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BARNES-JEWISH EXTENDED CARE	401 CORPORATE PARK DRIVE SAINT LOUIS, MO 63105

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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 §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.	F 655	**Opening Statement:** Please accept this Plan of Correction as our Credible Allegation of Compliance. Submission of this Response and Plan of Correction is not a legal admission that a deficiency was correctly cited and is also not to be construed as admission against interest by Barnes-Jewish Extended Care, the Administration or any employee, agents, or other individuals who may draft or who may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by Barnes-Jewish Extended Care of the truth of any facts alleged or correctness of any conclusion set forth in this allegation by the Survey Agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Candace E Bacon	VP + Senior Administrator	6/13/24

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 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 §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.	F 655		

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F 655	Continued From page 1 (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 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 ensure each resident's care plan accurately reflected the residents' needs and medical conditions upon admission. This failure was noted in 5 of 17 sampled residents, including Resident #199, whose gastrostomy tube (g-tube, a surgical opening made in the stomach to feed nutrition directly into the stomach) was not included on the care plan, Resident #299 whose continuous positive airway pressure (CPAP, used to treat sleep apnea) was not included on the care plan, Resident #298 whose urinary catheter was not included and Resident #301, whose intravenous (IV) line was not included on the care plan, and for Resident #248 when a foot wound was not included on the care plan. The census was 69. Review of the facility's "Care Planning" policy, revised 11/22 showed: -It is the responsibility of all members of the interdisciplinary team to know and comply with this policy; -Initial/Baseline care plans must be completed within 48 hours of the resident's admission, and should include pain levels, fall risks, skin conditions, assistance with Activities of Daily Living (ADLs), and the risk for hospitalization no later than eight hours after admission; -The initial care plan is based on several areas, such as physician orders, pertinent diagnoses that would impact the resident's care, dietary	F 655		

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orders, therapy services, social services, and utilization of the assessment tool to identify needs, risks, preferences, and services or treatment to be administered by facility staff.

1. Review of Resident #199's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/17/24, showed:
-Cognitively intact;
-Diagnoses included malignant neoplasm (a cancerous tumor) of the larynx;
-Independence with ADLs including bathing, dressing, and personal hygiene;
-An admission date of 5/16/24.

Review of the resident's baseline care plan, entered on 5/17/24, made no mention of the resident's g-tube site or the resident's necessity to receive medications through his/her g-tube site.

Observation on 5/20/24 at 11:46 A.M., showed the resident resting in bed with an enteral tube feeding (nutrition infused through a surgical opening in the intestine to meet a resident's caloric intake needs) infusing. The resident said he/she received scheduled enteral feedings and all medications through his/her g-tube and provided care for the g-tube site himself/herself.

Observation on 5/21/24 at 9:46 A.M., showed the resident resting in bed with an enteral tube feeding infusing. The resident said he/she got evening meds as ordered by the physician, administered through his/her g-tube.

Observation on 5/22/24 at 10:41 A.M., showed the resident resting in bed with an enteral feeding

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infusing. The resident said his/her g-tube was functioning properly and the dressing had been recently changed.

During an interview on 5/23/24 at 10:28 A.M., Certified Medication Technician (CMT) F said the Social Services Designee is responsible for completing baseline and comprehensive care plans at the facility, and the development of care plans begins at admission. CMT F said he/she expected a resident admitted with a g-tube and administered medications through a g-tube to be included on the care plan. CMT F said care plans are important so that each resident's specific needs can be met by facility nursing staff.

During an interview on 5/23/24 at 10:11 A.M. Licensed Practical Nurse (LPN) E said the Social Services Designee and floor nurses are responsible for completing baseline and comprehensive care plans at the facility, and the development of care plans begins at admission. LPN E said he/she expected a resident admitted with a g-tube and being administered medications through a g-tube to be included on the care plan. LPN E said care plans are important so that each resident's specific needs can be met by facility nursing staff.

During an interview on 5/23/24 at 12:35 P.M., the Administrator and Director of Nursing (DON) said Nurse Managers in conjunction with the facility MDS Coordinator, are responsible for developing care plans, and care planning starts upon admission. The DON said baseline care plans should include fall risks, whether residents are at risk for skin breakdown, active wounds and surgical lines, and other immediate needs. The DON said the resident's g-tube status should be

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included on the care plan.

2. Review of Resident #299's electronic medical record (EMR) and resident information card, showed:
-An entry MDS, dated 5/13/24, showed an admission date 5/13/24;
-A baseline care plan showed general information that included a diagnosis of obstructive sleep apnea (OSA, breathing interrupted during sleep);
-Diagnoses included cancer, high blood pressure, depression, high cholesterol and sleep apnea;
-CPAP device was not listed on the resident's baseline care plan and information card.

Observation on 5/20/24 at 11:21 A.M., showed the resident's CPAP rested on top of the headboard.

During an interview on 5/23/24 at 10:16 A.M., Registered Nurse (RN) B said the CPAP should be listed on the care plan.

During an interview on 5/23/24 at 12:35 A.M., the DON said she expected the CPAP to be on the resident's care plan.

3. Review of Resident #298's EMR and resident information card, showed:
-An entry MDS, dated 5/10/24, showed an admission date 5/10/24;
-A baseline care plan, dated 5/10/24, showed the resident as incontinent of bowel and bladder;
-Indwelling urinary catheter (a tube inserted into the bladder through the urinary tract to drain urine) not indicated on resident information card;
-Diagnoses include sleeplessness, seizure, bipolar disorder (a mood disorder characterized with manic highs and depressed lows) and

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neurogenic bladder (difficulty emptying the bladder due to neurological conditions).

Observation on 5/21/24 at 6:54 A.M., showed the resident's indwelling urinary catheter in use and attached to the resident's bedrail.

Observation and interview on 5/22/24 at 6:58 A.M., showed RN B and Certified Nursing Assistant (CNA) C performed a skin assessment while the resident lay in bed. CNA C said that he/she drains the indwelling urinary catheter gravity bag at the end of the shift. RN B said nurses should change the indwelling urinary catheter every thirty days or as needed.

During an interview on 5/23/24 at 10:16 A.M., RN B said he/she expected to see the indwelling urinary catheter on the care plan and any nurse can update the care plan.

During an interview on 5/23/24 at 12:35 P.M., the DON said if a resident has an indwelling urinary catheter, she expected it to be on the care plan.

4. Review of Resident #301's EMR, showed:
-Admit date 5/16/24;
-Diagnoses included stroke, infection, high blood pressure, and pacemaker (a device to help control the heart rate);
-The resident's baseline care plan did not identify the use of any intravenous (IV) devices.

Observation on 5/21/24 at 6:41 A.M., showed the resident had an IV pole with tubing at the bedside, and a double lumen peripherally inserted central catheter (PICC, a device which delivers fluids directly into a much larger vein) inserted into the right side of the resident's neck.

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F 655	Continued From page 6 During an interview on 5/23/24 at 10:16 A.M., RN B said he/she expected to see a PICC line on a care plan and any nurse can update the care plan. During an interview on 5/23/24 at 12:35 P.M., the DON said if a resident has a PICC line, she expected it to be on the care plan. 5. Review of Resident #248's EMR, showed: -Admit date 5/19/24; -Diagnoses included cellulitis, altered mental status, wound on coccyx, wound on right heel, right foot toes are amputated; -The resident's baseline care plan, in use at the time of the survey, did not identify wound care of the resident's right foot surgical incisions. During an interview on 5/20/24 at 11:48 A.M., the resident said he/she was at the facility for rehab and to heal the surgery incisions on his/her foot. During an interview on 5/23/24 at 11:36 A.M., LPN K said he/she was aware of the resident's wounds being treated on the resident's right foot. He/She expected for wound care to be on the care plan. During an interview on 5/23/24 at 12:38 P.M., the DON said she expected wounds and surgical incisions to be on the care plan to ensure staff know how to care for the resident properly.	F 655		
F 677 SS=D	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	F 677		

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services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Base on observation, interview and record review, the facility failed to ensure two residents' Activities of Daily Living (ADL) needs were met by failing to ensure both residents received at least two showers/bed baths weekly (Residents #248 and #249) . The sample was 17. The census was 69.

Review of the facility's "AM and PM Care" policy, revised 10/2022, showed:
-Purpose: to provide grooming and hygiene for each resident, assisting with bathing, dressing and elimination as needed;
-Policy: it shall be the policy of Bethesda that each resident receives assistance with ADLs as needed throughout each day. Consideration will be given to making the experience as home-like and individual as possible;
-Procedure: on the designated day, assist the resident with their bath or shower.

1. Review of Resident #248's electronic medical record (EMR), showed:
-Admit date 5/19/24;
-Cognitively intact;
-Diagnoses included cellulitis, altered mental status, wound on coccyx, wound on right heel, right foot toes are amputated.

Observation on 5/20/24 at 12:00 P.M., showed the resident had greasy hair.

During an interview on 5/23/24 at 8:30 A.M., the resident said he/she has not had a shower or bed bath since his/her arrival to the facility. He/She

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felt dirty and uncomfortable and would like a shower.

During an interview on 5/23/24 at 11:42 A.M., Licensed Practical Nurse (LPN) G said the resident had received a bed bath on 5/21/24 but the nursing staff who gave him/her the bath forgot to document. He/She expected for staff to document anytime they give a resident a shower or bed bath.

2. Review of Resident #249's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/20/24, showed:
-Admit date of 5/13/24;
-Cognitively intact;
-Diagnoses included below the knee amputation of the left leg.

During an interview on 5/20/24 at 1:55 P.M., the resident said he/she had only received one bed bath since he/she arrived at the facility. He/She said he/she would like a shower and feels dirty. He/She said he/she had not refused any bed baths or showers since arriving to the facility.

Review of the facility's shower documentation on 5/23/24 at 9:59 A.M., showed the only shower the resident received was on 5/17/24.

During an interview on 5/23/24 at 12:41 P.M., the Director of Nursing (DON) said the resident has a history of refusing ADL care.

3. During an interview on 5/23/24 at 12:08 P.M., Certified Nursing Assistant (CNA) M said staff should document showers and refusal of showers in the resident's chart.

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F 677	Continued From page 9 4. During an interview on 5/23/24 at 12:41 P.M., the DON said she expected all residents to receive at least two showers or bed baths weekly. She expected nursing staff to document when showers are given and when a resident refused a shower.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one resident (Resident #301). The resident admitted from the hospital on 5/16/24. The facility admission nursing assessment identified an open area on the buttock and a double lumen peripherally inserted central catheter (PICC, a device which delivers fluids directly into a much larger vein) inserted into the right side of the resident's neck. There was no order for the PICC line dressing change, flushing, or care. In addition, facility staff failed to complete treatment orders and apply dressing changes as ordered to the buttocks. The sample was 17. The census was 69.	F 684		

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Review of the facility's Central Vascular Access Device (CVAD) Flushing and Locking policy, dated 1/15/2004 and last revision 6/1/21, showed:
-Licensed nurses providing infusion therapy in the post-acute setting;
-To be performed by licensed nurses according to state law and facility policy. The nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy with his/her scope of practice;
-A prescriber's order is required to access/flush/lock a catheter.

Review of the facility's Prescribing and Ordering of Medication/Products policy, dated effective date 4/2002 and last revision 1/24, showed:
-To establish guideline for properly obtaining physician orders and processing these orders;
-To obtain admission orders from the physician, check the transfer sheet from the discharging facility as a reference;
-Enter orders into the resident's medical record.

Review of Resident #301's electronic medical record (EMR), reviewed on 5/21/24 at 11:45 A.M., showed:
-Admit date 5/16/24;
-Diagnoses included stroke, infection, high blood pressure, and pacemaker (a device to help control the heart rate);
-An admission wound assessment, dated 5/16/24, showed a wound to the buttocks; unstageable (the actual base and condition of the ulcer cannot be determined), clear drainage, peri wound (the skin surrounding the wound bed) excoriated (reddened), measured 3.7 x 4.6 x 0.0 centimeter (cm).

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Review of the resident's electronic physician order sheet (ePOS), showed:
-A order dated 5/16/24, for intravenous (IV) medication, Cefazolin (antibiotic) 2 gram (G) every 8 hours;
-An order dated 5/17/24, for Calvida (barrier cream). Cleanse wound on buttocks with cleanser and apply Calvida;
-An order dated 5/20/24, for Medi honey (ointment to assist in wound healing and prevent infection). Cleanse wound on buttocks with cleanser, protect peri wound with skin prep (barrier wipe), apply to wound bed Medi honey gel, cover wound with bordered foam, change as needed for soiling and/or saturation;
-An order dated 5/22/24 at 5:23 P.M., to add foam to the buttocks pressure ulcer (wound caused by pressure or friction) and change every three days;
-No order for the PICC line, dressing change, care, or flushing.

Observation on 5/21/24 at 6:41 A.M., showed the resident had an IV pole with tubing at the bedside, and a double lumen PICC line inserted into the right side of the resident's neck. The dressing over the PICC line was dated 5/14/24 8:00 P.M.

Observation on 5/22/24 at 7:08 A.M., showed Registered Nurse (RN) B and Certified Nursing Assist (CNA) C performed care on the resident. Upon turning the resident over, no dressing was present on the resident's buttocks wound. The wound had an oval shape, approximately the size of a half dollar, with no drainage. The wound bed appeared beefy read with approximately a nickel size area of yellow stringy tissue. RN B applied Calvida cream to the resident buttocks. The ordered treatment to cleanse wound on buttocks

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F 684	Continued From page 12 with cleanser, protect peri wound with skin prep, apply to wound bed Medi honey gel, and cover wound with bordered foam dressing was not completed as ordered. Dressing to the PICC line was dated as changed on 5/21/24 at 9:00 P.M. Observation on 5/23/24 at 7:38 A.M., showed CNA L provided a bed bath to the resident. The resident's buttocks wound was open to air with no treatment in place. RN B instructed CNA L to apply Calvida to the resident buttocks. CNA L applied the Calvida cream. The ordered foam dressing was not applied. During an interview on 5/23/24 at 10:16 A.M., RN B said that a resident should have an order for a PICC line, included with the order is the type of access, dressing change, and flush. Nurses should follow physician's orders for wound treatments. During an interview with the Director of Nursing (DON) on 5/23/24 at 12:35 P.M., she said that a resident with a PICC line should have orders and the orders should include flushing, dressing change, and monitoring. On 5/24/24 at 11:04 A.M., she said that nurses should perform wound treatments per physician's orders.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure one resident (Resident #298) who was admitted with a indwelling urinary catheter (thin tube inserted into the bladder to drain urine) had a physicians order to provide care for the catheter. The sample size was 17. The census was 69.

Review of the facility's Prescribing and Ordering of Medication/Products policy, dated effective

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date 4/2002 and last revision 1/24, showed:
-To establish guideline for properly obtaining physician orders and processing these orders;
-To obtain admission orders from the physician, check the transfer sheet from the discharging facility as a reference;
-Enter orders into the resident's medical record.

Review of Resident #298's electronic medical record (EMR) and resident information card, reviewed on 5/21/24 at 10:40 A.M., showed:
-An entry Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff, dated 5/10/24, showed an admission date 5/10/24;
-A baseline care plan showed the resident as incontinent of bowel and bladder;
-Indwelling urinary catheter not indicated on resident information card;
-No order for an indwelling urinary catheter;
-Diagnoses include sleeplessness, seizure, bipolar disorder (a mood disorder characterized with manic highs and depressed lows), and neurogenic bladder (difficulty emptying the bladder due to neurological conditions).

Observation on 5/21/24 at 6:54 A.M., showed the resident's indwelling urinary catheter in use and attached to the resident's bedrail.

During an interview on 5/23/24 at 10:16 A.M., Registered Nurse (RN) B said that he/she would expect to see a physician order for the indwelling urinary catheter, included with the order would be the size of the catheter, diagnosis for the catheter, balloon size, routine for changing, and monitoring output.

During an interview with the Director of Nursing

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F 690	Continued From page 15 (DON) on 5/23/24 at 12:35 P.M., she said would expect to see a physician order for the indwelling catheter, included with order would be the size, monitoring, and cleaning.	F 690		
F 692 SS=D	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; §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 ensure one resident maintained acceptable parameters of nutritional status to the extent possible, for one resident (Resident #34) who experienced a significant weight loss (weight loss of 5% or more in the last month, loss of 7.5% or more in the last three months, or loss of 10% or more in the last six	F 692		

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months) of -10.35% from July 2023 to January 2024. During this timeframe, the facility's Registered Dietician (RD) completed two nutritional assessments, noted a decline in the resident's meal intake, and did not recommend additional nutritional interventions. The resident was not served fortified cheesy eggs as recommended by the RD, and the RD's recommendation for fortified pudding did not get added to the resident's meal ticket. Nursing staff failed to consistently chart the resident's meal intake, which is reviewed during the RD's nutrition assessments, and the resident was not served preferred foods at meals. The sample was 17. The census was 69.

Review of the facility's Nutritional Intervention Program policy, revised November 2023, showed:
-Purpose: To provide guidelines for assessing the need for medical nutritional products and administering nutritional supplements to residents. To ensure that residents are receiving medical nutritional products per physician's orders and consumption is monitored and documented;
-Responsibility: It is the responsibility of the nursing and clinical nutrition staff to initiate the program in collaboration with physicians when a resident exhibits the need for a nutritional supplement. The Nurse Manager or Charge Nurse is responsible for the oversight of all nutritional supplements;
-Policy: There will be a program to provide a palatable nutritional supplement pass program to enhance the nutritional status of residents as recommended by clinical staff. It will be the policy of the company to administer nutritional supplements to residents in agreement with

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physician's orders;
-Nursing and clinical staff will assess residents for the following indicators of the need for Nutritional Interventions:
--An un-planned weight loss;
--Resident exhibits a decline in usual meal consumption;
-RD/doctor will make recommendations for interventions based on resident preferences and nutritional needs;
-All efforts to use regular food and beverage will be made. Use of "medical nutritional products/ formulas" will be used as a last resort and only when other attempted interventions are unsuccessful;
-Offer high calorie/fortified foods/beverage options. A variety of items can be offered to prevent taste fatigue and better acceptance by residents. No physician order is required for fortified foods;
-The RD/doctor will document the assessment/progress note the number of fortified/enhanced foods needed per day for the resident. This information is included on the care plan and noted on the resident's meal ticket.

Review of the Resident #34's medical record, showed:
-Diagnoses included Multiple Sclerosis (MS, disease of the central nervous system), autoimmune hepatitis (when the body's immune system attacks the liver), hypothyroidism (underactive thyroid), high blood pressure, gastroesophageal reflux disease (GERD, stomach contents leak backwards into the esophagus) and depression;
-A physician order, dated 3/3/22, for fortified foods: fortified cheesy eggs and fortified oatmeal;
-A physician order, dated 4/19/22, for Boost Plus

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(nutritional shake) once daily;
-A physician order, dated 12/13/22, for Boost Breeze (nutritional shake) 237 milliliters (mL) twice daily;
-On 7/24/23, weighed 163.3 pounds (lb.).

Review of the resident's quarterly nutrition assessment, completed by the facility's previous RD, dated 8/17/23, showed:
-Current weight: 161 lb.;
-Diet: Regular with average meal intake reported approximately (~) 70 percent (%) in the past 30 days;
-Nutrition interventions: Boost Plus once daily (360 kilocalories (kcal, a unit of energy), 14 grams (g.) protein), fortified eggs (435 kcal, 20 g. protein), fortified oatmeal (430 kcal, 14 g. protein) with breakfast;
-Resident is historically alert and oriented to person and place. Able to feed self after set-up assistance with supervision;
-Estimated energy needs based on current body weight: 1772 to 2127 kcal per day, 70 g. protein per day. Resident needs to consume approximately 75% of meals to meet calculated needs without in place interventions, suggesting continued need for in place interventions;
-No change to nutrition plan at this time.

Review of the resident's weights, showed:
-On 9/5/23: 163.3 lb.;
-On 10/19/23: 154 lb.;
-On 10/23/23: 152.6 lb.

Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/1/23, showed:
-Resident unable to complete Brief Interview for

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Mental Status (BIMS);
-Substantial/maximal assistance required for eating;
-Weight: 153 lb.

Review of the resident's annual nutrition assessment, completed by the facility's previous RD, dated 11/14/23, showed:
-Current weight: 153 lb. -5% weight loss in three months. 0.65% weight loss in 6 six months. No significant weight changes noted;
-Diet: Regular with average meal intake reported ~55% in the past 30 days;
-Nutrition interventions: Boost Plus once daily (360 kcal, 14 g. protein), fortified eggs (435 kcal, 20 g. protein), fortified oatmeal (430 kcal, 14 g. protein) with breakfast;
-Resident is historically alert and oriented to person and place. Able to feed self after set-up assistance with supervision;
-Estimated energy needs based on current body weight: 1772 to 2127 kcal per day, 70 g. protein per day. Resident needs to consume approximately 75% of meals to meet calculated needs without in place interventions, suggesting continued need for in place interventions;
-No change to nutrition plan at this time.

Review of the resident's weights, showed:
-On 11/16/23: 149.2 lb.;
-On 11/20/23 and 11/29/23: 150.3 lb.;
-On 12/7/23: 149.9 lb.;
-On 12/18/23: 149.4 lb.;
-On 1/24/24: 146.4 lb.;
-Significant weight loss of -10.35% in six months, from 7/24/23 to 1/24/24.

Review of the resident's quarterly MDS, dated 1/30/24, showed:

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-Resident rarely/never understood;
-Substantial/maximal assistance required for eating;
-Weight: 146 lb.;
-No weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.

Review of the resident's quarterly nutrition assessment, completed by the facility's current RD, dated 2/6/24, showed:
-Diet: Regular;
-Nutrition interventions: Boost Plus once daily (360 kcal, 14 g. protein), fortified eggs (435 kcal, 20 g protein), fortified oatmeal (430 kcal, 14 g. protein) with breakfast;
-Weight: 146.4 lb. No significant weight changes noted.
-Estimated energy needs based on current body weight:
-Energy needs: 1848 to 1980 kcal;
-Protein needs: ~66 g. per day;
-Resident needs to consume ~80 to 85% of meals to meet their daily energy needs. Current intake per nursing staff documentation is ~58% of meals;
-Resident appears to not be meeting their nutritional needs as evidenced by reported intake less than estimated needs. Will continue current nutrition interventions. Will add fortified pudding daily (340 kcal, 15 g protein) to promote kcal intake.

Review of the resident's electronic Physician Order Sheet (ePOS), showed no order for fortified pudding.

Review of the resident's weights, showed:
-On 2/22/24: 148.2 lb.;
-On 2/28/24: 143.3 lb.;

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-On 3/4/24: 144 lb.;
-On 3/11/24: 145.6 lb.;
-On 3/19/24: 142.7 lb.;
-On 3/26/24: 142.4 lb.

Review of the resident's March 2024 meal intake, showed:
-93 meals total;
-30 meals missing documentation of meal intake;
-Six meals documented with 0% of meal consumed;
-Average of total average meal consumption: 44%.

Review of the resident's weights, showed:
-On 4/17/24: 140 lb.;
-On 4/22/24: 139.9 lb.

Review of the resident's quarterly MDS, dated 4/28/24, showed:
-Substantial/maximal assistance required for eating;
-Weight: 140 lb.;
-Weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, not on physician-prescribed weight-loss regimen.

Review of the resident's quarterly nutrition assessment, completed by the facility's current RD, dated 4/29/24, showed:
-Diet: Regular diet with regular texture;
-Nutrition interventions: Boost Plus once daily (360 kcal, 14 g. protein), fortified oatmeal (430 kcal, 14 g. protein) with breakfast, fortified pudding daily (340 kcal, 15 g. protein);
-Weight: 139.9 lb. Patient with 11% weight loss in six months (significant for timeframe);
-Estimated energy needs based on current body weight:

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-Energy needs: 1848 to 1980 kcal;
-Protein needs: ~66 g. per day;
-Resident needs to consume ~80 to 85% of meals to meet their daily energy needs. Current intake per nursing staff documentation is ~61% of meals;
-Resident appears to not be meeting their nutritional needs as evidenced by reported intake less than estimated needs. Will continue current nutrition interventions.

Review of the resident's April 2024 meal intake, showed:
-90 meals total;
-46 meals missing documentation of meal intake;
-Five meals documented with 0% of meal consumed;
-Average of total average meal consumption: 60%.

Review of the resident's RD note, dated 5/3/24, showed the nurse reported to the RD that the resident is having difficulty chewing regular texture food and that resident would benefit from mechanical soft diet for chewing. Downgraded diet to regular diet with mechanical soft texture. Diet order modified to promote by mouth (PO) intake, reduce risk of weight loss, and preserve quality of life.

Review of the resident's ePOS, showed an order, dated 5/13/24, for mechanical soft diet.

Review of the resident's care plan, in use at the time of survey, showed:
-Resident is alert and oriented to self and not able to express his/her needs;
-Usual body weight is ~155 lb.;
-Meals/snacks/fluids:

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F 692	Continued From page 23 -Resident is offered a regular diet with mechanical soft texture; -Resident is able to feed self after set-up assistance with supervision; -Resident is at nutrition/hydration risk because of advanced age and diagnosis of depression; -Please offer fortified oatmeal and cheesy eggs, which provide an additional 430 kcal each and 13 g./21 g. protein, respectively; -Resident will maintain his/her weight +/-6% through next 90 day review; -No documentation regarding the resident's significant weight loss, average meal intake, substantial/maximal assistance from staff required for eating, preferred foods, or RD's recommendation on 2/6/24 for addition of fortified pudding. Review of the resident's meal intake from 5/1/24 through 5/21/24, reviewed 5/22/24, showed: -63 meals total; -22 meals missing documentation of meal intake; -Five meals documented with 0% of meal consumed; -Average of total average meal consumption: 35%. Review of the resident's meal tickets, showed: -Breakfast: fortified eggs, fortified oatmeal; -No documentation of fortified pudding. Observation on 5/20/24 at 1:04 P.M., showed the resident sat upright in a reclining chair with Certified Nurse Aide (CNA) A seated next to the resident, attempting to provide feeding assistance. Lunch was served on a divided plate and included raw baby carrots. No fortified pudding was observed. Review of the dietary	F 692		

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slip, showed the mechanical soft diet. CNA A held bites of food to the resident's mouth and the resident did not eat. CNA A held a container of Boost Breeze to the resident's mouth and the resident drank the shake. During an attempted interview, the resident did not respond. During an interview, CNA A said the resident used to eat independently, but now requires feeding assistance from staff. The resident does not eat much, but will drink nutritional shakes. It is unknown why the resident is no longer eating much and he/she does not have a new health condition. He/She should receive a mechanical soft diet but today was served raw carrots.

Observation on 5/21/24 at 8:08 A.M., showed the resident sat upright in bed with a plate of breakfast on his/her bedside table. Breakfast consisted of scrambled eggs with no cheese, a biscuit, and a bowl of oatmeal. No fortified cheesy eggs were served. No banana or frosted flake cereal was served. CNA A attempted to feed the resident and the resident did not eat.

Observation on 5/21/24 at 1:27 P.M., showed the resident's lunch tray on a cart of trays on the hall. CNA M removed the resident's lunch tray and showed the plate consisted of full portions of spaghetti and large steamed broccoli florets. A small plate contained a piece of cake with one bite missing. A carton of Boost Breeze was empty. No fortified pudding was observed.

Observation of breakfast preparation on 5/22/24 at 7:01 A.M., showed Cook O made regular texture scrambled eggs and pureed eggs. He/She did not make fortified cheesy eggs.

Observation on 5/22/24 at 8:24 A.M., showed the

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resident sat upright in bed with CNA A seated next to the bed, attempting to provide feeding assistance. Breakfast served consisted of scrambled eggs, a muffin, mechanical soft sausage with gravy, a cup of yogurt and a bowl of oatmeal. No fortified cheesy eggs were served. No banana or frosted flake cereal were served. CNA A held bites of food to the resident's mouth and the resident did not eat. CNA A held a carton of Boost Breeze to the resident's mouth and the resident drank the shake. During an interview, CNA A said the resident used to eat independently and consumed 100% of his/her meals. Then the resident declined a little and staff had to start feeding him/her, but the resident still ate 100% of his/her meals. A couple months ago, the resident moved to his/her current room and completely declined. He/She no longer feeds him/herself at all and consumes less than 25% of each meal served. He/She likes the nutritional shakes and loves bananas and pancakes at breakfast, but doesn't really eat anything else. CNA A told the RD about the resident's food preferences and the RD said the kitchen seldom has bananas.

Observations on 5/23/24, showed:
-At 8:20 A.M., the resident seated at a table in the dining room while CNA N provided feeding assistance. Breakfast served consisted of scrambled eggs, pancakes, and a bowl of oatmeal. No fortified cheesy eggs were served. No banana or frosted flake cereal were served;
-At 8:30 A.M., 75% of the resident's pancakes and eggs consumed. During an interview, CNA N said the resident is still eating his/her breakfast. He/She likes pancakes. It is hit and miss how much food the resident will eat because it depends on if the resident likes the food served.

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During an interview on 5/23/24 at 10:06 A.M., Cook O said he/she did not make fortified cheesy eggs on 5/22/24. He/She expected nursing staff to communicate a resident's dietary preferences with dietary staff. Dietary slips that go out with resident trays are generated by the RD.

During an interview on 5/23/24 at 10:09 A.M., the Dining Services Director said the RD generates the dietary slips that show what residents are served at each meal. If a resident with weight loss is only willing to eat certain foods, like bananas, it should be communicated to dietary so they can add it to the food order.

During an interview on 5/23/24 at 10:14 A.M., CNA H said the resident receives a regular diet, not mechanical soft or puree. He/She has no issues with chewing or swallowing. He/She requires total assistance from staff, including while eating. His/her appetite is alright. He/She closes his/her mouth and shakes his/her head no when he/she doesn't want to eat. He/She really likes drinking Boost shakes and will drink 100% of them. If he/she is not eating the meal served, staff should offer him/her a Boost or a different supplement. CNAs are responsible for charting a resident's intake of each meal served during the shift.

During an interview on 5/23/24 at 10:32 A.M., Licensed Practical Nurse (LPN) I said the resident is alert and oriented to self. He/She requires feeding assistance from staff. He/She has not been eating well, generally consuming 25% of each meal. He/She loves to drink Boost shakes. If the resident doesn't eat his/her meal, it should be reported to the nurse and the resident

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should be given an extra Boost shake. This should also be documented in the resident's record. It is expected that CNAs chart a resident's meal intake during each shift, especially if a resident has had weight loss.

During an interview on 5/23/24 at 10:50 A.M., LPN E said it is expected that CNAs chart meal intake at each shift. If a resident is not eating, it should be reported to the nurse.

During an interview on 5/23/24 at 11:00 A.M., the facility's current RD said she completes admission, quarterly, and annual nutrition assessments on all long-term care residents. Some residents may be seen more frequently based on clinical judgement. He/She just identified the resident's weight loss during the resident's quarterly assessment in April 2024, and now the resident is on the high-risk caseload. Prior to this, the resident was having weight loss, but it was not significant. Before the RD started working at the facility in November 2023, the resident was feeding him/herself and now requires feeding assistance. His/Her decline in health has been a natural progression, and there has not been any new disease process. During her nutrition assessments, the RD reviews the resident's chart, including labs, weights, and meal intake. She expected nursing staff to chart routinely so she can assess the resident. Recently, it was reported the resident had difficulty chewing so the RD changed his/her diet to mechanical soft. Raw carrots and large steamed broccoli would not be considered mechanical. The resident's meal intake has remained the same since being changed to mechanical. When meal intake decreases, the RD will ask residents if there is anything in

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particular they will eat. Resident #34 is not interviewable. The RD knows the resident like bananas, frosted flake cereal, potatoes, peas, corn, and no cheese on his/her sandwiches. The facility does not have frosted flake cereal and bananas were on order, but did not arrive with the food order. The RD enters the resident's diet orders, including fortified foods, and preferences into a computer system shared with dietary. Dietary can adjust their food orders to add the foods preferred by residents. The RD can also add a resident's dislikes, which would prompt dietary staff to provide a substitution. The facility stopped doing fortified cheesy eggs a while ago. Residents didn't seem to like them, so the facility started using fortified milk (regular whole milk with added dry milk flavoring) instead. Residents didn't seem to like that, either. The facility is in the process of trying to identify other options. The order for fortified cheesy eggs should be removed from the resident's ePOS. The order for fortified pudding should be added to the ePOS. While the resident likes pancakes, the kitchen may not be able to make pancakes every morning for one particular resident. The resident's food preferences should be provided.

Review of the resident's dietary profile, provided 5/23/24, showed at breakfast, the resident likes bananas and frosted flakes.

During an interview on 5/23/24 at 12:25 P.M., the Dining Services Director said it was not a problem for dietary staff to make pancakes daily for one resident who is not eating other foods. Dietary can provide substitutions for items based on what the resident's preferences are, which should be communicated to dietary by the RD via the shared computer system. The facility does not

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F 692	Continued From page 29 have bananas or frosted flakes right now. During an interview on 5/23/24 at 12:35 P.M., the Director of Nurses and Administrator said the resident has had significant weight loss. When he/she does not eat, it is expected that staff offer the resident a shake. If fortified cheesy eggs are not made anymore, it is expected the RD and dietary staff come together to identify an alternate fortified food or nutritional supplement. Any nutritional intervention identified and recommended by the RD should be added to the resident's ePOS, meal ticket, or care plan, and should served to the resident. It is expected that nursing staff communicate a resident's food preferences to dietary and the RD. It is expected that CNAs chart meal intake during every shift to assist the RD during her nutritional assessments. It is expected that residents receive diets per orders, and raw carrots should not be served to a resident with difficulty chewing who should receive a mechanical soft diet.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure physician	F 695		

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orders were obtained for the use of a continuous positive airway pressure (CPAP, machine that keeps the airways open during sleep for persons with sleep apnea) for one resident (Resident #299) and to ensure CPAP masks were properly stored while not in use for infection control purposes for two residents (Residents #299 and #146). The sample was 17. The census was 69.

Review of the facility's CPAP/Bilateral Positive Airway Pressure (BIPAP, mechanical breathing device)/Average Volume Assured Pressure Support (AVAPS, mode of non-invasive ventilation)/Trilogy Ventilator (device used to provide pressure support, pressure control, or volume control during breathing support) policy, revised November 2021, showed:
-Purpose: To provide guidelines for staff to assist the resident in using a CPAP/BIPAP/AVAPS/Trilogy Ventilator device;
-Responsibility: It will be the responsibility of all licensed nursing staff to know and follow these guidelines;
-Policy: A physician's order is required for CPAP/BIPAP/AVAPS/Trilogy Ventilator. Pressure settings are to be set by the durable medical equipment (DME) company per physician order/direction. If the resident brings equipment from home, the settings used at home can be used if approved by the physician;
-Obtain physician's order for device use;
-If device is from home, the order should specify "home settings;"
-Add device use and care to resident's care plan/resident profile;
-Equipment cleaning:
-Wipe mask daily using a damp cloth;
-The policy failed to provide guidance for mask storage while not in use.

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1. Review of Resident #299's electronic medical record (EMR) and resident information card, reviewed on 5/21/24 at 8:46 A.M., showed:
-An entry Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 5/13/24, showed an admission date 5/13/24;
-A baseline care plan showed a diagnosis of obstructive sleep apnea (OSA, breathing interrupted during sleep);
-Diagnoses included cancer, high blood pressure, depression, high cholesterol, and sleep apnea;
-CPAP device was not listed on the resident's baseline care plan and information card;
-No physicians order for the CPAP on admission. New order obtained 5/23/24 8:00 A.M.

Observations on 5/20/24 at 11:21 A.M., showed the resident's CPAP tubing rested over the top of the headboard, mask faced down and rested against the headboard.

During an interview on 5/21/24 at 6:46 A.M., the resident said he/she receives supplies every six weeks to his/her home and that he/she takes care of the CPAP machine while at the facility.

During an interview on 5/22/24 at 10:32 A.M., Registered Nurse (RN) B said that the resident takes care of the CPAP, the mask should be stored when not being used, and he/she only monitors the machine to see if it is clean. On 5/23/24 at 10:16 A.M., RN B said that there should be on order for the CPAP.

During an interview on 5/23/24 at 10:27 A.M., Certified Nursing Assistant (CNA) C said he/she is aware that the resident has a CPAP, the mask

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should be stored when not being used, and that the resident takes care of it.

During an interview with the Director of Nursing (DON) on 5/23/24 at 12:35 A.M., she said she would expect there to be an order for the CPAP.

2. Review of Resident #146's admission MDS, dated 4/6/24, showed:
-Cognitively intact;
-Supervision/touch assistance required for sit to stand;
-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), obstructive sleep apnea, and acute and chronic respiratory failure.

Review of the resident's electronic physician order sheet (ePOS), showed:
-An order dated 5/13/24, for CPAP application, apply CPAP at bedtime. Check every two hours for mask placement and complications;
-An order dated 5/14/24, for CPAP removal every 24 hours, clean mask and rinse humidifier with soap and water. Rinse and let air dry.

Review of the resident's care plan, in use at the time of survey, showed:
-General: Resident is at facility for physical therapy/occupational therapy for COPD exacerbation. Resident uses a rented CPAP to assist him/her at night with home settings. Please ensure to rinse and fill humidifier each night and monitor him/her throughout the shift for mask placement and/or complications;
-Vitals/pain: Resident wears CPAP at night.

Observations on 5/20/24 at 11:28 A.M. and 1:06 P.M., showed the resident sat upright in a recliner

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chair next to his/her bed with oxygen on via nasal cannula (device used to deliver oxygen with two small tubes that fit into the nostrils). A CPAP machine sat on a nightstand next to his/her bed, not in use. The CPAP mask was uncovered and with no barrier, face down on top of miscellaneous items in the open top drawer of the nightstand.

Observations on 5/21/24, showed:
-At 7:59 A.M., the resident sat upright in bed. His/Her CPAP machine was not in use. The CPAP mask was uncovered and had no barrier on top of the nightstand, behind the CPAP machine, with the base of the mask face down directly on the table and partially touching the base of a table lamp;
-At 9:40 A.M., the resident sat upright in bed. His/Her CPAP machine was not in use. The CPAP mask was uncovered with no barrier on top of the nightstand, behind the CPAP machine, with base of the mask face down directly on the table and partially touching the base of a table lamp. Licensed Practical Nurse (LPN) G entered the resident's room and spoke with the resident;
-At 11:13 A.M., LPN G and CNA A entered the resident's room;
-At 11:31 A.M. and 1:16 P.M., the resident sat upright in his/her recliner. His/Her CPAP machine was not in use. The CPAP mask was uncovered with no barrier on top of the nightstand, behind the CPAP machine, with base of mask face down directly on the table and partially touching the base of a table lamp.

During an interview on 5/21/24 at 1:16 P.M., the resident said he/she uses his/her CPAP machine at night. He/She does not clean the CPAP mask. He/She thinks the staff might clean it, but isn't

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sure. He/She does not have a protective covering to store the CPAP mask while not in use and was not sure if he/she was supposed to cover the mask when not in use.

Observations on 5/22/24, showed:
-At 8:27 A.M., the resident sat in bed. His/Her CPAP machine was not in use. The CPAP mask was uncovered with no barrier, at the bottom of the open top drawer in his/her nightstand, face down with base of mask touching the bottom of the drawer. During an interview, the resident said he/she used his/her CPAP last night and removed it him/herself at 7:30 A.M.;
-At 12:44 P.M., the resident sat in his/her recliner chair. His/Her CPAP machine not in use. The CPAP mask uncovered and with no barrier, at the bottom of the open top drawer in his/her nightstand, face down with base of mask touching the bottom of the drawer.

During an interview on 5/22/24 at 1:43 P.M., CNA A said the resident wears a CPAP at night. The resident was wearing his/her CPAP mask when CNA saw the resident earlier that morning. Nurses handle the CPAP machines, not the aides.

During an interview on 5/23/24 at 10:32 A.M., LPN I said the resident can use his/her CPAP on his/her own. Nursing staff puts the resident's CPAP mask on him/her at night.

3. During an interview on 5/23/24 at 10:32 A.M., LPN I said nursing staff is responsible for cleaning CPAP masks. CPAP masks should be stored in a plastic bag while not in use.

4. During an interview on 5/23/24 at 10:50 A.M.,

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F 695	Continued From page 35 LPN E said some residents can remove their CPAP masks themselves and some require assistance from the nurse. Nurses are responsible for ensuring CPAP masks are stored in plastic bags while not in use. 5. During an interview on 5/23/24 at 12:35 P.M., the DON and Administrator said residents, nursing and respiratory therapy staff are responsible for ensuring CPAP masks are stored properly. After CPAP mask use, either the resident or nursing staff should rinse off the mask and store it in a bag. Since Resident #146 does not stand or walk, it is expected that nursing staff assist him/her with CPAP mask cleaning and storage. It is expected that CPAP use be indicated on a resident's care plan. Department heads complete their respective portions of a resident's care plan upon admission and comprehensive care plans are overseen by MDS staff.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 740		

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review, the facility failed to provide necessary behavioral health services to maintain the highest practicable psychosocial well-being for one resident (Resident #6) who expressed feelings of being better off dead and thoughts of unplugging his/her left ventricular assist device (LVAD, a device implanted in the chest to help the heart pump blood). The sample was 17. The census was 69.

Review of Resident #6's medical record, showed:
-Admission date 5/11/23;
-Diagnoses included history of stroke with residual hemiparesis (weakness on one side of the body), heart disease, heart failure, atrioventricular block (interrupted or delayed heart rate), ischemic cardiomyopathy (heart's decreased ability to pump blood properly), and presence of heart assist device.

Review of the resident's physical therapy evaluation, dated 11/9/23, showed:
-Discharge environmental factors/social support: Resident has been staying at this facility. Previously, resident lived with family. Resident reported independence with activities of daily living (ADLs);
-Prior residence and living arrangement: Resident was living in a two-level home. Resident was using front-wheeled walker (FWW) and wheelchair;
-Physical mobility scale = 13/45 which indicates resident is dependent for functional mobility.

Review of the resident's electronic physician order sheet (ePOS), showed:
-An order, dated 11/28/23, for ventricular assist device;
-An order, dated 1/3/24, for duloxetine

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(antidepressant medication) 30 milligrams (mg.) delayed release capsule, 20 mg. daily for depression.

Review of the resident's Social Services (SS) note, dated 2/28/24, showed the Social Services Coordinator (SSC) documented completion of a quarterly assessment with the resident. Brief interview of mental status (BIMS) placed resident in cognitively intact range. Score of 9 on the Patient Health Questionnaire (PHQ, an assessment tool used to screen for depression), which placed resident in the mild depression range. Resident expressed having little interest in doing things. He/She expressed feeling depressed every day. He/She states he/she feels depressed because he/she can't walk and can't take care of his/her business. He/She expressed having thoughts about self being better off dead. He/She stated he/she has thought about unplugging his/her heart machine. SSC informed floor nurse of the above information. SSC asked if they have a psychologist or psychiatrist that comes in to visit with the long-term care patients. Nurse said no, and he/she will inform the doctor of the above information.

Review of the resident's nurse's note, dated 2/28/24, showed the nurse documented the Social Worker (SW) reported to the nurse that resident desired to end his/her life by disconnecting his/her LVAD. Notified Nurse Practitioner (NP) of resident's statements and received orders to send resident to hospital for psych evaluation. Notified resident of transfer, resident states he/she does not want to go but continues to confirm to nurse and Certified Nurse Aide (CNA) of desire to unplug his/her LVAD machine. Upon emergency medical service

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(EMS) arrival, resident stated he/she often feels this way and cries and prays.

Review of the resident's hospital record, dated 2/28/24, showed:
-Chief complaint: Patient presents with suicidal ideation;
-History of present illness (HPI): Resident reports he/she was brought into the emergency department (ED) because he/she did not deny occasional passive thoughts of suicide when SW asked him/her about it. He/She reports he/she chronically has transient thoughts of pulling out his/her LVAD because he/she is sick of going in and out of hospitals;
-ED provider notes: Resident denies any active suicidality. He/She states the SW asked if he/she ever had suicidal thoughts and he/she reported that over the past three years he/she has had these intermittent thoughts but does not currently have any suicidal ideation. He/She says his/her biggest complaint is that he/she has not been allowed to walk as much as he/she would like to and as such has been inadequately rehabbed;
-Clinical impressions: Depression, unspecified depressive type.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/2/24, showed:
-Cognitively intact;
-Little interest or pleasure in doing things, 7-11 days (half or more of the days);
-Feeling down, depressed, or hopeless, 12-14 days (nearly every day);
-Feeling tired or having little energy, 12-14 days (nearly every day);
-Thoughts that you would be better off dead, or of

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hurting yourself in some way, 2-6 days (several days);
-Social isolation: Sometimes;
-Substantial/maximal assistance required for lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer.

Review of the resident's care plan, in use at the time of survey, showed:
-Resident has an LVAD that controls the functions of his/her heart;
-Requires assistance of one to two persons for transfers and assistance of one person for ambulation;
-Prefers to get up and dressed each day by 1:00 P.M. for at least one hour and lay resident down upon request;
-The care plan failed to identify the resident's reported feelings of depression, expression of suicidal ideation, and activities of interest.

Review of the resident's physician progress note, dated 4/1/24, showed:
-General: Alert and oriented, mild distress;
-Resident asking about wheelchair. Discussed with nurse, not sure if going to use.

Review of the resident's medical record, showed:
-No therapy assessments completed after 11/9/23;
-No documentation of social services follow-up between 2/28/24 and 5/20/24.

Observation on 5/20/24 at 11:02 A.M., showed the resident on his/her back in bed, watching TV. No wheelchair in his/her room. During an interview, the resident said staff does not want him/her to stand or walk on his/her own because they are afraid he/she will have a stroke. He/She

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relies on staff to get him/her up out of bed and he/she cannot walk. He/She does not have a wheelchair to be able to leave his/her room. He/She keeps asking for a wheelchair and therapy to get stronger. Last week, he/she asked the doctor again about a wheelchair and therapy but it still has not happened. He/She purchased a pedal exercise machine to get stronger, but staff will not help him/her use it. He/She just stays in bed all day.

Observation on 5/21/24 at 1:21 P.M., showed the resident sat in a wheeled reclining chair in his/her room. No wheelchair in his/her room. During an interview, the resident said he/she is happy to be up out of bed today. He/She would like to have a wheelchair so he/she could leave his/her room for a while. He/She cannot move the reclining chair without staff assistance.

During an interview on 5/22/24 at 12:30 P.M., the resident said he/she is not happy and feels sad. There is nothing interesting to do. He/She lays in bed all day. People act surprised when he/she says he/she isn't happy, but he/she asked what does he/she have to be happy about. He/She used to have a job where he/she stayed active. After he/she retired, he/she still kept busy by going out shopping and seeing family and friends. Now, he/she does nothing. He/She can't get out of bed on his/her own and cannot leave his/her room. The nurses get mad when he/she tries to put his/her legs over the side of the bed. He/She is tired all the time from being in bed all the time and would like to get out of bed. He/She does not have a wheelchair and is stuck in his/her room. He/She has wheelchairs at home that could be brought to the facility. He/She does not have a current plan to hurt him/herself and told

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the SW this yesterday. He/She does not see the SW regularly and does not receive counseling.

During an interview on 5/22/24 at 1:12 P.M., the SSC said she has been working with the facility since January 2024. She met with the resident on 2/28/24 to complete the resident's quarterly BIMS and PHQ-9 assessments. During the assessment, the resident said he/she felt he/she would be better off dead. The SSC reported this to the resident's nurse, whose name the SSC could not recall. When asked who is responsible for following up with a resident after they express feelings of being better off dead, the SSC said that is a good question. She is not sure what follow-up was made with the resident after the SSC reported to the nurse on 2/28/24. She is not sure if the facility has a psychiatrist or psychologist they work with. She is not sure if the facility works with a particular counseling agency to whom they can refer residents. She met with the resident yesterday, 5/21/24, to complete the resident's quarterly BIMS and PHQ-9 assessments and the resident did not indicate he/she felt he/she would be better off dead. The resident is young for being a long-term care resident, so that could place him/her on the depression scale. The resident said he/she is tired and has little energy, and the resident sleeps all day. The resident likes to watch TV and spend time with family, but they don't visit as often as he/she would like. SSC does not know if the resident has any other preferred activities or interests.

Review of the resident's SS note, dated 5/22/24, showed the SSC completed quarterly assessments with the resident on 5/21/24. BIMS placed resident in the cognitively intact range.

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Scored 2 on the PHQ-9 which placed resident in the minimal depression range. He/She expressed feeling down for a few days. He/She stated he/she feels down because he/she "can't do for self." He/She expressed feeling tired. He/She stated he/she likes to sleep and sleeps all day and that's why he/she feels tired. He/She enjoys sleeping, talking on the phone with family, eating his/her snacks in his/her room and watching TV.

During an interview on 5/22/24 at 1:43 P.M., CNA A said the resident seems sad. He/She wants staff to unplug his/her LVAD. He/She told the SW this a while ago, and the resident went out to the hospital, and came right back. He/She has not made suicidal statements since then. He/She does not seem happy. He/She cannot stand up on his/her own and says no when staff ask him/her if he/she wants to get out of bed. He/She can't do therapy at the facility because he/she is a long-term resident. He/She does not have a wheelchair, but has a reclining chair with wheels on it that staff can push. The resident loves shopping, eating food from outside of the facility, and visiting with people, especially family.

During an interview on 5/23/24 at 10:15 A.M., CNA H said the resident requires two staff to assist him/her with transfers. Sometimes he/she likes to get out of bed, and sometimes he/she doesn't. His/Her LVAD limits what activities he/she can do. He/She likes to watch TV, talk on his/her phone and with people, and to eat.

During an interview on 5/23/24 at 10:32 A.M., LPN I said the resident requires two staff to assist with transfers and he/she cannot walk on his/her own. He/She gets out of bed occasionally.

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He/She does not have a wheelchair and has a recliner with wheels that staff can push. He/She is sad and wants to live at home and with family. He/She is lonely. He/She likes to shop and to talk to staff when they go into his/her room.

During an interview on 5/23/24 at 12:35 P.M., the Director of Nurses (DON) and Administrator said the resident is a long-term care resident of the facility. He/She goes out to the hospital frequently. When he/she returns to the facility, he/she is motivated, but then when therapy assesses him/her, he/she is not interested. Facility staff beg him/her to get up out of bed and to go to activities, but he/she is not interested in any of it. He/She does not attempt to stand at the facility, but hospital staff reported the resident stood during his/her her most recent hospitalization. The DON and Administrator are not sure if the resident has a wheelchair. Physically, the resident would be able to use a wheelchair, but whether he/she would use it may not be the case. If the resident spoke about a wheelchair in his/her meeting with the physician and the physician wanted the resident to have a wheelchair, the physician would communicate this to nursing staff. The DON said it was her understanding that when the resident expressed suicidal ideation on 2/28/24, it was because the resident's favorite aide had been off for a couple days. When the aide returned, the resident was angry and said he/she would pull out his/her LVAD wires. The resident was sent out to the hospital, where he/she said he/she had no intension of pulling out his/her LVAD. The DON and Administrator said when the resident returned to the facility, it expected that nursing staff and SS should have followed up with the resident regarding his/her suicidal statements. It is

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F 740	Continued From page 44 expected that the facility's department heads come together to discuss ideas and identify interventions that may help improve the resident's mood. The resident's feelings of sadness and identified interventions should be documented on the resident's care plan.	F 740		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store medication and	F 761		

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medical equipment in accordance with professional principles, including abiding by the expiration date on stock medications in facility medication rooms and medication carts. Concerns were found in one of two medication rooms and in two of six treatment carts in the facility. The sample size was 17. The census was 69.

Review of the facility's "LTC Facility's Pharmacy Services and Procedures Manual", revised 12/01/22, showed:
-Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to pharmacy supplier;
-Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened.

1. Observation of the third floor medication room on 5/21/24 at 1:21 P.M., showed:
-One bottle of SunMark gentle laxative expired February, 2024;
-One bottle of HealthStart 3 milligram (mg) melatonin supplement, expired October, 2023;
-Five bottles of Rugby meclizine (a medication used to control nausea, vomiting, and dizziness), expired March, 2024;
-One bottle of SunMark 12-hour mucus relief

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guafenesin (a medication used to control coughing and to clear phlegm from the chest and nose) 600 mg tablets, expired January, 2024;
-Two bottles of Amneal Folic Acid (Vitamin B) 1mg tablets expired January, 2024;
-Three bottles of GeriCare Oyster Shell Calcium 500 mg supplement tablets, expired April, 2024;
-Two bottles of GeriCare Ferric X-150 150 mg iron supplement tablets, expired March, 2024.

2. Observation of a third floor nursing staff medication cart on 5/22/24 at 10:46 A.M. showed:
-One bottle of GeriCare Magnesium Oxide (an antacid and mild laxative medication) 400 mg supplement tablets, expired October, 2023;
-One bottle of NorthStarX Omeprazole (an antacid used to reduce stomach upset) Extended Release 200 mg capsules, expired March, 2024.

3. Observation of a second floor nursing staff medication cart on 5/22/24 at 10:53 A.M., showed:
-One 16 ounce (oz) bottle of GeriCare Milk of Magnesium (a medication to treat stomach upset, constipation, and heart burn), expired April 2024. The bottle was opened and marked by staff as opened on "5/13/24".

4. During an interview on 5/23/24 at 10:11 A.M., Licensed Practical Nurse (LPN) E said a facility pharmacy representative goes through the facility medication rooms "a few times per year" but was unsure if the medication rooms or medication carts were audited regularly. LPN E said the facility expected nursing staff to remove expired medications from medication carts and destroy or dispose of them per facility policy.

4. During an interview on 5/23/24 at 10:23 A.M.,

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F 761	Continued From page 47 Certified Medication Technician (CMT) F said a facility pharmacy representative goes through the facility's medication rooms and medication carts "a couple times a month" to look for expired medications and to pick up medications and biologicals that need to be destroyed. CMT F said the facility expected CMTs and nurses to remove expired medications from medication carts if discovered in order to be destroyed or wasted per facility policy. 5. During an interview on 5/23/24 at 12:35 P.M., the Director of Nursing (DON) and Administrator said they expected all expired medications in the facility to be removed from medication carts and destroyed per facility policy. The DON and Administrator said they expected staff to discard expired medications when found on a treatment cart or medication room, and not to administer expired medications to residents at the facility.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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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
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corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program when staff failed to wear appropriate personal protective equipment (PPE), in accordance with the facility's policy, during high-contact activities with residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) (Residents #295, #301, #6, #200, #249, and #9). The sample was 17. The census was 69.

Review of the facility's Enhanced Barrier Precautions (EBP) policy, revised February 2024, showed:
-Purpose: To provide direction for the implementation of precautions to prevent transmission of novel or targeted multidrug-resistant organisms (MDRO) utilizing guidelines from Centers for Disease Control (CDC);
-Responsibility: It is the responsibility of each

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administrator to enforce this procedure for his/her respective residence. It is the responsibility of all employees to understand and comply with the specific procedures in each residence as related to this policy;
-Policy: It is the policy of the company to implement EBP to prevent transmission of novel or targeted MDRO as defined by CDC to residents, staff, volunteers, visitors or any other individuals providing services under a contractual agreement;
-Definitions: "Enhanced barrier precautions" refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices);
-EBP shall be implemented for resident with any of the following:
-Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO;
-Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions (precautions that reduce the risk of transmission of infectious materials by direct contact) do not apply;
-Implementation of EBP:
-Make gowns and gloves available immediately outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray;
-Disposable or dedicated medical equipment is not required; but any reusable medical equipment should be cleaned and disinfected with an appropriate agent between residents;
-High-contact resident care activities are:

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F 880	Continued From page 51 -Dressing; -Bathing; -Transferring; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; -Wound care: any skin opening requiring a dressing; -EBP should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activity; -EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical devices is removed. Review of the facility's EBP signage, undated, showed: -Enhanced Barrier Precautions; -Everyone must clean their hands, including before entering and when leaving the room; -Providers and staff must also: -Wear gloves and a gown for the following high-contact resident care activities; -Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), wound care. 1. Review of Resident #295's electronic medical record (EMR), showed: -An entry Minimum Data Set (MDS), a federally	F 880		

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mandated assessment instrument completed by facility staff, dated 5/14/24 showed:
-Diagnoses included wound infection, fusion (joining two or more bones) of the cervical spine, and generalized muscle weakness;
-An order, dated 5/7/24, for patient isolation, EBP;
-An order, dated 5/8/24, for Unasyn (antibiotic) 3 gram (gm), intravenous (IV) every six hours for wound infection.

Observation on 5/21/24 at 9:08 A.M., showed an EBP sign on the resident room door. Licensed Practical Nurse (LPN) J entered the resident room without gown or gloves and proceeded to administer the resident IV medication, through double lumen peripherally inserted central catheter (PICC, a device which delivers fluids directly into a much larger vein) inserted into the right arm.

2. Review of Resident #301's EMR, showed:
-Admit date 5/16/24;
-Diagnoses included stroke, infection, high blood pressure, and pacemaker (a device to help control the heart rate);
-An order, dated 5/16/24, for patient isolation, EBP.

Observation on 5/21/24 at 6:44 A.M., showed a laminated placard titled EBP on the resident room door. Registered Nurse (RN) B entered the resident's room without a gown and proceeded to check the residents blood sugar.

Observation on 5/22/24 at 7:08 A.M., showed a laminated placard titled EBP on the resident room door. RN B and Certified Nurses Assistant (CNA) C entered the resident room without gowns on, and exposed the resident's heels and buttocks for

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skin observation.

Observation on 5/23/24 at 7:38 A.M., showed a laminated placard titled EBP on the resident room door. CNA L did not wear a gown while he/she provided a bed bath to the resident.

3. Review of Resident #6's medical record, showed:
-Diagnoses included heart failure and presence of heart assist device;
-An order, dated 2/26/24, for patient isolation, EBP, for left ventricular assist device (LVAD, device implanted in the chest to help the heart pump blood from one of the main pumping chambers to the rest of the body or to the other side of the heart).

Observation on 5/20/24 at 11:02 A.M., showed no EBP sign outside the resident's room.

Observation on 5/20/24 at 1:00 P.M., showed an EBP sign posted on the front of the door to the resident's room. During an interview, the resident said staff just told him/her that he/she is being quarantined and he/she does not know why. Staff told him/her it had something to do with having an LVAD, but the LVAD is not new and he/she has had it the whole time he/she has been at the facility.

Observation on 5/21/24 at 1:29 P.M., showed the resident sat in a recliner chair. CNA A was in the resident's room with no gown or gloves on, moving items throughout the room. He/She lifted and smoothed the blanket on the resident's bed with ungloved hands. As he/she walked through a small space in between the resident's bed and bedside table, his/her clothing caught and moved

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the blanket on the resident's bed. He/She picked up a blanket from the table at the foot of the resident's bed and placed it over the resident, using ungloved hands, to cover the resident's feet and smooth the blanket on top of the resident's shoulders.

During an interview on 5/22/24 at 1:43 P.M., CNA A said the resident has an LVAD. A gown and gloves are required when changing the resident, but not when transferring or touching them.

4. Review of Resident #200's medical record, showed:
-Diagnoses included subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it) left posterior cerebral artery aneurysm (bulge in the wall of an artery);
-An order, dated 5/13/24, for patient isolation, EBP, for gastrostomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications).

Observation on 5/22/24 at 1:28 P.M., showed an EBP sign posted on the front of the door to the resident's room. The resident sat in a recliner chair in front of a bedside table. CNA A was in the resident's room with no gown or gloves on, adjusting items on the bedside table. CNA A asked if the resident was wet and the resident said no. CNA A said, "Let me check," and with ungloved hands, he/she lifted the resident's shirt and pulled the waistband of the resident's pants forward and downward to expose the resident's brief. CNA A moved his/her hands along the waistband of the resident's pants and told the resident he/she was wet and CNA A would come back in a few minutes to change him/her. CNA A picked up a plastic bag filled with soiled linens,

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exited the room, and brought the bag of soiled linens down the hall to the soiled utility room. Upon exiting the soiled utility room, CNA A attempted to sanitize his/her hands using a dispenser on the wall, but the dispenser did not work. CNA A walked down the hall and entered another resident's room.

5. Review of Resident #249's admission MDS, dated 5/20/24, showed:
-Cognitively intact;
-Diagnoses included below the knee amputation of left leg and moderate calorie malnutrition.

Review of the resident's EMR, showed the resident was on EBP for an infected wound on the resident's right upper leg.

Observation on 5/22/24 at approximately 10:00 A.M., showed LPN D in the resident's room to transfer him/her to his/her wheelchair. LPN D touched the resident's arm while guiding him/her into the wheelchair for transport. LPN D was not wearing a gown or gloves.

6. Review of Resident #9's admission MDS, dated 4/26/24, showed:
-Cognitively intact;
-Diagnoses including atrial fibrillation (a-fib, a heart condition that causes the upper chambers to beat faster than the lower chambers of the heart, reducing oxygenation of the organs), coronary artery disease (a blockage in one of the arteries to the heart), and heart failure.

Review of the resident's EMR, showed the resident on EBP for his/her indwelling urinary catheter.

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Observation on 5/22/24 at 8:19 A.M., showed a member of the physical therapy staff providing care to the resident, including transferring the resident from his/her bed to the chair, and moving the resident's urinary catheter bag from the bed frame to the chair frame. The physical therapy staff member then wheeled the resident out into the hallway to conduct the resident's scheduled therapy session. For the duration of the observation, the physical therapy staff member wore gloves, but no gown or mask was donned or doffed by the staff member.

7. Observation on 5/21/24 at 7:32 A.M., showed CNA M walked down the 300 hall with a blood pressure monitor on a rolling stand. He/She entered Room 304, which had an EBP sign posted on the front of the door. CNA M did not sanitize his/her hands upon entry and placed the blood pressure cuff around the resident's right arm. He/She removed the blood pressure cuff, placed the cuff on the rolling stand, and exited the room. CNA M did not sanitize his/her hands upon exiting the room. He/She rolled the stand down the hall and entered Room 305.

8. During an interview on 5/22/24 at 1:43 P.M., CNA A said EBP signs are posted outside of the room of residents who have wounds, catheters, colostomies or tube feedings. Those residents require extra precautions to make sure urine or colostomy (fecal matter) doesn't get on staff. Gloves and yellow gowns are required when providing personal care to these residents. Gowns and gloves are not required when transferring or touching the residents. Staff should sanitize their hands when they enter the resident's room and when they exit.

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9. During an interview on 5/23/24 at 10:15 A.M., CNA H said if a resident is on EBP, staff should wash their hands every time they go in and out of the room. Staff should wear whatever PPE the sign says. Staff should always wear gloves in the room of a resident who is on EBP. CNA H also prefers to wear a gown because he/she never knows if the resident might have something contagious. Gowns are usually in a container outside of the resident's room, but if not, gowns can be found in the supply closet on the hall.

10. During an interview on 5/23/24 at 10:32 A.M., LPN I said if a resident has a medical device, such as an LVAD, a particular infection, or anything that makes them more susceptible, they are placed on EBP. Nurse Managers are responsible for placing the EBP signs outside of the resident rooms. EBP requires staff to wear gloves and gown while providing any type of direct care. Gowns can be located in the closet of the resident's room or in the supply closet on the hall. It would not be appropriate for staff to touch a resident on EBP with ungloved hands. When taking vitals with the machine on the rolling stand, staff should sanitize the equipment after each use.

11. During an interview on 5/23/24 at 10:50 A.M., LPN E said if a resident is on EBP, it means extra precautions must be taken because the resident has wounds or a medical device, such as a g-tube, LVAD, or catheter. Staff should wear a gown and gloves every time they provide any type of direct care to a resident on EBP. Staff should try and make sure gowns are available right outside of the resident's room, but they are also found in the closets on each hall. When taking vitals with the machine on the rolling stand, staff

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should sanitize the equipment after each use.

12. During an interview on 5/23/24 at 10:16 A.M., RN B said that if he/she had to perform any care related to wounds, he/she should wear gown and gloves. He/She said the yellow gowns are located in storage and also in the residents' rooms.

13. During an interview on 5/20/24 at 12:26 P.M., the Director of Nurses (DON) said rooms with an EBP sign posted on them require staff to wear gloves and gowns in the room if they are providing direct care. On 5/23/24 at 12:35 P.M., the DON said she is currently the facility's Infection Preventionist. The DON and Administrator said residents are placed on EBP if they have a wound, indwelling medical device, or MDRO. Staff should have a heightened sense of awareness when working with these residents. For residents on EBP, staff should wear gowns and gloves in any high-touch situations, including when checking a resident's brief, handling linens, performing transfers, and using a blood pressure cuff. Therapy staff should also wear gowns and gloves while working with the residents on EBP. All staff have been educated on using gowns and gloves during all high touch activities with residents on EBP. Gowns can be located in the closets of each resident's room and in the supply closets on the halls.

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A4062	19 CSR 30-85.042(53) Medication Labeling All prescription medications shall be supplied as individual prescriptions. All medications, including over-the-counter medications, shall be packaged and labeled in accordance with applicable professional pharmacy standards and state and federal drug laws and regulations. The United States Pharmacopoeia (USP) labeling shall include accessory and cautionary instructions as well as the expiration date, when applicable, and the name of the medication as specified in the physician's order. Over-the-counter medications for individual residents shall be labeled with at least the resident's name. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F761.	A4062		
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 See the deficiencies cited at F677, F684, F690, F692, F695, and F740.	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	A4076		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace E Brooks | TITLE: VP + Senior Administrator | (X6) DATE: 6/13/24

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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 See the deficiencies cited at F677, F684, F690, F692, F695, and F740.	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	A4076		

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A4076	Continued From page 1 This regulation is not met as evidenced by: Class II See the deficiency cited at F677.	A4076		
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 See the deficiency cited at F880.	A4086		

PLAN OF CORRECTION

Provider/Supplier Name:	Barnes-Jewish Extended Care
Street Address, City, Zip:	401 Corporate Park Drive, Clayton, MO 63105
Date of Survey:	5/23/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265439

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F655	Residents 299, 298 and 301 have discharged.	7/6/2024
	Residents 199, 248 and all residents will have a care plan that accurately reflects their needs and medical conditions upon admission.	
	The Staff Development Coordinator or designee will educate all licensed nursing staff on accurately completing the baseline care plan to ensure all of their needs and conditions are included.	
	Nursing Management will audit new admissions weekly to ensure resident needs and medical conditions are included on the baseline care plan.	
	The Director of Nursing/designee will report results monthly (including action plans for noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
	Corrective action completion date 7/6/2024.	

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Barnes-Jewish Extended Care
Street Address, City, Zip:	401 Corporate Park Drive
Date of Survey:	5/23/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265439

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F677	Resident 249 has discharged.	7/6/2024
	Resident 248 and all residents will be offered showers/bed baths at least twice weekly.	
	The Staff Development Coordinator/designee will educate all nursing staff on offering residents baths or showers at least twice weekly as well as documenting ADL care once offered and provided, including any refusals of care.	
	Nursing Management will perform weekly audits to monitor bath/shower compliance. Any deficient practice and corrective action will be noted on the audit tool and corrected.	
	The Director of Nursing/designee will report audit results monthly (including action plans for noted deficiencies) at the facility's QAPI meeting to ensure continued compliance.	
	To be completed by 7/6/2024.	

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PLAN OF CORRECTION

Provider/Supplier Name:	Barnes-Jewish Extended Care
Street Address, City, Zip:	401 Corporate Park Drive, Clayton, MO 63105
Date of Survey:	5/23/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265439

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F684	Resident 301 has been discharged.	7/6/2024
	All residents will receive treatment and care in accordance with professional standards.	
	The Staff Development Coordinator/designee will educate all Licensed Nursing Staff on the process for entering orders accurately upon admission and communicating any changes. All Nursing Staff will be educated on identifying and communicating any changes in resident skin condition, as well as, how to verify any ordered treatments.	
	Nursing Management/designee will conduct a weekly audit to ensure orders are entered accurately and for accuracy of wound treatment orders.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies), for 3 months at the facility's QAPI meeting to ensure continued compliance.	
	To be completed by 7/6/2024.	

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F690	Resident 298 has been discharged.	7/6/2024
	All residents with indwelling catheters will have a physician's order to provide care for the catheter.	
	The Staff Development Coordinator/designee will educate all Licensed Nursing Staff on the process for entering orders accurately upon admission and communicating any changes.	
	Nursing Management/designee will conduct a weekly audit to ensure catheter orders are entered accurately.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
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F692	Resident 34 and all residents will maintain acceptable parameters of nutritional status to the extent possible.	7/6/2024
	Resident 34 has been reassessed and has appropriate interventions in place.	
	The Staff Development Coordinator/designee will educate all Nursing Staff and Activities on documenting resident food intake, including accurately measuring the amount consumed.	
	The Dining Services Director/designee will educate all dining staff on identifying and serving fortified foods, food preference and food texture parameters.	
	Nursing Management will audit resident meal intake documentation weekly.	
	The Dining Services Director/designee will perform meal accuracy audits weekly.	
	The Interdisciplinary team will meet weekly to discuss weight loss and to ensure interventions are making a positive impact on the resident's nutritional status. Resident meal intake will also be included in the discussion.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
	The Dining Services Director/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F695	Residents 299 and 146 have been discharged.	7/6/2024
	All residents utilizing continuous positive airway pressure (CPAP) will have physician orders for use and proper storage of the CPAP mask for Infection Control Purposes.	
	The facility policy will be revised to include guidance for CPAP mask storage when not in use.	
	The Staff Development Coordinator/designee will educate all staff on the updated policy for CPAP mask storage when not in use. All licensed Nursing Staff will be educated on the process of entering physician orders for the use of a CPAP machine.	
	Nursing Management will conduct weekly audits to ensure physician orders for use of a CPAP machine are in place, as well as proper storage of CPAP mask when it is not in use.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
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F 740	Resident 6 has been reassessed by the Interdisciplinary team and has appropriate interventions in place ensure highest practicable psychosocial well-being.	7/6/2024
	All residents with the need for behavioral health support will receive services to maintain the highest practicable psychosocial well-being.	
	The Staff Development Coordinator/designee will educate all staff on identifying suicidal ideation and reporting any signs observed. All Nursing, Social Service, and Activities staff will be educated on implementing interventions for any residents identified with behavioral health concerns.	
	The Interdisciplinary Team (IDT) will meet weekly to discuss any residents that are identified for behavior monitoring to ensure the appropriate interventions are in place and productive. The IDT will also review resident PHQ9 scores weekly as a method to monitor any changes in resident mood.	
	Nursing Management will audit interventions and any subsequent documentation weekly for residents identified for behavior monitoring.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
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F761	All medication rooms and carts will have medications stored in accordance with professional principles, including abiding by expiration dates.	7/6/2024
	All expired medications have been removed and destroyed.	
	The Staff Development Coordinator/designee will educate all licensed Nursing Staff on properly identifying and destroying all expired medications.	
	The Night Shift Supervisor/designee will conduct a weekly audit of all medication rooms and carts to ensure all expired medications have been removed and destroyed.	
	The Director of Nursing/designee will report audit results monthly (including action plans for any noted deficiencies) for 3 months at the facility's QAPI meeting to ensure continued compliance.	
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F 880	Residents 9, 249, and 301 have been discharged.	7/6/2024
	Residents 200, 295, 6, and all identified for enhanced barrier precautions will receive care and service during high contact activities from staff wearing the appropriate PPE to prevent development and transmission of communicable diseases and infections.	
	The facility has identified a consistent location to store gowns for patients identified for enhanced barrier precautions.	
	The Housekeeping Supervisor has inspected all hand sanitizer dispenser to ensure they are working properly.	
	The Staff Development Coordinator/designee will educate all staff on properly doning and doffing PPE, specifically gowns for patients identified for enhanced barrier precautions. All staff will be educated on the new location to find gowns for patients identified with enhanced barrier precautions. All staff will be educated on proper hand hygiene and the process of reporting any hand sanitizer dispensers that are not working properly. All licensed Nursing Staff will be educated on ensuring the appropriate signage is in place for resident with enhanced barrier precautions.	
	The Infection Preventionist/designee will conduct weekly audits of enhanced barrier precaution compliance, including PPE, hand hygiene, and signage.	
	The Housekeeping Supervisor/designee will conduct weekly audits to ensure hand sanitizer dispensers are working properly. The Housekeeping Supervisor/designee will report audit results monthly (including action plans for any noted deficiencies) at the facility's QAPI meeting to ensure continued compliance.	

	The Infection Preventionist/designee will report audit results monthly (including action plans for any noted deficiencies) at the facility's QAPI meeting to ensure continued compliance.	
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A4062	See plan of correction for F761.	7/6/2024
A4075	See plan of correction for F677, F684, F690, F692, F695, and F740.	7/6/2024
A4076	See plan of correction for F 677.	7/6/2024
A4086	See plan of correction for F880.	7/6/2024

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