STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265703	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebird Wellness and Rehabilitation	9350 Green Park Road Saint Louis, MO 63123

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 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 interview and record review, the facility failed to ensure staff provided adequate supervision and assistance to prevent accidents for one resident (Resident #2) when one staff repositioned the resident, who had a diagnosis of quadriplegia (loss or partial loss of movement and sensation in all four limbs) onto their side and left the resident unattended to obtain supplies. When the staff member returned to the room, the resident was on the floor. The sample was 16. The census was 158.The administrator was notified on 10/9/25 at 6:30 P.M., of past noncompliance which began on 8/9/25. Once the nurse was made aware of the incident, he/she assessed the resident, completed a skin and pain assessment, administered pain medication, started neurological checks, and notified the Medical Doctor (MD). The resident complained of pain and requested to go to the hospital. The resident was sent out to be evaluated. The facility obtained a statement from the Certified Nurse Aide (CNA) and the resident. Staff were in-serviced on proper incontinence care, taking supplies with them when they entered the room, and not leaving residents unattended. In addition, the Administrator and Director of Nursing (DON) had a care plan meeting with family. The CNA is no longer employed by the facility. This deficient practice was corrected on 8/11/25. Review of the facility's Activities of Daily Living (ADL) policy, dated March, 2018, showed the following:-Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good personal hygiene;-A resident's ability to perform ADLs will be measured using clinical tools, including the [NAME] Data Set (MDS). The following MDS definitions: total dependence - full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. Review of Resident #2's medical record, showed:-Alert to person, place, time, and situation;-Diagnoses included: generalized muscle weakness and quadriplegia;-Used a low air loss mattress (a specialized type of mattress that used a pump to circulate air through the mattress). Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident had an ADL Self Care Performance Deficit:--Goal: Resident will improve current level of function in (bed mobility, transfers, eating, dressing, toilet use and personal hygiene, ADL score) through the review date;--Interventions included: Bed mobility: roll left to right: dependent; Personal and toilet hygiene: dependent;-Focus dated 8/11/25: Resident has had an actual fall, 8/9/25 minor injury,:--Goal: The resident will resume usual activities without further incident through the review date; the resident's injured areas will resolve without complication by review date;--Interventions included: Educate staff that there is to be two people providing ADL care, such as turning, bathing, dressing, transfers, and incontinent care, at all times; for no apparent acute injury, determine and address causative factors of the fall; monitor/document /report as needed for 72 hours to medical doctor (MD) for signs and symptoms for pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Review of the facility's (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall report dated 8/9/25 at 4:46 P.M., showed the following for the resident:-Fall: no injury;-Nursing description: CNA informed the nurse that as he/she had the resident on his/her right side to provide personal care, he/she (the resident) had a spasm causing his/her legs to jump, making him/her fall out of bed. Upon entering the room, resident was noted to be on the floor, lying on his/her back with his/her bedside table overturned next to him/her. Upon assessment, no injury was noted at this time. Resident complained of pain to his/her neck and back of head. Resident stated that he/she hit his/her head on the bedside table on the way down. Resident stated that he/she fell when being changed and hit the back of his/her head on the bedside table on his/her way to the floor;-Was this incident witnessed? No;-Mental Status: Oriented to person, place, time, and situation. Review of the resident's progress notes dated 8/9/25, showed:-At 4:30 A.M., and late entry 11:16 A.M., CNA informed the nurse that as he/she had resident on his/her right side to provide personal care, he/she had a spasm causing his/her legs to jump, making him/her fall out of bed. Upon entering room resident was noted to be on the floor, lying on his/her back with his/her bedside table overturned next to him/her. Upon assessment no injury was noted at that time. Resident complained of pain to his/her neck and back of head. Resident stated that he/she hit his/her head on the bedside table on the way down. Resident assisted to bed and personal care provided. Requested to be sent out. MD notified. Gave orders to send to hospital for further eval. Spouse made aware via phone;-At 5:37 A.M., Emergency Medical Service (EMS) here to transport resident via stretcher times two;-At 10:39 A.M., resident returned from hospital ER by ambulance. Computed tomography (CT, a diagnostic imaging procedure that used X-rays and computer technology to create detailed, cross-sectional images of the inside of the body) scans of head and neck were done and are negative. Contusion (bruise) noted to back of head. No other injuries were noted. Review of the facility's investigation, showed:-CNA B's handwritten statement dated 8/9/25: around 4:30 A.M.: CNA B was changing the resident in his/her room as CNA B had the resident rolled over cleaning him/her his/her foot dropped off the bed causing him/her to fall off before CNA B could catch him/her;-Registered Nurse (RN) C's handwritten statement, undated: The resident's statement of the incident as told to RN C. The resident stated that CNA came into his/her room to change him/her. He/She stated the CNA rolled him/her onto the edge of the bed and then left the room to get supplies. The resident stated he/she fell off the side of the bed and hit his/her head on the bedside table. The resident stated the CNA came back in his/her room and saw him/her on the floor. He/She then left the room and came back 10 minutes later to get him/her off the floor. He/She was then lifted off the floor back into bed. He/She stated at this time he/she asked to go to the hospital;-SSD's handwritten statement, dated 8/10/25: Resident verbal statement document by SSD, fell out of bed after being left on his/her side in bed. The CNA then left the room with no other statement, assumed to go get another aid. Resident does not know who other aid was. No explanations given but resident was assisted back into bed. Resident stated it was appropriate with no harm intended by physical touch. During an interview on 10/9/25 at 1:20 P.M. the SSD said she was not at the facility when the fall occurred. She got a statement from the resident, who said the caregiver was CNA B. The CNA prepped him/her to be changed or transferred and left out of the room. SSD said she could not recall any further details about the incident but said nursing followed up. The resident usually did not complain and if he/she had a concern he/she would tell us. During an interview on 10/9/25 at 6:55 A.M., Licensed Practical Nurse (LPN) D said he/she worked the morning on 8/9/25 when the resident fell, but he/she was not in the room when the incident occurred. The CNA reported he/she had the resident on their side, and he/she fell from the bed. When LPN D entered the room, he/she saw the resident on the floor on his/her right/back side. The bed was normal height (he/she pointed to approximate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waist height). There was no immediate injury, he/she complained of neck and back of the head pain. He/She was given pain medication. The resident was sent to the hospital. LPN D could not recall the name of the CNA but said the CNA was no longer at the facility. After the resident returned from the hospital, he/she told the day nurse the CNA left out of the room and that's when he/she fell. The day shift nurse reported it to management. LPN D worked the evening shift on 8/9/25 and the resident also told him/her the same thing. The resident required two person assist for ADL care. LPN D assumed the CNA was caring for the resident by him/herself. During an interview on 10/9/25 at 11:03 A.M., RN B said if a resident's care plan showed the resident was dependent for ADL Care, that meant the resident required two-person assistance. CNAs knew which residents required two persons assistance from report, or they could look at the ADL sheet or the Kardex. The resident required two-person assistance for providing personal care/hygiene and for turning and positioning. Sometimes the resident would jerk. The fall occurred between 4:00 and 5:00 A.M. When the resident returned from the hospital, he/she told RN B there was only one aide in the room, the aide rolled him/her onto his/her side and left out of the room to go get something and he/she fell. RN B said staff should take their supplies with them when they enter the room. During an interview on 10/9/25 at 2:00 P.M., Assistant Director of Nursing (ADON) said the resident told them the CNA was doing care by him/herself and the CNA flipped his/her legs over (crossed legs). The aide forgot some items and left to obtain them. The resident was on a low air loss mattress, and he/she was top heavy and fell off the edge of the bed. He/She hit his/her head on the dresser and had a small laceration. The resident was sent to the hospital to be evaluated. She would expect staff to use two person assist for any resident who used a low air loss mattress and/or mechanical lift for transfers. Staff should gather all supplies before going into the room. Staff were in-serviced on keeping supplies in the residents' room and using two staff for care. During an interview on 10/9/25 at 3:45 P.M., The Director of Nursing (DON) said staff knew which residents required two-person assistance by looking in the computer or they could ask the nurse. The DON heard the CNA left out of the room to get supplies, the resident was left unattended and fell. The nurse assessed the resident; no injuries noted. He/She requested to go to the hospital and was sent out. Neurological checks were completed. Staff were in-serviced, the CNA was terminated, and the Administrator and DON had a care plan meeting with the family. The DON expected staff to obtain all supplies before going into the room to provide care, staff should not leave residents unattended, and quadriplegia residents should have two-person assistance. During an interview on 8/9/25 at 11:30 A.M., Certified Medication Technician (CMT) E said the resident required two-to-three-person assistance. If he/she did not know what type of care a resident needed he/she would ask the nurse. During an interview on 10/9/25 at 12:25 P.M., CNA F said the resident was only able to move his/her head and neck and needed two person assist. During an interview on 10/9/25 at 6:00 P.M., the Administrator said she would expect staff to use two-person assistance for care for residents who are dependent on staff for care and used a low air loss mattress, the care plan should have shown the number of staff required to provide assistance. Staff should make sure they have their supplies when they go into a resident's room. Staff are expected to follow the facility's policy and procedures. 2585289