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F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Missouri, Department of Health and Senior Services. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 07/29/24 to 08/01/24. Survey Census: 80 Sample Size: 26 Supplemental Sample: 2	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to assess one of one sampled resident (Resident (R) 37) for the safe self-administration of medications. This failure could potentially lead to medications being left by staff at the resident's bedside where other residents could access them. Findings include: Review of the facility's policy titled "Self-Administration of Medications Policy" dated 10/23 indicated, ". . .It is the policy of this facility that if a resident requests to self-administer medication(s), the interdisciplinary team (IDT) will assess the resident to determine if it is clinically	F 554		9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Franklin
TITLE: Executive Director
(X6) DATE: 08/16/2024

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.

Best IDR POC

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appropriate to honor the resident's choice, in order to maintain the resident's highest practicable level of functioning. The resident has the right to defer responsibility to the facility. A resident may only self-administer medications after the IDT has determined which medications may be safely self-administered. . ."

Review of a facility document titled "Resident Information" indicated R37 was admitted to the facility on 06/18/24.

Review of R37's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/24/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had a history of choking during meals or when swallowing medications.

Review of R37's"Care Plan" failed to indicate the facility assessed the resident for safe self-administer of her medications.

Review of R37's electronic medical record (EMR) failed to show evidence the facility assessed the resident for the safe self-administration of her medications.

During an interview on 07/30/24 at 12:17 PM, R37 stated she no longer required skilled Speech Therapy and could identify when she needed to pull food from her mouth if she began to pocket the food. During this interview, Licensed Practical Nurse (LPN) 2 entered into the resident's room and the resident informed LPN 2 that she could not swallow the vitamin and asked if LPN2 could crush the vitamin. The resident pointed to a

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F 554	Continued From page 2 crumbled-up tissue with a slight orange spot in the middle of it. LPN2 retrieved the tissue and said that she would do that for the resident. During an interview on 07/30/24 at 12:19 PM, R37 stated LPN 2 left a Tylenol and a Vitamin at her bedside for her to take by herself. The resident stated LPN2 was not present when she took her pills. During an interview on 07/30/24 at 4:15 PM, LPN 2 confirmed she left the vitamin and Tylenol at R37's bedside and alone. During an interview on 08/01/24 at 1:14 PM, the Director of Nursing (DON) stated R37 wanted the medications left at her bedside and the facility was honoring her choice. The DON stated that residents should not be unsupervised, with medications, unless the facility previously assessed the resident for the safe self-administration of medications.	F 554		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect one resident (Resident #38) from misappropriation of property when a staff	F 602	Past noncompliance: no plan of correction required.	

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member took the resident's wallet, and used his/her credit card to purchase take-out food and groceries. The census was 79.

The administrator was notified on 7/24/24 of the past non-compliance. The facility had completed their investigation, interviewed staff and residents, notified the police and terminated Certified Nurse Aide (CNA) A. The deficiency was corrected on 7/24/24.

Review of the Abuse and Neglect (Suspected) Policy, revised March 2022, included the following:
-Residents have the right to be free from any type of abuse, including verbal, physical, psychological, sexual, and emotional abuse and/or exploitation;
-Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

Review of Resident #38's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/27/24, showed the following:
-Cognitively intact;
-No behaviors;
-Diagnoses included high blood pressure, diabetes, total knee replacement;
-Hearing and vision adequate;
-Understands others.

Review of the facility's investigation, submitted 7/16/24, showed the following:
-The resident said a couple of nights before, he/she had CNA A help read the card verification

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value (CVV) on the back of his/her credit card and the CNA returned the card. He/She wanted the wallet returned and did not want to file charges;
-A Timeline of Events for July 12, 2024, created by the Director of Nursing (DON);
-Separation of employment completed for CNA A.

During an interview on 7/24/27 at 11:10 A.M., the resident said he/she was shopping one night and could not read the CVV on the back of the credit card. He/She asked the AP to help him/her read the number. The CNA went to get his/her glasses, came back and read the number and returned the wallet to the resident. The resident placed the wallet near the head of the bed. On 7/12/24, he/she could not recall the exact time, he/she received a call regarding fraudulent charges on his/her credit card. The resident reviewed the online banking information and noted the charges at a grocery store and a food restaurant. That is when he/she first noticed his/her wallet was missing. The DON and Nurse Supervisor (NS) came to the resident's room, gathered information and the NS assisted the resident in calling the credit card company to get the times of the transactions. The NS called the restaurant and was given a description of the person who used the card to purchase food.

During an interview on 7/24/24 at 11:20 A.M., the DON said he/she was present in the facility the day of the incident. At approximately 2:55 P.M., she was notified by an employee the resident reported he/she was missing a wallet and there were charges on his/her credit cards. The DON and NS went immediately to the resident's room. The resident said a couple of nights before, he/she had the CNA help him/her read the CVV

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on the back of the credit card and the CNA returned the card. The resident did not realize his/her wallet was missing until the bank fraud department contacted him/her for some charges that occurred on 7/12/24. The resident reviewed his/her account and was unable to locate the wallet, and the resident notified a staff member. After gathering the information, the NS contacted the local police department and requested an officer to come make a report. The DON reviewed the staffing sheets and noted the CNA was scheduled for that evening but was running late. When the CNA arrived, carrying a plain white bag with food items, he/she was directed to complete education on the computer in the part of the building with no resident contact. The Police Officer arrived, took the statement from the resident, staff, and requested the CNA be brought to the conference room. The CNA confirmed he/she took the wallet and made purchases at the grocery store and restaurant.

During an interview on 7/24/24 at 2:41 P.M., the NS said the resident reported the wallet as stolen. The resident got a notice from his/her bank for fraudulent charges. The NS helped the resident call the bank and get times of the charges to the card. The NS called the restaurant, where the card was used, and the staff provided a description of the person, the car, and the items ordered. When the CNA arrived to the facility, the DON instructed the AP to complete computer training in a different part of the facility, away from resident contact. The police interviewed the resident and staff. The CNA was brought to the conference room. The next time the NS saw the CNA was out front of the lobby at the police car. The DON said the CNA was arrested and the officer was waiting for a female officer.

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F 602	Continued From page 6 Review of the Police Department Investigative Report, showed: -A purple coin purse/wallet with twist latch was stolen. Contents included a driver's license, Costco credit card, Credit Union debit card, American Association of Retired Persons (AARP) membership card, PNC Bank Credit Card, library card, twenty-three dollars ($23.00) in cash, two un-signed blank checks; -The Alleged Perpetrator (AP) was charged with Stealing (Class D Felony)-all other property and Fraudulent Use of Credit/Debit Device. Total value $46.03; -Fraudulent charges, takeout food fifty-one dollars ($51.00) and groceries fifty-seven dollars and ninety-nine cents ($55.99); -The AP admitted to taking the wallet and was arrested. MO00239018	F 602		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that	F 726		9/6/24

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licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based upon document review and interview, the facility failed to ensure staff were trained in required infection control practices such as enhanced barrier protection (EBP) and/or other isolation precautions. The facility failed to have staff's competencies in relation to the infection control training. This failure placed all 80 residents at risk of infection. The lack of adequate training and evaluation of staff's competencies had the potential for residents' needs to go unmet and/or result in a lack of services provided by the facility.

Findings include:

Review of the course printouts for available education on the computer-based system provided by the facility revealed the "Annual Mandatory Courses" list indicated Bloodborne Pathogens as the only infection control related education. The "Course and Curriculum

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Assignments by Group: Surrey Place ..." for different disciplines lists indicated Targeted COVID-19 Training as the only infection control related education.

Review of Registered Nurse (RN)1's, RN3's, and Licensed Practical Nurse (LPN)3's "Progress Report" for completed education for date ranges 02/25/23 through 07/31/24, 02/13/23 through 07/31/24 and 12/21/22 through 07/31/24 respectively, provided by the facility, indicated 2023-2024 Influenza Training, Bloodborne Pathogens, Hand Hygiene, and Targeted COVID-19 Training as the only infection control related education completed.

Review of RN2's education, provided by the facility, indicated Infection Preventionist Basic Bootcamp for Long Term Care Facilities dated March 2019 as the only infection prevention education completed.

Review of Certified Nursing Assistant (CNA)6, CNA7, CNA8, CNA9, and CNA10, education related to training/testing of infection control requirements, provided by the facility, revealed no documented training or competency testing related to infection control such as EBP or isolation precautions. The "New Employee Orientation" checklist from each file listed "Hand Hygiene & Infection Control" as checked off education, but the corresponding detailed information was not contained in the file.

Interview on 07/31/24 at 1:50 PM, the Administrator stated the facility did not have a staff educator. The Administrator stated required training is given to the facility from the main hospital and it is up to facility management to

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F 726	Continued From page 9 make sure new training and other education is disseminated to the staff. On 08/01/24 at 9:05 AM, the Administrator was asked for policies related to training of staff and determining staff's competencies, however, no policies were provided Interview on 08/01/24 at 10:45 AM, the Director of Nursing (DON) stated that the Assistant Director of Nursing (ADON) began teaching the current IP however, neither of them, DON or ADON, were fully trained to be an Infection Preventionist. During an interview on 07/31/24 at 2:45PM, the Administrator stated that she had received CMS guidance regarding EBP and had reviewed this information with the staff earlier this year. The Administrator was unable to provide documentation that staff had received EBP training. (Refer to F880)	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		9/6/24

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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, record review, the facility failed to ensure two of three medication carts (Alpine unit and Canyon unit), and one of two treatment carts (Alpine unit) were locked and secured on three of three resident halls. This failure created a risk of medications being misappropriated or tampered with. Also, the facility failed to remove expired blood collection tubes from two of the three medication rooms (Alpine unit and Dakota Bluffs unit).

Findings include:

1. On 07/30/24 at 2:15PM, observation of the Alpine unit medication room revealed the following:

31 of 31 BD vacutainer blood collection tubes with expiration date on 01/31/24.
Three of 13 Kangaroo Epump Enplus Spike with Flush Bag (used for nutritional feeding) with expiration dates of 01/31/24 and 05/31/24

Interview on 07/30/24 at 2:31 PM, Licensed Practical Nurse (LPN) 4 stated that she was not sure who was responsible for removing expired

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medications and equipment from the medication room.

2. Observation on 07/30/24 at 2:29 PM, on the Alpine unit was an unlocked treatment cart at the nurse station. The cart was unattended by nursing staff.

On 07/30/24 at 2:40 PM, the treatment cart remained unlocked and was brought to the attention of LPN 4, who stated that she was the last one to use the treatment cart and thought she had locked it. LPN4 stated it was hazardous to leave the cart unlocked since it contained wound supplies which could be dangerous if ingested.

3. On 07/30/24 at 3:31PM an inspection of the Dakota Bluffs unit medication storage room revealed the following:

Seven of eight Magellan three milliliter(ml) syringes with hypodermic needles size 21 gauge by one and a half needle had an expiration date of 10/31/23.

Five of 10 Magellan three ml syringes with hypodermic safety needle size 25 gauge by five eighth inch with an expiration date of 09/30/22.

Three hundred and eighty-eight lavender top BD vacutainer blood collection tubes with expired date of 04/30/24.

During an interview on 07/30/24 at 3:25 PM, LPN 3 confirmed the expired dates on the syringes and the vacutainer collection tubes. LPN3 stated that she was unsure as to who was responsible for checking the medication storage room.

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4. Observation on 07/30/24 at 3:45PM, the Alpine unit medication cart was left unlocked while nurse gave medication to a resident at the nurse station. Certified Medication Technician (CMT)'s back was turned away from the cart. She returned to the cart 2.35 minute later and locked the cart.

An interview 07/30/24 at 3:50PM, CMT1 stated she did not realize that she left the cart unlocked.

5. Observation on 07/31/24 at 8:50 AM, Registered Nurse (RN)2 left the medication cart unlocked on the Canyon Creek Hall.

Interview on 07/31/24 at 9:05 AM, RN2 stated that she was unaware that she left the cart unlocked.

6. Observation on 07/31/24 at 5:15 PM, the treatment cart was unlocked at the Dakota Bluff Hall nurses station. There were one cognitively impaired residents seated around the nurses station. There were no staff present at the station to supervise the residents. Review of Resident (R)24's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/12/24 revealed a "Brief Interview for Mental Status (BIMS)" revealed R24 was severely cognitively impaired and unable to complete the "BIMS."

Interview on 7/31/24 at 5:20PM, LPN 3 stated that it was an expectation that all medication and treatment carts were to be kept locked.

Interview with the Director of Nursing (DON) on 07/31/24 at 11:30AM, the DON stated that the nurses are expected to always keep the

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F 761	Continued From page 13 medication and treatment carts locked when not in used. The DON stated that the facility did not have policy regarding the locking of the medication and treatment carts.	F 761		
F 812 SS=F	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, review job description, and facility policy review, the facility failed to ensure one of one dietary freezer, and three of three nourishment room (Alpine Park, Canyon Creek, and Dakota) refrigerators had all food labeled, dated and was free of dirt and sticky shelves. This failure has the potential to create the environment for food-borne illnesses to occur throughout the population of 80 residents.	F 812		9/6/24

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Findings include:

Observation and interview on 07/29/24 at 9:34 AM, on the shelves in the dietary department walk-in freezer revealed an unsealed bag in a box of frozen fish, an unsealed bag of hashbrowns, and an unsealed bag of potato wedges. The Food Service Director (FSD) stated the bags should not be left opened and the bags should be labeled with the "opened" date after using them.

Observation and interview with the FSD on 07/31/24 at 8:46 AM of the shelves of the refrigerator on the Alpine Park Unit revealed the following food items not labeled or dated:

There was a three-compartment to-go container of meat and vegetables, a to-go container of broccoli cheddar soup, a glass container of oriental dumplings, and a plastic bowl of watermelon with no label and/or date. The FSD confirmed the above observations and confirmed the food in the refrigerators should be labeled and dated.

Observation and interview with the FSD on 07/31/24 at 8:58 AM of the refrigerator on the Canyon Creek Unit revealed the following food items not labeled, dated, and/or expired:

There was one-half of a tuna sandwich wrapped in parchment paper, a to-go container of spaghetti with red sauce, a to-go container of rice, a to-go container of cake, a plastic container of a thick white substance, a plastic container of salsa, a to-go container of meat and cheese, and a to-go container of watermelon with no label and/or date. There was a to-go container of fruit that expired on 07/27/24, a parfait that expired on

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05/05/24, and a to-go container of soup that expired on 04/06/24. The refrigerator was observed to have dirty/sticky shelves. The FSD confirmed the above observations and confirmed the food in the refrigerators should be labeled, dated and food with expiration dates should be thrown out.

Observation and interview with the FSD on 07/31/24 at 9:10 AM of the refrigerator on the Dakota Unit revealed the following food items as not labeled, dated, and/or expired:

3. There were two containers of potato salad, a plastic container of corn, and three-compartment to-go container of fruit all with no label and/or date. There was a container of Greek yogurt that expired on 07/30/24 and a to-go container of fruit that expired on 07/27/24. The refrigerator was observed to have dirty/sticky shelves. The FSD confirmed the above observations and confirmed the food in the refrigerators should be labeled, dated and food with expiration dates should be thrown out.

Review of the facility's policy titled, "Food Safety Requirement: Procurement, Use, and Storage of Foods and Beverages in the Kitchenettes" revised 12/2017, provided by the facility, revealed it is the purpose of the facility, "To follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness; To provide safe and sanitary storage, handling, and consumption of food and fluids brought to residents by family or other visitors ... .expiration date of 3 days later by nursing staff or other qualified Surrey Place employee. Food is to be removed after 2 days due to unknown conditions prior to being placed in the refrigerator or freezer. Bulk, brick-pack

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F 812	Continued From page 16 juices or other beverages will be dated with Date opened and Expiration Date, which is 7 days later." Review of the undated "Food & Nutrition Serv-Surrey" Manager [FSD] job description, provided by the facility, revealed it is the responsibility of the FSD to coordinate with other departments to plan, direct and control aspects of the Food & Nutrition Departments activities. The FSD "oversees ... storage ...to ensure quality ...to increase patient satisfaction."	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;	F 838		9/6/24

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F 838	Continued From page 17 (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to conduct and document	F 838		

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a comprehensive Facility-wide Assessment to determine what resources were necessary to care for its residents competently during day-to-day operations. The facility failed to ensure the Facility Assessment included infection control services, such as surveillance and antibiotic use, as well as the facility employing an Infection Preventionist (IP) who would was responsible for overseeing the infection control program. The lack of an adequate facility assessment had the potential for residents' needs to go unmet and/or result in a lack of services provided by the facility to competently care for all 80 residents who resided at the facility. at the time of the survey.

Findings include:

Review of the undated "Facility-wide Self-Assessment," provided supplied by the facility indicated the assessment failed to address the following pertinent characteristics affecting day-to-day operations and potential emergency situations:

1. Failed to include staffing requirements based on resident acuity levels.

2. Failed to include an evaluation of the training program, including the specialized training and competencies of the staff who worked in the facility, such as the IP and other clinical specialties/services routinely provided for the residents. (Refer to F726)

3. Failed to include infection control services, such as surveillance and antibiotic use, as well as the facility employing an Infection Preventionist (IP) who was responsible for overseeing the infection control program. (Refer to F882)

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F 838	Continued From page 19 4. Failed to ensure the IP had sufficient time to assess, develop, implement, monitor, and manage the facility's Infection Prevention and Control Program (IPCP). (Refer to F882) During an interview on 07/25/24 at 10:45 AM, the Administrator confirmed the Facility Assessment did not address staffing requirements based on resident acuity levels, the assessment did not address an evaluation of the facility's training program and provide infection control services overseen by the IP. During an interview on 08/01/24 at 2:23 PM, the Administrator was asked specifically why the infection control program was not included in the Facility Assessment and why there was no mention of the IP. The Administrator stated she has not seen other examples of a written Facility Assessment mention that they provide infection control surveillance and employ an IP to oversee the program.	F 838		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/6/24

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F 880	Continued From page 20 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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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§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.
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 observations, record review, review of policies, interviews, and review of Centers for Disease Control (CDC) guidelines and Centers for Medicare & Medicaid Services (CMS) guidance, the facility failed to follow acceptable standards of practice for infection prevention and control when providing wound care for Resident #35. The facility also failed to ensure one (Resident (R)144) of one resident with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) was placed in contact precautions. This had the potential for MRSA to spread to staff and to other residents. The facility failed to ensure R1 and R36 were placed in enhanced barrier precautions (EBP) for wounds and R294, R6, R35 for use of a catheter. This had the potential for the residents to develop multi-drug resist organisms. The facility failed to ensure dedicated equipment, such as a stethoscope and blood pressure cuff, was assigned to R37 who was in contact precautions for a diagnosis of Clostridium difficile (C-diff). This had the potential for staff and other residents to develop C-diff. The facility nurses failed to

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perform during wound treatment for one of one resident (R1) hand hygiene prior to donning gloves and failed to change gloves and perform hand hygiene after removing the old dressing and applying the new dressing. This failure had the potential of contaminating the clean dressing. The facility failed for one of one resident (R5) with a suction machine in their room, to clean the suction machine cannister that was observed with yellowish fluid. The facility failed to ensure a diagram of the current facility's water system was developed as part of their water management program and prevention of pathogens. Finally, the facility failed to ensure four ice machines out of four were properly cleaned on a routine basis. This had the potential for the facility to develop water pathogens.
The census was 79.

Findings include:

Review of the facility's infection control policy, dated October 2023, showed:
-Policy: It is the policy that this facility's Infection Prevention and Control Program (IPCP) is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. The IPCP includes a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards;
-Standard and transmission-based precautions to be followed to prevent the spread of infections,

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including:
--Hand hygiene to be followed by staff with direct care, handling resident care equipment and the environment;
--Resident Care Activity procedures including wound care;
--Environmental cleaning and disinfection of resident care equipment, including shared equipment.

1. Review of Resident #35's admission sheet, showed the resident was admitted to the facility on 7/2/24 with diagnoses that included severe malnutrition, failure to thrive, chronic obstructive pulmonary disorder (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and a history of falls.

Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/8/24, showed:
-Cognitively intact;
-Required partial to moderate assistance with eating, personal hygiene and upper body dressing;
-Dependent on staff for toileting, bathing, transfers, putting on/taking off shoes and lower body dressing;
-Used a wheelchair.

Review of the resident's electronic Physician's Orders, showed:
-7/20/24, Cleanse resident's right leg wound with wound cleanser, apply triple antibiotic ointment (TAO) then apply 4 inches by 4 inches gauze, wrap in Kling wrap (rolled gauze dressing) and secure with tape. No tape to the skin.

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Observation of the resident's right lower leg dressing change on 7/24/24 at 5:30 P.M., showed:
-Registered Nurse (RN) A rolled the Canyon Creek (hall resident resided on) treatment cart #2 to the resident's room and positioned it in front of the doorway;
-RN A explained to resident what he/she was going to do;
-RN A exited the room;
-RN A entered the room with a pillow and bedding pad;
-RN A folded the pillow and placed it under the resident's right lower leg, then folded the pad in half and placed it on top of the pillow. RN A then placed the resident's right leg on top of the pillow and pad;
-RN A used hand sanitizer on his/her hands, donned gloves and began to gather supplies onto the top of treatment cart #2 without the use of a barrier or disinfecting the top of the cart;
-RN A removed his/her scissors out of his/her pocket and placed the unsanitized scissors on top of the unsanitized cart;
-RN A gathered the supplies off the top of the unsanitized cart and placed them on to the right side of the pad and the scissors onto the right side of the pad;
-RN A used the scissors, cut open the visibly soiled dressing to the resident's right leg and placed the used scissors back onto the right side of the pad;
-RN A cleansed the wound with wound cleanser and 4 by 4 gauze, then removed the soiled dressing from beneath the resident's leg and disposed of the dressing and gauze in the trash on the treatment cart;
-RN A doffed his/her gloves, used sanitizer on

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his/her hands and donned new gloves;
-RN A opened the gauze 4 by 4 and placed on the left side of the pad, opened the cotton tipped applicator and placed it on the left side of the pad;
-RN A opened the antibiotic ointment and applied some to the cotton swab and then applied it to the wound, added more ointment and applied to other areas of the wound three times, placed the open and used ointment package on the right side of the pad;
-RN A placed the gauze 4 by 4 on the wound and then walked to the treatment cart in the open doorway;
-RN A removed the rolled gauze from the cart and placed it, open, on the right side of the pad;
-RN A wrapped the rolled gauze around the leg/wound, grabbed the dirty scissors off the pad and cut the clean rolled gauze with the dirty scissors;
-RN A gathered the trash and supplies, threw away the supplies and placed the used bottle of wound cleanser in the cart and the used/dirty scissors on the cart top without a barrier;
-RN A doffed his/her gloves, sanitized his/her hands and donned clean gloves;
-RN A removed the tape from the drawer of the cart, used a marker and initialed and dated the tape, and removed two pieces of tape;
-RN A taped the rolled gauze in two areas to make sure it was secure;
-RN A removed the pad and pillow from under the resident's leg and placed them in the dirty bin in the hallway;
-RN A placed the cart in the hallway and returned to the resident's room to assist the resident with covering up and adjusting his/her position in bed;
-RN A exited the room, doffed his/her gloves, sanitized hands and pushed the treatment cart to the nurse's station;

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-RN A gathered two packages of cookies and took them to resident per resident request;
-RN A walked back to the treatment cart and placed his/her dirty scissors and marker inside a glove, twisted it closed and walked away from the cart leaving the glove sitting on top.

During an interview on 7/24/24 at 5:53 P.M., RN A said:
-He/she usually used foam sanitizer instead of washing his/her hands;
-Hands should be washed between glove changes and before exiting the resident's room after the treatment;
-He/she did not wash his/her hands with soap and water at any point before, during and after wound care;
-He/she got used to using the foam sanitizer so that is what he/she does;
-If the resident had C-diff, he/she would always wash his/her hands with soap and water before exiting the room;
-He/she usually washes his/her scissors and marker outside the resident's room and lets them air dry on top of the cart, then places them back into his/her pocket;
-He/she placed the scissors and marker inside the glove to remind himself/herself that they still need to be cleaned before placing them back into his/her pocket;
-Do not need a barrier for the top of the cart;
-He/She will use a bed pad for a barrier, open the supplies and set them on the bed pad;
-If the bed pad gets soiled, he/she would change the pad after cleansing the wound and before adding a clean dressing;
-Sometimes, he/she will either place two pads under the wound and remove the top one after cleansing the wound or just keep folding the

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soiled pad as needed.

During an interview on 7/24/24 at 6:05 P.M., the Director of Nursing (DON) said:
-He/she expected staff to wash hands when entering a room to provide care, if the gloves get soiled, and after care is completed;
-Hand sanitizer is ok to use instead of washing hands with soap and water as long as the hands are not visibly soiled;
-He/she expected staff to use soap and water if the resident has C-diff;
-Staff does not need to use a barrier if they have a clean surface;
-As long as the supplies are in individual packaging, a barrier or cleaning the top of the cart is not required before placing the packaging on top of the cart;
-He/she expected staff to sanitize scissors before and after use;
-Sanitizing the scissors after removing the dressing and before using them on clean supplies is not required if it is the same resident;
-It is ok to use the same pad for clean and dirty items as long as the clean items and the dirty items are placed in separate areas of the pad;
-It is not acceptable to place clean items with dirty items.

2. Review of the Resident (R) 144's electronic medical records (EMR) revealed the resident was admitted to the facility on 07/23/24 with diagnoses that included septic arthritis and swollen right knee. Review of the R144's EMR document titled "Resident Summary Sheet" indicated while in the hospital, due to blood cultures and synovial fluid on 07/19/24 and nasal culture dated 07/21/24 tested positive for MRSA.

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Review of R144's Physician Orders dated 07/23/24 provided by the facility revealed the resident was to receive Vancomycin (antibiotic), 1,750 milligrams (mg) in 517.5 milliliters (ml) intravenous (IV, a soft, flexible tube placed inside a vein, usually in the hand or arm) every 12 hours for bone/joint infections.

Observation on 07/29/24 at 10:30AM revealed R144 in his room in bed with a dressing covering the right knee area. There was no signage or Personal Protective Equipment (PPE) cart outside the resident's room.

Observation on 07/30/24 at 3:30 PM revealed R144 in his room and no PPE setup outside the resident's room. The resident's right knee dressing was changed on 07/30/24.

Observation on 07/31/24 at 8:10 AM revealed no PPE setup or signage posted outside R144's room. Interview with R144 during this observation revealed the nurses wore gloves when doing dressing changes. R144 was not sure if the nurses wore gloves when hanging his IV medication. The resident further stated the staff do not wear a gown or gloves when providing his care.

Observation on 07/31/24 at 8:33AM revealed Certified Nurse Aide (CNA) 5 was observed exiting R144's room after taking his vital signs. The CNA was not wearing any PPE, nor did she disinfect the blood pressure apparatus.

Interview on 07/31/24 at 8:40 AM, CNA 5 stated she received infection control training (isolation precautions) during orientation. CNA5 stated that if a resident is in isolation precautions there will

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be signage on the door identifying what personal protective equipment is required and there will be a cart outside the resident's room with the PPE. The CNA also stated staff should wear gowns, masks, and gloves and practice hand sanitation for residents in isolation. The CNA was unfamiliar with EBP.

Interview on 07/31/24 at 9:26 AM, RN 2 on the Canyon Creek Hall team 1-2 revealed only one resident was on isolation precautions. The resident was admitted to the facility yesterday and tested positive for COVID. RN2 stated the resident was in contact isolation which required staff to perform hand hygiene, don an N95 face mask, gown, and gloves. RN2 further stated there were no residents on EBP at this time. RN2 stated that the required PPE for residents on EBP would be face mask and face shield, if the employee desired face shield, and gloves. RN2 stated in her unit she had several residents with wounds and indwelling (drainage tube inserted into the urethra)/suprapubic (drainage tube inserted into the abdomen) catheters.

Interview on 07/31/24 at 9:39 AM, RN1 on the Canyon Creek Hall Team 2-3 stated that she did not have any residents on any type of isolation precautions. RN1 stated the PPE for residents on contact isolation should be face mask, gowns, and gloves. The RN stated that she had never heard of EBP. RN1 acknowledged that R144 had a wound infection of the right knee but did not know what organism was growing from the wound. RN1 was asked if a resident had MRSA in a wound, would that require isolation precautions. RN1responded that the resident should be placed on Contact Isolation.

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Interview on 07/31/24 at 10:11 AM, the Assistant Director of Nursing (ADON) stated that she was familiar with the residents on the Canyon Creek Hall and not sure if there were any residents with the diagnosis of MRSA on the Canyon Creek Hall. The ADON stated staff providing care to residents on contact isolation should wear gowns, mask, and face shield mask to prevent splash back of resident secretions, and gloves. The ADON stated she would have read the policy for EBP. She stated that she found out this morning prior to this interview that staff were not following the EBP guidance. The ADON stated that several residents had wounds that required dressing, indwelling urinary /Suprapubic catheters and intravenous therapy. These residents were not on any type of isolation precautions.

Interview on 07/31/24 at 1:10PM, CNA 5 revealed there was only one resident on the unit that was on isolation precautions. CNA 5 stated the staff should wear face mask, gown, and gloves when providing care for the resident. CNA 5 was asked what PPE was used for residents on EBP. CNA 5 responded, "What's that?"

Interview on 07/31/24 at 02:45PM with the Administrator and the DON revealed the DON was unaware that R144's was positive for MRSA. The DON had to review the resident's chart. The DON stated that Infectious Disease physician felt that since R144 was afebrile and asymptomatic it was not necessary to place the resident in isolation. The DON was asked to review the resident's microbiology report which indicated the resident tested positive with MRSA in blood, wound, and nasal cultures on 07/19/24 and 07/21/24. The DON stated the resident's blood culture done on the 07/23/24 was negative.

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However, the DON was unable to answer or explain why the resident did not have repeat culture of the resident's wound and the nares. The Administrator stated that since the resident's wound was covered it would not be necessary for the resident to be in isolation. The Administrator stated she had received CMS guidance regarding EBP and had reviewed this information with the staff earlier this year. The Administrator and the DON could not explain why R144 was not placed in some type of EBP. The DON was unable to provide documentation regarding the guidance the Infectious Disease physician indicated about not placing the resident in isolation. The Administrator was unable to provide documentation that staff had received EBP training.

Interview on 08/01/24 at 4:19PM, R144's physician stated that he usually takes directions from the Infection Disease physician at the hospital regarding placing residents in isolation. The Infectious Disease physician felt that since the resident was afebrile and exhibited no symptoms it was not necessary to place the resident in isolation. The Physician admitted that he was not familiar with the EBP. After reviewing CMS guidance on EBP, R144's physician agreed the resident should be placed on EBP.

3. Review of a facility policy titled "Isolation Guidelines Policy" dated 10/23 failed to include enhanced barrier precautions under their procedures.

a. Review of a facility document titled "Resident Information" indicated R1 was admitted to the facility on 12/01/15.

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Review of R1's significant change "MDS" with an Assessment Reference Date (ARD) of 06/13/24 with a "Brief Interview of Mental Status (BIMS)" score of four out of 15 which revealed the resident was severely cognitively impaired. The "MDS" indicated the resident was at risk for the development of pressure ulcers and had none.

Review of a facility document titled "Wound Care Center Physician Note" dated 07/18/24 indicated R1 had a pressure ulcer on her left ankle. In addition, the resident had a pressure ulcer on her left buttock.

During an interview on 07/30/24 at 6:04 PM, Licensed Practical Nurse (LPN) 2 confirmed R1 was not on EBP and that there was no PPE available for staff to use outside of R1's room.

b. Review of a facility document titled "Resident Information" indicated R36 was admitted to the facility on 07/19/24.

Review of R36's admission "MDS" with an ARD of 06/20/24 indicated the resident had a "BIMS" score of 13 out of 15 which revealed the resident was cognitively intact.

Review of a facility document titled "Wound Care Center Physician Note," dated 07/25/24 indicated R36 had stage four posterior pressure ulcers with bi-lateral ankles.

During an interview on 07/30/24 at 6:04 PM, LPN2 confirmed that R36 was not on EBP and that there was no available PPE outside of R36's room for staff to use.

c. Review of a facility document titled "Resident

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Information" indicated R294 was admitted to the facility on 07/19/24.

Review of a facility document titled "Active Order Profile" dated 07/19/24 indicated the resident had an order for a suprapubic catheter.

Review of R294's admission "MDS" with an ARD of 07/25/24 indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact. The "MDS" indicated the resident had an indwelling catheter.

During an interview on 07/30/24 at 6:04 PM, LPN 2 confirmed R294 was not placed on EBP and there was no PPE available outside of R294's room for staff to use.

d. Review of a facility document titled "Resident Information" indicated R6 was admitted to the facility on 07/17/24.

Review of a facility document titled "Active Order Profile" dated 07/17/24 indicated R6 had an order for an indwelling urinary catheter.

Review of R6's admission "MDS" with an ARD of 04/16/24 indicated the resident had a "BIMS" score of 14 out of 15 which revealed the resident was cognitively intact. The "MDS" indicated the resident had an indwelling urinary catheter.

During an interview on 07/30/24 4:22 PM, RN2 stated R6 had an indwelling catheter and did not have any EBP in place. RN2 stated there was no PPE available for use with this resident. Observation at this time revealed there was no PPE on the outside of R6's room for staff to use.

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e. Review of a facility document titled "Resident Information" indicated R37 was admitted to the facility on 06/18/24.

Review of a facility document titled "Active Order Profile" dated 07/07/24 indicated R37 required contact precautions due to a diagnosis of C-diff.

Review of R37's admission "MDS" with an ARD of 06/24/24 indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact.

During an observation on 07/30/24 at 12:17 PM, LPN1 entered R37's room to retrieve a tissue in which the resident had spit out a vitamin that she could not swallow. LPN 1 wore gloves but no protective gown. On the outside of the resident's room was a sign titled "Contact Plus" and directed staff to don (put on) a gown and gloves prior to entering the resident's room.

During an interview on 07/30/24 at 4:10 PM, CNA 1 stated prior to entering into the room with a resident who was under contact precautions was to don a gown and gloves.

During an interview on 07/30/24 at 4:11 PM, CNA 2 stated there was no dedicated equipment, such as a stethoscope and blood pressure cuff in R37's room.

During an interview on 07/30/24 at 4:15 PM, LPN 1 confirmed she did not don a gown prior to entering R37's room and that she knew the resident was in contact isolation. LPN 1 stated she did not know if R37 had dedicated equipment, such as a stethoscope and blood pressure cuff in her room.

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f. Review of a facility document titled "Resident Information" indicated R35 was admitted to the facility on 07/02/24.

Review of a facility document titled "LTC (Long-Term Care) All Orders" dated 07/31/24 indicated the resident was ordered to have an indwelling catheter placed.

Review of R35's admission "MDS" with an ARD of 07/08/24 indicated the resident had a "BIMS" score of 14 out of 15. The "MDS" indicated the resident had an indwelling urinary catheter.

During an observation on 07/29/24 at 11:39 AM, R35's room was observed with no PPE on the outside of her room.

During an interview on 07/30/24 at 4:18 AM, RN1 stated that R35 had a catheter and was not on EBP. RN1 confirmed that there was no PPE outside of R35's room for staff's use. RN 1 stated contact precautions required the donning of PPE prior to entering a resident's room, and enhanced precautions included donning PPE prior to any care contact with a resident.

During an interview on 07/30/24 4:22 PM, RN2 stated R6 had an indwelling urinary catheter and did not have any EBP in place. RN2 stated there was no PPE available for use with this resident. RN2 stated R36 had bi-lateral heel pressure ulcers and had no EBP in place and no PPE available for use. RN2 stated EBP included donning PPE prior to entering into a resident room.

4. Observation of R1's wound care on 07/31/24 at

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5:28 PM, revealed LPN5 performed hand hygiene before donning gloves. LPN 5 removed the dressing on R1's left ankle, then cleaned the ankle with wound cleanser. LPN5 then applied xeroform gauze to the open area and then covered the xeroform with a border dressing. LPN5 failed to perform hand hygiene and change gloves after removing the old dressing and applying the new dressing. LPN 5 then without changing her gloves moved R1's sacral wound dressing. LPN5 cleaned R1's sacral wound with the wound cleanser and applied a layer of calmoseptine ointment (moisture barrier) to the sacral area. LPN 5 never left the resident's bedside to change her gloves and perform hand hygiene.

During an interview on 07/31/24 at 5:43PM, LPN 5 stated that she went in the bathroom and changed her gloves.

Interview 08/01/24 at 11:30AM, the DON stated that nurse are expected to perform hand hygiene and change gloves when removing old dressings and applying new dressing for each wound.

5. Observation on 07/29/24 at 12:10 PM and on 07/30/24 at 8:45 AM of R5's room revealed a suction machine in the corner of the room on the floor. The machine had the disposable canister still in the holder and attached by the hoses. The canister contained 290 ml of yellowish fluid.

Interview on 07/31/24 at 12:20 PM, RN2 stated she had not known R5 to use the suction machine for some time, but the machine remained in his room for an emergency related to his condition. RN2 stated she had noticed the machine on the floor earlier but did not notice that

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the canister had fluids in it. RN2 stated the practice is to leave all respiratory machines on a table and not the floor, to empty the canister as needed and clean the machine after use and/or for storing.

Interview on 08/01/24 at 9:28 AM the DON stated R5 came with the suction machine but had not used it for a long time. The DON stated the machine should not have been placed on the floor for any reason, the machine should have had the canister cleaned or thrown away and the entire machine cleaned as well.

6. Review of a facility undated policy titled, "Water Management Policy and Procedures" Indicated, ". . . It is the intent of this facility to implement a water management program that will inhibit microbial growth in building water systems and to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. . ."

Review of the CDC website titled "Legionella. Prevention and Control," dated 03/25/21, indicated, "The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. . .Key Elements. . .Seven key elements of a Legionella water management program are to. . . Establish a water management program team. . . Describe the building water systems using text and flow diagrams. . . Identify areas where Legionella could grow and spread. . . Decide where control measures should be applied and how to monitor them. . . Establish ways to intervene when control limits are not met. . . Make sure the program is

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running as designed (verification) and is effective (validation). . ."

During an interview conducted on 07/30/24 10:16 AM, the DON stated there were no Legionnaires in the facility.

During an interview on 07/31/24 at 3:36 PM, the Maintenance Director (MD) verified there was no water diagram of the facility's water system.

7. Observation and interview on 07/30/24 at 10:25 AM revealed the kitchen's ice machine to have an orange-colored substance and a dark gray substance on the outside portion of the see-through ice dispenser. The Food Service Director (FSD) stated there should not be any colored substances on the spout and that the ice machine was not clean.

Observation and interview with the FSD on 07/31/24 at 8:46 AM of the ice/water machine on the Alpine Park Unit revealed the machine to have a white crusty material on the water dispensing area and the grate by the drain. The FSD confirmed the machine was not clean.

Observation and interview with the FSD on 07/31/24 at 8:58 AM of the ice/water machine on the Canyon Creek Unit revealed the machine to have a white crusty material on the water dispensing area and the grate by the drain. The FSD confirmed the machine was not clean.

Observation and interview with the FSD on 07/31/24 at 9:10 AM of the ice/water machine on the Dakota Unit revealed the machine to have a white crusty material on the water dispensing area and the grate by the drain. The FSD

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURREY PLACE ST LUKES HOSP SKILLED NURSING	14701 OLIVE BLVD CHESTERFIELD, MO 63017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 confirmed the machine was not clean. On 07/30/24 and 07/31/24 the FSD was asked for a policy on the maintaining and cleaning of the ice/water machine. A policy was not provided. Interview on 07/31/24 at 4:27 PM, the MD stated that the facility has a company that comes every quarter to take the ice machines apart and thoroughly clean them. The MD stated housekeeping was responsible for cleaning the ice machines between quarterly cleanings. The MD stated there is no documentation that indicates the ice/water machines were cleaned by housekeeping.	F 880		

PLAN OF CORRECTION

Provider/Supplier Name:	St. Luke's Hospital's Surrey Place
Street Address, City, Zip:	14701 Olive Blvd Chesterfield, MO 63017
Date of Survey:	7/29/24-8/1/20

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265414
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Correction does not constitute as an admission on the part of Surrey Place that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determinations are correct. *Staff who were observed during the visit do not agree with all the information in the Statement of Deficiencies. Surrey Place may exercise its option to request an IDR within the required timeframe, after further review of the evidence.* *Despite the disagreement with some of the allegations in the Statement of Deficiencies, we have taken the following steps to assure continuing compliance with the cited regulation.*	
F554	**Resident Self-Admin Meds -Clinically Appropriate** **Corrective Action:** R 37 is an alert and oriented short term rehab patient that requested to self-administer her daily vitamin and APAP (Tylenol). R 37 had been seen by her physician the morning of 7/30/24. The request to self-administer was completed. **Identification of Residents Potentially Affected:** Any resident could be affected by the self-administration policy if they make a request to self-administer or if there would be a situation where medications were left unattended. **Systemic Measures:** Staff will be in-serviced on completing all steps of the self-administration policy prior to leaving any medications at the bedside **Monitoring:** DON/ADON or designee will monitor for compliance.	9/6/24
F602	**Free from Misappropriation/Exploitation** **Past noncompliance: No Plan of Correction Required**	
F726	**Competent Nursing Staff**	9/6/24

	Corrective Action: The facility is adding the term Enhanced Barrier Precautions other isolation precautions and staff competencies in relation to infection control training. **Identification of Residents Potentially Affected:** This could potentially affect all patients at the facility. **Systemic Measures:** Additional care learning modules and in-services to be assigned and completed by staff specifically including infection control and enhanced barrier precautions. **Monitoring:** DON/ADON or designee will monitor for compliance conducting audits and review of employee care learning completion and in-service attendance	
F761	**Label/Store Drugs and Biologicals** **Corrective Action:** The medication and treatment carts were locked and the medication rooms were checked and any expired blood collection tubes were removed. **Identification of Residents Potentially Affected:** This could potentially affect all patients in the facility. **Systemic Measures:** Staff will be in-serviced on securing medication and treatment carts. Expired supplies will be placed in labelled boxes and removed from supply room. Staff will be in-serviced on checking dates and where to place expired supplies. **Monitoring:** DON/ADON/Clinical Supervisor or designee will monitor for compliance	9/6/24
F812	**Food Procurement, Store/Prepare/Serve-Sanitary** **Corrective Action:** Staff cleaned the freezer and kitchenettes to ensure that food is labelled, dated, and free of dirty or sticky shelves. **Identification of Residents Potentially Affected:** This has the potential to affect all patients in the facility. **Systemic Measures:** Staff will be in-serviced about food storage, labelling, and cleaning of dietary freezers and kitchenettes. **Monitoring:** Food Service Manager, Registered Dietician, or designee to monitor for compliance	9/6/24
F838	**Facility Assessment**	9/6/24

	Corrective Action: Facility updated Facility Assessment to include included infection control services, such as surveillance and antibiotic use, as well as the facility employing an infection preventionist who was responsible for overseeing the infection control program. **Identification of Residents Potentially Affected:** This has the potential to affect all patients in the facility. **Systemic Measures:** Facility assessment updated and will continue to review and change as needed. **Monitoring:** Executive Director or designee to monitor for compliance	
F880	**Infection Prevention and Control** **Corrective Action: -A**cceptable standards of practice for infection prevention were placed for R1, R35, R144 R1, R294, R6, and R36 including enhanced barrier precautions for wounds, for use of catheter and dedicated equipment such as stethoscope and bp cuff was assigned to R37. Suction machine cannister that was observed with yellowish fluid was cleaned. A diagram of the current facility's water system was included as part of the water management program and prevention of pathogens. The facility had 4 of 4 ice machines cleaned by on outside contractor. **Identification of Residents Potentially Affected:** This has the potential to affect all patient in the facility **Systemic Measures:** Additional care learning modules and in-services to be assigned and completed by staff specifically including infection control, enhanced barrier precautions, and wound care. Facility to maintain diagram of water system. Facility to properly clean ice machines on routine basis. **Monitoring:** DON/ADON/Clinical Supervisor or designee to monitor for compliance of nursing in-services/modules. Maintenance supervisor to monitor compliance for water system diagram and ice machine cleanings.	9/6/24

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

An administrator signature on the 2567 & approved POC could not be found in file.

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SURREY PLACE ST LUKES HOSP SKILLED NURSING	14701 OLIVE BLVD CHESTERFIELD, MO 63017

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{F 000}	INITIAL COMMENTS	{F 000}		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from significant medication error after one resident with an allergy to penicillin (a class of antibiotics that are commonly used to treat bacterial infections) was ordered and administered Zosyn (a penicillin antibiotic used to treat infections) intravenously (IV, into the vein) to treat a urinary tract infection (UTI) (Resident #503). The facility failed to get a detailed account of the resident's reaction to penicillin after it was reported and the resident's reactions were not documented in the medical record. The resident's family reported to facility staff the resident's reaction to penicillin was blood clots, he/she was highly allergic, and "it could kill" him/her. The nurse reported he/she was informed the resident's reaction was only blood clots. The pharmacy and the physician were informed the resident's reaction were only blood clots. The resident was administered Zosyn IV and thirty minutes later, he/she had difficulty breathing, was administered four liters of oxygen, and was transported to the emergency room. The resident was diagnosed with anaphylaxis (a severe, potentially life-threatening allergic reaction), was noted to be hypoxic (a condition that occurs when the body or part of the body does not receive enough oxygen at the tissue level) and was	F 760		10/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/20/2024

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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administered two rounds of epinephrine (adrenaline, emergency treatment for severe allergic reactions including anaphylaxis caused by unknown substances). The sample was four residents. The census was 65 with 52 in certified beds.

Review of the facility's Medication Orders Policy, reviewed February 2021, showed:
-Policy: Medication Orders shall be clear and accurate. Practitioners with delineated clinical privileges shall be able to give orders. Written patient medication orders for treatment shall be dated, timed and signed by the prescriber. All other medication orders will be entered into the hospital computer system via CPOE. Orders entered by a non-physician, shall be countersigned by the ordering physician;
-Process for Accepting a Telephone Order: The hospital minimizes the use of verbal and telephone medication orders. Only authorized prescribers can give telephone orders;
-Telephone orders are permitted. When taking a telephone order, the listener will type the order into CPOE. The listener will read the entire transcribed order back to the prescriber, including the patient's name and will use words instead of abbreviations. The prescriber will countersign the telephone order;
Telephone orders are not to be taken for anti-neoplastic agents, except to discontinue or hold the antineoplastic agent. A telephone order that seems inconsistent with the patient's problem will be questioned/clarified before the order is implemented;
-Preprinted and electronic standing orders, order sets, and protocols for medication orders include the following Processes for use: Review and approval of standing orders and protocols by the

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medical staff and the hospital's nursing and pharmacy leadership;
-Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines;
-Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols;
-Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

Review of Resident #503's face sheet, showed:
-Admitted on 3/12/24;
-Admit reason: Covid positive, fever, acute urinary retention, weakness, failure to thrive, malnutrition, congestive heart failure exacerbation;
-Allergies: Penicillin and Zosyn.

Review of the resident's allergy list, updated 3/27/24, showed:
-Penicillin: Reaction: anaphylaxis;
-Zosyn: Reaction: anaphylaxis.

Review of the resident's allergy list, provided by staff and received on 9/12/24, showed:
-Penicillin: Reaction: Cancelled;
-Updated: 2/27/17;
-Source: Family;
-Received: 3/25/24;
-A handwritten note showed, "allergy status was cancelled in 2017. It was reviewed as cancelled

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again on 3/25/24 because of it being listed in history once reviewed and confirmed as cancelled medication order continued/medication administered".

Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 3/18/24, showed:
-Diagnoses included atrial fibrillation (a-fib, irregular heartbeat), heart failure, hypertension (HTN, high blood pressure), benign prostate hyperplasia (BPH, a non-cancerous enlargement of the prostate gland), hyperlipidemia (abnormally high levels of lipids or fats in the blood), dementia, malnutrition and anxiety;
-Severe cognitive impairment;
-Has physical behaviors;
-Incontinent of bowel and bladder;
-Administered anticoagulant (medication that reduces blood clots), antibiotic and anti-anxiety medications.

Review of the resident's care plan, initiated 3/25/24, showed:
-Plan: Long term care genitourinary (urinary and genital organs) Interdisciplinary Plan of Care (IPOC);
-Intervention: Monitor symptoms of UTI (voiding pain, mental status change) and notify nurse if present;
-Note urine color, clarity, amount, odor;
-Promote optimal fluid and nutrition intake intervention: Provide perineal care (peri care, washing the genitals and anal area);
-Notify physician for variations in evaluation findings.

Review of the physician's progress notes, dated

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3/17/24, showed:
-Patient concerns: Recent UTI greater than 100,000 colony forming units (cfu)/ milliliter (ml) Citrobacter Koseri (bacteria), this is a multi-drug resistant (MDRO) that is resistant to three or more class of antibiotics. Contact precautions are required. Consider an infectious disease consult if indicated;
-Impression and Plan: UTI - Citrobacter Koseri;
-Plan: Start Nitrofurantoin (Macrobid, antibiotic used to treat and prevent urinary tract infections).

Review of the physician progress notes, dated 3/19/24, showed:
-Patient concerns: Follow up of UTI, tolerating Macrobid, gets very agitated on day to day treatments, follow up of labs;
-Impression and Plan: Potassium 5.1 (normal potassium level for adults, 3.5 to 5.0) and blood urea nitrogen (BUN, measures kidney function) 44 (normal BUN level, 8 to 23 milligrams per deciliter for adults over 60);
-Lokelma (used to treat high potassium levels) 10 grams (g) by mouth x one now;
-Increase oral fluids;
-UTI - Citrobacter Koseri;
-Plan: Start Nitrofurantoin, Lokelma x one dose.

Review of the physician progress notes, dated 3/21/24, showed:
-Patient concerns: Follow up of UTI, tolerating Macrobid, more calm, cooperative, no chest pain, headaches, cough, nausea, vomiting, diarrhea, fever;
-Impression and Plan: UTI - Citrobacter Koseri on Macrobid;
-Plan: Start Nitrofurantoin, repeat urinalysis (UA, a test that examines urine to detect and manage a range of disorders) and culture.

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Review of the physician progress notes, dated 3/25/24, showed:
-Patient concerns: Follow up UA and culture and sensitivity (C&S), still showing white cells and bacteria, more compliant;
-Impression and Plan: UTI - Citrobacter Koseri on Macrobid completed will repeat UA, still showing bacteria and white cells;
-Will start him/her on Zosyn 3.375 gram (g) every 8 hours;
-Plan: Will start Zosyn 3.375 every 8 hours for five days.

Review of the progress notes, showed:
-Service date/time: 3/25/24 at 6:00 P.M.;
-Performed by Assistant Director of Nursing (ADON) on 4/12/24 at 8:42 P.M.;
-Signed by ADON on 4/12/24 at 8:42 P.M.;
-Received call from pharmacy stating that Physician A wanted to start the patient on IV Zosyn. Patient's chart stated that he/she had an allergy to penicillin and the pharmacist asked me to ask patient or family what the reaction was. Son stated that the reaction was that it caused "blood clots". Pharmacist stated that Zosyn does not cause blood clots and that we were ok to hang the IV.

Review of the resident's progress note, signed by the ADON on 4/12/24 at 8:42 P.M., provided by staff and received 9/12/24, showed a handwritten note, "Nurse did talk to son, the source of "history of antibiotic allergy" which was cancelled in 2017 and son stated that the reason was that it caused "blood clots". This information was reported to doctor and pharmacist and medication was cleared and approved for administration".

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Review of the progress notes, showed:
-Service date/time: 3/25/24 at 11:43 P.M.;
-Signed by Licensed Practical Nurse (LPN) B on 3/25/24 at 11:49 P.M.;
-This nurse started patient on Zosyn IV as ordered. After 30 minutes of going back into the room to check on the patient, noticed that he/she was not him/herself. Patient stated that he/she did not feel good and he/she was yelling out, serum pressure oxygen (SPO2) was low, this writer applied oxygen at 4 liters (L) via nasal cannula, blood pressure was not reading. Physician A called left voicemail (LVM). Son called, made aware of resident's condition, and 911 called to have patient sent to hospital.

Review of the progress notes, showed no documentation of the resident's behavior on 3/25/24, resident's signs and symptoms of allergy to penicillin, conversations between the resident's family and nursing staff, and conversations between nursing and pharmacy or physician.

Review of the resident's hospital record, dated 3/25/24 at 11:35 P.M., showed:
-Chief Complaint: Nurse hung antibiotic at rehab. Thirty minutes later, patient had respiratory rate and complaints of burning sensation. Patient is a Do Not Resituate (DNR, medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient's breathing or heart stops);
-History of present illness: The onset was prior to arrival. He/She is an 85-year-old who is being treated at rehab facility for pneumonia. He/She was getting antibiotics and 30 minutes later when the staff went to check on, he/she was found less responsive and was having some difficulty breathing. Paramedics were called. Emergency

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Medical Service (EMS) report is not available. The prearrival report suggests that he/she was hypotensive (low blood pressure) and heart rate of 110. He/She was given two rounds of epinephrine intramuscularly (within or into a muscle). He/She was not noted to be wheezing. He/She was noted to be hypoxic (a condition that occurs when the body or part of the body does not receive enough oxygen at the tissue level). He/She was put on nonrebreather (a medical device that provides oxygen to patients in emergency situations) mask. Patient cannot provide any history. Further information as noted above in the triage;
-EMS report: allergic reaction to intravenous line (IV) antibiotics, from rehab, 2 IM cpi given;
-Vitals: 60/40 (low blood pressure is a reading lower than 90/60);
-110 a-fib, unable to get O2 (oxygen);
-Spoke with his/her son who is present at the bedside. Apparently visited him/her this afternoon and he/she was not feeling good at that time. He/She was not feeling well. He told the surgery place that he/she gets blood flow from penicillin. No other reaction was noted. DNR/DNI (Do Not Intubate) was confirmed with the son.

During an interview on 9/11/24 at 12:18 P.M., the ADON said pharmacy called from the hospital. The resident had the allergies to penicillin and pharmacy asked if the resident would be able to tell them what happened. The resident could not. His/Her son was reached and the son said it "almost killed" him/her and "gave (him/her) blood clots". They got an IV in him/her, and even pharmacy recommended running it slower, but the ADON could not confirm that for sure. They started that night, but he/she had a reaction and they sent him/her out 911. The ADON was not

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there at the time the resident was sent out. Physician A was contacted. The ADON looked for the note in the medical record. He/She said it happened a long time ago, but confirmed there was no other note on him/her and if there was no documentation, he/she did not want to say the physician was notified. The ADON already left when resident had a change in condition. LPN B hung the IV. LPN B was upset that the information was not conveyed to him/her regarding the reaction to penicillin. They stayed with the resident the first few minutes and for a regular antibiotic, they do checks for the first two hours. It's visually assessing the resident, eyes on the resident. The pharmacy said the allergy to penicillin was in there, but the severity was not documented, so that was why they wanted to contact someone in the family. The ADON did not remember if he/she took the order for the medication. The son said blood clots first, but pharmacy said it was not possible. The ADON went back to the son and said it was not on the list of reactions and not possible. The son said "I am not medical", but the son said the blood clots. The ADON did not have "almost killed" him/her documented, but he/she realized he/she said it in the beginning of the interview. He/She did not want to say that for sure. The pharmacy called the facility. Someone else could have put the order in. The ADON checked the medial record and said the order was put in by Physician A, from what the ADON was able to see. The ADON was asked if he/she felt comfortable administering the Zosyn. The ADON said with the pharmacy saying it was ok, he/she felt comfortable administering medication. Anytime there is a new medication, they keep an eye on the resident whether it is a possible allergy or not. There is no protocol if there was uncertainty of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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symptoms or reaction to a medication. It should be the same situation with any antibiotic administered. They keep an eye on the resident.

During an interview on 9/11/24 at 1:57 P.M., the Director of Pharmacy returned to the record in their system. The resident was allergic to penicillin, but no reaction was listed. They did put the order through. They talked to Physician A and he/she said the resident was resistant to all medications for a UTI, so the only option was Zosyn. The ADON talked to the son and the patient did not have an allergy to penicillin, just a history of blood clots. There is a letter from the daughter, who wrote in a letter that the patient was quite severely allergic to penicillin. The son talked to the ADON and the only reaction to penicillin was he/she had blood clots and that was why he/she was on Coumadin (anticoagulant medication that prevents and treats blood clots). The information "blood clot reaction not from Zosyn" did not come from pharmacy for the ADON to tell. The physician may have felt it was not a real allergy. The Director of Pharmacy was asked about a letter from the daughter he/she mentioned. He/She "heard" the daughter said the resident was allergic. The Director of Pharmacy just saw penicillin allergy in the chart, but no reaction was documented. There was no documentation of anaphylaxis in the medical record for what he/she could see. The allergy showed the reaction was blood clots. Pharmacy spoke to the physician and the physician was facilitating the order. There was no documentation of contact with nursing or with the ADON. If patient had a reaction of anaphylaxis, they would not have gone forward with that order. There was no documentation of severe anaphylaxis in the medical record. The resident

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	265414	A. BUILDING _____ B. WING _____	R 09/11/2024

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was treated for anaphylaxis in the hospital and he/she had sepsis. The physician contacted the pharmacy to order it and the physician talked to the nurse. That was what they were told. Blood clots is what pharmacy was told the son said. It came from the ADON, but he/she but did not see it in the pharmacy records. He/She said it was what he/she was just told.

During an interview on 9/11/24 at 2:48 P.M., the Administrator and Director of Nursing (DON) said they were here at the time the resident was admitted and were aware he/she went out to the hospital. The DON said he/she had allergies listed and the son talked to the nurse and they reported there was an allergy to it and the resident got blood clots. Blood clots was not an allergic reaction. The Administrator said Physician A was aware the son made a statement about penicillin causing blood clots. The information was from the nurse to the doctor. Physician A ordered the Zosyn because it was not a true side effect of penicillin and there was only a few antibiotics he/she could use. The son believed the resident was on blood thinner because of the allergy, but it was atrial fibrillation. The DON said when an order is entered, they have to click a button if physician is aware of the order, press if they want to continue to order or if the physician approved or not. The DON said she was here and the son did not say "it could kill" him/her. There was no other reaction other than blood clots. The DON was there when the IV or the peripheral was placed. The DON was not at the facility during the resident's change in condition. The son was hopeful and grateful because resident was combative and total care. The son did not want the resident to go out to the hospital. Allergies are located in the allergies tab in the medical record.

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The allergy to penicillin was documented, but no reaction was documented. Some residents cannot say what the reaction is, but they do inquire about allergies, even food allergies, before it is administered. The Administrator and DON only knew about contact with the son, no other family member called, sent a letter, or spoke to about allergies. The DON would have to look into the notes, but believed the nurse talked to the physician. She was certain nursing was in contact with pharmacy and the physician multiple times. It may not be documented, but the medication would not be sent over without the approvals. For antibiotics and any medication, there is an assessment, and nursing would take vitals. For antibiotics, it specifies the reason they are on it. Nursing was back in the room several times and at the half hour mark after administration. The resident had hypoxia and shortness of breath. They had been in there several times prior; they changed him/her because he/she was incontinent. The Administrator said she was sure the physician was on the phone with nursing. The order should not come over without physician approvals. If Physician A is not on the phone, he is electronically communicating with staff. The Administrator said they may not have policies requested by the surveyor for physician orders, IV medication administration, and change in condition. The DON said she will look for them.

During an interview on 9/11/24 at 3:15 P.M., Physician A said he/she believed the pharmacy called to inform him/her the urine culture showed different bacteria. The cultures were looked at and Zosyn was recommended. Physician A wanted to review the record and call back. At 4:45 P.M., Physician A called back. The resident

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was confused and he/she had a UTI. He/She was on Macrobid. The pharmacy called and said it was MDRO and there was greater than 100,000 from the culture from March 14th, and was resistant other than Zosyn. He/She called the pharmacy to guide him/her. The other option that left was Zosyn. He/She went into sepsis due to UTI and was resistant to all medications. The only option left was Zosyn because he/she became septic. The order came from pharmacy. The information regarding allergies to blood clots was not clear on the penicillin allergy. Everything else was resistant in the urine culture. All 12 antibiotics were resistant to the bacteria. There was no discussion regarding resident being "highly allergic" or "it could kill" him/her. Anaphylaxis was not mentioned. The resident was also confused. It was one of the concerns. If the UTI was not treated, they have to consider hospital re-admission. They wanted to treat the UTI because it was sensitive. Physician A would not administer Zosyn if it was relayed the resident was "highly allergic" and "it could kill" him/her. Sometimes someone says they are allergic from 30 years ago. A lot of people say they are allergic and penicillin caused a rash. Labeling yourself allergic to penicillin, you are not able to take a lot of medications. If they stated blood clots, that is a mild allergy. It is unusual to have a blood clot allergy to penicillin. The resident was to treat the Citrobacter on March 14th. This is MDRO on the lab. Physician A asked pharmacy, and they said the only option was IV Zosyn. There was complete understanding he/she was on Macrobid and he/she was really confused. The fear was the resident not responding and he/she would go into sepsis.

During an interview on 9/11/24 at 3:25 P.M., the

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resident's son said he did not remember the nurse's name he spoke to. He/She just stuck his/her head in the room. The phone was on his/her shoulder. He/She asked why did he/she have penicillin on the allergy list. He told him/her that it caused blood clots, he/she was "highly allergic" and that "it could kill" him/her. It had been on his/her list for 30 or 40 years. They updated it 2017 at the hospital. Apparently that was not listed on the reactions. The son left the facility at 6:30 P.M., they called him and and resident was sent to the emergency room at 11:00 P.M. The resident was gasping for air, they came in, and gave him/her a breathing treatment in the emergency room. They would not let the son in when he got there. There were two nurses and doctor in there. They said the resident was in critical condition. Penicillin allergy is on his/her list and they gave it to him/her anyway. They know they messed up and now he/she is on hospice and now his/her heart is damaged on one side. That was the indication he got from the doctor. It was a result of the Zosyn. The son said years ago, the resident had a blood clot and he/she was slumped over in the car. His/Her spouse thought he/she had the flu, so he/she gave the resident a penicillin capsule. He/She started having a reaction, so they drove to a car dealership, and they called EMS and took him/her to hospital. That was when they found out he/she was allergic to penicillin. That was 30 years ago. He/She had numerous venous thrombosis in the legs in his/her history. He/She had pin sized blood clots in the past. Anything with penicillin should be kept away from him/her. If there's bacteria, the physician has to be careful of what he/she prescribes. He/She is incapacitated now and is on hospice. The resident still had a UTI at the new facility and even at the hospital. At 3:43 P.M.,

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the son called back and said someone from the hospital or the facility called him in the past and they said they did nothing wrong and he told the nurse it caused blood clots. The son confirmed in addition to blood clots, "highly allergic" and "it could kill" him/her were communicated to the nurse.

During an interview on 9/11/24 at 4:00 P.M. the DON said the part of "it could kill" him/her meant the blood clots. The son was asked what the reaction would be, and he said it would cause blood clots. The resident was started on Eliquis (blood thinner) due to atrial fibrillation. He was asked if it was blood clots and he said "I am not medical" and that is the only reaction he knew he/she had. Once the resident was discharged from hospital, his/her son did not want him/her to come back. The day the resident received the Zosyn, it was an all day ordeal. He/She was demented and combative. The son thought sending him/her out would cause more confusion. The son told the resident, "they have to stick you, they have an IV". They got the IV placed and re-visited back and forth with the pharmacy and doctor. It was never mentioned any amount of penicillin was lethal. The Administrator said the physician made the decision and there were limited antibiotics. There was no documentation of anaphylaxis and no shortness of breath. They did explore every opportunity of what happens with penicillin. The statement made "tried to kill" him/her that was when they were discharge planning at the hospital. They spoke to the physician who approved the medication. The son was aware and was okay with the medication. The physician was aware of the blood clots. Everything was a team effort. The son was aware Zosyn was administered, and convinced resident

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to take it. The DON was asked if the information was documented. The DON said all the documentation goes back to the order. There is a lot to do and select different options. She would have to check if there is documentation. If anything was refused, they would have documented it. They talked to the son and patient, and documented they inserted the IV and it is a task that pops up in the record. They document by exception. The Administrator said either pharmacy called the facility or they called pharmacy. Once the order goes to pharmacy, if they see an allergy, they will call. There is a safety there that would go through the pharmacist. She did not recall if the resident was administered other medications. The son was adamant about wanting the IV medications. She believed the son's take was he would convince him/her to take the IV and they could coordinate to give it when the son was here. The son thought it would be quicker and more effective. When the resident was admitted, he/she was already total care and the son was living in an imaginary world. The resident's insurance did not believe he/she was able to stay for rehab stay because he/she would not get better. He/She did not have the potential to improve from a rehab stay. His/Her condition was already poor so there was no other chance of improvement.

During an interview on 9/11/24 at 4:39 P.M., the DON provided documentation from social service notes. The son did not mention "it could kill" him/her, but the social worker notes showed the son said "the facility tried to kill resident".

During an interview on 9/11/24 at 4:39 P.M., the ADON returned with the DON and Administrator. The ADON said he/she should have slowed down

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F 760	Continued From page 16 during the initial interview. If the son said "it could kill" him/her, it would have been in his/her note. The ADON said there was a lot of mentioning of "it could kill" him/her from the son, but it was after the resident received Zosyn. The Administrator said the "they could have killed" him/her part that was said by the son was not related to the blood clots. It was after what occurred when the penicillin was administered. The Administrator said they did not see it as a medication error. It was cleared by the pharmacist. They did not make a medication error. If the son said it "almost killed" him/her, they would have asked more questions. MO00240500	F 760		

Missouri Department of Health and Senior Services

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	15467	A. BUILDING: _____ B. WING _____	R-C 09/11/2024

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A4060	19 CSR 30-85.042(51) Medication Errors/Adverse Reactions Reported All medication errors and adverse reactions shall be reported immediately to the nursing supervisor and the resident's physician and, if there was a dispensing error, to the issuing pharmacist. II/III This regulation is not met as evidenced by: Class II* See the deficiency cited at F760. *Higher classification merited due to the extent of the violation.	A4060	Please see attached plan of correction.	

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan Franklin

TITLE: Executive Director

(X6) DATE: 9/20/24

PLAN OF CORRECTION

Provider/Supplier Name:	St. Luke's Hospital's Surrey Place
Street Address, City, Zip:	14701 Olive Blvd Chesterfield, MO 63017
Date of Survey:	9/11/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265414
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Correction does not constitute as an admission on the part of Surrey Place that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determinations are correct. *We disagree with various allegations, interpretations, and conclusions set out in the Statement of Deficiencies and are filing an Informal Dispute Resolution request in accordance with State and Federal requirements, in which we will cover our disagreements to the extent that the IDR procedures allow us to do so.* *In spite of the disagreement with some of the allegations in the Statement of Deficiencies, we have taken the following steps to assure continuing compliance with the cited regulation.*	
F 760	**Residents are Free of Significant Med Errors** **Corrective Action:** R 37 is no longer a patient. Allergies and medications were reviewed prior to administration of medication. **Identification of Residents Potentially Affected:** Any resident receiving medication could be affected. **Systemic Measures:** Staff have been in-serviced on (1) completing all steps of the medication order policy, (2) documenting any investigation by facility staff of reported but unconfirmed reports of medication allergies, and (3) documenting communications with physicians and pharmacists about decisions by the physician to "cancel" or override reported but unconfirmed allergies and to proceed with administration of ordered medication for which there had been a previous allergy report. **Monitoring:** DON or designee will monitor for compliance.	10/02/2024

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

PLAN OF CORRECTION

Provider/Supplier Name:	St. Luke's Hospital's Surrey Place
Street Address, City, Zip:	14701 Olive Blvd Chesterfield, MO 63017
Date of Survey:	9/11/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265414

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A4060 19CSR 30-85.042(51)	**Medication Errors/Adverse Reactions Reported** **Corrective Action:** R 37 is no longer a patient. Allergies and medications were reviewed prior to administration of medication. **Identification of Residents Potentially Affected:** Any resident receiving medication could be affected. **Systemic Measures:** Staff have been in-serviced on (1) completing all steps of the medication order policy, (2) documenting any investigation by facility staff of reported but unconfirmed reports of medication allergies, and (3) documenting communications with physicians and pharmacists about decisions by the physician to "cancel" or override reported but unconfirmed allergies and to proceed with administration of ordered medication for which there had been a previous allergy report. **Monitoring:** DON or designee will monitor for compliance.	10/02/2024

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