STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265678	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bertrand Nursing and Rehab Center	603 Highway 62 West Bertrand, MO 63823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an appropriate diagnosis for the use of a psychotropic medication (a medication that alters the levels of chemicals in the brain that influence mood, behavior, and perception) for one resident (Resident #38) out of five sampled residents. The facility census was 53.Review of the facility's policy titled, Antipsychotic (a medication that affects the brain activities associated with mental processes and behavior) Medication Use, revised December 2016, showed:Antipsychotic medications may be considered for residents with dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed;Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time in our subject to gradual dose (GDR) reduction and re-review;Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective;The Attending Physician and other staff will gather and document information to clarify, a resident's behavior, mood, function, medical condition, specific symptoms, and risk to the resident and others;The Attending Physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications;Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident;Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (a guidebook that helps physicians and other mental health professionals diagnose mental illness, current or subsequent editions): Schizophrenia (a long-term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations); Schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions); Schizophreniform disorder (hallucinations); Delusional disorder (a false belief that is not based on reality); Mood (an emotional state of mind or feeling) disorders (e. g. bipolar disorder (a mental disorder that causes unusual shifts in mood), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act) with psychotic features, and treatment refractory major depression (a disease or condition that does not respond to treatment); Psychosis (a mental disorder with a severe loss of contact with reality) in the absence of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning); Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (emotional shifts in mood); Tourette's disorder (uncontrollable, repetitive movements or sounds); Huntington disease (a hereditary brain disorder that causes uncontrolled movements, cognitive (thinking, learning, and understanding) decline, and psychiatric problems worsening over time); Hiccups (not induced my other medications); Nausea and vomiting associated with cancer or chemotherapy; Antipsychotic medications will not be used if the only symptoms are one or more of the following: Wandering; Poor self-care; Restlessness; Impaired memory; Mild anxiety; Insomnia (difficulty falling asleep); Inattention or indifference to surroundings; Sadness are crying alone that is not related to depression or other psychiatric disorders; Fidgeting; Nervousness; Uncooperativeness;The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) while the benefits of the medication outweigh the risk or suspected or confirmed adverse consequences. 1. Review of Resident #38's July 2025 Physician's Order Sheet (POS) showed:admitted on [DATE];admitted to hospice on 11/15/24;discharged from hospice on 05/14/25;Diagnoses of unspecified convulsions (a sudden, irregular movement of the limb or of the body), unspecified dementia, unspecified severity, without behavioral (how a person acts or reacts) disturbance, psychotic (losing touch with reality) disturbance, mood disturbance, and anxiety (persistent worry and fear about everyday situations), Alzheimer's disease (progressive mental deterioration), unspecified and major depressive disorder (a serious medical illness that negatively affects how you feel, the way you think and how you act);An order for olanzapine (an antipsychotic medication) 2.5 milligram (mg) by mouth at bedtime related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, dated 11/15/24. Review of the resident's medical record showed:No documentation of an appropriate diagnoses for the use of olanzapine;No identified

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the safety of a resident by not assessing and evaluating the mobility rail (a rail to assist residents with positioning in bed) for five residents (Resident #3, #8, #16, #45, #51) out of five sampled residents. The facility census was 53. Review of the facility's policy titled, “Assistive Devices and Equipment,” dated January 2020, showed: The facility maintains and supervises the use of assistive devices and equipment for residents; The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment: appropriateness for resident condition - the resident is assessed for lower extremity strength, range of motion, balance and cognitive abilities when determining the safest use of devices and equipment. 1. Review of Resident #3's medical record showed: admitted on [DATE]; Diagnoses of hypertension (high blood pressure) and hypokalemia (decreased blood level of potassium); No assessment for the use of the mobility rail. Observations on 07/22/25 at 1:21 P.M., 07/23/25 at 1:20 P.M., and 07/24/25 at 10:20 A.M. showed: A U-shaped mobility rail in the upright position on the right side of the resident's bed. During an interview on 07/22/25 at 1:22 P.M., the resident said he/she used the mobility bar for getting up on the side of the bed. 2. Review of Resident #8's medical record showed: admitted to the facility on [DATE]; Diagnoses of cerebral infarction (stroke), major depressive disorder (a disorder characterized by persistently depressed mood or loss of interest in activities) and anxiety (intense, excessive, and persistent worry and fear about everyday situations); No assessment for the use of the mobility rail. Observations on 07/22/25 at 11:00 A.M., 07/23/25 at 3:20 P.M., 07/24/25 at 12:05 P.M., 07/25/25 at 1:25 P. M. showed: A U-shaped mobility rail in the upright position on the left side of the resident's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #16's medical record showed: admitted on [DATE]; Diagnoses of left side hemiplegia (paralysis of one side of the body), hypertension and type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar); No assessment for the use of the mobility rail. Observations on 07/22/25 at 2:17 P.M., 07/23/25 at 10:10 A.M., and 07/24/25 at 2:10 P.M. showed: A U-shaped mobility rail in the upright position attached to right side of the resident's bed. During an interview on 07/22/25 at 2:20 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed and turning side to side. 4. Review of Resident #45's medical record showed: admitted on [DATE]; Diagnoses of burst fracture of lumbar vertebra (vertebral fracture due to compression), heart attack, and chronic respiratory failure; No assessment for the use of the mobility rail. Observations on 07/22/25 at 11:11 A.M., 07/23/25 at 10:36 A.M., 07/24/25 at 8:17 A.M., and 07/25/25 at 9:43 A.M. showed: A U-shaped mobility rail in the upright position attached to the right side of the resident's bed. During an interview on 07/23/25 at 10:36 A.M., the resident said he/she used the mobility rail to turn in bed and with transfers out of the bed. 5. Review of Resident #51's medical record showed: admitted on [DATE]; Diagnoses of hypertension, anxiety, and depression (mood disorder that causes a persistent feeling of sadness and loss of interest); No assessment for the use of the mobility rail. Observations on 07/22/25 at 2:20 P.M., 07/23/25 at 3:24 P.M., 07/24/25 at 9:58 A.M., and 07/25/25 at 11:50 A.M. showed: U-shaped mobility rails in the upright position on both sides of the resident's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/22/25 at 2:20 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed and turning side to side while in bed. During an interview on 07/25/25 at 10:00 A.M., the Administrator said he visually inspected the rails on his daily rounds. He did not document the rail inspections. During an interview on 07/25/25 at 1:17 P.M., the Therapy Director said the facility did not document any assessments to determine if a resident needed or was able to use a mobility rail. During an interview on 07/25/25 at 1:57 P.M., the Maintenance Assistant said he/she did repair the mobility rails or added/removed them from the residents' beds when asked. He/She did not inspect the rails that were on the residents' beds.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 28 opportunities with four errors made, resulting in an error rate of 10. 71% for one resident (Resident #34) out of three sampled residents. The facility's census was 53. The facility did not provide a policy addressing priming of insulin pens. Review of the Fiasp/Novolog (fast-acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed:To prime the pen, turn the dose selector to two units;Keep the needle upwards and press the push button until the dose selector reads zero;Turn the dose selector to select the number of prescribed units to administer the insulin.1. Review of Resident #34's Physician's Order Sheet (POS), dated July 2025, showed:An order for Novolog FlexPen 16 units subcutaneously (injection under the skin) two times a day, dated 02/27/25;An order for Novolog FlexPen per sliding scale for a blood sugar of 51-200 = 0 units, 201-200 = 3 units, 301-350 = 5 units, 351-400 = 8 units, 401-500 = 10 units subcutaneously before meals, dated 04/14/24.Observation of Resident #34's medication administration on 07/23/25 at 11:39 A.M., showed:Licensed Practical Nurse (LPN) A administered 19 units of Novolog subcutaneously for a blood sugar of 265 with the resident's Novolog FlexPen;- LPN A failed to prime the Novolog FlexPen per the manufacturer's instructions prior to the administration of the insulin to the resident. Observation of Resident #34's medication administration on 07/24/25 at 4:38 P.M. showed:LPN B administered 8 units of Novolog subcutaneously for a blood sugar of 358 with the resident's Novolog FlexPen:LPN B failed to prime the Novolog FlexPen per the manufacturer's instructions prior to the administration of the insulin to the resident.During an interview on 07/25/25 at 1:45 P.M., Certified Medication Technician (CMT) C said he/she dialed up two units of insulin to waste and prime the needle before dialing up the dose the order required.During an interview on 07/25/25 at 1:45 P.M., LPN D said before administering the ordered dose of insulin, he/she wasted two units of insulin to prime the needle.During an interview on 07/25/25 at 2:15 P.M., the Director of Nursing (DON) said she would expect staff to prime the insulin pen needle with at least two units before administering insulin to residents.

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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 follow infection control protocols during wound care for one resident (Resident #7) out of two sampled residents. The facility census was 53. Review of the facility's policy titled, Dressings, Dry/Clean, last revised September 2013, showed:Wash and dry hands thoroughly;Put on clean gloves. Loosen tape and remove soiled dressing;Pull glove over dressing and discard into plastic or biohazard bag;Wash and dry your hand thoroughly;Put on clean gloves;Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress, and wound stage;Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually from the center outward);Use dry gauze to pat the wound dry;Apply the ordered dressing and secure with tape or bordered dressing per order;Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.Review of the facility's policy titled, Dressings, Soiled/Contaminated, last revised August 2009, showed:Gloves must be worn when changing a dressing and/or when handling items contaminated with blood, body fluids, or potentially infective materials.1. Review of Resident #7's medical record showed:Diagnoses of Alzheimer's disease (progressive brain disorder), cerebral infarction (stroke), mood disorder, dysphagia (difficulty swallowing), and anxiety.Review of the resident's Physician's Order Sheet (POS), dated July 2025, showed:An order to clean the open areas to the left lower extremity (LLE) with wound cleanser, pat dry with 4x4s, apply a thin layer of Multidex powder (absorbs drainage from open wounds) to open areas, cover with Telfa (a non-adherent dressing), wrap the LLE with Kerlix (gauze wrap), and secure with tape daily and as needed (PRN), dated 07/25/25;- An order to clean shears to the left hip, right hip, and the right knee with wound cleanser and cover with bordered gauze, dated 07/22/25. Observation of the resident's wound care on 07/24/25 at 2:00 P.M. showed:Licensed Practical Nurse (LPN) A, LPN B, and the Director of Nursing (DON) entered the resident's room, did not perform hand hygiene, and put on gloves;LPN A cleaned the right hip wound with wound cleanser and gauze, did not change gloves, did not perform hand hygiene, and patted it dry with clean gauze; - LPN A did not change gloves, did not perform hand hygiene, cleaned the right knee wound with wound cleanser and gauze, did not change gloves, did not perform hand hygiene, and patted it dry with clean gauze;LPN A did not change gloves, did not perform hand hygiene, cleaned the left hip wounds with wound cleanser and gauze, did not change gloves, did not perform hand hygiene, and patted it dry with clean gauze;LPN A removed gloves, did not perform hand hygiene, and touched the clean dressing with his/her bare hands;LPN A put on gloves, did not perform hand hygiene, cleaned the LLE with wound cleanser and gauze, did not change gloves, did not perform hand hygiene, and patted it dry with clean gauze;LPN A removed gloves, did not perform hand hygiene, and applied the Telfa dressings, gauze, and tape to the LLE with his/her bare hands;LPN B and DON removed gloves;LPN A, LPN B, and DON did not perform hand hygiene and exited the resident room.During an interview on 07/25/25 at 1:48 P.M., LPN D said when providing wound care, he/she would perform hand hygiene and put on clean gloves, remove the dirty dressing, remove the dirty gloves, perform hand hygiene, and put on clean gloves. Next, he/she would clean the wound, remove the dirty gloves, perform hand hygiene, and apply a clean dressing. Should perform hand hygiene and put on clean gloves between each wound. He/She would never touch a clean dressing with a dirty glove or with a bare hand. During an interview on 07/25/25 at 2:04 P.M., the DON said staff should not use their bare hands in any portion of wound care. Staff should perform hand hygiene and put on clean gloves when going from soiled to clean care to lower the risk of contamination.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct inspections of all bed frames, mattresses, and side rails as a part of a regular maintenance program for five residents (Resident #3, #8, #16, #45, and #51) out of five sampled residents. The facility census was 53. Review of the facility's policy titled, “Assistive Devices and Equipment,” dated January 2020, showed: The facility maintains and supervises the use of assistive devices and equipment for residents; The policy did not address an inspection of the mobility rail as part of the facility's maintenance program. 1. Review of Resident #3's medical record showed: admitted on [DATE]; Diagnoses of hypertension (high blood pressure) and hypokalemia (decreased blood level of potassium); No maintenance inspection for the mobility rail. Observations on 07/22/25 at 1:21 P.M., at 07/23/25 at 1:20 P.M., and 07/24/25 at 10:20 A.M. showed: - A U-shaped mobility rail in the upright position on the right side of the resident's bed. During an interview on 07/22/25 at 1:22 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed. 2. Review of Resident #8's medical record showed: admitted to the facility on [DATE]; Diagnoses of cerebral infarction (stroke), major depressive disorder (a disorder characterized by persistently depressed mood or loss of interest in activities) and anxiety (intense, excessive, and persistent worry and fear about everyday situations); No maintenance inspection for the mobility rail. Observations on 07/22/25 at 11:00 A.M., 07/23/25 at 3:20 P.M., 07/24/25 at 12:05 P.M., and 07/25/25 at 1:25 P.M. showed: - A U-shaped mobility rail in the upright position on the left side of the resident's bed. 3. Review of Resident #16's medical record showed: admitted on [DATE]; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diagnoses of left side hemiplegia (paralysis of one side of the body), hypertension and type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar); No maintenance inspection for the mobility rail. Observations on 07/22/25 at 2:17 P.M., 07/23/25 at 10:10 A.M., and 07/24/25 at 2:10 P.M. showed: A U-shaped mobility rail in the upright position attached to right side of the resident's bed. During an interview on 07/22/25 at 2:20 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed and turning side to side. 4. Review of Resident #45's medical record showed: admitted on [DATE]; Diagnoses of burst fracture of lumbar vertebra (vertebral fracture due to compression), heart attack, and chronic respiratory failure; No maintenance inspection for the mobility rail. Observations on 07/22/25 at 11:11 A.M., 07/23/25 at 10:36 A.M., 07/24/25 at 8:17 A.M., and 07/25/25 at 9:43 A.M. showed: A U-shaped mobility rail in the upright position attached to the right side of the resident's bed. During an interview on 07/23/25 at 10:36 A.M., the resident said he/she used the mobility rail to turn in bed and with transfers out of the bed. 5. Review of Resident #51's medical record showed: admitted on [DATE]; Diagnoses of hypertension, anxiety, and depression (mood disorder that causes a persistent feeling of sadness and loss of interest); No maintenance inspection for the mobility rail. Observations on 07/22/25 at 2:20 P.M., 07/23/25 at 3:24 P.M., 07/24/25 at 9:58 A.M., and 07/25/25 at 11:50 A.M. showed: U-shaped mobility rails in the upright position on both sides of the resident's bed. During an interview on 07/22/25 at 2:20 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed and turning side to side while in bed. During an interview on 07/25/25 at 10:00 A.M., the Administrator said he visually inspected the rails on his daily rounds. He did not document the mobility rail inspections. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/25 at 1:57 P.M., the Maintenance Assistant said he/she did repair the mobility bars or added/removed them from the residents' beds when asked. He/She did not inspect the rails that were on the residents' beds.