STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265701	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joe Manor	10 Lake Drive Bonne Terre, MO 63628

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer for eleven residents (Resident #18, #25, #28, #34, #44, #49, #53, #81, #111, #126, and #131) out of 28 sampled residents and one resident (Resident #139) outside the sample. The facility's census was 139. Review of the facility's policy, Transfer or Discharge, Facility-Initiated, revised October 2022, showed: - Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy; - Each resident will be permitted to remain in the facility, and not be transferred or discharged unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; - The resident and representative are notified in writing of the following information: the specific reason for the transfer or discharge, including the basis; the effective date of the transfer or discharge; the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ; the Notice of Facility Bed-Hold and policies; - A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative; - When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected; - Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility; - Under the following circumstances, the notice is given as soon as it is practicable, but before the transfer or discharge: the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; the resident's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days; - Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). 1. Review of Resident #18's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 04/21/24; - The resident transferred to the hospital on [DATE] and returned to the facility 07/09/24; - The resident transferred to the hospital on [DATE] and returned to the facility 08/13/24; - The resident transferred to the hospital on [DATE] and returned to the facility 09/24/24; - The resident transferred to the hospital on [DATE] and returned to the facility 10/16/24; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 2. Review of Resident #25's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfers. 3. Review of Resident #28's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 05/02/24; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 4. Review of Resident #34's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 04/23/24; (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE] and returned to the facility 06/18/24; - The resident transferred to the hospital on [DATE] and returned to the facility 10/25/24; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 5. Review of Resident #44's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 6. Review of Resident #49's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 7. Review of Resident #53's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 05/27/24; - The resident transferred to the hospital on [DATE] and returned to the facility 08/05/24; - The resident transferred to the hospital on [DATE] and returned to the facility 12/31/24; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 8. Review of Resident #81's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 12/07/24; - No documentation that the resident's representative was informed in writing of the (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer/discharge to a hospital at the time of transfer. 9. Review of Resident #111's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 10. Review of Resident #126's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfers. 11. Review of Resident #131's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. 12. Review of Resident #139's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer. During an interview on 02/13/25 at 1:42 P.M., the Social Services Designee said the floor nurses send out the transfer forms upon discharge. During an interview on 02/13/25 at 1:50 P.M., Registered Nurse (RN) C said the nurse that sends a resident out is responsible for sending the face sheet, medication list, code status, Durable Power of Attorney (DPOA-legal document that allows someone to make decisions for another person), bed hold policy, and Situation/Background/Assessment/Recommendation (SBAR-a structured way to send information between people). The patient transfer form is copied and one goes to the hospital with the resident, the other goes with the ambulance personnel. During an interview on 02/13/25 at 2:18 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect residents and/or resident's representatives to be notified of transfers in writing.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for four residents (Resident #18, #34, #44, and #53) out of 28 sampled residents. The facility's census was 139. Review of the facility's policy titled, Bed Holds and Returns, revised October 2022, showed: - Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies; - All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours). 1. Review of Resident #18's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 07/09/24; - The resident transferred to the hospital on [DATE] and returned to the facility 08/13/24; - The resident transferred to the hospital on [DATE] and returned to the facility 09/24/24; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 2. Review of Resident #34's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 04/23/24; - The resident transferred to the hospital on [DATE] and returned to the facility 10/25/24; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 3. Review of Resident #44's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. 4. Review of Resident #53's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility 08/05/24; - The resident transferred to the hospital on [DATE] and returned to the facility 12/31/24; - No documentation that the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of transfer. During an interview on 02/13/25 at 1:42 P.M., the Social Services Designee said the floor nurses send out the bed hold policies upon resident discharge, and then the bed holds are scanned into the system. During an interview on 02/13/25 at 1:50 P.M., Registered Nurse (RN) C said the nurse that sends a resident out is responsible for sending the face sheet, medication list, code status, Durable Power of Attorney (DPOA-legal document that allows someone to make decisions for another person), bed hold policy, and Situation/Background/Assessment/Recommendation (SBAR-a structured way to send information between people). During an interview on 02/13/25 at 2:18 P.M., the Administrator, Director of Nursing and Assistant Director of Nursing collectively said they would expect residents and/or resident's representatives to be made aware of bed holds in writing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for two residents (Resident #41 and #131) out of 28 sampled residents and two residents (Resident #40 and #138) outside the sample. The facility's census was 139. The facility did not provide a policy regarding MDS accuracy. Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) version 3.0 Manual showed: - Section J1400 should be coded yes if the resident is receiving hospice services; - Section N0300 should state the number of days during the 7-day look-back period that any type of injection was received; - Section N0350A should state the number of days during the 7-day look-back period that insulin injections were received. 1. Review of Resident #40's medical record showed: - An admission date of 05/01/24; - Diagnoses of type 2 diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin, leading to high blood sugar levels), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), morbid obesity (a severe form of obesity characterized by an excessive amount of body fat that significantly impacts health and well-being), and hypertension (a condition where the blood pressure in the arteries is consistently elevated above normal levels); - An order for Humalog Injection Solution (an insulin used to lower blood sugar) 100 units per milliliter (ml), inject eight units subcutaneously (beneath the skin) one time only, dated for 12/31/24 and completed on 12/31/24; - An order for Ozempic Subcutaneous Solution (anti-diabetic medication used for the treatment of type 2 diabetes) two milligrams (mg) per three ml, inject 0.25 mg subcutaneously every Friday, dated 01/10/25, discontinued 01/16/25; - Medication Administration Record (MAR), dated January 2025, showed the resident received an injection of Ozempic on 01/10/25 and did not receive insulin in the seven day look back period; - A quarterly MDS assessment, dated 01/14/25, with Section N0350A coded as receiving one injection of insulin in the seven day look back period. 2. Review of Resident #41's medical record showed: - An admission date of 09/12/24; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of obstructive sleep apnea (a sleep disorder that occurs when your upper airway becomes blocked during sleep), shortness of breath, respiratory failure (a condition making it difficult to breathe on your own), chronic kidney disease (kidneys do not filter waste and fluid like they should), heart failure (the heart does not pump blood as well as it should), diabetes mellitus (chronic condition that affects the way the body processes blood sugar), and COPD; - An order for Ozempic Subcutaneous Solution Pen-injector two mg per three ml. Inject 0.5 mg subcutaneously one time a day every Thursday, dated 10/09/24; - MAR, dated December 2024, showed the resident received an injection of Ozempic on 12/12/24 and did not receive insulin in the seven day look back period; - A significant change MDS assessment, dated 12/13/24, showed Section N0350A coded as receiving one injection of insulin in the seven day look back period. 3. Review of Resident #131's medical record showed: - An admission date of 10/08/24; - Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and altered mental status; - An order for Haloperidol Lactate Injection Solution (antipsychotic medication) five milligrams (mg) per milliliter (ml), inject 10 mg intramuscularly every eight hours as needed for agitation and aggression for 14 days. Alternate with Ativan (anxiety medication) two mg intramuscularly every eight hours as needed, dated 10/09/24 and discontinued 10/23/24; - MAR, dated October 2024, with Haldol 10 mg intramuscularly administered on 10/15/24 and 10/17/24; - An admission MDS assessment, dated 10/18/24, showed Section N0300 marked zero for injections received in the seven day look-back period. 4. Review of Resident #138's medical record showed: - An admission date of 02/26/23; - Diagnoses of COPD, dementia, and muscle weakness; - admitted to hospice on 12/20/24; - A significant change MDS assessment, dated 12/23/24, with Section J1400 Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? marked no. During an interview on 02/20/25 at 8:17 A.M., the MDS Coordinator said he/she would expect the MDS to accurately reflect the residents' condition at the time of the assessment. During an interview on 02/13/2025 at 2:18 P.M., the Administrator, DON, and ADON said they would (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expect the MDS assessments to accurately reflect the current condition of the resident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to implement a care plan with specific interventions to meet individual needs for four residents (Resident #31, #41, #55 and #111) out of 28 sampled residents. The facility's census was 139. Review of the facility's Comprehensive Person-Centered Care Plan Policy, last revised March 2022, showed: - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a a comprehensive, person-centered care plan for each resident; - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; - The comprehensive, person-centered care plan includes measurable objectives and time frames, describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being; - When possible, interventions address the underlying sources of the problems, not just symptoms or triggers; - Assessment of residents are on-going and care plans are revised as information about residents and residents' conditions change; - The IDT reviews and updates the care plans when there has been a significant change, when desired outcome has not been met, when resident has been readmitted from a hospital stay and at least quarterly. 1. Review of Resident #31's medical record showed: - admission date of 07/17/24; - Diagnoses of paraplegia (inability to voluntarily move lower parts of the body), rheumatoid arthritis (a chronic inflammation affecting small joints in hands and feet), morbid obesity, muscle weakness and lack of coordination; - Bed assessment and consent, dated 01/18/24; - Side rail assessment, dated 07/18/24; - Physician's Order Sheet (POS), dated February 2025, with an order for one quarter (1/4) upper side rails, bilaterally, for mobility. Observations of Resident #31 showed: - On 02/10/25 at 1:00 P.M., Resident #31 resting in bed with quarter rails up on both sides; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/11/25 at 12:21 P.M., Resident #31 resting in bed with quarter rails up on both sides; - On 02/13/25 at 9:30 A.M., Resident #31 resting in bed with quarter rails up on both sides. During an interview on 02/11/25 at 12:21 P.M., Resident #31 said he/she uses the side rails to grab onto during care and mobility. Review of Resident #31's care plan, last revised 01/08/25, did not address side rails. 2. Review of Resident #41's medical record showed: - admission date of 09/12/24; - Diagnoses of obstructive sleep apnea (a sleep disorder that occurs when the upper airway becomes blocked during sleep), shortness of breath, respiratory failure (a condition making it difficult to breathe on your own), chronic kidney disease (kidneys do not filter waste and fluid like they should), heart failure (the heart does not pump blood as well as it should), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that causes restricted airflow and breathing problems); - An order for BIPAP at bedtime, dated 10/02/24. Review of the resident's significant change MDS assessment, dated 12/13/24, showed: - Oxygen therapy in Section O (O0100C) coded as being in use in the seven-day look back period; - Non invasive mechanical ventilator (BIPAP) in Section O (O0100C) coded as being in use in the seven-day look back period. Observations of the resident showed: - On 02/10/25 at 12:46 P.M., the resident sat in a recliner with oxygen via nasal cannula (NC - a flexible tube inserted into the nose to administer supplemental oxygen) at 3.5 liters per minute (LPM), and a BIPAP at bedside; - On 02/11/25 at 9:28 A.M., the resident lay in bed with oxygen via NC at 3.5 LPM; - On 02/12/25 at 12:36 P.M., the resident lay in bed with oxygen via NC at 3.5 LPM. During an interview on 02/10/25 at 12:47 P.M., the resident said he/she always uses oxygen and has for quite some time and wears a BIPAP at bedtime. Review of the resident's care plan, last revised 02/10/25, showed it did not address use of BIPAP or oxygen. 3. Review of Resident #55's medical record showed: - admission date of 07/29/24; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of shortness of breath, COPD, and atrial fibrillation (abnormal heart beat); - An order for oxygen at two liters per minute via nasal cannula as needed, dated 07/29/24. Review of the resident's quarterly MDS assessment, dated 02/05/25, showed Section O (O0100C) coded as oxygen therapy being used in the seven-day look back period. Observations of the resident showed: - On 02/11/25 at 08:24 A.M., the resident sat in a recliner with oxygen via NC at 2LPM; - On 02/12/25 at 12:37 P.M., the resident sat in a recliner with oxygen via NC at 2LPM. During an interview on 02/12/25 at 12:38 P.M., the resident said he/she wears oxygen all the time. Review of the resident's care plan, last revised 02/07/25, did not address the use of oxygen. 4. Review of Resident #111's medical record showed: - admission date of 04/19/24; - Diagnoses of COPD, Type II diabetes, heart failure, urinary tract infection (UTI), over active bladder and mixed incontinence; - Nurses note, dated 02/07/25, showed that Resident #111 had a bladder mesh placement years ago (per family member) and it was later found to be damaging, causing frequent UTIs. Review of the resident's POS, dated February 2025, showed: - An order on 02/06/25, for Azo tablets (phenazopyridine-medication that soothes urinary tract infection pain), one tablet by mouth, daily for chronic UTI; - An order on 02/11/25, for macrobid (antibiotic), 100 milligrams (mg), one capsule, by mouth twice daily for 5 days for UTI. During an interview on 02/10/25 at 1:00 P.M., Resident #111 said he/she had a UTI and was taking antibiotics. He/She hoped to feel better soon. Review of the resident's care plan, last revised 02/10/25, showed it did not address chronic UTIs. During an interview on 02/13/25 at 2:18 P.M., the Administrator, Director of Nursing and Assistant Director of Nursing, collectively said they would expect care plans to be updated and to include the current condition of residents.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update and revise care plans with specific interventions to meet individual needs for five residents (Resident #1, #6, #18, #34, and #126) out of 28 sampled residents. The facility's census was 139. Review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised March 2022, showed: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) (a federally mandated assessment instrument completed by the facility staff) assessment. 1. Review of Resident #1's medical record showed: - admission date of 05/26/22; - Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), vitamin B-12 deficiency anemia (a condition where the body lacks enough healthy red blood cells due to a deficiency of vitamin B12), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), gastroesophageal reflux disease (GERD-a digestive disease in which stomach acid of bile irritates the food pipe lining), and shortness of breath; - Physician's Order Sheet (POS), last order review date of 01/14/25, showed no medication orders. - Review of Resident #1's care plan, initiated 06/15/22, next review date 02/26/25, showed: - GERD - give medications as ordered; - Antidepressant - administer antidepressant as ordered; - Anemia - give medication as ordered; - Risk for infection - administer antibiotic therapy as prescribed; - Urinary tract infection (UTI-an infection of any part of the urinary tract, the system of organs that make urine) - administer antibiotic therapy as prescribed; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Behavioral problems - administer medications as ordered, monitor/document for side effects and effectiveness; - Potentially physically and verbally aggressive - administer medications as ordered and monitor/document for side effects and effectiveness; - Cognitive impairment - administer medications as ordered and monitor/document for side effects and effectiveness. - Smoker, may smoke unsupervised; - Did not address the use of vapes. Observations of the resident showed: - On 02/12/25 at 2:15 P.M., a vape in the resident's room. - On 02/13/25 at 2:00 P.M., a vape on the resident's lap, while in his/her room. During an interview on 02/12/25 at 2:15 P.M., Resident #1 said he/she doesn't take any medications. 2. Review of Resident #6's medical record showed: - admission date of 01/04/22; - Code status of DNR (Do Not Resuscitate); - An order to admit resident to hospice with diagnosis of senile degeneration of the brain (a progressive decline in cognitive function that occurs with aging), dated 07/28/24; - Care plan, last revised on 01/21/25, showed the resident as a full code, dated 01/17/22. 3. Review of Resident #18's medical record showed: - An admission date of 10/04/22; - Resident is own responsible party; - No documentation resident was informed of upcoming care plan meetings. During an interview on 02/10/25 at 1:14 P.M., the resident said he/she is not informed about upcoming care plan meetings. The resident said he/she would like to attend the meetings. During an interview on 02/13/25 at 11:02 A.M., Registered Nurse (RN) S said he/she does not document when he/she talks to residents about their upcoming care plan meetings. RN S could not recall if he/she informed Resident #18 about upcoming care plan meetings. 4. Review of Resident #34's medical record showed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An admission date of 10/21/22; - Diagnosis of displaced fracture (occurs when the broken bone pieces move out of alignment, creating a gap or overlap between them) of right humerus (upper arm bone), epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures), dementia (a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior), generalized anxiety disorder (constant worry that cannot be controlled), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs); - Twelve unwitnessed falls dated 08/29/24, 09/17/24, 10/09/24, 12/22/24, 01/09/25, 01/16/25, 01/21/25, 01/28/25, 01/30/25, 01/31/25, 02/03/25, and 02/04/25. Review of the resident's significant change MDS assessment, dated 02/05/25, showed: - Severe cognitive impairment; - Two or more falls with injury (except major); - One fall with major injury. Review of the resident's care plan, last reviewed on 02/10/25, showed: - Resident is at risk for falls; - Interventions for fall risk last updated on 08/01/23. The facility failed to put interventions in place after twelve falls. 5. Review of Resident #126's medical record showed: - admission date of 10/02/24; - Diagnoses of bipolar disorder, schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), need for assistance for personal care, cognitive communication deficit (a communication difficulty due to an impairment in the cognitive processes), paraplegia (chronic condition that causes partial or complete paralysis of the lower body, including the legs and sometimes the abdomen), cannabis abuse (marijuana addition), alcohol dependence, stimulant abuse, psychoactive substance abuse (a patterned use of a drug in which the user consumes the substance in amounts or methods which are harmful to themselves or others), hallucinogen dependence (abuse of using psychoactive drugs that cause changes in mood, thought and perception); - An order for Apixaban (a blood thinner). Review of Resident #126's care plan, intitiated 10/02/24, next review date 04/14/25, showed: -Smoker, does use tobacco at times and vapes, unsupervised smoker. The care plan did not address smoking marijuana; -The care plan failed to address bleeding precautions, side effects, interactions and what to avoid (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while taking an anticoagulant. During an interview on 02/13/25 at 2:18 P.M., the Administrator, Director of Nursing, and Assistant Director of Nursing said they would expect care plans to be updated to reflect the current condition of the residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide consistent resident care for activities of daily living (ADLs) when the residents went an extended amount of time without showers for two residents (Resident #24 and #55) out of three sampled residents. The facility's census was 139. The facility did not provide a facility regarding shower frequency. 1. Review of Resident #24's medical record showed: - An admission date of 11/29/23; - Diagnoses of arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age), spinal stenosis (spaces inside the bones of the spine get too small), chronic obstructive pulmonary disease (COPD, disease that makes breathing difficult), diabetes mellitus (chronic condition that affects the way the body processes blood sugar), heart failure (the heart does not pump blood as well as it should), morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems), and severe chronic kidney disease (kidneys slowly get damaged and can't do important jobs like removing waste and keeping blood pressure normal). Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 11/27/24, showed: - Cognitive status intact; - Partial or moderate assistance for dressing; - Partial or moderate assistance for toileting; - Supervision or touching assistance for personal hygiene; - Partial or moderate assistance for bathing. Review of the resident's care plan, dated 02/04/25, showed: - The resident with an ADL self-care performance deficit due to morbid obesity, arthritis, spinal stenosis and dialysis that makes him/her weaker than normal; - Needs assist of one staff for toileting, transfers, and hygiene. Observation on 02/11/25 at 2:50 P.M. showed the resident lay in bed with unkempt, one quarter inch facial hair on chin. During an interview on 02/11/25 at 2:51 P.M., the resident said he/she may get a shower once every two weeks. He/She would like to have one at least twice per week, feels dirty not having a shower, and doesn't like to be seen with facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the shower schedule, last updated 02/05/25, showed the resident's showers were scheduled for Thursdays and Sundays on day shift. Review of the resident's shower sheets dated, December 2024 through January 2025, showed: - In December 2024, three showers documented as given or refused out of nine opportunities, a total of six opportunities for showers missed; - In January 2025, five showers documented as given or refused out of nine opportunities, a total of six opportunities for showers missed. 2. Review of Resident #55's medical record showed: - admission date 07/29/24; - Diagnoses of Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination), pain in thoracic spine, shortness of breath, fatigue, need for assistance with personal care, muscle weakness, COPD, and heart failure. Review of the resident's quarterly MDS, dated [DATE], showed: - Cognitive status intact; - Partial or moderate assistance for dressing; - Partial or moderate assistance for toileting; - Supervision or touching assistance for personal hygiene; - Partial or moderate assistance for bathing. Review of the resident's care plan, revised 07/29/20, showed: - The resident with limited physical mobility related to disease process and pain; - Needs assist of one staff for toileting and dressing. During an interview on 02/11/25 at 08:23 A.M., the resident said it has been two weeks since he/she has had a shower, and often only gets one a month, and is nervous he/she has an odor. Review of the shower schedule, last updated 02/05/25, showed the resident's showers were scheduled for Tuesdays and Fridays on day shift. Review of the resident's shower sheets, dated December 2024 through January 2025, showed: - In December 2024, two showers documented out of nine opportunities, a total of seven opportunities for showers missed; - In January 2025, one shower documented out of nine opportunities, a total of eight opportunities (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for showers missed. During an interview on 02/13/25 at 9:47 A.M., Certified Nursing Assistant (CNA) Q said there is a shower schedule. There are shower aides and showers are assigned for the hall aide. Some residents have scheduled appointments that they work around, and shower sheets are filled out and marked refused if the resident refuses. During an interview on 02/13/25 at 10:08 A.M., Registered Nurse (RN) C said residents should receive two showers per week, and they are given based on the shower schedule. During an interview on 02/13/25 at 10:10 A.M., the Assistant Director of Nursing (ADON) said residents should receive two showers per week unless they refuse, and the staff have to complete 33 showers per day in order to get them all completed. During an interview on 02/13/25 at 2:18 P.M., the Director on Nursing (DON) and the Administrator said residents should receive two showers per week.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to obtain an order for oxygen administration and failed to ensure a physician's order for bilevel positive airway pressure (BIPAP - a noninvasive ventilation device that helps people breathe by delivering pressurized air into the airways) included settings. This affected one resident (Resident #41) out of two sampled residents. The facility's census was 139. Review of the facility's policy titled, CPAP (continuous positive airway pressure)/BIPAP Support, revised March 2015, showed in preparation for BIPAP, review the physician's order to determine the oxygen concentration and flow, and the PEEP (positive end-expiratory pressure, settings) pressure for the machine. Review of Resident #41's medical record showed: - admission date of 09/12/24; - Diagnoses of obstructive sleep apnea (a sleep disorder that occurs when the upper airway becomes blocked during sleep), shortness of breath, respiratory failure (a condition making it difficult to breathe on your own), chronic kidney disease (kidneys do not filter waste and fluid like they should), heart failure (the heart does not pump blood as well as it should), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that causes restricted airflow and breathing problems). Review of the resident's Physician's Order Sheet (POS), dated February 2025, showed: - An order for BIPAP at bedtime, dated 10/02/24; - No order for BIPAP settings; - No order for oxygen. Observations of the resident showed: - On 02/10/25 at 12:46 P.M., the resident sat in the recliner with oxygen via nasal cannula (NC - a flexible tube inserted into the nose to administer supplemental oxygen) at 3.5 liters per minute (LPM), and a BIPAP at bedside; - On 02/11/25 at 9:28 A.M., the resident lay in the bed with oxygen via NC at 3.5 LPM; - On 02/12/25 at 12:36 P.M., the resident lay in the bed with oxygen via NC at 3.5 LPM. During an interview on 02/10/25 at 12:47 P.M., the resident said he/she always uses oxygen and has for quite some time, wears a BIPAP at bedtime, and the nurses put it on at night. During an interview on 02/13/25 at 10:03 A.M., Licensed Practical Nurse (LPN) D said residents with BIPAPs have an order for the settings and residents that wear oxygen have an order for oxygen. During an interview on 02/13/25 at 10:08 A.M., Registered Nurse (RN) C said residents should have (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order for oxygen if they are using it, and he/she would look at the order for BIPAP settings prior to applying the BIPAP to the resident. During an interview on 02/13/25 at 10:25 A.M., the Assistant Director of Nursing (ADON) said they use a company to set up a BIPAP machine when it's ordered. During an interview on 02/13/25 at 2:18 P.M., the Director of Nursing (DON) and the Administrator said they expect residents that wear oxygen to have a physician's order for oxygen and BIPAP orders should include settings for the BIPAP.

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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 an error rate of less than five percent (%) during medication administration. There were 35 opportunities with three errors made, for an error rate of 8.57%, which affected three residents (Residents #32, #102 and #133) out of seven sampled residents. The facility's census was 139. Review of the facility's policy titled, Insulin Administration, revised September 2014, showed: - The type of insulin, dosage requirements, strength, and method of administration must be verified before administration; - The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use. Review of the NovoLog (a rapid acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen (insulin in a pen-type device) instructions, revised February 2015, showed: - Before each injection small amounts of air may collect in the cartridge during normal use, to avoid injecting air and to ensure proper dosing; - Remove cap; - Attach needle; - Prime pen by turning dose selector to select two units; - Press and hold button and make sure drop of insulin appears; - Select dose; - Give injection. Review of the Insulin Lispro (a rapid acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) KwikPen (insulin in a pen-type device manufacturer instructions for use, revised July 2023, showed: - Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; - Not priming before each injection may result in too much or too little insulin; - Turn the dose knob to select two units; - Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top; - With the needle pointing up, push the dose knob until it stops and zero is seen in the dose (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	window, hold and count to five slowly; - There should be insulin at the tip of the needle, if not, repeat no more than four times. 1. Review of Resident #32's Physician's Order Sheet (POS), dated February 2025, showed an order for Novolog per sliding scale (progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges) for a blood sugar 200-250, give three units dated 09/15/24. Observation of the resident on 02/12/25 at 11:56 A.M. showed: - Certified Medication Technician (CMT) A administered Novolog three units subcutaneously (an injection just beneath the skin) to the resident per sliding scale for a blood sugar of 204; - CMT A failed to prime the Novolog pen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 2. Review of Resident #102's POS, dated February 2025, showed an order for Insulin Lispro, inject per sliding scale, for a blood sugar 221-260, give six units, dated 01/28/25. Observation of the resident on 02/12/25 at 11:51 A.M. showed: - CMT B administered Insulin Lispro six units subcutaneously to the resident per sliding scale for a blood sugar of 236; - CMT B failed to prime the Insulin Lispro pen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 3. Review of Resident #133's POS, dated February 2025, showed an order for Insulin Lispro, inject three units subcutaneously with meals, dated 12/19/24. Observation of the resident on 02/12/25 at 12:02 P.M. showed: - CMT A administered Insulin Lispro three units subcutaneously to the resident; - CMT A failed to prime the Insulin Lispro pen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. During an interview on 02/12/25 at 12:05 P.M., CMT A said he/she was taught to prime the pen when it was used for the first time. During an interview on 02/12/25 at 12:08 P.M., CMT B said he/she thought the insulin pen should be primed when it was first opened. During an interview on 02/12/25 at 12:15 P.M., the Assistant Director of Nursing (ADON) said she expects staff to follow insulin pen manufacturer's guidelines for insulin administration. During an interview on 02/13/25 at 2:18 P.M., the Director of Nursing (DON) and the Administrator said they expect to have a medication error rate of less than five percent.

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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 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 proper infection control practices and implement Enhanced Barrier Protections (EBP) during foley catheter (a thin, flexible tube inserted into the bladder to drain urine) care for one resident (Resident #31) out of 28 sampled residents. The facility's census was 139. Review of the facility's Handwashing/Hand Hygiene Policy, dated 2001, showed: - All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections; - All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors; - Hand hygiene products and supplies are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies; - Hand hygiene is indicated immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids or contaminated surfaces, after touching a resident or resident's environment, before moving from work on a soiled body site to a clean body site on same resident and immediately after glove removal; - Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea; - The use of gloves does not replace hand hygiene/hand washing. Review of the facility's EBP policy, revised August 2022, showed: - Enhanced Barrier Precautions (EBP) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MRDOs) to residents; - EBPs employ targeted gown and glove use during high contact resident care activity when contact precautions do not otherwise apply; - Gloves and gowns applied prior to performing high contact resident care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting to bathroom, during device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care; - EBPs are indicated for residents with wounds and/or indwelling medical devices; - EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 1. Observation of Resident #31's foley catheter care/peri care on 02/13/25 at 9:30 A.M., showed: - Resident's door with EBP signage and supplies accessible and hung on inside of door; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265701	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joe Manor	10 Lake Drive Bonne Terre, MO 63628

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Nursing Aide (CNA) E, entered the resident's room, donned gloves without washing or sanitizing hands, and did not don gown; - CNA E removed blanket from resident and removed gloves; - CNA E obtained wet washcloths, gloved, and provided catheter care, cleaning catheter tubing from peri area and down several inches; - CNA E folded washcloth and cleaned the resident's front peri area down the left side, folded washcloth and cleaned down the right side of the peri area; - CNA E obtained a clean washcloth and wiped under abdominal folds, removed gloves and did not sanitize or wash hands; - CNA E donned clean gloves without washing or sanitizing hands, obtained a clean washcloth and cleaned the catheter tubing again; - CNA E removed gloves, gathered trash, did not wash or sanitize hands and left the room with the bag of trash. During an interview on 02/13/25 at 9:45 A.M., CNA E said he/she had only worked at the facility for three weeks and did not know where the gowns were located. Hands should be washed in between dirty and clean and before leaving the room. He/She would have normally washed hands before leaving the room and sanitized again in the hall. During an interview on 02/13/25 at 2:18 P.M., the Administrator, Director of Nursing and Assistant Director of Nursing said they would expect staff to wear proper PPE for EBP when indicated, and for staff to perform hand hygiene between dirty and clean and prior to leaving resident rooms.