DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265345	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BRIDGETON	12145 BRIDGETON SQUARE DR BRIDGETON, MO 63044

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F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/12/2025

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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exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility staff failed to treat residents with dignity when staff removed one resident's personal items without the resident's permission while he/she was out of his/her room receiving a shower (Resident #68). Furthermore, staff spoke to three residents in an unprofessional manner (Resident #68, Resident #29, and Resident #45). Staff also used their personal cell phone while assisting one resident during meal time (Resident #22). The sample was 18. The census was 86.

Review of the facility's Dignity policy, reviewed, 9/26/24, showed:
-Policy: Each resident has the right to be treated with dignity and respect, interactions and activities with residents by staff, temporary, agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporation of the resident goals, preferences, and choices; Staff must respect the resident's individuality as well as honor and value their input;
-Procedure:
-All residents will be treated with dignity and respect: Examples of treating residents with dignity and respect include, but are not limited to:
-Treating all residents' possessions, regardless of their apparent value to others, with respect;
-Respecting residents' private space and property (For example, changing the radio or television station only upon a resident's request, asking permission to access resident's rooms, drawers, cabinets, and closets);

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-Promoting resident independence and dignity while dining, such as avoiding:
-Staff interacting/conversing only with each other rather than with residents while assisting with meals;
-Addressing residents by the name or pronoun of the resident's choice;
-Residents should not be excluded from conversations during activities or when care is being provided;
-Considering the resident's lifestyle and personal choices identified through their assessment processes, to respect and accommodate his or her individual needs and preferences.

Review of the facility Cell Phone policy, dated, 1/7/25, showed:
-Policy: The facility will ensure the appropriate usage of cell phones to safeguard resident privacy and to ensure the provision of highest quality resident care;
-Procedure: Associates should refrain from using cell phone in resident care areas at all times.

1. Review of Resident #68's, quarterly minimum data set, (MDS, a federally mandated assessment instrument completed by facility staff), dated 1/26/25, showed:
-The resident is cognitively intact;
-No behaviors or rejection of care;
-The resident is dependent on staff for showers and bathing.

Review of the resident's face sheet, undated, showed diagnoses that included: Anxiety, cognitive communication deficit, spinal stenosis (narrowing) of the lumbar region (lower back), chronic obstructive pulmonary disease (COPD,

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restricts airways in the lungs making it difficult to breathe).

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: The resident is resistant to care; The resident will make false assumptions towards staff and has a manipulative perception of healthcare concerns and needs being met; The resident presents with obsessive compulsive disorder (OCD), increased anxiety, and claustrophobic like behaviors.
-Interventions: Give a clear explanation of all care activities prior to and as they occur each contact; If the resident resists activities of daily living (ADL), reassure the resident, leave and return five to ten minutes later and try again; Provide the resident with opportunities for choice during care provision.

Review of the resident's progress notes, showed:
-On 2/17/25, at 11:14 A.M., the resident is making demands while staff are in the room to get the resident up for a shower. The resident is upset and said that the staff was taking all her things. This nurse was in room with the aide and observed the aide cleaning the resident's room and removing old linens and towels, this was explained to the resident and the resident remained upset.

During observation and interview on 2/27/25 at 11:05 A.M., Certified Nursing Assistant (CNA) D propelled the resident on the shower stretcher into the spa room. The resident said he/she hoped no one takes his/her stuff in his/her room while he/she is in the shower. CNA D completed the resident's shower and propelled the resident back to his/her room using the shower stretcher.

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Once the resident returned to his/her room, he/she immediately looked around the room and noticed that some of his/her clothing on his/her bedside table were missing along with two towels and a bed blanket. The resident was upset and asked CNA D two times, where is my clothing? CNA D replied that he/she didn't see any clothing on the resident's nightstand. The resident said it must have been another staff member that did it. CNA S entered the room and informed the resident that he/she took the resident's towels and bath blanket off the nightstand because it was soiled. CNA S said he/she did not see the resident's clothing. The resident described to CNA S what the clothing looked like. CNA S again said he/she did not take her clothing, and only removed soiled linen that was on the resident's nightstand. CNA S said to the resident, that he/she would will try his/her best to find the clothing. The resident asked CNA S to look in the soiled linen room for his/her clothing because his/her clothing did not have his/her name on it. CNA S said again, he/she would try his/her best to locate the resident's clothing. The resident said he/she was feeling very anxious.

During an interview on 2/24/25 at 9:40 A.M., the resident said he/she doesn't want to take showers anymore because when he/she is taken to the shower room by staff, another staff member goes into his/her room and removes linens and clothing without his/her permission. This makes him/her very upset and increases his/her anxiety. The resident said this has happened at least five times within the last six months.

During an interview on 2/27/25 at 2:10 P.M. CNA S said he/she had taken the resident's clothing

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and bed linens off his/her nightstand without the resident's permission. The linens that were on top of the clothing were soiled. CNA S said the resident will not allow the staff to remove things out of his/her room and the resident becomes upset when staff try to do so. CNA S said the resident was a "hoarder." He/She will discreetly remove clothing that needs to be laundered when the resident is not in his/her room.

During an interview on 2/27/25 at 2:25 P.M. Licensed Practical Nurse (LPN) T said staff should not remove items out of the resident's room without his/her permission. Staff should show the resident the soiled linens and explain to him/her that the linens and clothing were soiled and that they need to be removed. If the resident refuses, then the family may have to be called.

During a telephone interview on 3/3/25 at 11:31 A.M., with State Employee X and Resident #68, the resident asked CNA D if the resident was assigned to him/her and informed the CNA that he/she had a bowel movement (BM) and needed to be cleaned up. CNA D did not answer the resident but was heard speaking in the background to someone else. The resident said to State Employee X, this is what CNA D does to me, he/she assists the roommate and ignores me. The resident was heard informing CNA D that his/her light was on for a long time and that he/she has been sitting in BM and needed CNA D's help. CNA D was heard with a raised voice and said to the resident, "Your light wasn't on." The resident replied, to CNA D, "Yes, it was." CNA D replied with a raised voice, "No it was not" and said that he/she was waiting on towels. The resident said to CNA D that he/she called to the front desk at least 10 times, and the front desk

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hangs up on him/her. CNA D was heard with a raised voice, "I don't care. You can call the front desk as many times you want. I don't care." The resident said to State Employee X he/she wanted to be treated like everyone else.

During an interview on 2/28/25 at 9:34 A.M., the Administrator and the Director of Nursing (DON) said staff are expected to discuss the removal of the soiled linens and clothing prior to doing so. The staff are always professional in speaking with residents and are expected to continue to do so.

2. Review of Resident #29's quarterly MDS, dated 1/24/25, showed:
-The resident is cognitively intact;
-The resident is dependent on staff for toileting hygiene;
-Diagnoses include: Cognitive communication deficit, high blood pressure, and heart failure.

Review of the resident's care plan, in use of time of survey, showed:
-Focus: ADL assistance and therapy services needed to maintain or attain highest level of function;
-Interventions: Assist resident with mobility and ADLs as needed.

During observation and interview on 2/24/25 at 11:25 AM., CNA D and CNA U provided perineum care (peri-care, cleansing the genitals and rectal area) by turning the resident side to side on his/her bed. The resident said he/she feels as though he/she is not turned very much. CNA D said to the resident, "You know, things happen, and I tell all my residents they should just be happy to be alive." While washing the resident's back CNA D said to CNA U, "I'm only here two

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days a week and I am glad. I'm a good aide, but I am reconsidering working here."

During an interview on 2/24/25 at 11:35 A.M., the resident said the CNAs have a hard job. The resident heard the comments by CNA D and said he/she is happy to be alive.

During an interview on 2/27/25 at 2:10 P.M., CNA S said that staff should not speak over the resident. The resident should be involved in the conversations. All interactions with the residents should be positive, upbeat, and professional. Telling the residents that they should just be "happy to be alive" is something that should not be said by staff.

During an interview on 2/2/25 at 2:45 P.M., LPN T said the residents are to be spoken to in a professional manner and staff are not to speak over them during care. The staff should engage the resident in conversation and always be encouraging in a positive way.

During an interview on 2/28/25 at 9:34 A.M., with the Administrator and the DON, the DON said she wasn't understanding the context of the conversation that the staff had with the resident related to the comment that CNA D said, "I just tell all my residents that they just should be happy to be alive." In general, staff should not be talking over the resident while providing care and are expected to be professional with their conversations with residents.

3. Review of Resident #45's quarterly MDS, dated 12/16/24, showed:
-The resident has moderate cognitive impairment;
-Requires maximum assist from staff for toilet

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hygiene;
-Occasionally incontinent of urine and frequently incontinent of bowels.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: The resident has ADL self-care deficit related to hemiplegia (weakness to one side of the body), stroke, impaired balance, and limited mobility;
-Interventions: Assist the resident with toilet use and hygiene.

During an observation and interview on 2/24/25 at 12:15 P.M., CNA S entered the resident's room and the resident said he/she was "wet." CNA S checked the resident and said to the resident your "diaper" is dry. The resident insisted that he/she was "wet." CNA S removed the resident's brief and a small amount of stool was observed on the brief. CNA S said to the resident that the resident had a small BM and his/her "diaper" was not wet.

During an interview on 2/27/25 at 2:10 P.M., CNA S said a resident's brief can be called a diaper. He/She thought most residents wouldn't mind but guessed it depended on the resident and what they preferred. He/She didn't know what Resident #45 preferred.

During an interview on 2/27/25 at 2:25 P.M., LPN T said it is not appropriate to call the resident's incontinent brief a diaper. A diaper is used on children and an incontinent brief is used on the adult residents. The term diaper is demeaning.

During an interview on 2/28/25 at 2:45 P.M., with the Administrator and the DON, they said they

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would expect staff not to call the resident's incontinent brief a diaper while providing care to the resident.

4. Review of Resident #22's medical record, showed:
-Diagnoses included dementia, diabetes, and Parkinson's disease (brain disorder causing unintended or uncontrolled movements);
-Severe cognitive impairment.

Review of the resident's care plan, in use at the time of the survey, showed:
-Focus: ADL assistance and therapy services needed to maintain or attain highest level of function. The resident has a decline due to stroke with left sided weakness, resident is dependent with all daily living needs and transfers, resident is currently working with therapy services to increase functional mobility and strength;
-Goal: Resident wishes to attain prior level of function;
-Interventions: Assist with mobility and ADLs as needed. Diet is mechanical soft and resident needs to eat in the dining room.

Observation on 2/26/25, of lunch in the main dining room, showed:
-At 11:52 A.M., CNA M sat at the table next to the resident. CNA M held his/her cell phone in his/her lap, texting. The resident's drinks and dessert were on the table in front of the resident;
-At 11:55 A.M., CNA M sat next to the resident, texting on his/her phone and not assisting the resident. The resident's food remained on the table;
-At 11:57 A.M., CNA M tested on his/her phone and was not assisting the resident;
-At 12: 16 P.M., CNA M texted on his/her phone.

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F 550	Continued From page 10 The resident's food was on the table in front of the resident, untouched; -At 12:17 P.M., CNA M was still texting on his/her phone. The resident was not eating, and his/her food remained on the table in front of him/her; -At 12:19 P.M., CNA M put his/her phone back in his/her pocket. During an interview on 2/27/25 at 12:52 P.M., Registered Nurse (RN) P said the cell phone policy is that staff are not to have cell phones out in resident care areas. It is not appropriate to be on your phone while assisting residents in the dining room. During an interview on 2/27/25 at 12:55 P.M., CNA O said staff are not to have cell phones in resident areas. He/She would expect staff to be off their phones while assisting residents due to choking risks. During an interview on 2/27/25 at 1:26 P.M., the Dietary Director said she would expect staff to be off their phones during meal service. She would expect staff to have their phones put away while assisting residents. During an interview on 2/27/25 at 1:58 P.M., the Executive Director said he would expect staff to be off their phones while assisting residents in the dining room. Staff should not be on their phones in resident areas. MO00249674 MO00248977 MO00248931 MO00250429	F 550		
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F 558	Continued From page 11 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate the needs of one resident with mobility impairments when staff failed to ensure the resident had access to a call light adapted to meet his/her needs (Resident #9). The sample was 18. The census was 86. Review of Resident #9's medical record, showed diagnoses included multiple sclerosis (MS, disease of the central nervous system), quadriplegia (paralysis of all four limbs), seizures, abnormal posture, generalized muscle weakness, contractures to left and right hands, cognitive communication deficit, anxiety, and depression. Review of the resident's significant change Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 2/20/25, showed: -Severe cognitive impairment; -Clear speech; -Makes self understood: Usually understood; -Dependent for eating, oral hygiene, toileting, showers, dressing, rolling left and right, and sit to stand transfer. Review of the resident's care plan, in use at the time of survey, showed:	F 558		

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-Focus: Resident has impaired mobility secondary to MS. Total assist with all activities of daily living (ADLs);
-Focus: Resident has a communication problem related to neurological symptoms, weak or absent voice;
-Focus: Resident is at risk for falls due to his/her impaired mobility, seizure disorder, and use of psychotropic medications;
-Interventions included call light within reach;
-The care plan did not identify the resident required a specialized call light.

Observations on 2/24/25 at 10:52 A.M., 12:31 P.M., and 1:06 P.M., showed the resident in bed. A push button call light was on the floor behind the head of the bed.

Observations on 2/25/25 at 9:06 A.M., 12:40 P.M., and 2:11 P.M., showed the resident in bed. A push button call light was on the floor behind the head of the bed.

During an interview on 2/25/25 at 2:11 P.M., the resident said he/she could not move his/her arms or legs. He/She did not have a call light. He/She had no way to call staff for help when needed.

Observations on 2/26/25 at 7:20 A.M., 9:14 A.M., and 12:38 P.M., showed the resident in bed. A push button call light was on the floor behind the head of the bed.

Observation on 2/27/25 at 8:00 A.M., showed the resident in bed. A push button call light was on the floor behind the head of the bed. During an interview, the resident was soft spoken and provided verbal responses, in addition to nodding and shaking his/her head. He/She said he/she

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did not have a call light, but would like one. He/She could turn his/her head at a downward angle and demonstrated doing so during the interview.

During an interview on 2/27/25 at 1:32 P.M., the Therapy Director said the resident had some mobility issues and could not use a standard call light. She was not sure if the resident had a touchpad call light, and would check with maintenance on getting one.

During an interview on 2/27/25 at 1:40 P.M., Certified Nurse Aide (CNA) O said the resident's hands were contracted and he/she could not use a push button call light. The resident talked really quietly but could make his/her needs known.

Observation on 2/27/25 at 1:45 P.M., showed the Therapy Director entered the resident's room and picked up the push button call light off the floor from behind the resident's bed. It was connected to a tube she identified as a breath-activated call light. The Therapy Director placed the breath-activated call light on the resident's bedside table and said he/she was going to find a touchpad call light instead. The breath-activated call light was coated with a layer of dust. CNA O and CNA Q looked at the breath-activated call light and said they did not know the resident had that particular call light and the resident did not use it.

Observation on 2/57/25 at 1:54 P.M., showed the Maintenance Director tested the breath-activated call light on the resident's bedside table, and it successfully activated the panel on the wall. During an interview, the resident said he/she was happy to be getting a call light and it would make

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it easier for him/her to communicate.

During an interview on 2/27/25 at 2:03 P.M., Registered Nurse (RN) R said the resident moved his/her limbs and had limited mobility. The resident had some minor mobility in his/her neck. He/She could make his/her needs known to an extent. RN R was not aware the resident had a breath-activated call light. Nursing staff should ensure call lights were placed within a resident's reach.

During an interview on 2/28/25 at 7:11 A.M., the Infection Preventionist (IP) said the resident used to use the breath-activated call light, but his/her family opted against it. The resident did not really use his/her call light anyway. Yesterday, he/she was given a touchpad call light. He/She could move his/her head enough to be able to use it. The resident's need for a specialized call light should be documented on his/her care plan.

During an interview on 2/28/25 at 8:22 A.M., the Director of Nurses (DON) said all residents should have access to a call light they could use. The resident's family member told staff the resident did not use his/her call light, so the family member did not want the resident to have the breath-activated call light. These discussions should be documented in the resident's medical record. Yesterday, the DON spoke to the resident's family member about providing a touchpad call light. The resident had quadriplegia and his/her need for a specialty call light should be documented on his/her care plan.

During an interview on 2/28/25 at 9:24 A.M., the Executive Director said he expected staff to ensure call lights were accessible to residents.

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F 558	Continued From page 15 He expected residents to be provided call lights in accordance with their individual needs.	F 558		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure general accounting principles were followed by failing to follow up on outstanding checks during monthly resident trust fund (RTF) reconciliations. This facility identified 35 residents with funds handled by the facility. The census was 89. Review of the facility's Resident Trust Policy and Procedures, reviewed 6/15/22, showed: -In large part, these policies have been developed with the guidance of: -The Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual, State Operations Manual, Appendix PP - Interpretive Guidelines for Long-Term Care Facilities; -State laws and regulations must also be followed when they are more stringent or more specific;	F 568		

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-Each skilled nursing facility that is owned by the corporation shall: Manage a resident's personal funds via the Resident Fund Management Service (RFMS);
-The policy did not provide guidance for follow-up on outstanding checks.

Review of the facility's monthly RTF reconciliations from February 2024 through January 2025, showed outstanding checks as follows:
-Check #1194, dated 9/30/20: $660.37;
-Check #1212, dated 1/29/21: $150.00;
-Check #1245, dated 6/30/21: $1,500.18;
-Check #1253, dated 7/27/21: $10.00;
-Check #1279, dated 9/14/21: $100.00;
-Check #1292, dated 10/29/21: $50.00;
-Check #1398, dated 12/23/22: $296.45;
-Check #1401, dated 12/28/22: $27.26;
-Check #1474, dated 8/22/23: $25.00.

During an interview on 2/27/25 at 1:10 P.M., the Assistant Business Office Manager (ABOM) said she reconciles the RTF monthly and submits the reconciliations to the corporate office. She was not aware outstanding checks needed to be investigated. Following up on outstanding checks would be overseen by regional or corporate staff.

During an interview on 2/27/25 at 1:16 P.M., the Regional Business Office Manger said she was not aware there needed to be routine follow-up for outstanding checks. The monthly reconciliations are reviewed by the corporate office.

During an interview on 2/28/25 at 8:52 A.M., the Executive Director said he expects general accounting principles to be followed by the facility

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		

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update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure one resident's physician (Resident #26) was notified after the resident developed an elevated temperature on the evening shift of 2/24/25. The resident was sent to the hospital the next morning on 2/25/25, and admitted with a diagnosis of sepsis (a serious condition in which the body responds to infection) pneumonia (an inflammatory condition of the lungs. Symptoms may include productive or dry cough, chest pain, fever, and difficulty breathing.). The sample size was 18. The census was 86.

Review of the facility's Change in Resident's Condition or Status policy, issued on 11/26/18, and revised on 9/5/24, showed:
-Policy: This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. In the case of death of a resident, the resident's physician will be notified immediately by facility staff in accordance with State law;
-Federal Regulations: A facility must immediately

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inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: A significant change in the resident's physical, mental, or psychosocial status;
-Documenting communication: When health care team members provide information in an objective, standardized, and logical sequence, the resident receives safe, quality care timely, appropriate interventions;
-Implementation: Identify a suspected acute change in the resident's status. Review the resident's medical record, including advanced directives and health history. Obtain the resident's vital signs (temperature - T, pulse - P, respirations - R, blood pressure - BP) and oxygen saturation level (O2 Sat) using pulse oximetry. Complete a complete physical assessment, focusing on the identified change in the resident's status (for example: assess respiratory status for a resident with decreased oxygen saturation level). Communicate the change in the resident's status to the appropriate physician. Implement the treatment plan or initiate the resident's transfer to another health care facility. Document the procedure.

Review of the facility's Temperature Measurement policy, reviewed on 2/24/25, showed:
-Introduction: Body temperature represents the balance of heat a person produces with the heat that a person loses. A stable temperature pattern promotes proper function of cells, tissues, and organs. A change in this pattern usually signals the onset of illness;
-Oral temperature in adults normally ranges from 97 degrees to 99.5 degrees Fahrenheit (F). Axillary (armpit) temperature, the least accurate

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reading, reads 1 degree to 2 degrees lower;
-Documentation associated with temperature measurement includes: Temperature, route used, date and time of measurement, name of physician notified of an abnormal temperature, date and time of physician notification, any prescribed interventions, and response to those interventions.

Review of the facility Licensed Practical Nurse (LPN) job description, revised on 11/10/16, showed:
-The LPN delivers quality nursing care to patients through interpersonal contact and provide care and services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient in accordance with all applicable laws, regulations, and corporate standards;
-Reports to the Director of Nursing (DON) or other nursing supervisor;
-Specific Requirements: Must have advanced knowledge in field of practice. Must possess the ability to make independent decisions when circumstances warrant such action;
-Essential Functions: Must be able to knowledgeably and competently deliver quality nursing care to patients. Must be able to chart appropriately and timely. Must be able to report changes in patient condition. Must be able to concentrate and use reasoning skills and good judgment.

Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed:
-Speech Clarity: No speech, absence of spoken words;

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-Makes Self Understood: Rarely/never understood;
-Ability to Understand Others: Sometimes understands, responds adequately to simple, direct communication only;
-Functional Limitation in Range of Motion: Impairment on both sides of upper and lower extremities;
-Dependent: Helper does all of the effort. Resident does none of the effort to complete activity: Toileting hygiene, shower/bathing, upper/lower body dressing, and personal hygiene;
-Dependent: Roll left and right;
-Not attempted due to medical condition or safety concerns: Lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer;
-Diagnoses: Multidrug Resistant Organism (MDRO), pneumonia (An inflammatory condition of the lungs. Symptoms may include productive or dry cough, chest pain, fever, and difficulty breathing.), stroke, seizure disorder, malnutrition, and respiratory failure;
-Risk of Pressure Ulcers (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction): Yes;
-Unhealed Pressure Ulcers: No;
-Special Treatments and Programs: Oxygen therapy, suctioning (removes mucus and secretions), and tracheostomy (a surgically created hole in the windpipe) care.

Review of the resident's care plan, located in the electronic medical record (EMR), showed:
-1/16/25: Focus: At risk for respiratory illness. Goal: The resident will remain free from respiratory illness. Interventions: Monitor for change in condition and notify physician of findings;
-1/16/25: Focus: Impaired cognitive

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ability/impaired thought process related to TBI (traumatic brain injury). Goal: Resident's needs will be met. Interventions: Allow resident extra time to respond to questions and instructions. Ask yes/no questions;
-1/16/25: At risk for rehospitalization due to one hospitalization in the past six months. Goal: Will not have an avoidable rehospitalization related to current medical diagnoses. Interventions: Staff to provide timely communication to physician.

Observation on 2/24/25 at 8:56 A.M., showed the resident lay in bed with a family member at bedside, bathing the resident. The resident had a tracheostomy tube (a medical device inserted into the trachea to facilitate breathing) with humidified oxygen infusing and a gastrostomy tube (a tube surgically inserted through the abdomen into the stomach to provide hydration, nutrition and medications) with the tube feeding off while the family member bathed the resident. The family member said he/she came in every morning to check on the resident and bathed the resident every day. Another family member came in every evening.

Review of the resident's progress notes, located in the EMR, showed no documentation the resident had an elevated temperature, received Tylenol, or the physician was notified on the evening shift (3:00 P.M.-11:00 P.M.) of 2/24/25 or night shift (beginning at 11:00 P.M. on 2/24/25 and ending 7:00 A.M. on 2/25/25) .

Observation on 2/25/25 at 6:57 A.M., showed the resident lay in bed with humidified oxygen infusing through his/her tracheostomy tube. At 7:00 A.M., the resident's family member entered the room. He/She said he/she was concerned

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about the resident because the other family member that came in during the evening phoned him/her last night around 5:00 P.M. or 5:30 P.M., and said the resident had a temperature of 102.8 F, and staff gave the resident Tylenol. He/She removed the resident's covers and said the resident felt very warm to touch and he/she thought the resident still had a fever. At 7:08 A.M., the day shift nurse entered the room and the family member told him/her the resident felt hot to touch. The nurse said the night nurse told him/her during shift change they had taken the resident's temperature around 4:00 A.M., and it was 99.0 F.

Review of the resident's vital and weight section of the EMR, showed the following vitals documented on 2/25/25 at 7:58 A.M.: T-104.1, P-108, R-22, BP-130/42, and O2 Sat of 98%.

Review of the resident's progress note, showed on 2/25/25 at 8:18 A.M., the nurse contacted the resident's physician in regards to an elevated temperature and labored breathing. Vitals were taken and the physician said to send the resident out to the emergency room. Family member at bedside and notified. Unit Manager and DON made aware.

Review of the resident's hospital notes, dated 2/25/25 at 7:14 P.M., showed an admission diagnosis of sepsis, pneumonia.

During an interview on 2/25/25 at 2:53 PM, LPN F said he/she was assigned to the resident on the evening shift of 2/24/25. He/She assessed the resident around 3:30 P.M. and everything was fine. About 7:30 P.M., the resident's family member told him/her the resident felt warm and

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F 580	Continued From page 24 asked him/her to take the resident's temperature. He/She obtained an axillary temperature and the resident's temperature was 101 F. LPN F gave the resident Tylenol around 7:30 P.M. He/She thought the physician should be called when a resident had a temperature of 100.3 F or greater, but he/she was not sure. He/She did not document anything about the resident's temperature or administering the Tylenol, but should have. He/She did not contact the resident's physician because he/she was waiting on the resident's labs to come in that were obtained on 2/24/25. LPN F got a little swamped during the shift. He/She did not recall the last time he/she reviewed the facility's change in condition policy. During an interview on 2/26/25 at 9:53 A.M., the DON said she would have expected LPN F to have documented the resident's temperature, and administering the Tylenol. She would have expected the LPN to have contacted the physician and documented any new orders as well. During a telephone interview on 2/27/25 at 11:00 A.M., the resident's physician said he had not been made aware of the resident's elevated temperature on the evening of 2/24/25. Had the nurse notified him the resident had either a 101.2 F or 102.8 F fever, he probably would have sent the resident to the hospital. The resident was a complex patient with a tracheostomy. For a patient like that he would not want to wait for results from labs drawn at the facility. He would have expected the nurse to have notified him.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care needs were met for Resident #29. The facility failed to ensure Resident #29's hair was clean, facial hair was shaved, body was clean and free from odors, and failed to provide foot care. The sample was 18. The census was 86.

Review of the facility's ADL care policy, revised 2/12/24, showed:
-Policy: The resident will receive assistance as needed to complete ADLs. Any change in the ability to perform ADLs will be reported to the nurse.

Review of the facility's foot care policy, dated 8/28/18, showed:
-Policy: This facility will ensure that foot care provided is consistent with professional standards of practice and that foot care includes treatment to prevent complications from conditions such as diabetes, peripheral vascular disease (circulatory condition), or immobility. This facility will ensure that foot care also includes assisting the resident in making necessary appointments with qualified healthcare providers such as podiatrists and arranging transportation to and from appointments;
-Implementation: Clean and rinse foot, apply lotion to moisturize dry skin;
-Documentation: Documentation associated with

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foot care should include any abnormal findings, any nursing interventions and patient response.

Review of Resident #29's quarterly minimum data set (MDS, a federally mandated assessment instrument completed by facility staff), dated 1/24/25, showed:
-Diagnoses of congestive heart failure, muscle weakness, and toxic liver disease;
-Cognitively Intact.

Review of the resident's care plan, dated 2/25/25, showed:
-Focus: ADL Assistance and therapy services needed to maintain or attain highest level of function;
-Goal: Resident wishes to attain prior level of function;
-Interventions: Assist with mobility and ADLs as needed. Resident requires a mechanical Hoyer lift with all transfers;
-Focus: Resident is followed weekly by wound care team, and has been non-compliant with wound care;
-Interventions: Provide consistency in care to promote comfort with ADLs. Maintain consistency in timing of ADLs, caregivers and routine, as much as possible.

Review of the resident's most recent skin assessment, dated 2/25/25, showed:
-Dry skin noted but not the location;
-No mention of the resident's toe nails.

Observation and interview on 2/24/25 at 9:05 A.M., showed the resident awake in bed. The resident's hair was long, stringy, and oily. The resident's facial hair was unkempt. The resident had a musky odor emitting from him/her. The

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resident said he/she receives two bed baths a week, but staff do not always wash his/her hair. He/She said he/she sometimes spills his/her urinal on himself/herself.

During observation and interview on 2/24/25 at 11:25 A.M., Certified Nursing Assistant (CNA) D and CNA U provided perineum care (peri-care, cleansing the genitals and rectal area) by turning the resident side to side on his/her bed. While the resident was turned to his/her right side, there was a dark amber colored film located on the resident's buttocks, lower and upper back. CNA D said that the resident will spill his/her urinal, and the urine may leak onto the bed pad. The residents in that particular room like the temperature very warm, so it may make the resident sweat more as well. CNA D and CNA U said they try to wipe or scrub off the film, but it always returns. Both of the resident's feet had large chunks of white dry skin, large crevices of cracked skin, and jagged thick toenails. The resident's feet had a yellow like color. The resident's mattress was dark navy blue and white large flakes of dry skin from the resident's feet were visible on the mattress. The resident's hair was stringy and oily.

Observation on 2/25/25 at 9:08 A.M., showed both of the resident's feet had large chunks of white dry skin, large crevices of cracked skin, and jagged thick toenails. The resident's right big toe had a thick toenail that appeared red and green. The resident's feet had a yellow like color. The resident's mattress was dark navy blue and white large flakes of dry skin from the resident's feet were visible on the mattress.

Observation on 2/26/25 at 1:36 P.M., showed the

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resident had a dark amber colored film located on the resident's buttocks, lower and upper back. A urine odor emitted from the resident. The resident's hair was oily and stringy. The resident's facial hair was unkempt.

During an interview on 2/26/25 at 1:43 P.M., the resident said he/she has not seen a podiatrist since he/she arrived to the facility. He/She would like his/her toenail taken care of and his/her dry skin treated. He/She has a bowel movement everyday and sometimes spills his/her urinal up his/her back. It has been since about December since he/she has had an actual shower and not just a bed bath. His/Her hair had not been washed since the previous week. It had been at least a year since he/she had received a hair cut, and he/she wanted one. He/She had asked staff about a haircut but had never heard back.

During an interview on 2/27/25 at 1:02 P.M., the Infection Preventionist said she would expect nursing staff to document the dry skin and nail conditions of the resident's feet in the skin assessment. She would expect staff to ensure the resident is on the podiatrist list. She said the resident's toe nail is not able to be treated by facility staff and should be seen by a podiatrist. She would expect nursing staff to ask the resident if he/she would like his/her facial hair shaved. She would expect staff to wash the resident's hair and ensure it is cut if the resident requests a haircut. She would expect the staff to clean the resident's skin thoroughly during showers or bed baths.

During an interview on 2/28/25 at 8:02 A.M., CNA O said he/she would expect residents to receive at least two showers or bed baths a week.

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He/She would expect staff to be washing residents' hair and skin. He/She would expect staff to be asking residents if they want their facial hair shaved. He/She would expect any skin concerns or issues to be documented in the skin assessment or shower sheet. He/She would expect dry skin to be reported to the nurse. He/She said the resident's toe is beyond bad and should be seen by a podiatrist. He/She does not know if the resident was currently seen by the podiatrist. He/She would expect skin assessments to be completed and accurate.

During an interview on 2/28/25 at 8:16 A.M., the Social Services Director said he is in charge of putting residents on the list to see the podiatrist. He would expect nursing staff to let him know if there are any residents who need to see the podiatrist. He was not aware that Resident #29 needed to see the podiatrist. He would expect staff to ask the residents if they would like a hair cut and to let him know.

During an interview on 2/28/25 at 8:54 A.M., the Director of Nursing (DON) said she would expect residents to receive at least two showers or bed baths a week. She would expect staff to wash residents' hair and body and shave any unwanted facial hair. She would expect nursing staff to ask residents if they would like a hair cut. She would expect any skin concerns including dry skin or discoloration to be documented on the skin assessment. The social worker is in charge of putting residents on the list to be seen by the podiatrist. Once the nurse completes an assessment of the resident's feet, the resident should be placed on the podiatrist list if there are any concerns that cannot be addressed by facility staff. She would expect skin assessments to be

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F 677	Continued From page 30 completed and accurate. MO00249583 MO00248931 MO00250429	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 obtain labs as ordered for one resident (Resident #14), and to document a thorough, ongoing assessment following the resident's change in condition, and to appropriately communicate the resident's change in condition to the next shift. In addition, the facility failed to ensure staff provided feeding assistance in accordance with physician orders for one resident identified as dependent on assistance for eating (Resident #9). The sample was 18. The census was 86. Review of the facility's Change in Resident's Condition or Status policy, issued on 11/26/28, and revised on 9/5/24, showed: -Policy: This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's	F 684		

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condition or status.
-Procedure: The facility will utilize the Lippincott Procedure - Change in status, identifying and communicating, long-term care.

Review of the facility's Change in Status, Identifying and Communicating, Long-Term Care procedure, revised 8/19/24, showed:
-The facility will utilize the following Interact tools per policy: Situation, Background, Assessment and Recommendation (SBAR);
-Introduction: In a long-term care setting, any change from baseline in a resident's status must be identified and addressed. A resident is more likely to return to baseline status and avoid complications when a condition is recognized early so that it can be treated. When a nurse recognizes a potentially life-threatening condition or significant change in a resident's status, the nurse must communicate with other health care team members to meet the resident's needs;
-The resident should be assessed for changes from baseline status on admission, at present intervals based on the resident's condition and regulatory requirements, and whenever the resident's status changes. The resident's current status should also be checked against baseline status during medication administration and other routine activities. Notable changes include a decline in functional status, new or increasing confusion, temperature elevation, shortness of breath, and behavior changes. By identifying such risk factors as chronic diseases, previous hospitalizations, and notable conditions in the resident's medical history, the nurse can quickly anticipate some acute changes in status;
-A change in condition may happen quickly in just minutes, or slowly over hours or days. The condition may manifest as a change in condition

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or physical change. Unless the resident's condition is life-threatening, the resident can be assessed and a treatment plan started at the long-term care facility. A focused, thorough assessment of the resident's condition can help identify a recurring fluctuation in signs and symptoms such as a change in blood pressure or increased confusion that happens at the same intervals daily;
-At minimum, assessment should include: Reviewing the resident's medical record. Asking how the resident feels and what symptoms the resident has. Obtaining vital signs. Observing the resident's overall condition, including function and cognition. Exploring the resident's complaints;
-Recognizing status changes, assessing the resident, and intervening early on allows the resident to receive appropriate care, decreasing the need for transfer to an acute care facility or emergency department;
-Every health care team member is responsible for communicating a resident's change in status from baseline;
-Clear, professional communication improves diagnosis, care planning and implementation, and continuity of care. Essential elements of such communication include: Reviewing the resident's history, medications, laboratory test results, treatments, and other significant information. Providing details of the resident's current status using objective findings. Documenting communication;
-When health care team members provide information in an objective, standardized, and logical sequence, the resident receives safe, quality care timely, appropriate interventions;
-Implementation: Identify a suspected acute change in the resident's status. Review the resident's medical record, including advanced

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directives and health history. Obtain the resident's vital signs and oxygen saturation level using pulse oximetry. Complete a complete physical assessment, focusing on the identified change in the resident's status (for example, assess respiratory status for a resident with decreased oxygen saturation level). Communicate the change in the resident's status to the appropriate practitioner. Implement the treatment plan or initiate the resident's transfer to another health care facility. Document the procedure;
-Complications associated with identifying and communicating a change in a resident's status may include: Delay in treatment and disruption in care;
-Documentation associated with identifying and communication a change in a resident's status included: Acute status change in status, behavior changes, vital signs, oxygen saturation level, other assessment findings in the appropriate areas in the resident's medical record, nursing interventions and response to those interventions, communication with other health care team members, and diagnostic test results.

Review of the facility's Vital Signs policy, issued 11/26/18 and revised on 2/20/25, showed:
-Policy: Vital signs will be checked as needed and as ordered by the physician to aid in the diagnosis and treatment of the resident's medical condition and to assess for changes in condition. Abnormal vital signs will be reported to the licensed nurse.

Review of the facility's Pulse Oximetry policy, revised 2/24/25, showed:
-Introduction: Performed intermittently or continuously, oximetry is a relatively simple procedure used to monitor arterial oxygen

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saturation noninvasively. Pulse oximetry can aid clinical decision-making; however, it isn't a substitute for a clinical assessment;
-Completing the Procedure: If you detect and confirm a low oxygen saturation of peripheral oxygen (SpO2), administer supplemental oxygen, as needed and prescribed, according to your scope of practice. Regularly monitor and document the patient's SpO2 level. Document the procedure;
-Documentation: Documentation associated with pulse oximetry includes: date and time, activity level and position, probe site, concentration of supplemental oxygen (if applicable), method of oxygen delivery, SpO2 level, and episodes of desaturation.

1. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/18/24, showed:
-Cognitively intact;
-Diagnoses included congestive heart failure, chronic respiratory failure with hypercapnia (excessive carbon dioxide in the blood), high blood pressure and kidney failure,;
-Oxygen therapy received.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: Resident is at risk for rehospitalization due to diagnoses of congestive heart failure and chronic obstructive pulmonary disease (COPD, lung disease), and poor adherence to diet restriction;
-Interventions included: Labs as ordered;
-Focus: Resident has congestive heart failure;
-Interventions included: Check breath sounds and observe for labored breathing. Labs

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as ordered. Observe and report as needed (PRN) any signs/symptoms of congestive heart failure;
-Focus: Resident has oxygen therapy related to respiratory illness. He/She also uses a continuous positive airway pressure (CPAP, machine that keeps the airways open during sleep for persons with sleep apnea);
Interventions included observe for signs/symptoms of respiratory distress and report to physician PRN.

Review of the resident's hospital discharge summary, dated 2/18/25, showed:
-Hospitalized 2/13/25 through 2/18/25 with discharge diagnosis of congestive heart failure;
-Special instructions: Basic metabolic panel (BMP, blood test that measures sugar level, electrolytes, fluid balance, and kidney function) on Monday, 2/24/25.

Review of the resident's electronic physician order summary (ePOS), showed:
-An order, dated 2/18/25, for BMP on Monday, 2/24/25;
-An order, dated 2/18/25, for oxygen at 3 liters (L)/minute continuously per nasal cannula;
-An order, dated 2/18/25, for oxygen saturation (O2) rates every shift, may titrate to keep above 92%;
-An order, dated 2/24/25 at 9:47 A.M., for STAT chest x-ray.

Review of the resident's electronic medical record (EMR), reviewed 2/24/25 at 11:30 A.M., showed:
-No documentation of a BMP obtained on 2/24/25;
-O2 sat documented as 95% on 2/24/25 at 3:22 A.M.;

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-No documentation of a discussion with the physician related to the x-ray ordered on 2/24/25;
-No progress notes, assessments, or documentation related to a change in condition on 2/24/25.

Observation on 2/24/25 at 10:58 A.M., showed the resident in bed with hands and arms shaking. The resident's oxygen was on via nasal cannula, running at 5L. The resident exhibited short, rapid breathing. During an interview, the resident said he/she started shaking this morning and that is not normal for him/her. He/She described his/her breathing as "deep."

Observations on 2/24/25 at 1:11 P.M. and 4:53 P.M., showed the resident in bed with oxygen on via nasal cannula, running at 5L. The resident's breathing was rapid. The resident's eyes were open and he/she did not verbally respond during an attempted interview.

Review of the resident's EMR, reviewed 2/24/25 at 5:50 P.M., showed no progress notes, assessments, or documentation related to a change in condition on 2/24/25.

Observation on 2/25/25 at 6:17 A.M. showed Licensed Practical Nurse (LPN) B performed cardiopulmonary resuscitation (CPR) on the resident. The resident expired.

Review of the resident's EMR, reviewed 2/25/25 at 7:08 A.M., showed:
-No documentation of BMP obtained on 2/24/25;
-O2 sat documented as 94% on 2/25/25 at 12:45 A.M.;
-No assessments or documentation related to a change in condition on 2/24/25.

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During an interview on 2/25/25 at 9:19 A.M., Certified Nurse Aide (CNA) C said on the morning of 2/24/25, the resident's face was red, his/her lips were blue, and he/she was "in and out" of his/her normal state of mind. CNA C notified LPN A of the resident's change in condition. LPN A checked the resident's oxygen and it only got up to 78%.

During an interview on 2/25/25 at 9:33 A.M., LPN A said he/she was the nurse assigned to the resident on day and evening shift on 2/24/25. After breakfast, the resident was not his/her usual self, wasn't joking as usual, and his/her oxygen was at 60%. He/She did not want to go to the hospital. The resident's physician ordered an increase to the resident's oxygen to get his/her O2 sats to 88%, and a STAT chest x-ray. LPN A read the x-ray results to the physician and a new order was received to adjust the resident's medication. LPN A documented his/her assessments and discussions with the physician in the resident's EMR, but it all disappeared. When his/her shift was over on 2/24/25, LPN A was giving report to the night nurse, LPN B, when LPN B was pulled away to another resident's room. LPN A did not verbally discuss the resident's change in condition with LPN B. LPN A documented the change in condition on the report sheet and gave the report sheet to LPN B.

Review of the report sheet, dated 2/24/25, showed a handwritten note next to the resident's name, "Monitor breathing. O2 sats were low all day off and on."

During an interview on 2/25/25 at 10:25 A.M., LPN B said he/she came in for his/her shift on

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2/24/25 at 10:30 P.M. He/She did not get report from LPN A, who worked day and evening shift. LPN B was not aware the resident had a change in condition or that a STAT x-ray had been obtained that day. The resident has a standing order to check his/her oxygen at each shift and LPN B checked the resident's oxygen shortly after he/she came on shift, and the O2 sats were at 95%. LPN B did not check the resident's oxygen again during his/her shift. He/She removed the resident's CPAP at 5:00 A.M. and put the resident's oxygen on at 3L. He/She was not aware the resident received oxygen at 5L the day before or that he/she had shortness of breath. There was nothing on the report sheet about the resident's change in condition. If LPN B had been made aware the resident had a change in condition, he/she would have checked the resident's oxygen more frequently and would have adjusted the oxygen to ensure the resident's oxygen level was above 88%.

During an interview on 2/26/25 at 8:25 A.M., LPN B confirmed he/she did did not get verbal report from LPN A on the night of 2/24/25. He/She reviewed the report sheet when he/she came in for his/her shift and nothing was written next to the resident's name. There was no documentation on the report sheet about the resident's breathing or O2 sats.

During an interview on 2/25/25 at 8:53 A.M., Physician E said staff notified him/her of the resident's shortness of breath. The physician ordered staff to increase the resident's oxygen to 5L and adjust the oxygen so his/her O2 sats were around 92%. He/She ordered a STAT x-ray, which showed increased infiltrates due to the resident's congestive heart failure. He/She

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expected staff to communicate the changes in between shifts. He/She understands that documentation from staff could improve, and the documentation could improve the communication with staff in between shifts.

During an interview on 2/25/25 at 12:19 P.M., the LPN Unit Coordinator said the resident's BMP was scheduled to be completed on 2/24/25. The lab company came out to the facility on that day, but missed his/her labs, as well as the labs for seven other residents. The resident's BMP was scheduled for the next draw day, but he/she expired. The facility has had ongoing issues with their lab company and they are trying a new lab company.

During an interview on 2/26/25 at 9:25 A.M., the Director of Nurses (DON) said the resident returned from the hospital on 2/18/25 with orders for a BMP to be completed on 2/24/25. The lab company came out to the facility on 2/24/25, but did not draw any of the residents' labs on the schedule for that today. The facility has been having issues with the lab company for a long time. The facility's corporate office makes the determination which lab company to use. On 2/24/25, LPN A notified her of Resident #14's change in condition. The DON went over next steps with LPN A in great detail, instructing him/her to notify the physician, to document the assessments for a change in condition, and to encourage the resident go out to the hospital. The DON instructed LPN A to document everything that happened, from the time he/she assessed the resident, in the EMR. LPN A did not document anything in the medical record like he/she was supposed to. An SBAR should have been completed at the time of the change in

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condition. LPN A should have known what to do and there was no explanation why the documentation did not get done. He/She should have documented the resident's vital signs and assessments related to his/her change in condition. LPN A said he/she gave report to LPN B and wrote the oxygen issues down on the report sheet. LPN B should have read the report sheet, as well as the x-ray results, which were at the nurse's station with the report sheet. LPN B should have followed up by encouraging the resident to go out to the hospital and by rechecking his/her oxygen levels, especially when they were up and down so much on 2/24/25.

During an interview on 2/28/25 at 9:34 A.M., the Executive Director said he expected nursing staff to communicate changes in condition to the oncoming shift. Nursing staff should document their observations, assessments, and communication with the physician in the resident's medical record. Assessments should be completed in accordance with the facility's policies and procedures.

2. Review of Resident #9's medical record, showed diagnoses included dysphagia (swallowing disorder) following cerebral infarction (stroke), multiple sclerosis (MS, disease of the central nervous system), quadriplegia (paralysis of all four limbs), seizures, abnormal posture, generalized muscle weakness, anxiety and depression.

Review of the resident's speech therapy discharge summary, dated 8/8/24, showed:
-Mann Assessment of Swallowing Abilities (a screening tool for identifying eating and swallowing disorders in patients with stroke):

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Patient with overall score of 130, indicates severe dysphagia and severe aspiration;
-Diet recommendation: Minced and moist;
-Compensatory strategies/positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies during oral intake: General swallow techniques/precautions along with upright posture for greater than 30 minutes after meals.

Review of the resident's ePOS, showed an order, dated 2/7/25, for aspiration precautions. Sit at 90 degree angle (chin to neck angle, not head of bed), alternate liquids and solids, small single sips, small bites, no straws, 100% supervision.

Review of the resident's significant change MDS, dated 2/20/25, showed:
-Severe cognitive impairment;
-Clear speech;
-Makes self understood: Usually understood;
-Dependent for eating.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: Activities of daily living (ADL) assistance and therapy services needed to maintain or attain highest level of function. Resident has MS, he/she is dependent with all daily living needs and transfers;
-Goals included: Resident will perform eating with dependent assist;
-Interventions included: Assist with mobility and ADLs as needed. He/She requires extensive/total assistance to complete ADLs. Pillow on left side of head;
-Focus: Resident has impaired mobility secondary to MS. Total assist with all ADLs;
-Goals included: Resident is dependent with

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feeding;
-Focus: Resident has a swallowing problem related to swallowing progression of MS;
-Goals: The resident will not have injury related to aspiration through the review date. The resident will have no choking episodes when eating through the review date;
-Interventions included: Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards. Refer to Speech Therapist (ST) for swallowing evaluation.

Observation on 2/24/25 at 1:06 P.M., showed the resident sat in bed. The head of the bed elevated approximately 35 degrees and the resident slumped down with his/her head leaning toward his/her left shoulder, with no pillow on the left side of his/her head. CNA D stood next to the resident's bed providing feeding assistance. CNA D scooped a large spoonful of dessert into the resident's mouth. The resident grimaced and pushed the food out of his/her mouth.

Observation on 2/25/25 at 12:40 P.M., showed the resident in bed with the head of bed elevated approximately 35 degrees. The resident slumped down in bed with his/her head leaning toward his/her left shoulder, with no pillow on the left side of his/her head. CNA C stood next to the resident's bed, providing feeding assistance. CNA C held a cup of water to the resident's mouth and he/she used a straw to drink the water.

Observation on 2/26/25 at 12:17 P.M., showed the resident in bed with the head of bed elevated approximately 35 degrees. The resident slumped down in bed with his/her head leaning toward his/her left shoulder, with no pillow on the left side

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of his/her head. CNA N stood next to the resident's bed providing feeding assistance.

During an interview on 2/27/25 at 8:00 A.M., the resident said he/she cannot reposition him/herself. He/She can turn his/her head downward, but cannot straighten his/her neck or body.

Observation on 2/27/25 at 8:52 A.M., showed the resident in bed with the head of bed elevated approximately 35 degrees. The resident slumped down in bed with his/her head leaning toward his/her left shoulder, with no pillow on the left side of his/her head. CNA D stood next to the resident's bed providing feeding assistance. CNA D held a cup of water to the resident's mouth and he/she used a straw to drink the water. During an interview, CNA D said the resident sometimes has a wedge pillow, but his/her family member doesn't like it and removes it. The resident requires total care and feeding assistance. He/She is a choking risk and has swallowing issues. His/Her current positioning is ok and he/she coughs when he/she has swallowing issues. He/She can have straws.

During an interview on 2/27/25 at 1:34 P.M., ST Z said the resident should sit up at a 90 degree angle while eating due to aspiration precautions. He/She has poor swallowing capabilities. He/She must remain seated at a 90 degree angle for at least 30 minutes after eating. He/She cannot have straws due to aspiration precautions. Straws contribute to poor bolus control and he/she would have better swallowing control with smaller sips. After ST Z assesses a resident, he/she notifies the nurse of his/her recommendation and enters the documentation in

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the resident's EMR.

During an interview on 2/27/25 at 1:40 P.M., CNA O said the resident requires feeding assistance from staff. He/She cannot move his/her arms or legs. Staff should ensure he/she is sitting straight up while eating. There are no other special instructions to follow while providing feeding assistance. He/She can have straws. He/She does not have issues with swallowing or choking and is not an aspiration risk. Nurses tell CNAs if there are any special precautions to take when providing feeding assistance.

During an interview on 2/27/25 at 2:03 P.M., Registered Nurse (RN) R said the resident requires feeding assistance from staff. Staff should sit at bedside when providing feeding assistance. While eating, the resident must be seated completely upright, at 90 degrees, due to aspiration risk. He/She cannot have straws due to aspiration risk. Straws can cause liquids to go down too quickly. He/She should remain upright for an hour after eating to help with swallowing and digestion. He/She has limited mobility, cannot move him/herself, and leans toward the left side. Aides should ensure the resident is in the correct position when providing feeding assistance. Aides know what the correct position is by getting report from nurse.

During an interview on 2/28/25 at 7:11 A.M., the Infection Preventionist said the resident used to be an aspiration risk but is not anymore. The portion about "no straws" on his/her physician order should be removed. He/She has to sit straight at 90 degrees while eating and staff should ensure he/she is positioned that way while providing feeding assistance.

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F 684	Continued From page 45 During an interview on 2/28/25 at 8:22 A.M., the DON said the resident went out to the hospital on 1/31/25 and came back with discharge paperwork showing he/she was not an aspiration risk. His/Her physician orders should have been updated when he/she came back from the hospital to show he/she was not an aspiration risk. The resident requires feeding assistance from staff and staff should ensure the resident is seated upright at a 90 degree angle while eating. He/She should remain seated upright for about 15 to 30 minutes after eating to assist with digestion. Staff should utilize pillows to assist in positioning the resident. She expected staff to provide feeding assistance in accordance with physician order. During an interview on 2/28/25 at 9:34 A.M., the Executive Director said he expected staff to ensure residents are seated upright at a 90 degree angle when providing feeding assistance. He expected staff to provide feeding assistance in accordance with physician orders.	F 684		
	MO00248395			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		

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(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed ensure staff obtained a treatment order, and provided daily monitoring for one resident (Resident #26) with a history of dermatitis (skin inflammation, typically characterized by itchiness, redness and rash) on his/her coccyx (tailbone)/sacrum (area located above the coccyx) that was observed to have an open area on the morning of 2/24/25. It was not identified by staff and the physician was not notified until the morning of 2/25/25. In addition, the facility failed to ensure licensed nurses who signed bath sheets showing an "open area" and/or a circle around the coccyx/sacrum of an anatomical figure on the bath sheet documented an assessment of the findings on the bath sheets. The sample size was 18. The census was 86.

Review of the facility's Skin Integrity & Pressure Ulcer (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction)/Injury Prevention and Management policy, revised on 8/25/21, showed:
-Policy: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards;
-Procedure: A skin assessment/inspection should be performed weekly by a licensed nurse. Skin observations also occur throughout points of care

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provided by Certified Nursing Assistants (CNAs) during activities of daily living care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the Nurse. The Nurse will complete further inspection/assessment and provide treatment if needed;
-When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident.

Review of the facility's Treatment Orders policy, reviewed 5/24/24 and revised on 7/9/24, showed:
-Policy: Treatment orders are written per Physician orders. If a resident has multiple wound sites, a complete and separate treatment order must be written for each site;
-Based on the comprehensive assessment of a resident, the facility must ensure that: A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing;
-Procedure: After observation/evaluation of the affected skin area, the physician is notified;
-The physician writes a treatment order that includes at least the following: Site of wound, name of cleanser, name of ointment, type of dressing, and number of times to perform the treatment/duration of treatment.

Review of Resident #26's wound company note, dated 11/21/24 (the last time the resident was seen by the wound care company), showed:
-Chief Complaint: Patient has a rash;

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-Buttock: Irritated dermatitis;
-Treatment: Zinc oxide based barrier cream as directed;
-Reason: Decreased skin irritation;
-Incontinence Brief Dermatitis Improved;
-Will sign off, please re-consult as needed. Continue present skin care and breakdown prevention.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed:
-Speech Clarity: No speech, absence of spoken words;
-Makes Self Understood: Rarely/never understood;
-Ability to Understand Others: Sometimes understands, responds adequately to simple, direct communication only;
-Functional Limitation in Range of Motion: Impairment on both sides of upper and lower extremities;
-Dependent, Helper does all of the effort. Resident does none of the effort to complete activity: Toileting hygiene, shower/bathing, upper/lower body dressing, and personal hygiene;
-Dependent: Roll left and right;
-Not attempted due to medical condition or safety concerns: Lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer;
-Diagnoses: Multidrug Resistant Organism (MDRO,), pneumonia (an inflammatory condition of the lungs. Symptoms may include productive or dry cough, chest pain, fever, and difficulty breathing.), stroke, seizure disorder, malnutrition, and respiratory failure;
-Risk of Pressure Ulcers: Yes;
-Unhealed Pressure Ulcers: No;

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F 686	Continued From page 49 -Special Treatments and Programs: Oxygen therapy, suctioning (removes mucus and secretions), and tracheostomy (a surgically created hole in the windpipe) care. Review of the resident's treatment administration record (TAR), dated 1/1/25 through 1/31/25, showed no treatment to the resident's buttock/coccyx or sacrum. Review of the resident's care plan, showed: -1/16/25: Family is resistive to care and implementation from professional maintenance care and assisting with maintaining baseline well-being. Family removes treatments in place to skin integrity concerns, performs tracheostomy care; -Goal: The resident will cooperate with care; -Interventions: Educate resident/family/caregivers of the possible outcomes of not complying with treatment or care; -1/16/25: Focus: Impaired cognitive ability/impaired thought process related to TBI (traumatic brain injury); -Goal: Resident's needs will be met; -Interventions: Allow resident extra time to respond to questions and instructions. Ask yes/no questions; -1/16/25: Focus: Rash, contact dermatitis to buttock and is followed by wound care company; -Goals: Will have no complications from rash. The resident will have no signs or symptoms of infection. The rash will heal by next review date; -Interventions: Avoid scratching and keep hands and body parts from excessive moisture. Observe skin rashes for increased spread of infection. Seek medical attention if skin becomes bloody or infected.	F 686		

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Review of the resident's weekly skin integrity data collection notes (completed by the licensed nurse) dated 2/24/25 and 2/21/25, showed
-Skin Condition: Open areas/wounds - blank;
-Rash - blank;
-Describe skin color - normal;
-Describe temperature - warm;
-Describe moisture - normal;
-Describe turgor (refers to how quickly skin returns to normal position after being pinched) - good;
-No documentation about a rash or contact dermatitis to the buttocks.

Review of the resident's Shower Sheet/Skin Condition Report (anatomical figure on the form completed by the Certified Nurses Aide (CNA) and given to a licensed nurse for review after a shower/bath), forms showed:
-2/1/25, evening shift, completed by CNA J: "Open area" checked, and the sacrum/coccyx area circled. A nurse co-signed the form;
-2/5/25, day shift, completed by CNA J: "Open area" checked, and the sacrum/coccyx area circled, and a licensed nurse had co-signed the form;
-2/8/25: No CNA documentation or signature. A licensed nurse checked "other" and documented incontinence brief dermatitis. The licensed nurse circled the area on the resident's sacrum/coccyx, and documented the shower had been given by the family on day shift;
-2/15/25: A licensed nurse checked "other" and documented incontinence brief dermatitis. The licensed nurse circled the area on the resident's sacrum/coccyx, and documented the shower had been given by the family on day shift;
-2/19/25, evening shift, CNA I documented the

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resident's family did the shower every morning on day shift. The CNA circled the area on the sacrum/coccyx. LPN Unit Coordinator (UC) co-signed the shower sheet;
-2/22/25, evening shift. A CNA circled the area on the sacrum/coccyx, and an LPN wrote incontinence brief dermatitis and co-signed the shower sheet.

Observation on 2/24/25 at 8:56 A.M., showed the resident lay in bed on a low air loss mattress. A family member was at the bedside bathing the resident. The resident had a tracheostomy tube (a medical device inserted into the trachea to facilitate breathing) with humidified oxygen infusing and a gastrostomy tube (a tube surgically inserted through the abdomen into the stomach to provide hydration, nutrition and medications) with the tube feeding off while the family member bathed the resident. The family member said he/she came in every morning to check on the resident and bathed the resident every day. Another family member came in every evening. The family member said the resident had a red area on his/her coccyx that had been there for months. After he/she bathed the resident he/she applied Desitin (incontinence brief rash medication) that he/she brought in to the area. He/She had seen the CNAs applying Desitin as well as A&D ointment (used to keep moisture off the skin), but not the licensed nurses. He/She removed a few packets of the A&D ointment from the resident's night stand drawer to show the surveyor. He/She turned the resident onto his/her left side, which revealed an inflamed red area on the coccyx/sacrum area that had a white cream applied over it. In the center of the red area was an open area with a small amount of blood drainage.

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Review of the resident's physician's order sheet (POS), showed no order for Desitin, A&D ointment, or zinc oxide to the resident's buttocks/sacrum/coccyx.

Review of the resident's TAR, dated 2/1/25 through 2/28/25, showed no order for Desitin for the dermatitis, and no order for the open area.

Observation on 2/25/25 at 7:35 A.M., showed the resident lay in bed. LPN UC and CNA J entered the room to complete a skin assessment. CNA J said he/she had been at the facility for approximately 9 months and the area on the resident's sacrum/coccyx had looked that way on and off the entire time. LPN UC described the sacrum/coccyx area as being red with red drainage and open. He/She worked yesterday on the day shift and no one told him/her about the area being open. He/She was not sure if there was a current treatment or not.

Review of the resident's skin wound note in the progress notes, showed:
-The LPN UC documented on 2/25/25 at 8:05 A.M., Writer in room to assist with skin assessment. Upon assessment noted that resident has open area to coccyx/sacral wound. Writer completed assessment, informed treatment nurse and called physician to obtain orders. Went back to room to measure area to coccyx/sacral 2.1 centimeters (cm) (length) by 0.5 cm (width) by 0.8 cm (depth). Obtained order to cleanse with normal saline (sodium/water solution), pat dry, apply skin prep (a thin sticky film) to periwound (the area surrounding the open area) apply calcium alginate (an absorbent dressing) and cover with border gauze. Family,

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Director of Nursing (DON) and treatment nurse informed of new order;
-LPN UC documented on 2/25/25 at 9:00 A.M., Follow-up on assessment. Small amounts of blood noted with exudate (drainage) to disposable pad. Noted resident had previous incontinence brief dermatitis. Resident will be followed by the wound care company team for wound treatments.

Review of the resident's weekly skin integrity data collection note, dated 2/25/25 at 8:16 A.M., showed:
-Skin Condition: Open areas/wounds - blank;
-Rash - blank;
-Describe skin color - normal;
-Describe temperature - very warm;
-Describe moisture - moist;
-Describe turgor - fair;
-Describe findings - No new finding, old wound to coccyx. Physician notified.

During an interview on 2/25/25 at 8:20 A.M., the facility Wound Nurse said the resident used to be seen by the wound care company at one time, but it'd been awhile. They had diagnosed the area on the resident's bottom as contact dermatitis. The facility wanted the resident to continue to be seen by the wound care company because the resident's bottom would break open and bleed. The resident was supposed to have an order for zinc oxide ointment (a mineral used to treat incontinence brief rash) on the area every shift, and the CNAs should apply between the nurse's applications. She reviewed the February TAR and confirmed there was no treatment order for the zinc oxide and/or Desitin to be applied every shift. Since the open area was noted on 2/24/25, staff would have provided care (incontinent care and turning and repositioning) to the resident

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throughout the day and should have noticed the open area and reported it to the charge nurse. If a treatment was not on the TAR, the computer system would not prompt the nurse to apply the treatment.

During an interview on 2/25/25 at 8:25 A.M., the Assistant Director of Nursing said the resident's family did not want the resident to use the zinc oxide. They wanted Desitin to be used. No one contacted the physician to get an order for the Desitin as far as she was aware.

During an interview on 2/25/25 at 10:33 A.M., CNA I said he/she had worked at the facility for about one year and the resident's bottom has been red and excoriated since he/she had worked there. The family had asked the CNAs to put Desitin cream on the resident's coccyx. If the coccyx was left wet too long it would breakdown and bleed. If it was kept dry and the Desitin was used, it wouldn't bleed. He/She told the nurses about the resident's coccyx in the past.

During an interview on 2/25/25 at 11:19 A.M., the facility Wound Nurse said the area on the resident's coccyx was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous).

During an interview on 2/25/25 at 1:02 P.M., the DON said there should have been on-going assessments of the resident's coccyx by the licensed nurses. There should have been a treatment, either the zinc oxide or Desitin on the TAR for staff to follow. Licensed nurses, not

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F 686	Continued From page 55 CNAs, should apply the treatment when there was skin broken down. She would have expected the licensed nurse who signed the resident's bath sheets to have assessed the resident's coccyx and documented any changes in the progress notes. If the area on the coccyx changed, she expected the physician to be notified. She confirmed the open area on the resident's coccyx was a stage 2 pressure ulcer. During an interview on 2/28/25 at 9:34 A.M., the Administrator said he expected staff to follow facility policies.	F 686		
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 review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being by addressing the residents' behaviors related to his/her anxiety for one resident (Resident #68). The sample was 18. The census was 86.	F 740		

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Review of the facility's Behavioral Health Services Policy, reviewed 9/6/24, showed:
-Policy: The facility will provide behavior heal care and services that create an environment that promotes emotional and psychosocial will-being, meets each resident's needs, and includes individualized approaches to care;
-Procedure: Complete the nursing assessment and social services assessment upon admission/readmission. Quarterly, and as needed with change in condition;
-Through this assessment the facility should identify residents who:
-Develop decreased social interaction and/or increase withdrawn, angry or depressive behaviors, and may have verbalizations indicating these;
-Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable;
-Ensure an accurate diagnosis of mental disorder or psychosocial adjustment difficulty, or Post Traumatic Stress Disorder (PTSD) was made by a qualified professional;
- Identify if the resident would benefit based on above assessments in conjunction with: mental health history and current medication regimen , and additional mental health consultation (psychiatry, psychology, and clinical social work). If determined need is present, the facility should consult with attending physician to make a referral to mental health professional for assessment and potential for ongoing follow up;
-Initiate behavioral monitoring, behavior management care plan, as indicated by assessment findings, use of psychoactive medications, resident and or responsible party conversations, and observations. The Social

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Worker is primarily responsible for initiation of the behavioral management care plan.
-The facility must provide necessary behavioral health care and services within include:
-Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy (self-directing), privacy, socialization, independence, choice and safety;
-Ensuring direct care staff interact and communicate in a manner that promotes meant and psychosocial well-being;
-Providing an environment and atmosphere that is conductive to mental and psychosocial well- being;
-Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community; Meaningful activities are those that address the resident's customary routine, interests, preferences, and enhance the resident's well-being;
-Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated;
-Communicate the behavioral management care plan to the resident and/or to the responsible party and to relevant member of the interdisciplinary team;
-Provide resident/responsible party and staff education as needed;
-Review and revise the behavioral management care plan as indicated.

Review of Resident #68's face sheet, undated, showed diagnoses included: Anxiety, cognitive

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communication deficit, and spinal stenosis (narrowing) of the lumbar region (lower back), chronic obstructive pulmonary disease (COPD, restricts airways in the lungs making it difficult to breath).

Review of the resident's Spiritual Assessment, dated 10/30/23, showed:
-Information source: Resident;
-Beliefs: God;
-Choice of spiritual participation: Visitor support/ Counselor;
-What brings you spiritual peace: Speaking with God;
-How can the facility meet your spiritual needs: Nothing at this time;
-How are you responding to stress of this illness and/ treatment: The best I can.

Review of the resident's Social Service Assessment, dated 10/31/24, showed:
-The resident has a current psychiatric related diagnosis;
-The resident has a diagnosis of anxiety;
-The resident is currently taking Duloxetine 30 mg (medication used to treat depression and anxiety);
-Describe the resident's current status, including psychiatric related diagnosis and especially address the "problem" areas or interventions that Social Services is currently reviewing: None.
-No additional Social Service Assessment available for review.

Review of the resident's physician order sheets, showed an order, dated 12/27/24, to check for comfort, safety, pain, and incontinence every hour.

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Review of the resident's Nurse Practitioner (NP) psychiatry progress notes, dated 12/30/24, showed:
-Narrative: The resident reported that he/she is doing good. The resident denied feeling sad or anxious. The resident does not feel any issues with her mood or behaviors. The resident commented that he/she only uses the call light when he/she needs to be changed. The resident adamantly refuses any medication changes. Per the nursing report, the resident is compliant with the medication regimen. The resident is noted to use his/her call light very often with minor requests;
-Assessment: The resident is currently stable and does not pose a risk to self or others. The resident's past history for emotional difficulties, and personal and social stressors that contribute to the current presentation. The resident is willing to participate in treatment;
-Plan: Discussed with staff the ongoing treatment plan. Staff educated regarding the medication regimen and instructed to notify the provider if any adverse reactions emerge. Staff are instructed to report any suicidal or homicidal ideations, or any significant changes in mental status or level of functioning. Assure the resident with safety, nutrition, and hydration.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated, 1/26/25, showed:
-Cognitively intact;
-No behaviors or rejection of care.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: The resident is resistant to care. The

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resident will make false assumptions towards staff and has a manipulative perception of healthcare concerns and needs being met. The resident presents with obsessive compulsive disorder (OCD), increased anxiety, and claustrophobic like behaviors;
-Interventions: Give a clear explanation of all care activities prior to and as they occur for each contact. If the resident resists activities of daily living (ADLs), reassure the resident, leave and return 5-10 minutes later and try again. Provide the resident with opportunities for choice during care provision;
-Focus: The resident at times expresses unrealistic ideas or presumptions related to things that may be heard outside of resident's room. The resident make threats towards staff about harming self, and has threatened staff to throw himself/herself on the floor. The resident constantly presses the call light every 10 minutes and calls the from desk at least 10 times per day;
-Interventions: Administer medications as ordered. Anticipate and meet the resident's needs. Provide care with two aides. When answering the call light step away and obtain another staff member if needed for extended conversation and provide care to the resident's request. Explain all procedures to the resident before starting and allow the resident to adjust to changes. If reasonable, discuss the resident's behavior. Explain or reinforce why behavior is inappropriate and or unacceptable. Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Praise any indication of the resident's progress or improvement in behavior;
-Focus: The resident declines to participate in independent tasks offered to improve daily living;
-Interventions: The resident prefers to stay in bed

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and only wear soft socks foot wear. The resident likes towels in the room at random places and changes the location of where towels are placed. Towels under both sides of pillow, on the bedside table, and the side of the bed. Location changes of the towels vary from day to day and the resident will request at least four to six towels placed in random spots.

Review of the resident's diagnoses listed in the electronic medical record (EMR), dated 2/26/25, showed the resident did not have a diagnosis of claustrophobia or OCD listed.

Review of the resident's progress notes, showed:
-On 2/7/25 at 10:45 P.M., this nurse was summoned to the resident's room by the resident's roommate, this nurse was made aware by the resident's roommate that the resident called the Department of Health and Senior Services (DHSS) with concerns. This nurse spoke with the resident of concerns he/she could help with, and the resident voiced that he/she had no concerns or questions;
-No follow up note related to the resident's behavior was documented;
-On 2/17/25 at 11:14 A.M., the resident is making demands while staff are in the room to get the resident up for a shower. The resident is upset and said that the staff was taking all his/her things. This nurse was in room with the aide and observed the aide cleaning the resident's room and removing old linens and towels, this was explained to the resident and the resident remained upset;
-On 2/17/25, at 11:24 A.M. , the resident was being placed back in bed from having a shower, the resident began to curse, said the staff doesn't do anything for him/her and threatened to call the

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DHSS because the aide did not leave the call light in reach. The aide informed the resident that he/she was coming right back and that he/she was just obtaining some linens;

-No follow up note related to the resident's behaviors was documented.

-On 2/19/25 at 1:42 P.M., the resident is frequently on his/her call light despite making frequent rounds and checks;

-On 2/19/25 at 11:05 P.M., the resident's physician documented, the resident is quite demanding and wants some sort of inappropriate treatment. At times the resident asks for antibiotics and cough syrup. Rounds were made with the Infection Preventionist (IP) and the IP did not have any concerns but said the resident is very needy and wants medications that are not appropriate;

-Plan: Did not address the resident's behaviors or anxiety.

-On 2/22/25, at 12:13 P.M., the aide was giving care to the resident's roommate and the resident demanded that the aide stop giving care to the resident's roommate and retrieve the resident's lunch or the resident was going to report the aide;

-No follow up note related to the resident's behavior was documented.

Observation and interview on 2/24/25 at 9:40 A.M., 2/25/25 at 12:55 P.M., and 2/28/25 at 8:35 A.M., showed the resident lay in bed listening to Christian music. The resident said he/she doesn't want to take showers anymore because when he/she is taken to the shower room by staff, another staff member goes into his/her room and removes linens and clothing without his/her permission. This makes him/her very upset and increases his/her anxiety. The resident said this has happened at least five times within the last

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six months. The resident said that the "unknown" about his/her day increases his/her anxiety. He/She is rarely informed on a daily basis who the nurse or who the aides are for the day. He/She requires nebulizer treatments (a medication to assist with breathing) as needed and must wait prolonged periods of time for the treatment. That creates anxiety and increased shortness of breath (SOB). He/She will turn on his/her call light to be cleaned because no one comes in for hours. Sometimes when he/she turns the call light on, staff turn it off without even asking what he/she needs. If he/she doesn't get a response to the call light, the resident will call the front desk. The resident said he/she is incontinent of bowel and bladder and does not like to lay in a soiled brief for extended periods because he/he is prone to urinary tract infection (UTI) and bed sores (wounds that occur laying in one position for extended periods). The resident is grateful that his/her snacks and drinks are provided but feels as though his/her care concerns are landing on deaf ears and the staff get "tired" of answering his/her light or the front desk phone. He/She lacks a sense of trust with the staff and facility administration because they make it feel like everything that he/she has issues with are not important, lack any type of evidence, or he/she makes things up. The resident does not know how to file a grievance and has never spoken to the Ombudsman. The resident said he/she does not want his/her medication changed related to his/ her anxiety but is open to speak with a counselor. The resident said his/her Christian values are important to him/her. He/She prays a lot to calm his/her "nerves". He/She has never been offered any type of chaplain services since he/she has been at the facility. There are certain staff members that he/she works better with, but

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it seems like those staff members are not assigned to him/her consistently.

Review of the facility's grievance log for November and December 2024 and dated January 2025, showed no grievances filed by the resident.

Observation on 2/26/25 at 9:29 A.M., showed Certified Nursing Assistant (CNA) N entered the resident's room without knocking, walked past the resident's bed and assisted the resident's roommate. At 9:37 A.M., CNA N exited the room and did not acknowledge the resident while leaving the room. The resident used his/her grabber to maneuver things in the room.

Observation and interview on 2/27/25 at 11:05 A.M., showed CNA D propelled the resident on the shower stretcher into the spa room. The resident said he/she hoped no one took his/her stuff in his/her room while he/she is in the shower. CNA D completed the resident's shower and propelled the resident back to his/her room using the shower stretcher. Once the resident returned to his/her room, he/she immediately looked around the room and noticed that some of his/her clothing on his/her bedside table was missing along with two towels and a bed blanket. The resident was upset and asked CNA D two times, "Where is my clothing"? CNA D said he/she didn't see any clothing on the resident's nightstand. The resident said it must have been another staff member that did it. CNA S entered the room and informed the resident that he/she took the resident's towels and bath blanket off the nightstand because it was soiled. CNA S said he/she did not see the resident's clothing. The resident described to CNA S what the clothing

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looked like. CNA S again said he/she did not take the resident's clothing, only took the soiled linen that was resting on the resident's nightstand. CNA S said to the resident, "I will try my best to find your clothing". The resident asked CNA S to look in the soiled linen room for his/her clothing because his/her clothing did not have his/her name on it. CNA S said again, "I will try my best" to locate the resident's clothing. The resident said he/she was feeling very anxious.

During an interview on 2/27/25 at 2:10 P.M. CNA S said he/she had taken the resident's clothing and bed linens off his/her nightstand without the resident's permission. The linens on top of the clothing were soiled. CNA S said the resident would not allow staff to remove things out of his/her room. The resident became upset when staff tried to do so. CNA S said the resident was a "hoarder". He/She would discreetly remove clothing that need to be laundered when the resident was not in his/her room. When working with the resident, two aides were to be in the room to provide care. He/She wasn't sure why but just thought the "more the merrier". The resident turned his/her call light on a lot for minor things and was more demanding when DHSS was in the building. CNA S said staff were not to argue with the resident. He/She felt as though staff tried their best to meet the resident's needs with a positive spirit and attitude and not create any emotional distress for the resident.

During an interview on 2/27/25 at 12:45 P.M. and 2:25 P.M., Licensed Practical Nurse (LPN) T said he/she thought the resident didn't like the staff and believes the resident's family doesn't like the staff. The resident is on his/her call light frequently and calls the front desk frequently. The

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resident is always upset about something, and LPN T will try to redirect the resident with being extremely nice to him/her. Staff should not remove items from the resident's room without his/her permission. The resident requires a lot of time sometimes when you answer his/her call light. LPN T said he/she just goes along with the resident's requests and just "deals with it" because that is the resident's personality. Staff should not argue with the resident when the resident demands things because that increases the resident's anxiety. LPN T was not aware of any type of special behavioral management that is required for the resident. Everyone in the building that works with the resident is aware of the resident's anxiety and behaviors. All behaviors are documented in the progress notes.

During an interview on 2/26/25 at 9:35 A.M., the Psychiatry NP AA said he/she has been recommending a counseling service to come in and meet with residents in the facility for at least six months. He/She has been asking the Social Service Director (SSD) to get the counseling services arranged. NP AA said his/her time with the resident is limited but a counselor could spend an extended amount of time with the resident. The resident has anxiety issues related to his/her care and current living situation and would benefit from counseling services. The resident also may have cognitive issues related to time and may not realize how often he/she places the light on. The resident refuses any new medication changes. NP AA encourages staff to be proactive and make sure the resident has everything he/she needs before leaving the resident's room. NP AA said the resident does not refuse his/her visits.

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During an interview on 2/26/25 at 11:15 A.M., Receptionist Y said that the resident calls the front desk at least three to 30 times a day. The resident is always anxious sounding and upset when he/she calls and says no one is answering his/her light. The resident requires a lot of reassurance. The resident will frequently call and say that he/she needs to be changed. The resident will also request a shower, nebulizer treatments and other medications. The resident mainly requests names of staff who will be taking care of him/her for the day and what staff members are going to be giving him/her medications. Receptionist Y will call the nurses' desk when the resident calls and let them know what the resident's request are. Receptionist Y said the frequent calls to the front desk from the resident have been occurring for at least a year.

During an interview on 2/25/25 at 11:30 A.M. and on 2/27/25 at 12:35 P.M. the SSD said he was aware the resident called the front desk a lot with care issues. The resident doesn't get visitors very often and does not come out of his/her room. The resident's family member has recently stopped coming into visit the resident. The SSD was not sure why. The resident is always requesting someone go out and buy him/her snacks, bottled water and soda. The resident had issues with a staff member in the past but was not aware of any issues lately. The resident requires more attention and "special focus" because he/she calls DHSS so much with complaints. The SSD will go in and make rounds and speak with the resident daily and tries to solve any issues the resident may have, but doesn't file a grievance every time. Staff and/or the SSD will purchase the resident snacks. The facility goes above and beyond making the

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resident happy with frequent room visits, purchasing Nutty Butters (a type of peanut butter snack) and drinks with their own money. The SSD was not aware of any spiritual needs for the resident. The Activity department is responsible to complete the Spiritual Assessment. The SSD said he would reach out and see if the resident would like a preacher to visit and pray with him/her. The SSD was aware that the Psychiatry NP has been requesting a counseling service for the resident for at least 6 months. He has informed the Administrator of the counseling service request, but the Administrator said it is tied up with corporate red tape. The SSD also said the Ombudsman has been in to visit the resident. No documentation or e-mails were provided by the SSD related to the Ombudsman visiting the resident when requested.

During an interview on 2/25/25 at 2:45 P.M., the Activity Director (AD) said she has been providing daily one on one activities with the resident because the resident does not like to leave her room. The AD and the resident tend to talk about the different holidays coming up. The resident will frequently go off topic and just ask the AD to straighten the resident's bedside table. The AD confirmed a spiritual assessment had not been completed since 10/30/23. The assessments were to be completed yearly. The Activity Department had recently obtained a new assistant within the last two weeks and will begin to read the Bible with the resident.

During an interview on 2/28/25 at 9:34 A.M., with the Administrator and the Director of Nursing (DON), the DON said the resident can be pleasant, sweet, kind, demanding, cooperative and aggressive; it varies day to day. The DON

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said she is in the resident's room "1,000 times a day". They were aware the resident calls the front desk with multiple issues and frequently calls DHSS with his/her issues, and all the department heads are involved with the resident's care and needs. The resident will not start his/her day without knowing who the resident's aide is. The facility is being proactive by meeting with the resident everyday and providing snacks when he/she requests. He/She refuses any psychiatric care and does not want to change any medications. The Administrator said the resident develops anxiety when his/her call light is not answered and then he/ she calls the front desk. The Administrator has personally gone down to the resident's room after the resident calls the front desk with his/her requests. A grievance is not completed each time because the residents' concerns are usually dealt with at the time. If a grievance was made each time the resident had an issue, it would be a huge book. The Administrator has adjusted the air conditioner temperature and has fixed a privacy curtain issue. The Administrator and the DON feel as though they go above and beyond by visiting the resident daily and providing snacks out of their own pockets. The resident's behaviors and follow up visits are documented in the resident's EMR. The Administrator was aware of the Psychiatry NP's request for counseling services for the resident. He has been working on the credentialing and vetting process for obtaining the counseling services since last fall. It takes a while because it is a process with steps to follow. All outside companies have to be vetted due to concerns of Medicare and Medicaid fraud and to ensure the recommended provider does not have a relationship with the outside counseling service. The DON said she would expect all assessments

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F 740	Continued From page 70 to be completed to address the resident's needs and that includes a spiritual assessment. They would expect the staff to answer the resident's call light timely and address the resident's needs in a professional manner. The staff are always professional when speaking with the resident and will continue to do so. The DON feels as though they have tried to work with the resident regarding the resident's concerns but think that is just his/her personality. During a telephone interview with State Employee X and the resident on 3/3/25 at 11:31 A.M., the resident asked CNA D if the resident was assigned to CNA D. The resident informed CNA D that he/she had a bowel movement (BM) and needed to be cleaned up. CNA D did not answer the resident but was heard speaking in the background to someone else. The resident told State Employee X, "this is what CNA D does to me, he/she assists the roommate and ignores me". The resident was heard informing CNA D that his/her light was on for a long time and that he/she has been sitting in BM and needed CNA D's help. With a raised voice, CNA D could be heard telling the resident, "Your light wasn't on". The resident replied, to CNA D, "Yes, it was". CNA D replied with a raised voice, "No it was not" and said that he/she was waiting on towels. The resident told CNA D that he/she called the front desk at least 10 times and the front desk would hang up on him/her. With a raised voice, CNA D said, "I don't care. You can call the front desk as many times you want. I don't care". The resident told State Employee X he/she wanted to be treated like everyone else.	F 740		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 71 §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, facility staff failed to discard expired medications from the medication carts, failed to ensure all medication bottles had a date of expiration, failed to ensure eye drops/ointments were dated when opened, and failed to ensure insulin pens were stored in the refrigerator and not in the medication cart. The facility identified four medication carts, two were sampled, and problems were identified in both. The census was 86.	F 761		

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Review of the facility Medication Storage and Administration Quick Reference Guide, dated 8/2022, showed:
-Insulin Vials and Pens: Store unopened insulin in the refrigerator;
-Ophthalmic Solutions Storage Parameters: Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow the manufacturer instructions, or facility policy.

1. Observation of the South 2 medication cart on 2/24/25 at 4:38 P.M., showed:
-South 1 medication cart:
-One opened stock bottle (used for multiple residents) of Rena Vite tablets (multivitamin) expired on 12/23/24. Licensed Practical Nurse (LPN) A confirmed the expiration date, removed the bottle from the medication cart and said it should be discarded;
-One opened tube of bacitracin/polyophthalmic eye ointment (an antibiotic ointment), delivered by the pharmacy on 11/23/24. The ointment tube had no date documented of when it was opened. LPN A said the eye ointment should be discarded 30 days after opening. Without knowing the opening date, staff would not know when to discard the ointment;
-One opened tube of bacitracin/polyophthalmic eye ointment, delivered by the pharmacy on 1/6/25. The tube had no date documented of when it was opened. LPN A said the eye ointment should be discarded 30 days after opening. Without knowing the opening date, staff would not know when to discard the ointment;
-One opened stock bottle of liquid docusate sodium (laxative), approximately three fourths empty, with no expiration date on the bottle. The

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LPN Unit Coordinator said there was no expiration date and removed the bottle from the medication cart;
-One opened stock bottle of stock folic acid (vitamin B) with an expiration date of 1/2024. The LPN Unit Manager said the folic acid was expired;
-One opened bottle of Coenzyme Q10 (a vitamin-like substance made naturally in the body) with an expiration date of 2024 (day and month illegible). The expiration date was confirmed by LPN Unit Coordinator, and removed from the medication cart;
-One glargine insulin (long acting insulin) pen, unopened, and delivered from the pharmacy on 2/21/25. The LPN Unit Coordinator said the insulin pen should be stored in the refrigerator until opened.

2. Observation of the South 2 medication cart on 2/24/25 at 4:38 P.M., showed:
-South 2 medication cart:
-One opened bottle of of prednisolone AC 1% ophthalmic eye drops (used to treat eye inflammation) delivered from the pharmacy on 1/10/25. The eye drop bottle did not have the date it was opened on it;
-One unopened aspart insulin (fast acting insulin) pen, delivered by the pharmacy on 2/17/25. The LPN Unit Coordinator said the insulin pen should be stored in the refrigerator until opened;
-One opened stock bottle of boric acid vaginal suppositories (used to treat yeast infections). The suppositories had no expiration date listed on the container. The LPN Unit Coordinator said there was no expiration date on the container;
-The LPN Coordinator said eye drops and ointments should be discarded after 30 or 31 days after opening. Any medication that is expired or without an expiration date should be removed

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F 761	Continued From page 74 from the medication cart. During an interview on 2/28/25 at 9:34 A.M., the Administrator said he expected staff to adhere to policies regarding eye drops and ointments so they can be discarded at the appropriate time. He expected staff to follow the facility policies on medication storage. The Director of Nurses said she expected insulin pens to be stored in the refrigerator until ready to use. Expired medications should be not be on the medication cart.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.	F 801		

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(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the

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position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to designate a person to serve as the director of food and nutrition services with the appropriate certification, when a consultant Registered Dietician (RD) was not employed full-time with the facility. The census was 86.

Review of the facility's certified dietary manager job description, undated, showed:
-License and certification: Must have completed an approved Certified Dietary Manager course. Must maintain an active certification.

During an interview on 2/28/25 at 9:53 A.M., the Dietary Director said she has her required qualifications but did not have a physical copy of the documentation.

During an interview on 2/28/25 at 10:02 A.M., the Executive Director said he would expect the Dietary Director to have the required certifications. The Dietary Director did have the

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F 801	Continued From page 77 required certifications, but they have expired.	F 801		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff performed appropriate hand hygiene during meal service and failed to serve food in accordance with professional food safety standards, which affected three residents (Resident #22, #24, and #27). The sample was 18. The Census was 86. Review of the facility's hand hygiene policy, dated 6/13/23, showed: -Policy: The facility has adopted the Centers for Disease Control and Prevention (CDC) core infection prevention and control practices for safe	F 812		

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healthcare delivery in all settings for indications for hand hygiene;
-Procedure: Hand hygiene should be performed before and after contact with resident, after contact with objects or surfaces in the resident's environment.

1. Review of Resident #22's medical record showed:
-Diagnoses included dementia, diabetes, and Parkinson's disease (brain disorder causing unintended or uncontrolled movements);
-Severe cognitive impairment.

2. Review of Resident #24's medical record showed:
-Diagnoses included muscle weakness and dementia;
-Severe cognitive impairment.

3. Review of Resident #27's medical record showed:
-Diagnoses included depression and muscle weakness;
-Moderately impaired cognition.

4. Observation on 2/24/25, of lunch in the main dining room, showed:
-At 12:24 P.M., Restorative Aide (RA) BB grabbed onto Resident #27's wheelchair handle as he/she sat down next to the resident at the table;
-At 12:25 P.M., RA BB picked up Resident #27's spoon and started to feed the resident;
-At 12:28 P.M., RA BB picked up Resident #24's straw, opened it, and placed it in the resident's drink. RA BB then picked up the resident's drink and gave Resident #24 a drink.

5. Observation on 2/26/25, of lunch in the main

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dining room, showed:
-At 11:52 A.M., Certified Nurses Aide (CNA) M sat at a table next to Resident #22. CNA M had his/her phone in his/her hand, texting;
-At 11:55 A.M., CNA M was still seated at the table texting on his/her phone. Using his/her right hand, he/she wiped his/her forehead;
-At 11:59 A.M., CNA M stood up and positioned Resident #24's feet onto his/her wheelchair foot rest and then propelled Resident #24 out of the dining room;
-At 12:00 P.M., CNA M returned to the dining room without sanitizing his/her hands. CNA M walked up to the kitchen doorway, resting his/her hands on the doorframe. He/She was handed a drink for Resident #22 and went to sit back at the table;
-At 12:02 CNA M touched his/her chair handles as he/she sat back down. He/She repositioned Resident #27 up closer to the table by pulling the wheelchair's arm rest;
-At 12:03 P.M., CNA M used his right hand to wipe his/her head;
-At 12:12 P.M., CNA M picked up Resident #27's spoon with his/her right hand and swiped his/her ungloved left hand across the bowl of the spoon, dipped the spoon in the resident's food, and gave the resident a bite;
-At 12:13 P.M., CNA M picked up Resident #22's cup and handed it to the resident;
-At 12 :14 P.M., CNA M held onto Resident #22's wheelchair handles as he/she stood up from his/her chair and went to the kitchen to get a drink for the resident;
-At 12:15 P.M., CNA M sat back down at the table, took his/her phone out of his/her pocket and started texting;
-At 12:20 P.M., CNA M took the cup out of Resident #22's hand, and propelled the resident

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out of the dining room in his/her wheelchair;
-CNA M did not sanitize hands when leaving the dining room or entering back into the dining room;
-At 12: 21 P.M., CNA M sat back down at the table next to Resident #27. He/She picked up the resident's straw, opened it, and placed it into the resident's drink. He/She rubbed his/her ear with his/her hand. He/She then picked up the resident's silverware and started to cut up the resident's food;
-At 12:23 P.M., CNA M scooped up food onto Resident #27's spoon, brought the spoon close to his/her mouth and blew on the food, and then fed the resident;
- At 12:24 P.M., CNA M scooped up food onto Resident #27's spoon, brought the spoon close to his/her mouth and blew on the food, and then fed the resident;
-At 12:26 P.M., CNA M picked a piece of fried chicken up from Resident #27's plate with his/her ungloved hand and placed it onto the resident's spoon and then fed the chicken to the resident.

6. During an interview on 2/27/25 at 1:55 P.M., CNA L said hand hygiene is to be performed before entering the dining room, after touching residents or objects, and in between assisting residents. It is not appropriate to blow on residents' food to cool it down. Food should be set to the side if it is too warm. It was not appropriate to pick food up with your hands and place it on the fork; that would be a germ issue.

7. During an interview on 2/27/25 at 1:24 P.M., the Dietary Director said all staff should wash or sanitize their hands before entering the dining room, after touching a resident, after touching themselves, or after touching surfaces. She said it is not appropriate for staff to blow on resident

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F 812	Continued From page 81 food when feeding them. Food should be set aside if it is too warm. It is not appropriate for staff to pick up food with their hands when feeding a resident. She said it is not appropriate for staff to clean silverware with their hands and then use the silverware to feed a resident. 8. During an interview on 2/27/25 at 1:58 P.M., the Executive Director said he would expect hand hygiene to be performed by staff when going between touching residents and objects. He would expect staff not to blow on residents' food. He would expect staff to use utensils to pick up residents' food. He would expect staff to clean silverware with a napkin or to get new silverware for residents. He would expect staff to sanitize their hands after wiping their head with their hand.	F 812		
F 880 SS=D	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, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 corrective actions taken by the facility.

§483.80(e) Linens.

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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 follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS), for three residents (Residents #26, #29 and #45) with wounds requiring treatments, gastrostomy tubes (g-tube, a tube that is surgically inserted into the abdomen and is used for liquid nutrition and medications), or tracheostomies (a surgically inserted tube inserted into the windpipe to assist with breathing). The sample was 16. The census was 86.

Review of the facility's EBP policy, revised 3/21/24, showed:
-Policy: The facility should use EBP as an additional MDRO mitigation strategy for residents that meet the following criteria, during high-contact resident care activities:
-Infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply;

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-Wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO;
-Wounds generally include chronic wounds, such as pressure ulcers (a wound cause by prolong pressure), diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers (wounds that are caused by damaged veins);
-Indwelling medical device examples include central line (access that is surgically inserted into a large vein that is used for fluids and medications) urinary catheters (a tube that drains the bladder), feeding tubes, and tracheostomies;
-Procedure: The facility should develop a process to communicate with residents who require the use of EBP for all contact resident care activities. The facility may choose to post signage on the door or wall outside of the resident's room indicating the resident is on EBP;
-Provide education to affected residents and visitors on the reason and use of EBP;
-Examples of high contact resident care activities requiring gown and glove use include:
-Dressing;
-Bathing or showering;
-Transferring;
-Providing hygiene;
-Changing linens;
-Changing briefs or assisting with toileting;
-Device care or use: Central line, urinary catheter, feeding tube, and tracheostomy;
-Wound care: any skin opening requiring a dressing.

Review of the facility's list of residents on EBP, dated 2/24/25, showed Resident # 26, Resident #29 and Resident #45 listed on EBP.

1. Review of Resident #26's quarterly Minimum

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F 880	Continued From page 85 Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed: -Speech Clarity: No speech - absence of spoken words; -Makes Self Understood: Rarely/never understood; -Ability to Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Dependent - Helper does all of the effort. Resident does none of the effort to complete activity: Toileting hygiene, shower/bathing, upper/lower body dressing, and personal hygiene; -Diagnoses: MDRO, pneumonia (an inflammatory condition of the lungs. Symptoms may include productive or dry cough, chest pain, fever, and difficulty breathing.), stroke, seizure disorder, malnutrition, and respiratory failure; -Feeding Tube; -Special Treatments and Programs: Oxygen therapy, suctioning (removes mucus and secretions), and tracheostomy care. Review of the resident's care plan, showed: -1/16/25: Focus: At risk for respiratory illness. Goal: The resident will remain free from respiratory illness. Interventions: Monitor for change in condition and notify physician of findings; -1/16/25: Family is resistive to care and implementation from professional maintenance care and assisting with maintaining baseline-well being. Family removes treatments in place to skin integrity concerns, performs tracheostomy care. Goal: The resident will cooperate with care. Interventions: Educate resident/family/caregivers of the possible outcomes of not complying with treatment or care;	F 880		

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F 880	Continued From page 86 -1/16/25: Focus: Impaired cognitive ability/impaired thought process related to TBI (traumatic brain injury). Goal: Resident's needs will be met. Interventions: Allow resident extra time to respond to questions and instructions. Ask yes/no questions; -1/16/25: Focus: Rash, contact dermatitis to buttock and is followed by wound care company. Goals: Will have no complications from rash. The resident will have no signs or symptoms of infection. The rash will heal by next review date. Interventions: Avoid scratching and keep hands and body parts from excessive moisture. Observe skin rashes for increased spread of infection. Seek medical attention if skin becomes bloody or infected; -1/16/25: Tracheostomy tube related to TBI. Goal: Will have no signs/symptoms of infection. Interventions: Observe for changes in level of consciousness, mental status, and lethargy. Review a sign for EBP, located on the door of another resident, showed: -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: Any skin opening requiring a dressing. Observation and interview on 2/24/25 at 8:56 A.M., showed personal protection equipment (PPE, gloves, gowns, masks, etc.) hanging on the outside of the room door, but no Enhanced	F 880		

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Barrier Precautions sign on the outside of the resident's door or room. Upon entering the room, there was a sign on the inside of the door with instructions on how to remove PPE upon leaving the room. The waste can to discard PPE sat along the wall next to the first bed in the room and was not placed next to the door exit. The resident lay in bed while a family member bathed the resident. The family member wore gloves, and a face mask, but no gown. The resident had a tracheostomy tube with humidified oxygen infusing and a g-tube. When the family turned the resident onto his/her side, an uncovered stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) was noted on the resident's coccyx (tailbone). During an interview, the family member said he/she comes in every morning to bathe the resident.

Observation on 2/24/25 at 11:08 A.M., showed no EBP sign on the outside of the room door.

Observation and interview on 2/25/25 at 6:57 A.M., showed no EBP sign on the outside of the room door. Upon entering the room, the waste can remained along the wall next to the first bed, and the resident's family member was at the bedside, bathing the resident. The family member wore gloves and a face mask, but no gown. Certified Nursing Assistant (CNA) H entered the room and then went back outside of the room door and got two gowns, one for him/her and one for the family member. While wearing gloves and gown, CNA H helped the family member pull the resident up in the bed. The CNA told the family member whenever personal care is provided, a

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gown needs to be worn. The family member said he/she had been bathing the resident everyday since the resident had been at the facility, and this is the first time anyone asked him/her to wear a gown. The family member put the gown on and finished bathing the resident.

During an interview on 2/28/25 at 7:20 A.M., the facility Infection Preventionist (IP) said she was not aware there was no Enhanced Barrier Precaution sign on the outside of the resident's door, but there should be. It is her and the Unit Coordinator's responsibility to ensure the signs are posted on the outside of the room. Gloves, gowns and masks are required while providing personal care to the resident. The IP had not educated the family member about the enhanced barrier precautions policy.

During an interview on 2/28/25 at 9:34 A.M., the Administrator said EBP signs should be posted on the outside of the door or room for residents who meet the enhanced barrier criteria. The trash can should be next to the exit per the facility policy. He and the Director of Nursing (DON) had seen the resident's family wearing a gown before, so they are not sure why the family member said he/she had not never been asked to wear one before. They did not have any documentation showing the resident's family had been educated by the facility on why he/she should wear PPE. The Administrator said he expects staff to follow the policy by ensuring signs are posted and waste cans are next to the exit.

2. Review of Resident #29's quarterly MDS, dated 1/24/25, showed:
-Diagnoses of congestive heart failure, muscle weakness, and toxic liver disease;

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	265345	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BRIDGETON	12145 BRIDGETON SQUARE DR BRIDGETON, MO 63044

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F 880	Continued From page 89 -Cognitively Intact. Review of the resident's care plan, dated 2/25/25, showed: -Focus: Resident has a venous ulcer (wound caused by abnormal or damaged veins) on the right lateral (lower) leg and left lateral leg, the resident is non-compliant with wound care and is followed weekly by a wound clinic team; -Goal: The resident's ulcer will be healed by the review date; -Interventions: EBP precautions. Review of the resident's Physician's Orders Summary (POS), in use at the time of the survey, showed: -An order, dated 10/22/24, for EBP to be worn every shift during close contact care due to the resident's leg wounds. Observation on 2/24/25 at approximately 10:30 A.M., showed the resident's door did not have an EBP sign posted. The Facility Wound Nurse entered the room without PPE and informed the resident that she was there to change the resident's dressing. CNA D entered into the room without PPE. The Facility Wound Nurse, with gloved hands but no gown, removed the resident's heel protectors and dressing to both legs. While wearing gloves but no gown, CNA D assisted the Facility Wound Nurse, holding the resident's legs while the Facility Wound Nurse dressed the resident's leg wounds. At 11:25 A.M., CNA U entered the room without an isolation gown, applied gloves and said he/she was going to assist CNA D in getting the resident cleaned up. CNA U and CNA D provided perineum care (peri-care, cleansing on the genitals and rectal area) by turning the resident	F 880		

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F 880	Continued From page 90	F 880		

side to side. The resident's upper body touched CNA U's and CNA D's uniform when they turned the resident. Staff did not wear an isolation gown during resident care.

Observation on 2/25/25 at 9:13 A.M., showed CNA N and CNA O entered the resident's room to transfer the resident from his/her bed to his/her wheelchair using a full mechanical lift. CNA N and CNA O both put on a pair of gloves upon entering the room. CNA N lifted the resident's feet with one hand while pulling a pillow out from under the resident's feet with his/her other hand and then placed the resident's feet back on the bed. Both CNA N and CNA O rolled the resident onto his/her left side with CNA O leaning up against the resident with his/her clothing touching the resident. The CNAs then rolled the resident to his/her left side with CNA N leaning up against the resident with his/her clothing touching the resident. While lowering the resident into his/her wheelchair from the lift, CNA O leaned against the resident while holding him/her in position with his/her clothing touching the resident. Both CNA O and CNA N did not wear a gown during the resident care..

During an interview on 2/28/25 at 7:26 A.M., CNA N said he/she did not know if the resident was on EBP precautions. The sign on the resident's door was an EBP sign, which means a gown and gloves needs to be worn when taking care of the resident.

3. Review of Resident #45's quarterly MDS, dated 12/16/24, showed:
-The resident has moderate cognitive impairment;
-Diagnoses include kidney disease, pneumonia, stroke, and depression;

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F 880	Continued From page 91 -Requires maximum assistance from staff for toilet hygiene; -Occasionally incontinent of urine and frequently incontinent of bowels; -The resident has a feeding tube. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has an activities of daily living (ADL) self-care deficit related to hemiplegia (weakness to one side of the body), stroke, impaired balance, and limited mobility; -Interventions: Assist the resident with toilet use and hygiene. -The care plan did not address EBP. Review of the resident's POS, dated 2/24/25, showed: -An order, dated, 2/24/25, EBP for g-tube, every shift. Observation and interview on 2/24/25 at 12:15 P.M., showed an EBP sign posted on the outside of the resident's doors and a caddy filled with isolation gowns, gloves and masks. CNA S entered the resident's room without PPE. The resident said he/she was "wet." CNA S applied gloves, checked the resident and changed the resident by turning the resident side to side. The resident's legs touched CNA S's uniform while being turned. During care of the resident, the resident's abdomen was exposed, and a g-tube was present. CNA S did not wear an isolation gown while providing care. During an interview on 2/27/25 at 2:25 P.M., Licensed Practical Nurse (LPN) T said EBP are required for residents who have tracheotomy tubes, urinary catheters, g-tubes and wounds.	F 880		

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F 880	Continued From page 92 Staff should be wearing gowns and gloves when providing any type of direct care to the residents. 4. During an interview on 2/28/25 at 7:21 A.M., the IP said Resident #29 has leg wounds and Resident #45 has a g-tube which requires EBP and PPE to be worn by staff when providing direct care. Both residents should have a sign posted for EBP. She would expect staff to be following EBP policies and procedures. She said staff should be wearing a gown, gloves, and regular mask if required. 5. During an interview on 2/28/25 at 9:58 A.M., the Executive Director and DON said staff are expected to wear PPE for residents that meet the EBP criteria. They would expect staff to use PPE during care for Resident #29 and Resident #45. They would expect staff to be following the facility's EBP policy. .	F 880		

Missouri Department of Health and Senior Services

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A1131	19 CSR 30-85.012(124) Nurses' Call System Requirements Facilities shall provide an electrically-powered nurses ' call system with indicator lights at the corridor entrance of each bedroom. Audible signals and indicating panels shall be located in each nurses ' station and utility room. Facilities shall provide signal buttons at the head of each resident bed, in each toilet room and in each bathroom. III This regulation is not met as evidenced by: See the deficiency cited at F558.	A1131		
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		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a	A4064		

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A4064	Continued From page 1 safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F761.	A4064		
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, and F686.	A4075		
A4076	19 CSR 30-85.042(67) Clean, Dry, Odor Free Each resident shall be clean, dry, and free of body and mouth odor that is offensive to others. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F677.	A4076		

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A4077	Continued From page 2	A4077		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F677.	A4077		
A4082	19 CSR 30-85.042(73) Skin Care-Oil, Lotion, Cream Each resident shall have skin care including the application of oil, lotion, and cream as needed to prevent dryness and scaling of skin. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F677.	A4082		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F686.	A4083		

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A4086	Continued From page 3	A4086		
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		
A4087	19 CSR 30-85.042(78) Dr Notification-Change in Condition In the event of accident, injury, or significant change in the resident's condition, facility staff shall notify the resident's physician in accordance with the facility's emergency treatment policies which have been approved by the supervising physician. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F580.	A4087		
A5014	19 CSR 30-85.052(14) Personnel Sufficient, Trained There shall be sufficient personnel properly trained in their duties to assure adequate	A5014		

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A5014	Continued From page 4 preparation and serving of food. II This regulation is not met as evidenced by: See the deficiency cited at F801.	A5014		
A7002	19 CSR 30-87.030(2) Wash Hands/Arms & Clean Fingernails Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean and after smoking, eating, drinking or using the toilet. Employees shall keep their fingernails clean and trimmed. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F812.	A7002		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: *Class II See the deficiency cited at F550.	A8030		

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A8030	Continued From page 5 *The higher classification due to the extent of the violation.	A8030		
A9009	19 CSR 30-88.020(9) Resident Funds Reconciled Monthly All written accounts of the residents ' funds shall be reconciled monthly and a written statement showing the current balance and all transactions shall be given to the resident, his/her designee, guardian and conservator, or conservator on a quarterly basis. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F568.	A9009		

PLAN OF CORRECTION

Provider/Supplier Name:	Life Care Center of Bridgeton
Street Address, City, Zip:	12145 Bridgeton Square Drive, Bridgeton, MO 63044
Date of Survey:	02/28/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F550	1. All staff educated on resident rights and dignity to include not using cell phones when providing care to residents, not talking over residents, respecting resident's personal belongings and not removing without resident permission and not referring to incontinent products as a diaper. Resident #68's clothing items were returned to her room after washing by housekeeping director, housekeeping director to handle residents soiled lien and staff to ask permission prior to removal. Social services followed up with residents #29, #45, and #22 on 2/27/25 and no issues/concerns noted by residents at that time. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Nurse assigned to dining room and or designee to monitor for cell phone compliance and correct immediately if violations noted. Department managers to monitor for compliance about resident dignity and report to DON/Administrator with any concerns. 4. Director of Nursing and/or designee to audit 5x/week then 4x/week then 3x/week then 2x/week then 1x/week, then monthly for six months and report findings to the Quality Assurance Committee.	3/28/2025
F558	1. Resident #9 had a new call light that met their needs installed in the resident room and unit manager set a task to check for call light every two hours. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Nursing staff in-serviced on ensuring resident call lights are in reach and working properly for the resident's needs and to check for when doing rounds. 4. Maintenance director to conduct weekly audits x 3 months to ensure residents have appropriate and working call lights in the room. Administrator and/or designee to conduct monthly audits to ensure compliance and report findings to the Quality Assurance Committee.	3/28/2025

F568	1. Facility resident trust fund policy updated to include guidance for follow-up on outstanding checks and appropriate action and documentation to be completed. Checks #1194, 1212, 1245, 1253, 1279, 1292, 1398, 1401, 1474 have all been followed up and documented with regard to next steps. Business to conduct audit to ensure all outstanding checks have been appropriately addressed with documentation to support. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Assistant business office manager to conduct monthly audits on outstanding resident trust fund checks and document findings and actions. 4. Business Office Manager to conduct monthly audits for compliance and report findings to the Quality Assurance Committee for review.	3/28/2025
F580	1. Nurses re-educated on E-interact, nurses educated on documenting change of conditions in PCC x 72 hours and ensuring physician, D.O.N., unit manager, and family representative are notified, and it is documented in chart. Nursing staff are educated on stop and watch tool for early signs of change in condition. D.O.N to be called with any change in condition and if unable to reach D.O.N., then notify assistant director of nursing and/or unit manager. Resident #26 had vitals taken on 2/25/2025 and nurse notified the physician of the findings, physician ordered resident transferred to hospital, resident admitted to hospital. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Unit manager to run daily order listing report and follow up for any changes in condition. Nurses to review labs daily and follow up with the D.O.N. and with any critical labs or concerns with lab services. Wound nurse to run order listing report daily and follow up with the director of nursing. Wound nurse and wound physician to exit with D.O.N. after their weekly rounds together to monitor for any change of condition. The Unit manager runs MAR/TAR audits daily and follow up for any concerns. Nurses to track vital signs and monitor for any change of conditions. Therapy staff to report any change of conditions with residents to the nurse staff. 4. Director of nursing and/or designee will conduct weekly audits x 3 months to ensure compliance and report findings to the Quality Assurance Committee.	3/28/2025
F677	1. Charge nurse to ensure that all showers are given as scheduled and bed baths must be approved by nurse management prior to giving as a substitute for shower room shower. Charge nurses to complete skin assessment on UDA with each shower and document for foot care, hair washed, and skin assessment on all UDA. If outside footcare is deemed needed for a resident, appropriate referral will be made for residents to be seen by a podiatrist. If resident needs shaved and agrees to being shaved, shaving services will be provided. If residents desire a haircut, then staff to let	

	unit manager and social services know so that services can be arranged. Resident #29 was cleaned, facial hair shaved, hair washed, and outside podiatry appointment made. Nursing staff in-serviced on ADL care. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Unit manager to ensure nurses are following policy and documenting that appropriate skin assessments are completed, and showers are documented along with foot care needs. Wound nurse to review all shower sheets and print skin assessments for the prior day to audit for compliance and report to D.O.N. 4. Director of Nursing and/or designee to audit weekly for compliance x 12 weeks then monthly thereafter and report findings to the Quality Assurance Committee for review.	
F684	1. Nurses educated on ensuring all interventions are properly documented in PCC and that change of conditions are appropriately documented and communicated with resident physician, director of nursing, and resident and/or responsible party along with the oncoming nurse at shift change. Unit manager to ensure that labs are drawn as ordered by the physician and notify the physician, director of nursing, residents and/or responsible party about any missed labs. Nursing staff educated on ensuring residents are appropriately positioned while being fed and for 30 minutes post feeding. Charge nurse to ensure those residents requiring special assistance and/or restrictions/modifications with eating and drinking have that information appropriately relayed to the nursing team. Resident #14's chart was updated by LPN A who to include the information regarding resident's change of condition and communication with the physician that had not been saved in the chart from 2/24/2025. The lab for resident #14 was rescheduled but resident passed away prior to the lab being drawn. Resident #9's orders were updated to reflect current aspiration risk and ability to use straws, resident positioned upright at 90 degrees during feeding. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Assistant director of nursing and/or designee to audit weekly x 8 weeks all residents who require assistance with eating to ensure appropriate orders are in place and nursing staff are properly aware of the instructions and will report the findings to the Director of Nursing. Assistant Director of Nursing to audits weekly x 8 weeks lab reports to ensure labs are timely drawn and appropriate notification has been completed should a lab be missed and reporting findings to the Director of Nursing. Assistant Director of Nursing to audit weekly x 8 weeks to ensure change of condition status is appropriately documented and communicated.	3/28/2025

	4. Director of Nursing and/or designee to conduct monthly audits x 3 months to ensure compliance and report findings to the Quality Assurance Committee for review.	
F686	1. New treatment order put in place for resident #26 on 2/25/25. Charge Nurse to complete skin assessment on all new admissions, readmissions, and discharges. Wound Nurse to conduct head to toe assessments on all new admissions and readmissions. Charge nurse to complete skin assessments with showers and initiate a change in condition if any new skin issues identified and contact the physician for orders, notify the responsible party, and document in the medical record. MDS to ensure all skin issues are appropriately care planned. Nursing staff in-serviced on facility wound care policy and procedures. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Wound nurse to conduct daily audits of the treatment administration record, order listings, and attend daily clinical meetings. Wound Nurse to also send weekly wound report to DON, ADON, MDS, and unit managers. 4. Director of Nursing to meet with wound nurse weekly to conduct wound physician exit meeting, review weekly wound report, discuss any unavoidable skin issue concerns and report findings to the Quality Assurance Committee.	3/28/2025
F740	1. The facility has a new outside counseling contract being finalized to provide supplemental services to residents 68 along with other residents identified as needing said services per recommendation of psychiatry services. All residents had a spiritual assessment completed by the activity director to ensure appropriate interventions are put in place to address the residents' need. Staff in-serviced on resident rights and dignity per F550 POC. Front desk educated on letting the Charge nurse know when resident #68 calls with questions to help address resident needs timely. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. The Social services director will conduct monthly audits x 3 months to ensure appropriate spiritual assessments are completed by the activity department and report findings to the administrator. The Social services director will conduct exit meetings with psychiatry services after each visits x 6 months to ensure any appropriate outside referrals are made and report findings to the administrator 4. The administrator and/or designee will conduct monthly audits x 6 months to ensure compliance with spiritual assessments and appropriate referrals to outside agencies are followed up and report findings to the Quality Assurance Committee.	3/28/2025
F761	1. Expired medications were removed from the medication cart. All medication carts were audited for expired medications and any expired medications were removed. All insulin pens in fridge to be dated once	3/28/2025

	opened. All med aides and nurses in-serviced on checking for expired medications and appropriate dating and storage of insulin pens. In-service education on proper medication storage was conducted for nurses and med aides. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Charge nurse and/or unit manager to audit daily for compliance and take appropriate action to discard any expired medications or any opened medications that require a date when opened that do not have a date. 4. Assistant director of nursing and or designee will audit weekly x 12 weeks for compliance and report findings to the Quality Assurance Committee for review.	
F801	1. The Dietary Services Director has more than two years of experience in the position as a director and completed a course of study in food safety and management prior to October 1, 2023, but her CDM license from the Association of Nutrition and Foodservice Professionals had expired. Dietary Services manager has completed a new course of study by ServSafe for the ServSafe Manager designation and passed test on 3/24/2025. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Facility Dietician will conduct annual audits on the certification of the dietary services director and report findings to the administrator. 4. The administrator will conduct annual audits of the dietary department certifications for compliance and report findings to the Quality Assurance Committee.	3/28/2025
F812	1. Nursing and dietary staff in-serviced on appropriate hand hygiene procedures when serving the needs of residents in the dining room to ensure residents #22, #24, and #27 are served food in accordance with professional standards for food safety. Nursing and dietary staff also in-serviced on not blowing on residents' food to cool the temperature of the food. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Unit managers and/or designee to conduct weekly audits x 3 months when in the dining room to ensure appropriate hand hygiene practices are being performed along with not blowing on resident food and report findings to the director of nursing. 4. Facility Dietician to conduct weekly audits when on site for compliance and report findings to the administrator for review with the Quality Assurance Committee.	3/28/2025
F880	1. All staff in-serviced on isolation precautions. Admissions team to ensure that new admissions who require isolation precautions have it noted on orange admission referral care for appropriate follow up by the nurse upon admission. Nurse to educate new families on isolation precautions and document the education in PCC. Handwashing in-service was conducted for staff. Residents #26, #29, and #45 had enhanced barrier	3/28/2025

	precautions sign add to the front of their room door. The family of resident #26 were educated on enhanced barrier precautions. 2. Any resident has the potential to be affected by the alleged deficient practice. 3. Assistant Director of nursing to conduct weekly audits x 12 weeks to ensure appropriate isolations precautions in place for residents requiring them upon admission or change in condition. 4. Director of Nursing and/or designee will conduct monthly audits for compliance and report findings to the Quality Assurance Committee for review.	

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:	Life Care of Bridgeton
Street Address, City, Zip:	12145 Bridgeton Square Drive, Bridgeton, MO 63044
Date of Survey:	2/28/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A1131	Please refer to CMS Form 2567, F558 POC	
A4062	Please refer to CMS Form 2567, F761 POC	
A4064	Please refer to CMS Form 2567, F761 POC	
A4075	Please refer to CMS Form 2567, F677, F684, and F686 POCs	
A4076	Please refer to CMS Form 2567, F677 POC	
A4077	Please refer to CMS Form 2567, F677 POC	
A4082	Please refer to CMS Form 2567, F677 POC	
A4083	Please refer to CMS Form 2567, F686 POC	
A4086	Please refer to CMS Form 2567, F880 POC	
A4087	Please refer to CMS Form 2567, F580 POC	
A5014	Please refer to CMS Form 2567, F801 POC	
A7002	Please refer to CMS Form 2567, F812 POC	
A8030	Please refer to CMS Form 2567, F550 POC	
A9009	Please refer to CMS Form 2567, F568 POC	

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