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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUVAIS REHAB AND HEALTHCARE CENTER	3625 MAGNOLIA AVENUE SAINT LOUIS, MO 63110

(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 000	INITIAL COMMENTS A Recertification and Complaint 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: 03/17/25- 03/20/25. Survey Census: 136 Sample Size: 48 Supplemental Residents: 17 Deficiencies were issued related to Intakes MO00250713, MO00247452, and MO00248617 at F584, F725, and F727. No deficiencies were issued related to Intake MO00251073.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barry Conner
TITLE: Administrator
(X6) DATE: 7/18/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and facility policy review, the facility failed to ensure medical records containing personal health information (PHI) were not accessible to 27 of 27 residents and/or visitors who resided on the secure unit. This failure had the potential to allow inappropriate access to resident records. The facility census was 136.

Findings include:

Review of the facility's policy titled, "General Provisions- Medical Records Manual-General," revised 10/24/22, revealed, "Active records are to be located in an area not accessible to unauthorized persons."

Review of the facility's policy titled, "Resident Rights," revised 05/01/23, indicated, ". . . State and federal laws guarantee certain basic rights to

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all residents in this Facility. These rights include, but are not limited to, a resident's right to . . . Privacy and confidentiality. . ."

Review of the facility's policy titled, "Confidentiality of Information and Personal Privacy," revised 10/01/17, indicated, ". . . The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records . . . Access to resident personal and medical records will be limited to authorized staff and business associates . . ."

During an observation on 03/19/25 at 7:39 AM, Certified Medication Technician (CMT) 6 administered medications to R38 in R38's room. The medication cart was located in the dining room. CMT6 left R38's electronic medical records (EMR) open which contained confidential and private medical information visible to any resident or visitor in the dining room. Multiple residents were in the dining room waiting for breakfast.

During an observation on 03/19/25 at 7:42 AM, CMT6 administered medications to R123 in R123's room. The medication cart was located in the hallway outside of R123's room. CMT6 left R123's EMR open which contained confidential and private medical information visible to any resident or visitor in the hallway outside of R123's room. Residents were observed walking down the hallway.

During an observation on 03/19/25 at 7:53 AM, CMT6 left the medication cart that was located in the dining room. CMT6 left the EMR for all residents on the hall open which contained confidential and private medical information visible to any resident or visitor in the dining

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F 583	Continued From page 3 room. There were 27 residents located on this hall. During an interview on 03/19/25 at 08:16 AM, CMT6 stated, "I didn't realize I was leaving the screen open." During an interview on 03/20/25 at 5:33 PM, the Director of Nursing (DON) stated, "The [EMR] screen should be locked when the nurse walks away from the medication cart. There would be privacy concerns if the screen was left open."	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

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§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, interview, and facility policy review, the facility failed to ensure the fifth-floor shower room was cleaned as required for one of one resident (Resident (R) 109) reviewed for the environment out of a total sample of 48. This failure had the potential to affect the resident's health and ability to utilize the shower area. The facility census was 136.

Findings include:

Review of the facility's policy titled, "Housekeeping- Restroom and Showers," revised 10/24/22, revealed ". . . Showers . . . Scrub bathtubs and showers . . ."

Review of R109's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted on 04/12/24. Diagnoses included displaced fracture, chronic obstructive pulmonary disease,

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chronic respiratory failure, and emphysema.

Review of R109's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/02/25 and located under the "MDS" tab of the EMR, revealed R109 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 2:09 PM, R109 stated he wished there were better places to take showers because the shower was not clean.

During an observation and interview on 03/17/25 at 2:25 PM with the Certified Nurse Aide (CNA) 1, the shower area had orange-colored stains on the lower sides of the standing shower tiles and within the shower grout. CNA1 stated the Housekeepers should have been cleaning the area.

During an observation and interview on 03/17/25 at 2:31 PM, the Maintenance Director (MD) stated the orange area was probably soap scum. He stated he did not see why the orange areas could not be removed.

During an observation and interview on 03/17/25 at 2:37 PM, Housekeeper (HSK) 1 observed the orange area and stated she did not usually work on the fifth floor. She stated they normally cleaned the shower rooms.

During an observation and interview on 03/17/25 at 2:40 PM, Housekeeping Manager (HSKM) stated the shower was supposed to be cleaned every day. She sprayed the orange area and

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F 584	Continued From page 6 while wiping, it was coming off. She confirmed the area was improving as she sprayed with a chemical and wiped. She stated there was no documentation of the shower rooms being cleaned. She stated it was supposed to be cleaned every day. She confirmed it had been a while since it had been deep cleaned. MO00248617 MO00251444	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy, the facility failed to complete a significant change Minimum Data Set (MDS) within 14 days of change for one of 10 residents (Resident (R) 23) reviewed for significant change assessments out of a total sample of 48. R10 showed a severe weight loss of 11.28% in six months and declined in mobility status that impacted more than one area of the resident's health status. This failure had the potential to	F 637		

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cause further decline in the resident's status without further intervention by staff, interdisciplinary review, or revision of the care plan. The facility census was 136.

Findings include:

Review of the facility's policy titled, "RAI Process", revised 10/24/22, indicated, ". . . Purpose: To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified . . . Policy: I. The Facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment for each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual . . ."

Review of R23's undated "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R23 was admitted to the facility on 12/15/23 with diagnoses that included Alzheimer's disease, anxiety disorder, insomnia, mood disorders, dysphagia, dementia, and depression.

Review of R23's annual "MDS," with an assessment reference date (ARD) of 12/02/24 and located under the "MDS" tab of the EMR revealed R23 had not normally used a wheelchair in the last 7 days.

Review of R23's quarterly "MDS," with an ARD of

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02/27/25 and located under the "MDS" tab of the EMR, revealed R23 had a change and had normally used a wheelchair in the last 7 days.

Review of R23's "Weights," located in the EMR under the "---" tab, revealed R23 weighed 133.0 pounds (lbs) on 08/07/24 and 118.0 lbs on 02/20/25. This constituted an 11.28% severe weight loss in six months.

Review of R23's "Progress Notes," dated 2/28/2025 at 11:32 AM and located under the "Progress Notes" tab of the EMR, revealed, ". . . SIGNIFICANT WEIGHT LOSS NUTRITION NOTE: weight: 118# 2/20/25, BMI 22.3; +2.3% in 1 month, -11.3% in 6 months. Diet: mechanical soft, super cereal with breakfast, milk/chocolate milk with meals, Magic Cup with lunch. Eats meals in SCU dining room. Ambulates ad lib. Staff reported intake varies and refuses to be fed. Order for weekly weights to follow trend. Receiving supercereal with breakfast, milk/chocolate milk with meals, and Magic Cup with lunch to help increase nutritional intake. Current weight indicates some weight gain x 1 month. Will continue to follow and intervene further prn [as needed]."

Review of R23's "MDS" tab of the EMR revealed no documented evidence a significant change assessment was completed when it was noted the resident had a major decline in nutritional status and a decline in mobility. It was recorded a quarterly "MDS," with an ARD of 02/27/25 was completed.

During an interview on 03/19/25 at 5:30 PM, the MDS Coordinator (MDSC) stated "We have IDT meetings to discuss residents. I would do the

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F 637	Continued From page 9 significant change assessment within 8 days. Significant change would include significant permanent changes in ADLs [activities of daily living], insurance status changes for hospice, significant weight, mood, and behavior changes." The MDSC stated she was unsure if changes in two care areas were required to qualify for a significant change MDS. During an interview on 03/20/25 at 10:34 AM, the MDSC stated, "The weight on 02/20/25 was not within 180 days of the August weight taken on 08/07/25 and was not in compliance per CMS guidelines and therefore does not count. Since the weight taken in August was greater than 180 days, we cannot use it for a significant weight loss."	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for two of 48 residents (Resident (R) R23 and R136) whose records were reviewed. This had the potential to cause unmet care needs for the residents. The facility census was 136. Findings include: Review of the facility's policy titled, "Assessment and Management of Resident Weights," revised 10/24/22, indicated, ". . . V. Significant Weight	F 641		

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Change Management: A. Significant weight changes will be reviewed by the Director of Nursing Services or designated licensed nurse. Significant weight changes are: i. 5% in one (1) month, ii. 7.5% in three (3) months, iii. 10% in six (6) months . . ."

Review of the facility's policy titled, "RAI Process," revised 10/24/22, indicated, ". . . Purpose: To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified . . . Policy: I. The Facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment for each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual . . ."

1. Review of R23's "Admission Record,", located under the "Profile" tab of the EMR, revealed R23 was admitted to the facility on 12/15/23 with diagnoses that included Alzheimer's disease, anxiety disorder, insomnia, mood disorders, dysphagia, dementia, and depression.

Review of R23's "Weights," located under the "Wts/Vitals" tab of the EMR, revealed:
On 08/07/24, the weight was 133.0 pounds (Lbs).
On 01/09/25, the weight was 115.4 Lbs.
On 02/02/25, the weight was 118.0 Lbs.

Review of R23's "Progress Notes," dated 01/20/2025 at 9:24 AM, revealed, ". . .

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SIGNIFICANT WEIGHT LOSS NUTRITION
NOTE: weight: 115.4# 1/9/25, BMI 21.8; essentially stable x 1 month, -6.2% in 3 months, -14.3% in 6 months . . ."

Review of R23's "Progress Notes," dated 02/28/2025 at 11:32 AM, revealed, ". . . SIGNIFICANT WEIGHT LOSS NUTRITION NOTE: weight: 118# 2/20/25, BMI 22.3; +2.3% in 1 month, -11.3% in 6 months . . ."

Review of R23's quarterly "MDS," with an ARD of 02/27/25 and located under the "MDS" tab of the EMR, revealed the resident was coded to have no weight loss of 5% or more in the last month or 10% or more in the last six months.

During an interview on 03/19/25 at 10:34 AM, the MDSC stated, "the weight on 02/20/25 for R23 was not within 180 days of the August weight taken on 08/07/25 and was not in compliance per CMS guidelines and therefore did not count. She stated, "Since the weight taken in August was greater than 180 days [old], we cannot use it for a significant weight loss."

2. Review of R136's "Admission Record," located under the "Profile" tab of the EMR,, revealed R136 was admitted to the facility on 12/05/24 with diagnoses that included congestive heart failure and chronic kidney disease stage 3. The resident was discharged on 12/30/24 to home.

Review of R136's "Order Summary," located under the "Orders" tab of the EMR, revealed an order dated 12/27/24 to "Discharge home 12/28/24 with all belongings including meds."

Review of R136's "Progress Notes," located

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F 641	Continued From page 12 under the "Prog Notes" tab of the EMR, revealed no documentation regarding R136's discharge. Review of R136's "Discharge MDS," with an ARD of 12/30/24, located under the "MDS" tab of the EMR, revealed the resident was coded to have discharged to "short-term general hospital." During an interview on 03/19/25 at 5:30 PM, the MDSC stated she was unable to provide an explanation for the discrepancy regarding the discharge status of R136 and stated, "The discharge assessment information would have been taken from the [EMR]." During a subsequent interview on 03/20/25 at 10:40 AM, the MDSC stated, "[R136] was discharged home and the discharge MDS has been modified."	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		

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serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews, and facility policy review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR) level one was updated with a new diagnosis after admission for one of two residents (Resident (R) 91) reviewed for PASARR out of a total sample of 48. This failure had the potential to affect the resident's need for any potential additional services. The facility census was 136.

Findings include:

Review of the facility's policy titled, "Pre-Admission Screening and Resident Review (PASRR)," revised 07/27/23, revealed, ". . . The facility also conducts Level 1 screen for current residents who have a mental illness or intellectual disability and experience a significant change in their condition based on MDS [Minimum Data Set] 3.0 guidelines . . . A negative PASRR Level 1 screen permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual ability arises later . . ."

Review of R91's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted on 08/03/23. It was recorded that a diagnosis of mood disorder was added on 12/06/23.

Review of R91's"Level One PASARR," located under the "Misc" section of the EMR and dated 08/02/23, revealed under the section "Does the

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F 644	Continued From page 14 individual have a current, suspected, or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition?" There was no documented evidence that R91's PASARR had been updated to include the diagnosis of mood disorder when it was added on 12/06/23. During an interview on 03/19/25 at 9:56 AM, the Social Services Director (SSD) stated she did not do anything regarding PASARRs. During an interview on 03/19/25 at 10:06 AM, the Business Office Manager (BOM) stated she did not do anything regarding the PASARR. She stated the Regional BOM (RBOM) oversaw the PASARR. The BOM called the RBOM, and the RBOM stated the facility usually sent her any changes. The RBOM stated that for a new diagnosis, they would do a duplicate PASARR to add the new diagnosis. She stated it would have been the MDS Coordinator (MDSC) who would have updated her. During an interview on 03/19/25 at 10:41 AM with the Administrator, Interim Director of Nursing (DON), and MDSC, the MDSC stated she did not update the BOM when R91 received the diagnosis of mood disorder. She stated she only updated the diagnosis in the EMR. She stated no one had ever asked her to do anything different. The Interim Director of Nursing (DON) stated she was unsure of who oversaw sending updates to the RBOM. The Administrator stated he thought it would be between Social Services or the BOM.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

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F 656	Continued From page 15 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement a care plan for a resident's hospice services for one of one resident (Resident (R) 57) reviewed for hospice out of a total sample of 48. This had the potential to cause unmet care needs. The facility census was 136.

Findings include:

Review of R57's "Face Sheet," located in the "Profile" tab of the EMR, revealed R57 was admitted to the facility on 11/18/24.

Review of R57's "Physician Orders," located under the "Orders" tab in the EMR and dated 02/07/25, revealed an order for hospice services.

Review of R57's "Care Plan," located under the "Care Plan" tab of the EMR and dated 02/07/25, revealed there was no evidence R57 had a care plan developed for hospice services.

During an interview on 03/19/25 at 5:29 PM, the MDS Coordinator (MDSC) stated the facility missed developing a care plan for hospice services for R57. She stated updating the care plan to include hospice was missed since the payor type was not updated.

During an interview on 03/20/25 at 5:42 PM, the

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F 656	Continued From page 17 Director of Nursing (DON) stated that a care plan should have been implemented for hospice services.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff followed physician orders for the use of a helmet related to fall safety for one of one resident (Resident (R) 2) reviewed for Helmet use out of a total sample of 48. This had the potential to increase R2's risk of injury with any fall. The facility census was 136. Findings include: Review of R2's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 08/24/23 and readmitted on 10/24/24 with diagnoses which included Parkinson's with dyskinesia, functional quadriplegia, mood disorder, schizoaffective, paranoid schizophrenia, vascular dementia, intellectual disabilities, and other seizures. Review of R2's quarterly "Minimum Data Set	F 684		

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(MDS)," with an Assessment Reference Date (ARD) of 01/08/25 and located under the "MDS" tab of the EMR, revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of six out of 15, which indicated severe cognitive impairment.

Review of R2's "Care Plan," revised 11/29/24 and located under the "Care Plan" tab of the EMR, revealed R2 wore a helmet for fall safety. It was documented the resident often refused to wear the helmet.

Review of R2's "Physician Orders," dated 03/20/25 and located under the "Orders" tab of the EMR, revealed an order dated 11/21/24 for R2 to have a helmet on to prevent major injuries due to continuous falls and to document all refusals in the progress notes.

Review of R2's "Nurses Notes," dated March 2025 and located under the "Prog (Progress) Notes" tab of the EMR, revealed no documentation staff offered the helmet to R2 or that he refused to wear the helmet.

During observations of R2 on 03/18/25 at 2:35 PM, 03/18/25 at 3:30 PM, 03/19/25 at 5:45 AM, and 03/19/25 at 8:20 AM, R2 did not have a helmet on.

During an observation and interview on 03/19/25 at 6:04 AM, Licensed Practical Nurse (LPN)8 stated she just documented "No" on the treatment record (TAR) when R2 was not wearing the helmet. She stated he had not been wearing the helmet. LPN8 stated she did not know she was supposed to document any refusals in the electronic medical record, LPN8 stated R2 did not

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F 684	Continued From page 19 have a helmet in his room. She stated she was not sure what happened to it. During an observation and interview on 03/19/25 at 7:28 AM, Certified Nurse Aide (CNA)2 stated he was unsure if R2 was supposed to wear a helmet. He stated he had heard the resident's family talking about it. He stated he had not seen the helmet. CNA2 went into R2's room and checked the room and the closet, but was unable to find a helmet. He stated he thought the family took it home and never brought it back, but he did not notify a nurse. During an interview on 03/20/25 at 5:44 PM, the Director of Nursing (DON) stated she expected staff to follow physician orders. She stated if there was an issue or concern, staff should have contacted the physician and staff should have attempted to locate the helmet.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		

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Based on record review, staff interview, and facility policy review, the facility failed to ensure vision services related to cataract surgery provided for one of two residents (Resident (R) R16) reviewed for vision and hearing services out of a total sample of 48. R16 had a failed appointment for cataract surgery in May of 2024 and the facility failed to reschedule the appointment. This failure had the potential to prevent R16 from living in the highest practicable physical well-being. The facility census was 136.

Findings include:

Review of the facility's undated policy titled, "Care and Services," revealed, "Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth."

Review of R16's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R16 was admitted to the facility on 02/28/22 with diagnoses that included "other specified cataract."

Review of R16's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/19/24 and located under the "MDS" tab of the EMR, indicated R16 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R16 was cognitively intact. The assessment indicated R16's vision was adequate without the use of corrective lenses.

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Review of R16's "Care Plan," dated 02/27/23 and located under the "Care Plan" tab of the EMR, revealed R16 had cataracts, and interventions included, "Arrange consultation with eye doctor PRN [as needed]."

Review of eye surgery appointment letter located under the "Misc" (miscellaneous) tab of the EMR revealed R16 was to have laser eye surgery on the right eye on 03/05/24, with post-operative follow-up visits scheduled for 03/07/24 and 03/12/24 respectively.

Review of R16's "Progress Notes," dated 03/05/24 and found under the "Progress Notes" tab of the EMR, revealed in part, "the resident returned from her eye appointment, did not have cataract surgery done, needs to reschedule because the resident stated the facility needed to send a Hoyer lift machine with her."

During an interview on 03/18/25 at 9:39 AM, R16 stated she should have had cataract surgery a year ago, but the facility did not send her again after it did not work out the first time.

During an interview on 03/19/25 at 1:25 PM, the 4th floor Unit stated she was not employed at the facility in March of 2024, but was able to find out that R16 needed a Hoyer lift in order to be placed in the chair for surgery at the surgery center in order to undergo the cataract surgery. She stated the surgery center did not have a Hoyer (a mechanical device that allows a person to be lifted and transferred with minimum physical effort) lift or the capacity to lift her into the chair, and the surgery was canceled. When asked why the issue was never revisited and the surgery attempted since last year, she stated she did not

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F 685	Continued From page 22 know. During an interview on 03/20/25 at 7:30 PM, the Director of Nursing (DON) stated she did not know why the facility did not attempt to reschedule R16's cataract surgery since it was canceled the previous year on 03/05/24.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of four residents (Resident (R) R2) reviewed for smoking out of a total sample of 48 did not smoke inside the facility. R2, who was assessed to need supervision while smoking locked himself in his bathroom and smoked. The facility census was 136. Findings include: Review of a facility policy titled, "Smoking by Residents," revised April 2024, indicated, ". . . Smoking is not allowed anywhere inside the facility . . . Residents will be allowed to smoke in designated smoking area(s) only . . . It may be necessary to counsel patients or responsible parties who violate the smoking policy. Violation	F 689		

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of this policy may compromise the safety of all residents and staff due to potential negative consequences that can occur. For this reason, any violations will result in the following actions:
1. First Offense - Written warning and counseling session with the understanding that continued violation will result in further action.
2. Second Offense - The Facility will notify your attending physician and a care conference will occur to discuss further consequences, which may include discharge to a more appropriate setting.
3. Third Offense - Due to the safety risks posed to Facility Staff and other residents including harboring flammable materials and paraphernalia around medical equipment, the Facility may initiate discharge based on resident safety concerns consistent with state and federal law . . ."

Review of R2's "Face Sheet" located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 08/24/23 and readmitted on 10/24/24 with diagnoses which included Parkinson's with dyskinesia, functional quadriplegia, mood disorder, schizoaffective, paranoid schizophrenia, vascular dementia, intellectual disabilities, and other seizures.

Review of R2's quarterly "MDS," with an ARD of 01/08/25 and located under the "MDS" tab of the EMR,, revealed R2 had a "BIMS" score of six out of 15, which indicated severe cognitive impairment.

Review of R2's "Care Plan," revised 02/06/24 and located under the "Care Plan" tab of the EMR, revealed, ". . . Potential for safety hazard, injury related to smoking . . ." Interventions in place

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were to wear a smoking apron during supervised smoking, smoking only in designated areas, smoking supplies to be stored by staff, to notify charge nurse of violation of facility protocol, and direct supervision by staff when smoking.

Review of "Progress Note," dated 03/11/25 at 9:02 AM, located under the "Prog Notes" tab of the EMR, and written by LPN2 revealed, ". . . Resident was observed smoking in his room with his bathroom door locked resident was educated on how important it is to not smoke in his room for safety reason will notify SW [Social Worker] about resident behavior . . ."

During an observation on 03/18/24 at 3:30 PM, R2 was observed in the outside smoking area. Staff placed a smoking apron on the resident and provided him with a cigarette. Staff lit the cigarette for R2. Staff then provided R2 with another cigarette. R2 smoked the first cigarette and attempted to light the second cigarette with the lit butt of the first cigarette. Staff took the lit butt from the resident and lit the second cigarette.

During an interview on 03/19/25 at 7:28 AM, CNA2 stated that on 03/11/25 he noticed R2's call light was on, and he went into the resident's room, and he observed the resident's bathroom door was closed and locked. He stated he knocked on the bathroom door, and he could smell smoke, but the resident would not open the door. CNA2 stated he had to leave the room and get maintenance to get the master key to unlock the door, but by the time maintenance got back, R2 had unlocked the door. CNA2 stated he could smell the smoke, but he was unable to find the lighter or cigarette. He stated R2 would get cigarettes from other residents. He stated they

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F 689	Continued From page 25	F 689		

were supposed to be changing R2's bathroom doorknob to one that did not lock, but it had not been done yet. CNA2 stated he was unsure why the doorknob had not been changed.

During an interview on 03/19/25 at 9:52 AM, LPN2 stated that on 03/11/25, CNA2 told her he was knocking on R2's bathroom door because it was locked and CNA2 had reported he believed R2 had been smoking in the bathroom. LPN2 stated CNA2 went to get the Maintenance Director (MD) and they both went to the resident's room. LPN2 stated she was not aware prior to that day that the bathroom door locked from the inside. She stated CNA2 told them they took the lock off the door. LPN2 stated she did not report to management because it was reported to maintenance, and she believed they would fix it. She stated that no residents should have smoking paraphernalia on them or in their rooms.

During an interview on 03/19/25 at 10:07 AM, the MD stated he was not aware of an issue with the bathroom door in R2's room and was not asked to do anything with the doorknob until this morning. The MD stated he was still waiting to get clarification on what needs to be done with doorknob.

During an interview on 03/20/25 at 5:44 PM, the Director of Nursing (DON) stated the lock on the resident's door was a safety lock. She stated it could be opened with any key, but they could have done a better job educating staff to ensure they knew how to unlock the door. She stated she was unsure what other changes were made to R2's plan of care after he was caught in the bathroom smoking. She stated she was not aware that R2 did not have a smoking

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F 689	Continued From page 26 assessment completed prior to 03/11/25, but she would have expected that one was completed prior to allowing the resident to smoke.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one of one resident (Resident (R)51), reviewed for oxygen administration out of a total sample of 48, received oxygen per nasal cannula according to the physician's order. This failure had the potential for the resident to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen.) The facility census was 136. Findings include: Review of R51's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R51 was readmitted to the facility on 04/10/23 with diagnoses that included chronic respiratory failure with hypoxia. Review of R51's "Physician Orders," dated 01/29/21 and located under the "Orders, tab in	F 695		

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the EMR, revealed R51 was to receive oxygen at two Liters per Minute (LPM) via nasal cannula as needed for shortness of breath.

Review of R51's "Care Plan," dated 01/10/23 and located under the "Care Plan" tab of the EMR,, revealed a focus of Pulmonary Hygiene/Respiratory. Interventions included administering oxygen per physician orders.

Review of R51's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/22/25 and located under the "MDS" tab of the EMR, revealed R51 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated no cognitive impairment. It was recorded R51 received oxygen therapy.

Review of R51's "Medication Administration Record (MAR)," dated 03/2025 and located under the "Records" tab in the EMR, revealed no documented oxygen use on 03/17/25, 03/18/25 and 03/19/25.

During observations on 03/17/25 at 9:25 AM, 03/18/25 at 11:45 AM, and 03/19/24 at 6:15 AM R51 was lying in bed with a nasal cannula on and oxygen flowing at three LPM. R51 stated he wore his oxygen continuously.

During an interview on 03/19/25 at 6:16 AM, Licensed Practical Nurse (LPN)8 confirmed R51 was wearing his nasal cannula and the oxygen flow was set at three LPM. LPN8 stated she was unable to answer why there was no documentation on the MAR about R51 being on oxygen. LPN8 stated she just assumed R51 was on oxygen continuously and she did not know

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F 695	Continued From page 28 what his correct LPM should have been. LPN8 stated she did not look at the LPM this morning and only obtained his blood oxygen saturation level. LPN8 stated she was unaware that he was on three LPM because she did not pay attention. She stated staff should be checking the LPM and the saturation and documenting on the MAR. During an interview on 03/20/25 at 5:29 PM, the Director of Nursing (DON) stated there should be some documentation on the MAR when a resident was placed on oxygen and they should be checking every shift to ensure the correct LPM.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725		

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limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, interview, and facility policy review, the facility failed to ensure adequate staffing on the fifth floor for four of 18 residents (Resident (R) 138, R97, R75, and R89) reviewed for staffing concerns out of a total sample of 48. This failure had the potential to affect quality resident care. The facility census was 136.

Findings include:

Review of the facility's policy titled, "Nursing Department- Staffing, Scheduling & Postings," revised 10/24/22, revealed, ". . . The facility will employ sufficient nursing staff as determined by resident assessments and individual plans of care . . ."

1. Review of R138's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted on 02/26/25. Diagnosis included acute respiratory failure.

Review of R138's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/12/25 and located under the "MDS" tab of the EMR, revealed R138 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was cognitively intact.

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During an interview on 03/17/25 at 11:39 AM, R138 stated the call light response times were long and could be 40 minutes. She stated they did not come, and she could not breathe. She stated it was taking a long time for a call light response this day and she was blind.

During an observation on 03/17/25 at 11:59 AM, R138's call light was on and a staff member (Certified Medication Technician (CMT) 1) on the floor was noted to be talking on the phone through earbuds.

During an interview on 03/17/25 at 12:05 PM, CMT1 was seated in the corner and stated she worked at the facility about once a week. She stated she was "on break" but was going to pass trays once they arrived.

During an observation on 03/17/25 at 12:08 PM, the trays arrived on the floor. CMT1 remained talking on the phone and started to pass trays. R138's call remained on. At 12:16 PM, the call light was answered by a different unidentified staff member. The call light was observed to be on from 11:59 AM through 12:16 PM.

2. Review of R97's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 08/28/23. Diagnoses included cognitive communication deficit, schizoaffective disorder, mood disorder, neurocognitive disorder with Lewy bodies, Parkinson's disease, dementia, depression, and other seizures.

Review of R97's quarterly "MDS," with an ARD of 01/09/25 and located under the "MDS" tab of

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EMR, revealed the resident had a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 10:19 AM, R97 stated there were not enough staff on the fifth floor, and there were no staff available on the weekends.

Review of R75's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 11/26/24. Diagnoses included bipolar disorder, paranoid schizophrenia, anxiety, and the history of falling.

Review of R75's quarterly "MDS," with an ARD of 02/24/25 and located under the "MDS" tab of the EMR, revealed the resident had a "BIMS" score of 14 out of 15, which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 10:48 AM, R75 stated they did not have staff at night and the call lights were not answered.

Review of R89's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 01/16/25. Diagnoses included anxiety, schizophrenia, difficulty in walking, and repeated falls.

Review of R89's quarterly "MDS," with an ARD of 02/19/25 and located under the "MDS" tab of the EMR, revealed the resident had a "BIMS" score of 11 out of 15, which indicated the resident was moderately cognitively impaired.

During an interview on 03/17/25 at 12:11 PM, R89 stated there were not enough staff on the fifth

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floor.

During an interview on 03/19/25 at 5:15 AM, CMT15 stated there were not enough staff on the fifth floor at night. She stated she was usually the only staff on the floor from 11:00 PM- 7:00 AM.. She stated there was one resident on the floor who had seizures.

Review of the February 2025 staffing sheets, provided by the facility, revealed the fifth floor (500-hall) had only one staff member, either a CMT or a Licensed Practical Nurse (LPN) on the floor for the 11:00 PM- 7:00 AM shift on the following nights: 02/14/25; 02/15/25; 02/16/25; 02/17/25; 02/18/25; 02/19/25; 02/20/25; 02/23/25; 02/24/25; 02/26/25; 02/27/25. There was no Certified Nurse Aide (CNA) on those shifts. (Eleven nights with one staff member (CMT or an LPN) on the floor)

Review of the March 2025 staffing sheets, provided by the facility, revealed the fifth floor (500-hall) had only one staff member, either a CMT or LPN, for the 11:00 PM- 7:00 AM shift on the following nights: 03/01/25; 03/02/25; 03/03/25; 03/05/25; 03/10/25; 03/11/25; 03/16/25. There was no CNA on those shifts. (Seven nights with one staff member (CMT or LPN) on the floor)

Review of the March 2025 staffing sheets, provided by the facility, revealed the fifth floor (500-hall) had no CMT or Licensed Practical Nurse (LPN) coverage for the 11:00 PM- 7:00 AM shift on the following nights: 03/09/25; 03/14/25. The floor was staff with only one CNA.

During an interview on 03/20/25 at 10:46 AM, the Scheduler stated she had been in this position for

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F 725	Continued From page 33 two years. She stated her expectation was to have at least one CMT and one CNA on nights for the fifth floor. She stated the CMT preferred to work by herself. The Scheduler stated the staff were supposed to call off at least two hours before their shift, but they had been calling off less than one hour, at times. She stated they did not tolerate staff talking on their phones during their shifts. She confirmed the missing coverage displayed on the staffing sheets and stated it was due to call-offs. During an interview on 03/20/25 at 12:21 PM, the interim Director of Nursing (DON) stated that for nights, staffing was tricky. She stated that ideally, they should have a nurse and a CNA. She stated if that pattern was not available, then a CMT and the nurse from 400-hall would cover the "nursing" duties. She confirmed she was aware of a staffing concern. She stated phone usage had been a struggle on the floor and that earbuds were not allowed. M00247452 MO00248617 MO00250713 MO00251444	F 725		
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	F 726		

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and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(3) The facility must ensure that 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 on staff interview and record review, the facility failed to ensure competencies were completed for Certified Medication Technician (CMT) staff to safely administer medications to residents for 10 (CMT2, CMT3, CMT4, CMT6, CMT8, CMT9, CMT10, CMT11, CMT12, and CMT14) of 10 CMT personnel reviewed. The facility census was 136.

Findings include:

During an observation on 03/19/25 at 7:34 AM, CMT6 was observed at his medication cart. Multiple medication cups were sitting on top of the cart. Each cup contained medications for

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F 726	Continued From page 35 different residents. CMT13 looked at the surveyor and then stacked the medication cups, placed them in the medication cart, and locked the cart. During an interview on 03/19/25 at 7:39 AM, CMT6 stated he/she knew it was not policy to prepare the residents' medications in advance. He/She stated he/she had signed the medications as being administered when he/she placed the medications into the medication cups. Review of ten CMT personnel files revealed the file for CMT2, CMT3, CMT4, CMT6, CMT8, CMT9, CMT10, CMT11, CMT12, and CMT14 revealed no documented evidence of medication administration competency checks for the CMTs. During an interview on 03/20/25 at 8:46 PM, the Director of Nursing (DON) stated the onboarding of CMTs included new employee orientation, validated certifications, and background screening. The DON stated CMTs were not required to have medication administration competency completed upon hire. She stated, "It is assumed that the CMT has the training when they complete their certification. They are given 3 days of orientation with another CMT or nurse for medication pass. As the DON, it is my job to oversee clinical services here at Beauvais."	F 726		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		

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§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
Based on interview, facility documentation, and facility policy review, the facility failed to ensure eight hours of Registered Nurse (RN) coverage every day of the week for 136 of 136 census residents. This failure had the potential to affect the safety of resident care. The facility census was 136.

Findings include:

Review of the facility's policy titled, "Nursing Department-Staffing, Scheduling & Postings," revised 10/24/22, revealed, ". . . The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days per week, unless a waiver applies . . ."

Review of the January 2025 staffing sheets, provided by the facility, revealed there was no RN coverage on 01/02/25, 01/09/25, 01/18/25, 01/23/25, 01/27/25, and 01/30/25.

Review of the February 2025 staffing sheets, provided by the facility, revealed there was no RN coverage on 02/01/25, 02/06/25, 02/10/25, 02/13/25, 02/15/25, 02/20/25, 02/24/25, and 02/27/25.

Review of the March 2025 staffing sheets,

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F 727	Continued From page 37 provided by the facility, revealed there was no RN coverage on 03/01/25, 03/02/25, 03/10/25, 03/15/25, and 03/16/25. During an interview on 03/20/25 at 10:46 AM, the Scheduler stated they had some staff currently transitioning to be an RN. She confirmed the lack of RN coverage in the building and stated it was difficult to get RNs. She stated the only RN working in a management role was the Director of Nursing (DON). She also confirmed there was no RN coverage due to call-offs. During an interview on 03/20/25 at 12:21 PM, the interim DON confirmed the lack of RN coverage in the facility. She stated if anything in the facility required an "RN" then she would handle it.	F 727		
F 758 SS=D	M00247452 MO00248617 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to monitor target behaviors for the use of psychotropic medications for one of five residents (Resident (R) 42) reviewed for unnecessary medications out of a total sample of 48. This had the potential to cause R42 to receive

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unnecessary medications. The facility census was 136.

Findings include:

Review of R42's "Resident Face Sheet," located under the "Continuity of Care (CCD)" tab of the electronic medical record (EMR), indicated the resident was re-admitted to the facility on 03/15/23 with diagnoses including mood disorder, anxiety disorder, schizophrenia, and major depression.

Review of R42's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 02/01/25 and located under the "MDS" tab of the EMR, revealed R42 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated no cognitive impairment. The resident was coded as receiving antipsychotic, antidepressant, and antianxiety medications.

Review of R42's "Physician Order Report," dated 03/20/25 and found under the "Orders" tab of the EMR, indicated R42 was to receive alprazolam (an antianxiety medication) 0.25 milligrams (mg) once daily, alprazolam 0.50mg twice daily, buspirone (an antianxiety medication) 15mg twice daily, and Seroquel (an antipsychotic medication) 300mg at bedtime. Further review revealed no documented evidence of target behaviors associated with the medications.

Review of R42's "Medication Administration Record (MAR)," dated February and March 2025 and found in the EMR under the "Orders" tab, revealed no documented evidence to show which specific behaviors were associated with the

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F 758	Continued From page 40 administration of the resident's psychotropic medications and required routine monitoring. During an interview on 03/20/25 at 10:06 AM, Licensed Practical Nurse (LPN)2 stated she was not aware of what targeted behaviors related to any of the resident's psychotropic medications. She stated R42 did not have any behaviors. LPN2 stated no one had told her of a time span to monitor a resident for target behaviors before letting the physician know. She stated staff were not monitoring behaviors or documenting them. She stated she was not sure what behaviors they should be monitoring for. During an interview on 03/20/25 at 5:37 PM, the Director of Nursing (DON) stated there should be an order to monitor target behaviors along with side effects. She stated staff should be documenting behaviors to indicate the need for prescribed medications.	F 758		
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		

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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, and policy review, the facility failed to ensure medications were labeled with open and discard dates, individual insulin syringes were labeled with the resident's name, and expired medications were disposed of and not made available on the medication cart for 4 of 4 medication carts reviewed. This had the potential to cause medication errors, adverse medication reactions, and residents to receive suboptimal therapeutic actions of medications. The facility census was 136.

Findings:

Review of the facility's policy titled, "Storage of Medication," dated 01/2024 revealed, ". . . Medications and biologicals are stored properly, following the manufacturer or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . . . Outdated, contaminated, discontinued or deteriorated medications and

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those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . . . and reordered from the pharmacy . . . if a current order exists . . ."

The following observations were made during reviews of medication carts throughout the facility:

1. During a medication administration observation on 03/18/25 at 12:53 PM on the 4th floor with Registered Nurse (RN)1, RN1 administered insulin with HumaLOG KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) insulin pen for R71. The insulin pen was not labeled with open or discard dates.

During an interview on 03/18/25 at 12:55 PM, RN1 acknowledged the pen did not have an open date or discard date. When asked how many days after opening before the pen must be discarded, she stated she thought it was 30 days, but was unsure and would ask her supervisor.

During a follow-up interview on 03/18/25 at 1:07 PM, RN1 stated her supervisor had confirmed the insulin pen must be discarded 28 days after first use.

2. During a review of the medication cart on the 5th floor on 03/20/25 at 11:07 AM with Licensed Practical Nurse (LPN) 6, the following were observed:
a. Novolin N NPH (insulin isophane human) Suspension 100 units/ml vial, received date 12/28/24, with no open or discard dates for R40.
b. Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) vial received date 11/01/24 with

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no open or discard dates for R111.
c. Basaglar Kwikpen received date 02/27/25 labeled with R138's name, with no open or discard dates.
d. Insulin Aspart 100 units per ml pen NovoLOG Pen received date 01/3/25. No open or discard dates for R110.
e. Lantus Solostar subcutaneous solution (insulin glargine) received date 03/10/25 with no open or discard dates for R106.
f. Lantus Pen with no patient label, no open or discard date.
g. Lyumjev KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro-aabc) with an open date of 2/19/25 was on its 29th day, for R75.
h. Basaglar Kwik pen insulin glargine subcutaneous solution pen-injector 100 unit/ml (insulin glargine) no open or discard received date 3/15/25 for R97.
i. HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) received date 12/24/24 for R106. The insulin pen cap had a sticker with a handwritten date 03/15/25 and the first name of R138.
j. HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) for R138 received date 02/27/25 with no open or discard date. This item was stored in the same bin and was identical in appearance to R106's insulin pen.
k. Vial of insulin lispro 100 units/ml received date 8/13/24. Open date 12/09/24 for R106. The discard date would have been 01/06/25, 28 days after the open date of 12/09/24.

During an interview on 03/20/25 at 11:33 AM, LPN6 stated, "They put the top on the wrong pen, but it is the same medication." The Assistant

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Director of Nursing/Infection Preventionist (ADON) 4 and the Assistant Director of Nursing/Unit Manager (ADON) 1 joined the conversation on 03/20/25 at 11:35. ADON4 acknowledged the handwritten name of R138 on the cap of R106's single person use insulin syringe could potentially cause a medication error and stated that as a nurse, she would be looking at the pharmacy's printed label, not the handwritten name on the cap. She stated, "You read labels, not caps." ADON4 further stated R138 was in the hospital and was unsure of when the two medications were open and when they should be discarded. When asked when the insulin pen for R106 was opened, ADON1 stated it looked like 03/15/25, but was not sure since the open date sticker on R106's medication had R138's handwritten name on it. ADON4 stated the insulin syringes and vials should be labeled with open and discard dates once opened and the seal is broken and that she would discard the medications immediately.

3. The following observations were made in the 4th floor cart with Certified Medication Aide (CMT)2 on 03/20/25 at 12:37 PM:
a. Ketorolac eye drops for R24 labeled as open on 01/15/25. No discard date.
b. For R87 prednisolone eye drops, no open or discard date.
c. Dorzolamide eye drops for R84. Marked opened on 01/16/25.
d. Ciprofloxacin Dexamethasone Eye Drops for R107 open 02/08/25, no open or discard date.

During an interview on 03/20/25 at 12:42 PM, CMT2 stated she did not know how long it was before the medications must be discarded after opening and did not know why they were not

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F 761	Continued From page 45 labeled with open and discard dates. 4. Observations during review of the medication cart on the 2nd floor with CMT3 on 03/20/25 at 12:52 PM revealed: a. Latanoprost eyedrops for R5 with no open or discard dates. b. Atropine 1% eyedrops for R13 with no open or discard dates. c. Latanoprost 0.005% for R339, no open and discard dates. d. Insulin pen Lispro opened on 10/30/24 labeled with the name of a resident deceased on 12/23/24. The pen cap was handwritten with the name of a resident that had been discharged from the facility on 02/12/25. e. Atropine 1% eye drops for R8. No open or discard dates. During an interview on 03/20/25 at 12:43 PM, CMT3 stated she had been gone for 12 days and all the eyedrops were in the medication cart when she returned to work. She stated she had no idea where some of the residents were and that some were no longer on the second floor, including R339 and R8. 5. The following observations were made of the 1st floor medication cart on 03/20/25 at 1:04 PM with CMT7: a. For R4, prednisolone 1%, no open or discard date. b. For R25 Polymyxin eye drops labeled for use for 7 days. Receive date 02/21/25. no open or discard date. c. For R18 Brimonidine 0.2 eye drops no open or discard date. d. For R65 latanoprost eyedrops expired 11/2/24. e. For R53 Tobramycin eye drops labeled for use	F 761		

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for 5 days, received date 2/4/24. No open or discard dates.
f. For R65 Dorzolamide eye drops opened 10/1/24 no discard date.
g. For R51 sublingual Nitroglycerin expired on 10/01/24.
h. For R18 Brimonidine 0.2 eye drops expired 09/12/24.
i. For R25 Olopatadine eye drops expired 07/11/24.
j. For R65 Brimonidine 0.2 eye drops expired 10/12/24.
k. For R51 sublingual Nitroglycerin 0.4 mg expired 11/20/22.
l. For R4 Prednisolone expired 08/01/24.

During an interview on 03/20/25 at 1:15 PM, CMT7 stated she did not know she had to label eyedrops with date opened and did not know how long it was before they were discarded.

During an interview on 03/20/25 at 2:08 PM, ADON4 stated the time limits for eyedrops vary, but they should be labeled with the date opened. ADON4 stated it was her expectation that staff should call pharmacy if they are unsure of duration after opening. She stated some eyedrops are different, and if they are antibiotics, staff should follow the order. ADON4 stated some insulins are good for 30 days, and some are good for 28 days. ADON4 stated staff should follow directions and consult the pharmacy. ADON4 stated it was her expectation that expired and outdated medications should be discarded.

During an interview on 03/20/25 at 6:04 PM, the Director of Nursing (DON) stated the standard of care is that insulin pens are good for 28 days, and insulins should be dated the day they are

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F 761	Continued From page 47 open. The DON stated that expired medications should be discarded, and medications of residents who have been discharged should be removed from the cart and discarded.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and sampling of a meal test tray, the facility failed to ensure food prepared by the facility was palatable for seven of seven residents (Resident (R) 42, R129, R77, R99, R109, R96, and R132) reviewed for palatability out of a total sample of 48. As a result of this deficient practice the residents had the potential for poor nutrition and weight loss. The facility census was 136. Findings include: 1. Review of R42's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 02/01/25 and located under the "MDS" tab of the EMR, revealed R42 had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated no cognitive impairment	F 804		

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During an interview on 03/17/25 at 11:48 AM, R42 stated the food did not taste good, and trying to get an alternative was "almost impossible."

2. Review of R129's admission "MDS," with an ARD of 02/14/25 and located under the "MDS" tab of the EMR, revealed R129 had a "BIMS" score of 14 out of 15 which indicated no cognitive impairment.

During an interview on 03/17/25 at 11:48 AM, R129 stated the food was "awful," and she did not like it. She stated she did not eat what they served a lot because of it.

3. Review of R77's modification admission "MDS," with an ARD of 01/18/25 and located under the "MDS" tab of the EMR, revealed R77 had a "BIMS" score of 14 out of 15, which indicated no cognitive impairment.

During an interview on 03/20/25 at 12:30 PM, R77 stated the French dip sandwich was bland and had no flavor. He stated the food's flavor was usually not good.

4. Review of R99's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 10/13/23. Diagnosis included moderate protein-calorie malnutrition.

Review of R99's quarterly "MDS," with an ARD of 01/03/25 and located under the "MDS" tab of the EMR, revealed the resident had a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 2:06 PM, R99 stated he did not like the meat and vegetables

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provided.

5. Review of R109's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 04/12/24. Diagnosis included obstruction pulmonary disease.

Review of R109's quarterly "MDS," with an ARD of 01/02/25 and located under the "MDS" tab of the EMR, revealed the resident had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 2:09 PM, R109 stated breakfast was cold, and the food was "inedible." He stated they had to eat what they gave them, and it was so greasy. He stated he was weak because he could not eat the food and had to buy his own. He stated he was running out of money and felt like he was going to die because the food was so bad.

6. Review of R96's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 02/22/24. Diagnosis included moderate protein-calorie malnutrition.

Review of R96's annual "MDS," with an ARD of 02/20/25 and located under the "MDS" tab of the EMR, revealed the resident had a "BIMS" score of 13 out of 15 which indicated the resident was cognitively intact.

During an interview on 03/17/25 at 2:22 PM, R96 stated the food needed improvement.

7. Review of R132's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted on 02/03/25. Diagnosis

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F 804	Continued From page 50 included chronic obstructive pulmonary disease. Review of R132's quarterly "MDS," with an ARD of 02/28/25 and located under the "MDS" of the EMR, revealed the resident had a "BIMS" score of 11 out of 15, which indicated the resident was moderately cognitively impaired. During an interview on 03/17/25 at 10:10 AM, R132 stated he could not tell if there was a menu, because they served the same food all the time. On 03/20/25, a test tray left the kitchen at 12:00 PM on a cart carrying 49 trays. The last tray was passed at 12:50 PM. The temperatures were taken of the foods on the test tray. The beef dip meat was 110 degrees Fahrenheit (F) and the tater tots measured 110 degrees F. During an interview on 3/20/25 at 4:42 PM, the Dietary Manger (DM) stated she had heard there were resident complaints about the food. She stated some residents asked for more seasoning in the food, but salt and pepper were available on request. She stated the younger residents seemed to be the ones who had more concerns. The DM stated they asked for specific seasonings that the facility did not offer. During an interview on 03/20/25 at 5:33 PM, the Director of Nursing stated she expected that residents would be served food they enjoyed.	F 804		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for	F 847		

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binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(m)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with

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federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure binding arbitration agreements were explained in a form and manner that residents understood and that the resident or their representative acknowledged that they understood the agreement for three of three residents (Resident (R) 92, R95, and R189) reviewed for binding arbitration agreements out of a total sample of 48. The facility census was 136.

Findings:

1. Review of R92's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/13/25 and located under the "MDS" tab of the electronic medical record (EMR), revealed R92 was admitted to the facility on 11/20/23 with diagnoses that included essential (primary) hypertension, chronic kidney disease, stage 3 type 2 diabetes mellitus and anemia. It was recorded R92 had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, which indicated R92 was cognitively intact.

Review of R92's "Admission Agreement," located under the "MISC (Miscellaneous)" tab of the EMR, revealed R92 signed a binding arbitration agreement electronically on 11/21/23.

R92's signature was appended to the binding arbitration agreement under the following

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verbiage:
"By signing below, the Resident/Resident Representative and the Facility agree to the terms of this Arbitration Agreement:" The signature panel failed to include the provision that the residents understood the agreement before signing the agreement.

During an interview on 03/20/25 at 5:58 PM, R92 stated she did not know what a binding arbitration agreement was and did not recall signing one.

2. Review of R95's quarterly "MDS," with an ARD of 03/04/25 and located under the "MDS" tab of the EMR, revealed R95 was admitted to the facility on 08/10/23 with diagnoses that included orthostatic hypotension, alcohol dependence with alcohol-induced mood disorder, and mild cognitive impairment. It was recorded R 95 had a "BIMS" score of 15 out of 15, which indicated R95 was cognitively intact.

Review of R95's "Admission Agreement," located under the "MISC" tab of the EMR, revealed R95 signed a binding arbitration agreement electronically on 08/11/23.

R95's signature was appended to the binding arbitration agreement under the following verbiage:
"By signing below, the Resident/Resident Representative and the Facility agree to the terms of this Arbitration Agreement:" The signature panel failed to include the provision that the residents understood the agreement before signing the agreement.

R95 was unavailable for interview.

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3. Review of R189's entrance tracking "MDS," located in the EMR under the "MDS" tab and with an ARD of 02/28/25, revealed R189 was admitted to the facility on 02/18/25 with diagnoses that included chronic diastolic (congestive) heart failure, unspecified severe protein-calorie malnutrition, and anxiety disorder due to known physiological condition.

Review of R189's "Admission Agreement," located under the "MISC" tab of the EMR, revealed R92 signed a binding arbitration agreement electronically on 02/20/25.

R189's signature in the binding arbitration agreement was appended to the following verbiage:
"By signing below, the Resident/Resident Representative and the Facility agree to the terms of this Arbitration Agreement:" The signature panel failed to include the provision that the residents understood the agreement before signing the agreement.

During an interview with R189 on 03/20/25 at 6:00 PM R189 stated, "No, I did not sign it. I don't know what that is."

During an interview on 03/19/25 at 4:41 PM, the Administrator stated he had been in the position for two years and was not the person responsible for presenting and explaining binding arbitration agreements to residents and their representatives, but the people responsible were not available. When asked what an arbitration agreement was, the Administrator stated it had something to do with legal or financial and he knew nothing about them.

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F 847	Continued From page 55 During a telephone interview with 03/19/25 at 4:57 PM, the regional director of business development (RDBD) stated arbitration was, if there were to be a lawsuit, the attorneys would meet behind closed doors and reach an agreement agreeable to those involved. The RDBD was unaware the facility had any current arbitration agreements. The RDBD was asked if she had ever been responsible for explaining the contents of an arbitration agreement to a prospective resident before they signed. She stated she had. The RDBD was asked if she explained to the residents that they were giving up the constitutional right to a trial, and that they had a right to a neutral venue and neutral arbitrator. She stated she did not know that. The RDBD was asked if she explained that residents have a right to rescind the agreement, she stated they had 30 days to rescind. The RDBD was asked if she was aware the residents have to sign that they understand as well as agree with the agreement. She stated she did not know that and that the current arbitration the facility had to be updated.	F 847		
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	F 880		

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

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

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by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility policies, the facility failed to deliver meal trays in a manner to prevent cross-contamination for seven of 48 sampled residents (Resident (R) 5, R8, R80, R117, R76, R93, and R91) reviewed for infection control, and administer medications in a manner to prevent cross-contamination for four of four residents (R41, R24, R92, and R106) observed during the medication pass observation. These failures could promote the spread of multi-drug-resistant organisms (MDROs) throughout the facility. The facility census was 136.

Findings include:

Review of the facility's policy titled, "Hand Hygiene," dated 10/24/22, revealed ". . . Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections . . . Staff follow the hand hygiene procedures to help prevent the spread of infections to other

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staff, residents, and visitors . . . Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy . . . Facility Staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances . . . In between glove changes . . . Hand hygiene is always the final step after removing and disposing of personal protective equipment. VII. The use of gloves does not replace hand hygiene procedures . . ."

Review of the facility's policy titled, "Personal Protective Equipment - Using Gloves," revised September 2010 revealed, ". . . When to Use Gloves 1. When touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin; 2. When the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc.; 3.When cleaning up spills or splashes of blood or body fluids;3.When cleaning potentially contaminated items; and 5. Whenever in doubt . . ."

1. During an observation of the noon meal tray delivery on 03/17/25 beginning at 12:06 PM, Certified Nurse Aide (CNA) 5 pushed the lunch tray cart containing Styrofoam cups and a pitcher of lemonade down hallway 200 and stopped near R5's room. CNA5 poured a cup of lemonade and delivered it to R5's bedside table. CNA5 pushed the bedside table in front of R5. CNA5 exited the room and did not perform hand hygiene. CNA12 followed CNA5 down the hallway pushing the lunch tray cart containing plates of food covered with plastic wrap labeled with each resident's name. CNA12 sorted through plates of food until finding R5's plate. CNA12 picked up a fork from

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the pile of forks on top of cart and delivered it to R5's bedside table. CNA12 moved R5's personal items and cup of lemonade on bedside table to make more room for her meal set up. CNA12 exited the room and did not perform hand hygiene.

At 12:09 PM, CNA5 poured a cup of lemonade and delivered it to R8's bedside table. CNA5 pushed the bedside table in front of R8. CNA5 exited the room and did not perform hand hygiene. CNA12 sorted through plates of food until finding R8's plate. CNA12 picked up a fork from the pile of forks on top of cart and delivered it to R8's bedside table. CNA12 moved R8's personal items and cup of lemonade on bedside table to make more room for her meal set up. CNA12 exited the room and did not perform hand hygiene.

At 12:11 PM, CNA5 poured a cup of lemonade and delivered it to R80's bedside table. CNA5 moved the bedside table in front of R80. CNA5 exited the room and did not perform hand hygiene. CNA12 sorted through plates of food until finding R80's plate. CNA12 picked up a fork from the pile of forks on top of cart and delivered it to R80's bedside table. CNA12 moved R80's personal items and cup of lemonade on bedside table to make more room for his meal set up. CNA12 exited the room and did not perform hand hygiene.

At 12:14 PM, CNA5 poured a cup of lemonade and delivered it to R117's bedside table. CNA5 pushed the bedside table in front of R117. CNA5 exited the room and did not perform hand hygiene. CNA12 sorted through plates of food until finding R117's plate. CNA12 picked up a fork

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from the pile of forks on top of cart and delivered it to R117's bedside table. CNA12 moved R117's personal items and cup of lemonade on bedside table to make more room for his meal set up. CNA12 exited the room and did not perform hand hygiene.

At 12:16 PM, CNA5 poured a cup of lemonade and delivered it to R76's bedside table. CNA5 pushed the bedside table in front of R76. CNA5 exited the room and did not perform hand hygiene. CNA12 sorted through plates of food until finding R76's plate. CNA12 picked up a fork from the pile of forks on top of cart and delivered it to R76's bedside table. CNA12 moved R76's personal items and cup of lemonade on bedside table to make more room for his meal set up. CNA12 exited the room and did not perform hand hygiene.

At 12:18 PM, CNA5 picked up R93's and R91's plates and two forks from the pile of forks on top of cart. CNA5 stacked the plates with both still covered in plastic wrap on top of another. CNA5 pushed R93's bedside table in front of R93 and moved his personal items on bedside table to make more room for his meal set up. CNA5 removed the plate stacked on top of the other plate and delivered it to R91, setting the plate on R91's bedside table. CNA5 pushed the bedside table in front of R91 and moved his personal items on his bedside table to make more room for his meal set up. CNA5 exited the room and did not perform hand hygiene. CNA12 poured two cups of lemonade and delivered them to R93 and R91's bedside tables. CNA12 exited the room and did not perform hand hygiene.

During the continuous observation of the noon

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meal tray delivery on 03/17/25 from 12:06 PM through 12:18 PM, CNA5 and CNA12 were observed delivering meal trays and drinks to eight residents. The CNAs touched overbed tables and personal belongings with each delivery. The CNAs did not perform hand hygiene during this continuous observation

During an interview on 03/17/25 at 12:30 PM, CNA5 stated, "Yes, I sanitized my hands, I have it right here in my pocket and use it in between each resident." CNA5 was not able to show the hand sanitizer from her pocket. CNA5 stated, "It's missing now, but I only passed two trays down on that hall. When I go into their rooms I wash my hands every single time. I washed my hands when I went back to my hall."

During an interview on 03/17/25 at 12:32 PM, CNA12 stated, "I'm sorry. I didn't know you were supposed to hand sanitize in between each resident. I was just trying to hurry and get them passed. No, I didn't use hand sanitizer in between passing trays. I'm sorry, but I will do it next time."

During an interview on 03/17/25 at 1:12 PM, Assistant Director of Nursing and Infection Preventionist (ADON 4) stated, "All the staff know they are required to do hand hygiene before resident care, in between residents, and after residents. We do in-services annually and have the upcoming annual skills fair check-off coming up next month. We do in-services quarterly and monthly as well and always cover infection control in them. We're always going around and doing reminders weekly and daily sometimes so that it's just always in their mind that they need to do it."

During an interview on 3/19/25 at 8:41 AM, the

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Director of Nursing (DON) stated, "We are continually doing ongoing education and training on infection control. Staff know to use hand hygiene before, during, and after resident care or whenever they touch any of the resident's personal items. We have a skills fair check-off scheduled for the first week of April for all staff. But we constantly give reminders weekly if not daily sometimes."

During an interview on 3/19/25 at 8:42 AM, the Administrator stated, "Staff know they should perform hand hygiene, and I will be making sure they all get reeducated again."

2. During medication administration observation on 03/18/25 at 1:07 PM with Certified Medical Technician (CMT)5, CMT5 entered R41's room, gave R41 oral medications in a cup, and exited R41's room without performing hand hygiene. CMT5 returned to her medication cart, touched her computer, dipped her hands in her pocket to retrieve medication cart keys, and opened the medication cart, touching the contents without performing hand hygiene.

On 03/18/25 at 1:24 PM CMT5 administered eye drops to R24. On 03/18/25 at 1:31 PM, CMT5 accidentally dropped the eyedrops lid on floor. CMT5 picked up the lid and screwed it back on. When asked, CMT5 confirmed she should have cleaned the lid before putting it back on.

During medication administration observation on 03/19/25 at 7:33 AM with Licensed Practical Nurse (LPN)5, LPN5 applied a pair of gloves and administered an insulin injection on R92. LPN5 removed the gloves and failed to perform hand hygiene before touching her computer, pocket,

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	265699	A. BUILDING _____ B. WING _____	C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUVAIS REHAB AND HEALTHCARE CENTER	3625 MAGNOLIA AVENUE SAINT LOUIS, MO 63110

(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 63 keys, and medication cart. LPN returned R92's insulin vial to the medication cart. At 7:36 AM, without performing hand hygiene, LPN5 applied another pair of gloves and wiped off the glucometer. LPN5 removed her gloves and did not perform hand hygiene. During an interview on 03/19/25 7:38 AM, LPN5 acknowledged she had changed gloves several times without performing hand hygiene between glove changes. During an observation with CMT2 on 03/19/25 at 8:26 AM, CMT administered a Spiriva inhaler to R106 without applying gloves. CMT2 had a cup of water which she stated was for R106 to rinse and spit after using the inhaler. At 8:26 AM, R106 rinsed his mouth with water and spat it out in a cup and gave the cup back to CMT2 who received it with her bare hand. CMT2 discarded the cup and returned to her medication cart without performing hand hygiene and touched her computer and medication cart. During an interview with CMT2 on 03/19/25 at 8:33 AM, CMT2 confirmed that she could have been exposed to R106's fluids and should have worn gloves and performed hand hygiene. During an interview on 03/19/25 at 11:07 AM, the Assistant Director of Nursing (ADON)1 stated staff should perform hand hygiene before entering residents' rooms, should wash their hands before and after applying gloves, and that CMT2 should have been wearing gloves during administration of the inhaler for R106.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		

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F 883	Continued From page 64 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 65	F 883		

immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to offer pneumococcal vaccines for two of seven residents (Resident (R) 92 and R95) reviewed for pneumonia vaccinations out of a total sample of 48. This practice had the potential to increase the risk for these residents to contract pneumonia. The facility census was 136.

Findings include:

Review of the policy titled, "Pneumococcal Disease Prevention," implemented 09/01/23 revealed, ". . . Pneumococcal vaccines are recommended for the following classifications of residents: A. All adults 65 years of age and older . . . Anyone 2 through 64 years of age who has a long-term health problem such as: heart disease, lung disease, sickle cell disease, diabetes, alcoholism, cirrhosis, leaks of cerebrospinal fluid or cochlear implant . . . Anyone 2 through 64

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F 883	Continued From page 66	F 883		

years of age who has a disease or condition that lowers the body's resistance to infection, such as: Hodgkin's disease; lymphoma or leukemia; kidney failure; multiple myeloma; nephrotic syndrome; HIV Infection or AIDS; damaged spleen, or no spleen; organ transplant . . . Anyone 2 through 64 years of age who Is taking a drug or treatment that lowers the body's resistance to Infection, such as: long-term steroids, certain cancer drugs, radiation therapy . . ."

1. Review of R92's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/13/25 and located under the "MDS" tab of the electronic medical record (EMR), revealed R92 was admitted to the facility on 11/20/23 with diagnoses that included essential (primary) hypertension, chronic kidney disease, type 2 diabetes mellitus and anemia. It was recorded R92 had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, which indicated R92 was cognitively intact. Review of MDS revealed R92 was admitted at the age of 65.

Review of R92's "Admission Agreement," located under the "MISC (Miscellaneous)" tab of the EMR, revealed R92 signed the agreement electronically on 11/21/23 and also signed a consent to receive the pneumococcal vaccination on 11/21/23 as follows:
"Pneumococcal Vaccine Informed Consent __
I hereby give the Center permission to administer pneumococcal vaccination series. PPSV23 is recommended for:
All adults 65 years of age and older,
Anyone 2 through 64 years of age with certain long term health problems,
Anyone 2 through 64 years of age with a

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F 883	Continued From page 67 weakened immune system, Adults 19 through 64 years of age who smoke cigarettes or have asthma." Review R92's "Immunization Record," located under the "Immunization" tab of the EMR, revealed no indication that R92 had received any pneumococcal vaccine. 2. Review of R95's quarterly "MDS," with an ARD of 03/04/25 and located under the "MDS" tab of the EMR, revealed R95 was admitted to the facility on 08/10/23 with diagnoses that included orthostatic hypotension, alcohol dependence with alcohol-induced mood disorder, and mild cognitive impairment. It was recorded R95 had a "BIMS" score of 15 out of 15, which indicated R95 was cognitively intact. Review of R95's "Admission Agreement," located under the "MISC" tab of the EMR, revealed R95 signed the agreement electronically on 08/11/23 and also signed a consent to receive the pneumococcal vaccination on 08/11/23 as follows: "Pneumococcal Vaccine Informed Consent __ I hereby give the Center permission to administer pneumococcal vaccination series. PPSV23 is recommended for: All adults 65 years of age and older, Anyone 2 through 64 years of age with certain long term health problems, Anyone 2 through 64 years of age with a weakened immune system, Adults 19 through 64 years of age who smoke cigarettes or have asthma." Review R95's "Immunization Record," located under the "Immunization" tab of the EMR, revealed no indication that R95 received the	F 883		

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F 883	Continued From page 68 Pneumococcal Prevnar 20 on 03/19/25. During an interview on 03/18/25 at 3:37 PM, the Assistant Director of Nursing/Infection Preventionist (ADON)4 stated R95 had declined the pneumococcal vaccine. When informed that R95 had consented to the vaccine, but never received it, ADON4 stated she will "look into it." During an interview on 03/20/25 at 6:18 PM, the Director of Nursing (DON) stated it was her expectation that R92 and R95 should have received the vaccines they consented to on admission.	F 883		

PLAN OF CORRECTION

Provider/Supplier Name:	Beauvais Rehab and Healthcare Center
Street Address, City, Zip:	3625 Magnolia Avenue Saint Louis MO 63110
Date of Survey:	3/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265699

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. The Plan of Correction constitutes the facility's credible allegation of compliance.	
F583	Resident #38 and #123 will not have their personal health information accessible to other residents and/or visitors. The facility will ensure medical records containing personal health information will not be accessible to residents or visitors on the secure unit. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will in-service CMT's and licensed nurses on ensuring the EMR is not left open when not present. DON/ADON or designee will make rounds 5x/week x 4 weeks to ensure there are no EMR's left open when not in use and without staff present. Any issues identified will be corrected and 1:1 education will be provided. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F584	The facility cleaned the 5th floor shower room. Resident #109 will shower in a clean shower room. Admin or designee will audit facility shower rooms to ensure they are clean.	4/24/25

	Current residents who reside at the facility have the potential to be affected. Admin or designee will in-service the housekeeping department on ensuring showers are clean. Admin or designee will audit each shower room once per week x 4 weeks to ensure it is kept clean. Any issues identified will result in 1:1 education by the admin or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F637	Resident #23 will have a significant change MDS assessment completed if required. Current residents who reside at the facility have the potential to be affected. MDS or designee will audit current residents with weight loss to to identify if any current residents require a significant change assessment. If residents are identified, a significant change MDS assessment will be set. Regional MDS/RNC or designee will in-service MDS coordinator on setting significant change assessments if criteria are met. DON/MDS or designee will audit 10 residents with weight loss weekly to identify if significant change criteria was met and if required a significant change assessment was set. Any issues identified will be corrected and 1:1 education will be completed by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F641	Resident #23 MDS assessment will be modified and corrected to accurately code weight loss. Resident #136 is no longer a current resident. MDS will be modified to accurately reflect discharge. Current residents who reside at the facility have the potential to be affected. Regional MDS/RNC or designee will in-service MDS coordinator on accurately completing MDS assessments related to weight loss and discharges. Admin/DON or designee will in-service the IDT on accurately completing MDS assessments.	4/24/25

	Regional MDS will audit 10 MDS assessments weekly to ensure weights were coded appropriately or discharge assessment was correct. Any issues identified will result in 1:1 education by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F644	Updated PASARR was completed by regional BOM for resident # 91, this resident did not meet the criteria for a new PASARR. Current residents who reside at the facility have the potential to be affected. MDS or designee will complete an audit for current residents during their next scheduled MDS assessment to identify if resident has any new qualifying psych DX and qualifying psych stay. If resident meets criteria BOM will be notified and a new PASARR will be completed. Regional BOM or designee will in-service the BOM, Admin, DON, MDS on ensuring an updated PASARR is completed if criteria is met. Regional BOM will audit 10 residents per week to ensure PASARR reflects current status. Any issues identified will be corrected and 1:1 education will be completed by the admin or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F656	Resident #57 wasn't on hospice services. MDS or designee completed an audit of residents on hospice services to ensure hospice was care planned. Current residents who reside at the facility have the potential to be affected. Regional MDS/RNC or designee will in-service MDS coordinator on ensuring hospice is care planned for residents on hospice services. DON or designee will audit 5 residents on hospice weekly to ensure their care plan reflects their hospice. Any issues identified will be corrected and 1:1 education will be provided by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25

F684	Resident #2 no longer has orders for a helmet. DON/ADON or designee completed an audit of current resident to identify which residents have orders for helmets to ensure order is in PCC and helmet is present and worn per MD orders. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee in-serviced the licensed nurses on ensuring if a resident has an order for a helmet that the physician orders are followed. If resident refuses this should be documented on the TAR. DON/ADON or designee will observe residents with helmets 3x/week to ensure helmet is worn per physician orders and if refused that this was documented. Any issues identified will result in 1:1 education by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F685	Resident #16 will have appointment rescheduled if ordered by the MD. Appointments will be discussed during stand up 5x/week. Current residents who reside at the facility have the potential to be affected. RNC or designee will in-service SSD, Admin, ADON and DON on ensuring appointments are scheduled as ordered. Admin or designee will audit 5 appointments per week to ensure resident attended as scheduled and any follow up appointments were made. Any issues identified will be corrected and 1:1 education will be provided by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F689	Resident #2's bathroom door lock was removed. Resident #2 was educated on the smoking policy. Admin or designee completed an audit of resident bathrooms to identify any bathrooms with locks that need removed. Current residents who reside at the facility have the potential to be affected.	4/24/25

	DON or designee will in-service facility staff on smoking policy to include if the resident is assessed to be able to smoke without supervision, they are to check out lighters from the receptionist and return when done. DON or designee will educate current smokers on facility smoking policy to include if assessed to be able to smoke without supervision are to return the lighters to the receptionist when done. Admin or designee will in-service maintenance on not having locks on the bathroom doors. DON/ADON or designee will round the facility daily 5x/week to identify if odors of smoke are present, if identified admin will be immediately notified and will be investigated and addressed. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F695	Resident #51 will receive oxygen per physician orders. Order will be reflected on the mar/tar. DON/ADON or designee will audit current residents on oxygen to ensure they are receiving oxygen per MD orders and to ensure this is reflected on the mar/tar. Current residents that reside at the facility have the potential to be affected. DON/ADON or designee will in-service licensed nurses on ensuring residents receive oxygen per MD orders and that order is reflected on the MAR/TAR. DON/ADON or designee will audit 10 residents on oxygen weekly to ensure oxygen is set per MD orders. Any issues identified will result in 1:1 education by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F725	5th floor will have adequate staffing. Resident #138 no longer resides at the facility. Resident #97, #75 and #89 will have their needs met in a timely manner. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will in-service nursing staff on answering call lights in a timely manner.	4/24/25

	Admin or designee will in-service the staffing coordinator on staffing the 5th floor to ensure resident needs are met. Admin or designee will in-service nursing staff on cell phone usage. DON/ADON or designee will observe 10 call lights a week on the 5th floor to ensure they were answered in a timely manner. Any issues identified will result in 1:1 education by the DON or designee. Admin or designee will observe 10 staff members weekly x4 weeks to observe for cell phone usage. Any issues identified will be corrected and 1:1 education will be provided by the admin or designee. Admin/DON/staffing coordinator will hold a daily staffing meeting 5x/week to review the 5th floor staffing sheets to ensure floor is staffed to meet the residents needs. If issues are identified, then DON/designee will post the openings and attempts will be made to bring in appropriate coverage Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F726	CMT's will have medication administration competencies completed. HR or designee will audit current CMT's to identify which CMT's need a medication administration competency completed. CMT's that have not had a medication administration competency completed within the last year will have competency completed. Current residents who reside at the facility have the potential to be affected. RNC will in-service DON and HR on ensuring CMTs' have medication administration competencies completed on an annual basis. DON/ADON or designee will in-service CMT's and licensed nurses on the rights of medication administration. DON/ADON or designee will audit 5 CMT's weekly to ensure they have had a medication administration competency completed within the past 12 months. Any adverse findings will result in competency being completed and education by the DON or designee. DON/ADON or designee will observe 5 resident medication passes per week by CMT to ensure medication administration rights were followed. Any adverse findings will result in 1:1 education by the DON or designee.	4/24/25

	Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F727	RN ad for additional coverage has been placed. Residents currently residing in the facility have the potential to be affected. Administrator/designee will educate staffing coordinator on RN coverage requirement. Administrator/designee will audit schedule 5x/week during daily stand up x 4 weeks to ensure there is RN coverage. If issues are identified, then DON/designee will post the openings and attempts will be made to bring in appropriate RN for coverage. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F758	Resident #42 will have their target behaviors monitored related to psychotropic medication use. DON/ADON or designee will audit current residents on psychotropic medications and ensure monitoring is in place for target behaviors. Current residents who reside at the facility have the potential to be affected. RNC or designee will in-service DON and nurse mangers on ensuring residents on psychotropic medication have target behavior monitoring in place. DON or designee will audit 10 resident's weekly who are on psychotropic medications to ensure behavior monitoring is in place for target behaviors. Any issues identified will result in 1:1 education by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F761	Residents insulin and eye drops will be labeled with the open dates. Expired medications will be discarded and re-ordered if needed. DON/ADON or designee will audit medication carts to ensure insulin and eye drops are labeled with open dates. Expired medications will be removed and replaced if needed.	4/24/25

	Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will in-service licensed nurses on ensuring insulin is labeled with resident name and open date. DON/ADON or designee will in-service licensed nurses and CMT's on ensuring eye drops are labeled with open date and that expired medications are removed from cart and re-ordered if needed. DON/ADON or designee will audit 3 medications carts weekly to ensure there are no expired medications present, and insulin and eye drops are labeled with name and open date. Any issues identified will be corrected and 1:1 education will be provided by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F804	Residents # 42, #129, #77, #99, #109, #96 and #132 will have food that is palatable and at the appropriate temperature. Current residents who reside at the facility have the potential to be affected. Admin or designee will in-service dietary manager on serving food that is palatable and at the appropriate temperature. Dietary manager will in-service dietary staff on serving food that is palatable and at the appropriate temperature. Dietary manager or designee will audit 10 test trays a week to ensure food is palatable and at the appropriate temperature. Any issues identified will be corrected and education will be provided by the Admin or designee. Dietary manager or designee will interview 10 residents a week to ensure food was palatable and at the appropriate temperature. Any issues identified will be corrected and education will be provided by the admin or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25
F847	Resident #189 no longer resides at the facility. Resident #92 and #99 will have an updated binding arbitration agreement provided to them. The Binding Arbitration Agreement for our facility was updated to include the verbiage that includes the agreement is voluntary and clearly communicated to the resident or resident	4/24/25

	representative as optional and not required as a condition of admission or to continue to receive care at the facility. Current residents that reside at the facility have the potential to be affected. ADM/designee in-serviced the Admission Coordinator on the updated Arbitration Agreement. The Arbitration Agreement was updated in the facility Admission Contract. The Administrator will audit admission and re-admission packets weekly x4 weeks to ensure the updated version of the Binding Arbitration Agreement is being used. Any issues identified will result in 1:1 education. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	
F880	Resident #5, #8, #80, #117, #93 and #91 will have meals delivered in a manner to prevent cross contamination. Resident #76 no longer resides at the facility. Resident #92, #41, #24 and #106 will have medications administered in a manner to prevent cross contamination. Current residents who reside at the facility have the potential to be affected. DON/ADON or designee will in-service nursing staff on sanitizing hands in between passing meal trays. DON/ADON or designee will in-service licensed nurses and CMTs on proper hand hygiene and glove changing when administering medications. DON/ADON or designee will observe 20 meal trays being passed per week to ensure proper hand hygiene was performed. Any issues identified will result in 1:1 education by the DON or designee. DON/ADON or designee will observe 10 medication passes per week to ensure proper hand hygiene and glove changes were completed. Any issues identified will result in 1:1 education by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25

F883	Resident #92 and #95 will have pneumonia vaccine offered and administered if consented and ordered by the MD. DON/ADON or designee will audit current residents to identify which residents need offered the PNU vaccine. Vaccine will be offered and administered if ordered by the MD over the next 30 days. Current residents who reside at the facility have the potential to be affected. DON or designee will in-service the IP on offering PNU vaccines and administering if consented and ordered by the MD. DON or designee will audit 10 residents a week to identify if resident was offered PNU vaccine, and if consented and ordered was administered. Any issues identified will be corrected and 1:1 education will be provided by the DON or designee. Results of the audit will be forwarded to the QAPI committee for review and recommendations for continued compliance.	4/24/25

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