3/27/24 at 3:50 P.M., the administrator said the following: - The resident IEP information, including the particular interventions needed to safely evacuate the residents assessed to need IEPs, was kept in electronic form in the resident's electronic medical records; - The resident IEP information including the particular interventions needed to safely evacuate the residents assessed to need IEPs was kept in paper-form in binders in the director of nursing office, the nursing office, and on each medication cart in the assisted living north and south and memory care; - It was her expectation that the IEP information would be accurately maintained and kept up-to-date electronically and in all the designated binders; - It was the responsibility of the director of nursing to make sure resident IEP information was accurately maintained and kept up-to-date electronically and in the designated binders; and - She was not aware that the IEP information was not in the binders on the medication or in the binder in the nurses station at the time of the onsite inspection.	A4511		

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A4776	Continued From page 7	A4776		
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #1) of 12 residents sampled when facility staff failed to prevent the resident's elopement from the facility. Staff failed to recognize the resident as a resident and he/she left the facility assisted by a facility staff member. Facility staff also failed to respond to a door alarm when the resident exited the facility. The facility census was 57. 1. Record review of Resident #1's face sheet showed the following: -Admission date of 11/25/23; -Diagnoses included unspecified dementia (memory and thought disorder), anxiety disorder (mental illness characterized by persistent fear), and heart disease. Record review of the resident's Individualized Service Plan as of 1/15/24 showed the following: -The resident had current or history of occasional disorientation to person, place, time, or situation and required some direction and reminding from others; -Required close observation/supervision for wandering including cueing/redirecting for safety;	A4776		

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A4776	Continued From page 8 -Required an electronic device on his/her right leg to alert staff if resident attempted to exit the locked memory care unit. 2. Record review of incident report dated 1/14/24 signed by the facility administrator showed the following: -On 1/14/24 at 9:39 P.M., Resident #1 pushed the front entrance door of the memory care unit and exited the building; -Within one minute, memory care partner (MC Partner) C went outside and retrieved the resident; -At 9:40 P.M., MC Partner C and Resident #1 returned to the building and the resident's vitals were assessed for a change in condition; and -On 1/15/24 at 10:30 A.M., Elopement Education was started with staff. Record review of the witness interview form completed by MC Partner C showed the following: -Statement dated 1/14/24; -MC Partner C was in the memory care unit and heard the memory care front door alarm going off; -MC Partner C ran to the door to see what happened and found Resident #1 on the front porch of the memory care unit wearing a coat; -MC Partner C went outside and told Resident #1 that it was too cold to be outside and the resident did not have a ride; -MC Partner C took Resident #1 by the arm and escorted her inside the memory care front door. Record review of Wunderground.com weather history for the facility location on 1/14/24 at 9:51 P.M. showed the outside ambient temperature was two(2) degrees Fahrenheit.	A4776		

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A4776	Continued From page 9 3. Record review of incident report dated 1/19/24 signed by the facility administrator showed the following: -On 1/29/24 at 10:35 A.M., Resident #1 left the memory care unit into the assisted living hallway with the assistance of a dietary server who held the door; -On 1/29/24 at 10:41 A.M., Resident #1 left the facility through an exterior door, the door alarm sounded, and the care partner working in the vicinity did not pursue the resident; -On 1/29/24 at 10:49 A.M., Resident #1 was observed walking in the parking lot on the opposite side of the building from which he/she exited; -On 1/29/24 at 10:57 A.M., Resident #1 was escorted into the building by the resident services director. Record review of witness statement form completed by dietary aide (DIET) B showed the following: -Statement dated 1/29/24; -DIET B walked from the bathroom in the assisted living wing of the facility to the memory care unit; -When crossing through a shared door between the assisted living wing and the memory care unit, -DIET B saw a person with a purple coat and a yellow purse walking toward the door; -DIET B did not recognize the woman as a resident and thought she was a visitor; -DIET B held the door for the woman to leave the memory care unit and enter the assisted living unit. Record review of witness statement form completed by medication tech (MED)A showed the following:	A4776		

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A4776	Continued From page 10 -Statement dated 1/29/24 -At approximately 10:40 A.M. on 1/29/24, the staff member was in apartment 126 when he/she received an electronic notification of an AL delayed egress door alarm; -At the time of the electronic notification, MED A heard an alarm sounding; -MED A left apartment 126, walked to the exit door sounding the alarm; -MED A saw a person with a purple coat and a purse walking down the sidewalk away from the exterior door; -The person had her back to MED A and MED A did not recognize the person as a memory care resident; - MED A reset the door alarm and returned to room 126. Record review of witness statement form completed by the resident services director showed the following: -Statement dated 1/29/24; -On 1/29/24 at 10:55 A.M., the resident services director received a telephone call from a staff member at the school located across a parking lot from the facility; -The school staff member told the resident services director that he/she noticed a resident in the parking lot when the school staff member drove into the parking lot in a bus; -The resident services director went to investigate and found Resident #1 sitting on a bench in front of the independent living facility across the parking lot from the facility; -The resident services director approached Resident #1 and escorted the resident into the assisted living building; -The resident services director reported Resident #1's elopement to the assisted living management when he/she returned the resident	A4776		

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A4776	Continued From page 11 to the assisted living building. Record review of Wunderground.com weather history for the facility location on 1/29/24 at 10:51 A.M. the exterior ambient temperature was 36 degrees Fahrenheit. 4. During interview on 3/27/24 at 3:50 P.M., the administrator said the following: -At the time of the elopement, the resident was wearing an electronic device designed to alarm if the resident exited an exterior door of the memory care unit; -Exiting an exterior door of the memory care unit required a keypad entry of a code to clear the alarm if the resident exited an exterior door of the memory care unit while wearing the electronic device; -Staff were expected to use a calibration device to verify the electronic device was in working condition daily and the device was found to be working as designed on the day of the elopement; -At the time of the elopement, the facility did not keep a book or binder with photos of the residents in memory care or assisted living to educate staff of the residents who had a likelihood of attempting to elope; -The dietary staff member had opened the door between the assisted living and memory care units to return to the memory care unit when he/she was approached by a person wearing a coat and carrying a purse which lead the staff member to assume the person was a visitor rather than a memory care resident; -The dietary staff member was new to working in the memory care unit and was not familiar with the residents who had a likelihood of elopement or exit seeking; -The care staff member who responded to the alarm on the assisted living exit door saw a	A4776		

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A4776	Continued From page 12 person in a coat and purse from behind and assumed the person was a visitor rather than a resident; - Staff on the memory care unit were not aware that the resident was gone from the unit during the 25 minutes following the resident's elopement; - Following the elopement, the resident was placed on 15 minute checks and staff were educated on protocols to prevent the elopement of residents from the memory care unit; and - It was her expectation that all staff would verify that any individual leaving the memory care unit was not an unescorted resident.	A4776		
A4799	19 CSR 30-86.047(47)(B) Physicians Orders Requirements Medication Orders. (B) Physician ' s written and signed orders shall include: name of medication, dosage, frequency and route of administration and the orders shall be renewed at least every three (3) months. Computer generated signatures may be used if safeguards are in place to prevent their misuse. Computer identification codes shall be accessible to and used by only the individuals whose signatures they represent. Orders that include optional doses or include pro re nata (PRN) administration frequencies shall specify a maximum frequency and the reason for administration. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to ensure physician's orders were signed at	A4799		

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A4799	Continued From page 13 least every three months for three residents (Residents #1. #2, and #3) of 12 residents sampled. The facility census was 57. 1. Record review of Resident #1's face sheet showed the following: - Admission date of 11/25/23; - Diagnoses included dementia (memory and thought process disorder), anxiety disorder (mental illness characterized by persistent fears), coronary artery disease (heart disease), anemia (low blood iron), hypertension (high blood pressure), atrial fibrillation (heart rhythm disorder), spinal stenosis (bone disease impacting the spine), and dysphagia (difficulty swallowing). Record review of the resident's physician order sheets (POS) for March, 2024 showed the following orders: - Amlodipine (medication to treat high blood pressure), 25 milligram (mg) and 5 mg by mouth daily; - Aspirin (medication to treat pain), 81 mg, by mouth daily; - Buspirone (medication to treat anxiety), 10 mg, by mouth three times a day; - Ferrous sulfate (medication to treat low blood iron), 325 mg by mouth every Thursday; - Flonase (medication to treat nasal allergies), 50 micrograms (mcg), 1 spray in each nostril daily; - Melatonin (medication to treat sleep disruption), 5 mg, by mouth every night; - Metroprolol (medication to treat high blood pressure), 50 mg, by mouth every eight (8) hours; - Mirtazapine (medication to treat depression), 15 mg, four (4) tablets by mouth every night; - Quetipine (medication to treat mental illness), 25 mg, by mouth every night; - Acetaminophen (medication to treat pain), 325	A4799		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31404	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD SENIOR LIVING OF WENTZVILLE	120 PERRY CATE BOULEVARD WENTZVILLE, MO 63385

(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) COMPLETE DATE
A4799	Continued From page 14 mg, two (2) tablets every four (4) hours as needed; - Miralax (medication to treat digestive disorders), 17 grams (gm), by mouth twice a day as needed; - Ondansetron (medication to treat nausea), 4 mg by mouth every six (6) hours as needed; and - Senna (medication to treat digestive disorders), 8.6 mg, by mouth daily as needed. Review of resident's paper chart and electronic medication record showed the most recent signed physician's orders were dated 12/2/23. 2. Record review of Resident #2's face sheet showed the following: - Admission date of 5/23/23; - Diagnoses included dementia, Alzheimer's disease (memory and thought process disorder), and insomnia (sleep disorder). Record review of the resident's POS for March, 2024 showed the following orders: - Donepezil (medication to treat Alzheimer's disease), 10 mg, one tablet by mouth every night; - Quetipine, 25 mg, one tablet by mouth twice a day; - Viativ chew (calcium chewable), by mouth twice a day; - Acetaminophen, 650 mg, suppository every six (6) hours as needed; - Bisacodyl (medication to treat digestive disorder), 10 mg suppository daily as needed; - Hyoscyamine (medication to treat digestive disorder), 0.125 mg, by mouth every four (4) hours as needed; - Lorazepam (medication to treat anxiety), 2 milligrams per milliliter (ml), 0.5 ml by mouth every four (4) hours as needed; - Morphine (medication to treat pain), 0.25 ml by mouth every two (2) hours as needed; and	A4799		

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BOULEVARD SENIOR LIVING OF WENTZVILLE	120 PERRY CATE BOULEVARD WENTZVILLE, MO 63385

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A4799	Continued From page 15 - Senna, 8.6 mg, by mouth daily as needed. Review of resident's paper chart and electronic medication record showed the most recent signed physician's orders were dated August, 2023. 3. Record review of Resident #3's face sheet showed the following: - Admission date of 4/28/23; and - Diagnoses included anxiety disorder, hypertension, dementia, Alzheimer's disease, osteoporosis (bone density disorder), and history of artificial hip. Record review of the resident's POS for March, 2024 showed the following orders: - Acetaminophen, 325 mg, two (2) tablets by mouth every six (6) hours; - Alprazolam (medication to treat anxiety), 0.5 mg by mouth three times a day; - Atenolol (medication to treat high blood pressure), 25 mg, one-half tablet by mouth daily; - Celecoxib (medication to treat pain and inflammation), 200 mg by mouth daily as needed; - Docusate sodium (medication to treat digestive disorder), 100 mg by mouth twice a day; - Donepezil, 10 mg by mouth every night; - Quetipine, 25 mg, by mouth twice a day; - Senna, 8.6 mg, two capsules by mouth every other day; - Sertaline (medication to treat depression), 100 mg every night; - Bisacodyl, 5 mg by mouth daily as needed; - Norco (medication to treat pain), 5-325 mg, by mouth every six (6) hours as needed; - Oxycodone (medication to treat pain), 5 mg by mouth every four (4) hours as needed; - Loperamide (medication to treat digestive disorder), 2 mg, two (2) tablets three (3) times a	A4799		

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BOULEVARD SENIOR LIVING OF WENTZVILLE	120 PERRY CATE BOULEVARD WENTZVILLE, MO 63385

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A4799	Continued From page 16 day as needed; - Meclizine (medication to treat nausea), 25 mg by mouth each night as needed; and - Zinc oxide, 30% cream, daily to affected area of skin as needed. Review of resident's paper chart and electronic medication record showed the most recent signed physician's orders were dated 9/25/23. 4. During interview on 3/27/24 at 3:50 P.M., the administrator said the following: - The staff member who had previously been assigned to verify the physician's orders were signed at least every three months was no longer working for the facility; - It was her expectation that physician order sheets would be sent to the physicians in a timely manner to ensure compliance with the regulation.	A4799		
A6031	19 CSR 30-87.020(31) Kitchen Waste Containers Covered Waste containers used in food-preparation and utensil-washing areas shall be kept covered when not in actual use. III This regulation is not met as evidenced by: Class III Based on observation and interview, the facility failed to ensure that waste containers used in food-preparation and utensil-washing areas were kept covered when not in use. The facility census was 57. 1. Observation on 3/14/24 at 10:28 A.M. of the assisted living kitchen showed the following: -Trash can in the cooking area of the kitchen had	A6031		

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A6031	Continued From page 17 no lid and no lid was found in the immediate area; -Trash can by the grill had no lid and no lid was found in the immediate area. Observation on 3/14/24 at 10:47 A.M. of the food preparation area showed two trash cans without lids and no lids were found in the immediate area. 2. Record review of Consultant Dietitian Report dated 12/1/2023 showed the following: -The report was signed by the registered/licensed dietitian hired by the facility to perform a kitchen inspection; and -The report identified a sanitary correction was needed due to the presence of trash can without lid. 3. During interview on 3/27/24 at 3:50 P.M. the dietary director said the following: -Trash can lids were to be ordered; -It was her expectation that dietary staff would follow basic sanitary standards.	A6031		
A7016	19 CSR 30-87.030(14) Food-Clean Containers, Storage, Covers Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be impervious and nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers. III This regulation is not met as evidenced by: Class III Based on observation, interview and record	A7016		

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A7016	Continued From page 18 review, the facility failed to ensure food was stored in a clean covered container. The facility census was 57. 1. Observation in the assisted living kitchen on 3/14/24 at 10:33 A.M. of the freezer in the cooking area of the kitchen showed the following: - Bag of French fry potatoes unsealed and open to the air; - Bag of onion rings unsealed and open to the air. Observation of the walk-in refrigerator on 3/14/24 at 10:36 A.M. showed the following: - A tray of a dozen fruit cups in glass dishes prepared for the previous day's dessert was uncovered and open to air; - Box of sausage patties unsealed and open to the air; - Two trays in dessert racks with desserts uncovered and open to the air; - A tub of unbagged lettuce on a lower shelf directly beneath jars of condiments with drips on the exterior of the jars. 2. Record review of the Consultant Dietitian Report dated 12/1/23 showed the following: - The report was signed by the registered/licensed dietitian hired by the facility to conduct a kitchen inspection; - The report listed sanitary conditions which required correction including an uncovered container of pasta and open bags of sweet potato fries, French fries, chicken patties, and hash browns. During interview on 3/27/24 at 3:50 P.M., the dietary director said it was her expectation that all dietary staff follow follow basic sanitation standards.	A7016		

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A7067	Continued From page 19	A7067		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Based on observation, interview and record review, the facility failed to ensure non-food contact surfaces in the kitchen were kept clean from dirt and debris. The facility census was 57. 1. Observation of the assisted living kitchen on 3/14/24 at 10:34 A.M. showed the shelf below the flat grill was contaminated with crumbs. Observation of the walk-in freezer on 3/14/24 at 10:43 A.M. showed a white substance spilled on the floor that could be scraped with a fingernail. Observation of the floor under the dishwasher on 3/14/24 at 10:48 A.M. showed a build up of white substance that could be scraped with a fingernail. 2. Record review of Consultant Dietitian Report dated 12/1/23 showed the following: - Report was signed by the registered/licensed dietitian hired by the facility to inspect the kitchen; - Sanitary conditions which needed correction included the presence of flour on the floor and food splatter near the fryer/oven. 3. During interview on 3/27/24 at 3:50 P.M., the dietary director said that it was her expectation that all dietary staff follow the basic sanitary	A7067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A7067	Continued From page 20 standards.	A7067		

PLAN OF CORRECTION

Provider/Supplier Name:	Boulevard Senior Living of Wentzville
Street Address, City, Zip:	120 Perry Cate Blvd, Wentzville, MO 63385
Date of Survey:	3-27-24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	31404

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
A4507	**Correction of cited deficiency:** The community will ensure residents who need more than minimal assistance due to being a 2 person transfer have individualized evacuation plans in place that include the two staff needed to ensure the safety of the residents. Resident #4 is no longer at the community. Resident #6 requires the use of a mechanical lift for transfers. Individualized Evacuation Plan has been modified to involve the assignment of two staff members during each shift to ensure comprehensive assistance in case of emergency. Resident #7 is no longer at the community.	4-15-24
	Assessment to identify other residents that might be affected: All residents who necessitate more than minimal assistance would be affected by any non-compliance. The Director of Wellness, or designee will review all Individualized Evacuation Plans for accuracy and will update if necessary. Identification of new residents that require an Individualized Evacuation Plan will be identified through the monthly wellness visits and a Community Based Assessment review that is completed every 6 months and upon significant change in condition.	4-15-24

	Procedure to ensure on-going compliance: The community will ensure adherence to this regulation by instituting a comprehensive plan. The Director of Wellness, or their designated representative, will conduct in-service training to educate all staff members on the policy regarding Individual Evacuation Plans. This training is designed to ensure a clear understanding of their respective roles in the event of an emergency necessitating evacuation: 1. Evacuation to an area of refuge within the community. 2. Transition from one smoke partition section to another within the community. 3. Utilization of emergency exits leading to the outside of the community.	4-5-24
	Monitoring of on-going compliance: To ensure continuous compliance with the Individualized Evacuation Plans, the Director of Wellness or designee will conduct three random audits quarterly. This monitoring process is established to guarantee that the community consistently adheres to the specified evacuation procedures.	4-15-24
A4511	**Correction of cited deficiency:** The community will ensure resident evacuation plans are readily available. Resident #4 is no longer at the community. Resident #6 Individualized Evacuation Plan including interventions needed to safely evacuate is kept electronically in the electronic medical records, paper form is kept in the red emergency binder at the front desk and at the nurses station, and paper form is kept, along with the evacuation schedule, in a binder at each medication cart in assisted living north and south and memory care Resident #7 is no longer at the community.	3-28-24
	Assessment to identify other residents that might be affected: All residents who necessitate more than minimal assistance would be affected by any non-compliance. The Director of Wellness, or designee will review all Individualized Evacuation Plans for staff access monthly.	3-28-24
	Procedure to ensure on-going compliance: The community will ensure adherence to this regulation by instituting a comprehensive plan. The Director of Wellness, or their designated representative, will conduct in-service training to educate all staff members on access to all resident Individualized Evacuation Plans.	4-5-24
	Monitoring of on-going compliance: To ensure continuous compliance with the Individualized Evacuation Plans, the Director of Wellness or designee will conduct monthly cart and red binder audits. This monitoring process is established to guarantee that the community consistently adheres to the specified evacuation procedures.	4-15-24
A4776	**Correction of cited deficiency:** The community will ensure that protective oversight is provided 24 hours a day. Residents departing the memory care premises on voluntary leave must be accompanied by a guardian or staff. Resident #1 requires the use of wander guard monitoring device that is in place and checked every shift, a picture of all memory care residents has been placed in picture binder at all 3 campus entrances and available for all staff and agency, 15 minute status checks were implemented for 72 hours, staff education was provided on elopement and protective oversight, and	3-28-24

	environment safeguards in place with Plant Operations Director checking exit door alarms weekly through TELS.	
	Assessment to identify other residents that might be affected: All residents who necessitate wander guard placement due to dementia/memory loss would be affected by any non-compliance. The Director of Wellness or designee will complete an elopement and mini mental evaluation every 6 months or with any significant change in condition.	3-28-24
	Procedure to ensure on-going compliance: Wellness Director will audit weekly documentation of the MAR for verification that the wander guard is in place and functioning properly every shift. (Twice daily). Business Office Director will audit new employee files to ensure that all staff have received Dementia training and elopement education upon hire and again on the last day of orientation to show competency of the policy. All staff were in-serviced on 1-30-24 on elopement prevention and procedure with safety measures.	3-28-24
	Monitoring of on-going compliance: All audit tools will be reviewed in the monthly Administration Logs and in weekly 1:1 with Executive Director and Director of Wellness.	3-28-24
A4799	**Correction of cited deficiency:** The community will ensure all physicians orders are signed at least every three months. Resident #1 had signed physician orders from 12/2/23. Current physician orders were reviewed and signed 1-31-24. Resident #2 had signed physician orders from 8/23. Current physician orders were reviewed and signed 1-31-24. Resident #3 had signed physician orders from 9/25/23. Current physician orders were reviewed and signed 1-31-24.	3-28-24
	Assessment to identify other residents that might be affected: Non-compliance of this regulation has the potential to affect all residents. The Director of Wellness or designee will audit the implemented purple Physician Order Sheet (POS) binder weekly x 4 weeks and then monthly after that.	4-1-24
	Procedure to ensure on-going compliance: . The Director of Wellness or designee will audit the implemented purple Physician Order Sheet (POS) binder monthly. The Director of Wellness will educate the nurse managers to the POS binder and the regulation.	4-1-24
	Monitoring of on-going compliance: The Director of Wellness **or** designee will audit monthly documentation of the physician order sheets and ensure physician signature every 3 months to meet compliance.	4-1-24
A6031	**Correction of cited deficiency:** The community will ensure that waste containers used in food-preparation and utensil-washing areas shall be kept covered when not in actual use. Waste containers and lids were ordered through Clark for all three kitchens. Culinary Director or designee will educate servers to ensure regulation is being met.	3-28-24
	Assessment to identify other residents that might be affected: Non-compliance of this regulation has the potential to affect all residents. Culinary Director will complete weekly walking rounds x 4 weeks in all 3 kitchens to ensure waste containers are covered.	3-29-24
	Procedure to ensure on-going compliance: Culinary Director will complete random walking rounds in all three kitchens to	3-29-24

	ensure waste containers covered. Culinary Director will review quarterly Dietician report and follow up with non-compliance items.	
	Monitoring of on-going compliance: Culinary Director will meet with Executive Director weekly for 1:1 to review rounds to ensure compliance. Culinary Director, Executive Director, and Director of Wellness will review quarterly Dietician report as a team to ensure correction of non-compliance items.	4-2-24
A7016	**Correction of cited deficiency:** The community will ensure all food whether raw or prepared if removed from container or package shall be stored in cleaned covered container except during necessary periods of preparation or service. Culinary Director or designee will complete weekly rounds to ensure container covers are sealed and non-absorbent except when linens or napkins are used for lining or covering bread or rolls.	3-28-24
	Assessment to identify other residents that might be affected: Non-compliance of this regulation has the potential to affect all residents. Culinary Director will complete weekly walking rounds x 4 weeks in all 3 kitchens to ensure food is stored proper package or containers. Culinary Director or designee will educate cooks to ensure regulation is being met.	3-28-24
	Procedure to ensure on-going compliance: Culinary Director will complete random walking rounds in all three kitchens to ensure waste containers covered. Culinary Director will review quarterly Dietician report and follow up with non-compliance items.	3-29-24
	Monitoring of on-going compliance: Culinary Director will meet with Executive Director weekly for 1:1 to review rounds to ensure compliance. Culinary Director, Executive Director, and Director of Wellness will review quarterly Dietician report as a team to ensure correction of non-compliance items. Culinary Director will meet with Executive Director monthly to review food safety and sanitation checklist.	4-2-24
A7067	**Correction of cited deficiency:** The community will ensure nonfood contact services of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, and other debris. Culinary Director or designee will educate both servers and cooks to ensure regulation is met.	4-16-24
	Assessment to identify other residents that might be affected: Non-compliance of this regulation has the potential to affect all residents. Culinary Director will complete weekly walking rounds x 4 weeks in all 3 kitchens to ensure nonfood contact services are clean.	4-16-24
	Procedure to ensure on-going compliance: Culinary Director or designee will complete monthly food safety and sanitation checklist. Culinary Director or designee will complete weekly audit of daily cleaning checklist for servers and cooks.	4-16-24
	Monitoring of on-going compliance: Culinary Director will schedule deep cleaning of the three kitchens that will cover the scrubbing of the floors and delegation of assigned surfaces to clean. Culinary Director or designee will continue to complete weekly audit of daily cleaning checklists for servers and cooks and will also continue to complete monthly food safety and sanitation checklist.	4-16-24

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.