STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265216	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Wellness and Rehabilitation Center	1333 Scenic Drive Herculaneum, MO 63048

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a baseline care plan (the minimum healthcare information necessary to properly care for the resident) upon admission with specific interventions needed to care for resident, and failed to assure the resident and/or guardian received a written summary of the baseline care plan for two residents (Resident #151 and #261) out of 32 sampled residents. The facility's census was 161. Review of the facility's policy, Care Plans, dated 01/15, showed: - Each resident will have a plan of care to identify problems, needs, and strengths that will identify how the team will provide care; - Responsibility of the nurse monitored by the Executive Director; - The Care Plan will be developed within two days; - The team along with the resident and/or family members will identify services needed, preferences, and ability and care level guidelines. 1. Review of Resident #151's medical record showed: - admitted on [DATE]; - Diagnoses of congenital malformation of the brain (a birth defect that occurs during development in the womb resulting in abnormal brain structure), borderline intellectual functioning (functioning on the border between normal intellectual functioning and intellectual disability), epilepsy (seizures) and hypothyroidism (when the thyroid gland does not make enough thyroid hormone). Review of the baseline care plan showed: - Not completed until 03/14/25; - No documentation that the care plan had been reviewed with the resident and/or resident's representative. 2. Review of Resident #261's medical record showed: (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted on [DATE]; - Diagnoses of adult failure to thrive (a syndrome of global decline in older adults, characterized by frailty, weight loss, decreased appetite, and a decline in functional abilities), protein calorie malnutrition (a condition resulting from inadequate intake of protein and/or calories, leading to a deficiency in these essential nutrients), and depression. Review of the baseline care plan showed: - No completion date documented; - No documentation that the care plan had been reviewed with the resident and/or resident's representative. During an interview on 04/11/25 at 4:35 P.M., the Administrator and Director of Nursing (DON) said they would expect the baseline care plan to be completed within 48 hours of admission and a summary of the baseline care plan to be provided to the resident and/or resident's representative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to appropriately assess the use of bed rails for three residents (Resident #107, #133, and #462) of 32 sampled residents. The facility's census was 161. Review of the facility's policy titled, Side Rail Use Evaluation, dated 02/25, showed: - The resident's risk for entrapment should be assessed prior to installation of bed rails; - Complete the Side Rail Evaluation form; - Documentation should contain alternatives prior to implementation of any type of rail(s), risk and benefits reviewed with the resident or resident representative, and informed consent obtained from the resident or resident representative. 1. Review of Resident #107's medical record showed: - admitted on [DATE]; - Diagnoses of displaced fracture (two or more portions of broken bone come out of proper alignment) of second cervical (neck) vertebra (series of small bones forming the backbone), burst fracture (a serious spinal injury where the vertebra shatters and breaks in multiple directions) of fourth thoracic (the middle section of the spine starting at the base of the neck and ending at the bottom of the ribs) vertebra, hemiplegia (paralysis of the muscles of the lower face, arm, and leg on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (a condition where a part of the brain is damaged or dies due to a lack of blood supply), dementia (a group of symptoms affecting memory, thinking and social abilities), metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood), type 2 diabetes (when the body cannot use insulin correctly and sugar builds up in the blood), hypertension (high blood pressure), and heart failure (when the heart can't pump enough blood to meet the body's needs, leading to organs not working properly); - An order for assist rails on both sides of the bed, dated 03/28/25; - No side rail evaluation completed for the resident; - No documentation of an informed consent signed explaining the risks and benefits. Review of the resident's significant change Minimum Data Set (MDS, a federally mandated assessment completed by the facility), dated 04/04/25, showed: - Moderate cognitive impairment; - Maximum assist from staff for bed mobility. Observation on 04/09/25 at 1:13 P.M. showed the resident eating lunch in bed with head of bed (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevated and assist bars on both sides of the bed. During an interview on 04/11/25 at 11:30 A.M., the resident said he/she uses the assist bars to turn in bed. 2. Review of Resident #133's medical record showed: - admitted on [DATE]; - Diagnoses of multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), heart failure, and hypertension. Review of the resident's quarterly MDS, dated [DATE], showed: - No cognitive impairment; - Independent for bed mobility. Review of the resident's Side Rail Evaluation, dated 01/14/25, showed: - Resident using assist rails on both sides; - No resident or family request to use side rails while in bed; - No interventions trialed before considering use; - No cause/medical symptom justifying use; - No benefits or risks listed; - No documented consent. Review of the facility's entrapment assessment binder showed an entrapment assessment not completed until 03/20/25. Observation on 04/08/25 at 12:12 P.M. and on 04/09/25 at 10:43 A.M. showed the resident up in a wheelchair and the bed with quarter rails on both sides in the up position. 3. Review of Resident #462's medical record showed: - admitted on [DATE]; - Diagnoses of nontraumatic intracerebral hemorrhage (bleeding within the brain that occurs without any prior trauma or injury), cerebral ischemia (a condition where the brain does not receive enough blood flow, resulting in a lack of oxygen and nutrients), hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation (a common heart rhythm disorder characterized by rapid, irregular beating of the heart's upper chambers), general anxiety disorder (a mental health condition characterized by persistent and excessive worry about various aspects of life, often about things that are not likely to happen), senile degeneration of brain (a progressive decline in cognitive function, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impacting memory, reasoning, and the ability to perform everyday activities), and chronic kidney disease (a progressive condition where the kidneys are damaged and can't filter waste and fluid from the blood effectively); - An order for assist rails on both sides of the bed, dated 03/22/25. Review of the resident's significant change MDS, dated [DATE], showed: - Moderate cognitive impairment; - Dependent on staff for bed mobility. Review of the resident's Side Rail Evaluation, dated 03/22/25, showed no other interventions had been trialed before considering the use of side rails. Observation on 04/10/25 at 7:46 A.M. showed the resident lying in bed with half bed rails up on both sides of the bed. Observation on 04/11/25 at 10:15 A.M. showed the resident holding the left side rail while being held onto his/her left side during wound care. During an interview on 04/11/25 at 11:31 A.M., the resident said he/she uses the side rails when staff reposition him/her in bed. During an interview on 04/11/25 at 4:35 P.M., the Administrator and Director of Nursing said they would expect staff to try alternatives before installing side rails, side rail assessments to be completed on all side rails and assess for entrapment risk prior to installation, and the risk/benefits of side rails to be explained to the resident and informed consent obtained before installation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during tracheostomy (surgical opening in the neck used to provide airway for breathing) care and g-tube (a medical device that delivers liquid nutrition directly to the stomach or small intestine through a flexible tube) medication administration for one resident (Resident #20) out of 32 sampled residents. The facility failed to maintain infection control practices when staff failed to wear proper personal protective equipment (PPE) for enhanced barrier precautions (EBP) for two residents (Resident #20 and #97) out of 32 sampled residents. The facility's census was 161. Review of the facility's policy, Enhanced Barrier Precautions, dated 04/24, showed: - EBP are indicated for residents with infections or colonization with a CDC-targeted MDRO when contact precautions do not apply or for resident with wounds and/or indwelling medical devices without secretions/excretions that are unable to be covered/contained and are not known to be infected/colonized with any MDRO during high-contact resident care activities as these residents are at an increased risk of being infected; - EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices); - EBP only requires use of gown/gloves when performing high contact resident activities: Device care or use: central line, urinary catheter, feeding tube, tracheostomy, or ventilator; - Duration: EBP are intended to remain in effect for the duration of the resident stay or until the wound is closed/medical device removed. Review of the facility's policy, Enteral Tube Medication Administration Procedures, dated 06/23, showed: - Check medication administration record (MAR)/electronic medication administration record (eMAR) for the prescribed medication, amount, and time of administration; - Verify type of enteral tube in place and select appropriate syringe for administration; - Prepare medications for administration, crush tablet and dissolve/mix in a small amount of water or other appropriate liquid; - Provide privacy and place resident in proper position; if in bed, elevate the head of bed; - Wash hands and apply gloves; - Verify tube placement per tube feeding policy, stop enteral feeding and flush tube with an approximate 15 milliliters (ml) of water prior to medication administration, administer each medication separately, flushing tube with approximately 15 ml of water after each dose unless fluid restricted; - Place the first medication into the syringe, allow flushes and medication to flow down tube via (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gravity, flush the tube with approximately 15 ml of water and clamp to prevent medication from clogging tube lumen (space within a tube); - Clean feeding syringe and return to bedside stand; syringes are replaced every 24 hours or as required by state regulation; - Restart enteral feeding; - Wash hands as per facility policy; - Document medication administration and chart water intake, if appropriate. 1. Observation on 04/09/24 at 11:30 A.M. of Resident #20's tracheostomy collar/mask, oxygen support system showed: - An EBP sign above the resident's bed and EBP supplies available in a hanging bin located on the resident's bathroom door; - Oxygen support tubing disconnected from trach collar and lying on the resident's floor in his/her room; - Trach collar shifted to the right side of the resident's neck and not centered over tracheostomy; - Licensed Practical Nursing (LPN) B entered the resident's room and donned a mask and gloves; - LPN B did not don a gown; - LPN B did not wash his/her hands; - LPN B picked up the oxygen tubing from the floor and reconnected the tubing between the resident's tracheostomy collar and the oxygen support system; - LPN B removed gloves and mask and exited the resident's room; - LPN B re-entered the resident's room, did not wash or sanitize hands and donned a mask and gloves; - LPN B opened a package with new oxygen support tubing; - LPN B replaced the part of the oxygen support tubing that had been previously on the floor; - LPN B removed gloves and mask and washed hands; - LPN B exited the resident's room. During an interview on 04/09/25 at 3:48 P.M., LPN B said he/she checked on the resident about an hour ago. Sometimes the oxygen tubing comes off when the aides move the resident around. Tubing should never be reconnected if it has been lying on the floor. He/She should have worn a gown, gloves, and mask and should have washed his/her hands when going to and from the resident's room. EBP should be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worn when a resident has a urinary catheter, tracheostomy, feeding tube, bacteria in their urine, or open wounds. 2. Observation on 04/10/25 at 1:33 P.M. of Resident #20's medication administration via feeding tube showed: - LPN A did not wash or sanitize hands; - LPN A removed a pill from the nurse's medication cart and placed the pill in his/her bare hand; - LPN A placed the pill in a plastic sleeve and crushed the pill; - LPN A placed the medication in a small, plastic cup; - LPN A entered the resident's room; - LPN A obtained and opened a new syringe package; - LPN A placed syringe and plastic cup containing the medication beside the sink without a barrier; - LPN A donned gloves and gown; - LPN A filled cup containing the medication with water from the sink; - LPN A pulled the privacy curtain and lifted the resident's gown to access g-tube/feeding tube site; - LPN A removed cap to g-tube and pulled syringe back, no residual was noted; - LPN A removed the plunger from the syringe and emptied water containing the medication into the syringe, residual medication was noted in the cup; - LPN A placed the cup on the bedside table without a barrier; - LPN A closed the g-tube cap; - LPN A picked up the cup off of the bedside table and took it to the sink to obtain more water for the residual medication; - LPN A removed the cap to the g-tube, and administered the remaining water and medication; - LPN A reconnected the feeding tube into the g-tube and turned feeding tube pump on; - LPN A lowered the resident's gown and pulled covers up around resident's arms; - LPN A removed gown and gloves and washed his/her hands. During an interview on 04/10/25 at 1:45 P.M., LPN A said he/she should have washed or sanitized his/her hands prior to getting the medication out of the medication cart, and before he/she started (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering the medication. He/She should absolutely not touch a pill barehanded. 3. Observation on 04/11/25 at 10:00 A.M. of Resident #97's wound care showed: - Signage hanging above the head of the bed showed the resident required EBP for care; - Registered Nurse (RN) C sanitized hands and gathered gauze, skin prep (a topical solution used as a barrier to protect skin), medication cup with gauze moistened by wound cleanser inside, and gloves from the treatment cart placed at the resident's doorway; - RN C entered the room without donning a gown and laid supplies on gloves on the bed as a barrier; - RN C donned gloves; - RN C positioned the resident's leg, and leaned against the bed without a gown as a barrier; - RN C removed the dressing from the left calf; - RN C wiped the wound with the wound cleanser moistened gauze; - RN C removed gloves, sanitized hands, and donned new gloves; - RN C wiped the wound with skin prep: - RN C removed gloves, sanitized, and obtained Mepilex border (an absorbent foam dressing) from the treatment cart; - RN C failed to don gloves and applied the Mepilex dressing with bare hands, touching the resident's leg and bed with his/her bare hands; - RN C sanitized hands and gathered gauze, skin prep, medication cup with gauze moistened by wound cleanser inside, and gloves from the treatment cart; - RN C donned gloves and removed dressing from the resident's left heel, - RN C removed gloves and repositioned the resident's foot with his/her bare hands; - RN C sanitized hands and donned gloves; - RN C wiped the wound with wound cleanser dampened gauze; - RN C removed gloves and sanitized hands; - RN C wiped the wound with skin prep; - RN C removed gloves and applied Mepilex dressing to the resident's heel with his/her bare hands, touching the resident and the resident's bed. During an interview on 04/09/25 at 3:25 P.M., the resident said staff occasionally wear a gown when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing care for him/her. During an interview on 04/10/25 at 12:30 P.M., RN C said he/she should have used EBP and worn a gown when performing a dressing change on a resident who required EBP. During an interview on 04/11/25 at 4:35 P.M., the Administrator and Director of Nursing (DON) said they would expect nurses not to handle medications with their bare hands and would expect nurses to replace tubing that has been lying on the floor and not to reconnect the tubing back to a machine. They said they would expect staff to wear gowns and gloves for residents on EBP.