STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide reasonable accommodations of individual needs and preferences by failing to assess if a resident's bed/side rails posed a safety risk or if they could be used by the resident safely, providing independence with bed mobility and/or transfers in and out of the bed. The facility removed Resident #38's bed with bed/side rails and replaced it with a regular bed without bed/side rails, without assessing and providing the resident an alternate accommodation to allow the resident to maintain independence with bed mobility, for one of 29 residents sampled (Resident #38). The census was 143. Review of Resident #38's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/14/19, showed: -Moderate cognitive impairment; -No behaviors; -Extensive assistance for bed mobility, dressing, personal hygiene, toilet use and with locomotion on and off unit; -Total dependence for transfers; -No bed/side rails used. Review of the resident's care plan, dated 12/22/19, showed the following: -Limited physical mobility related to weakness; -The resident continued to be at risk for pressure injuries and received treatment for [REDACTED]. Observation on 3/10/20 between 2:40 P.M. and 3:00 P.M., showed the resident lay on his/her back in bed. The resident's bed featured quarter length bed/side rails on both sides of the head of the bed and a LAL mattress. The resident grabbed the bed/side rail on his/her right side and used it to shift his/her weight from his/her bottom, to his/her side. The resident used the bed/side rails several times to shift and reposition his/her weight. Review of the resident's medical record on 3/10/20, showed no documented bed/side rail assessment completed. Observation on 3/11/20 at 2:00 P.M., showed the resident's bed no longer featured bed/side rails. During an interview on 3/11/20 at 2:00 P.M., the resident said staff changed out his/her bed because he/she couldn't have a bed with bed/side rails with a LAL mattress. He/she missed having bed/side rails because they helped him/her turn and reposition him/herself while in his/her bed. Now if he/she wanted to turn, he/she would need nursing staff to help him/her. Observations on 3/12/20 between 9:00 A.M. and 5:00 P.M. and on 3/13/20 between 9:00 A.M. and 4:00 P.M., showed the resident's bed no longer featured bed/side rails. During an interview on 3/16/20 at 11:00 A.M., the resident said he/she would like something to help him/her move and do some stuff on his/her own since his/her bed with bed/side rails was taken away. The bed/side rails gave him/her a little bit of independence and he/she liked this. Staff just came in his/her room and told him/her they were taking his/her bed. Staff did not ask the resident if this was okay with the resident and did not offer him/her anything else to help make things easier for him/her. During an interview on 3/16/20 at 12:32 P.M., the administrator said she was not aware the resident had a bed with bed/side rails and she was not aware the bed was removed and no alternate assistive device provided to the resident. The facility did not use beds with bed/side rails with LAL mattresses and this is probably why the resident's bed was swapped out for one without bed/side rails. Nursing should have been involved with the decision to swap out the resident's bed and the resident could have been assessed for use of an alternate positioning device such as a trapeze (a triangular bar hung over the bed to allow more independence by allowing the resident to assist with repositioning). Staff discuss equipment at their weekly clinical meetings to ensure residents have the right equipment and to make sure the equipment makes it on the care plans.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review, the facility failed to develop and implement written policies and procedures that include screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property by failing to complete required background checks timely for three of 10 employees sampled. In addition, the facility policy failed to require the nurse aide registry check on employees. The census was 143. Review of the facility's Employment Screening policy, revised 12/2016, showed: -In accordance with state and federal regulations, this facility will not knowingly hire, contract or retain any individual that is ineligible to work in healthcare facility, that has been excluded from participation in the Medicare or Medicaid programs, or that has not met required licensure or certification requirements for the position being considered; -Unless otherwise stipulated by this policy a new employee may not start working until all the following is completed or initiated: -At least two days prior to scheduled resident contact check the employment disqualification list (EDL) on any and all individual(s); -Criminal background check: At least two working days prior to scheduled resident contact, check the Missouri Family Care Safety Registry (FCSR) for registration and any disqualifying conditions; -The policy failed to require the nurse aide (NA) register check be completed on all employees to verify the employee does not have a federal indicator for abuse, neglect or misappropriation of resident property, disqualifying them from working in a federally certified facility. 1. Review of Registered Nurse C's employee file, showed: -Date of hire: 8/7/19; -FCSR letter dated 8/13/19; -EDL check completed 8/13/19; -NA registry check completed 8/13/19. 2. Review of Dietary Aid I's employee file, showed: -Date of hire: 3/15/19; -No NA registry check completed as of 3/10/20. 3. Review of Licensed Practical Nurse L's employee file, showed: -Date of hire: 2/6/19; -FCSR letter dated 2/7/19. 4. During an interview on 3/16/20 at 7:57 A.M., the Human Resource Director said he is responsible to ensure all required background checks are completed. Employee background check results should be obtained prior to employment. He was informed Registered Nurse C was starting at a later date than he/she actually did, that is why the background checks were completed late. Dietary Aid I was hired for dietary and not as a certified nursing assistant, so his/her NA registry check was not completed.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) assessment accurately reflected the resident's status, for five of 29 sampled residents (Resident #141, #143, #56, #38 and #60). The census was 143. 1. Review of Resident #141's medical record, showed: -An incident note, dated 11/9/19, resident stated he/she had an area on his/her bottom that he/she wanted evaluated. Upon assessment, Non blanchable, red excoriation noted to left buttocks. Area approximately 3.3 x 1.0 centimeter (cm). Physician notified and new orders obtained; -An order dated 11/10/19, for skin prep wipes to left gluteal (buttocks) two times day; -An annual MDS, dated [DATE], showed: -Other ulcer, wounds and skin problems: No; -Moisture associated skin damage (MASD): Not marked; -A weekly wound observation tool, dated 12/10/19: Left buttocks MASD measured 1.8 x 2 x 0.1; -A weekly skin observation, dated 2/11/20: Left buttocks open area; -A quarterly MDS, dated [DATE], showed: -Other ulcer, wounds and skin problems: No; -MASD: Not marked. During an interview on 3/12/20 at 6:35 P.M., the Director of Nursing (DON) said the wound on the resident is MASD and not pressure. During an interview on 3/16/20 at 8:44 A.M., the MDS coordinator said MDS should be accurate. 2. Review of Resident #143's medical record, showed: -A skin/wound note, dated 2/13/20 at 4:30 P.M., showed: -Area to left gluteal fold observed as shearing measuring 0.5 x 1.0 x 0.1, with no drainage; -Area to left back observed as open area measuring 0.5 x 0.5 x 0.1, with no drainage present; -Area to right lateral (side) and plantar (bottom) foot observed as fluid filled blister with periwound (skin surrounding the wound) purplish in color; -An area to

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) right and left buttocks observed as unstageable (depth of wound not known due to coverage of the wound bed) and measured 5.0 by 7.5 by 0.1, moderate drainage; -Area to right back observed as open area measuring 2 x 3 x 0.1; -An admission MDS, dated [DATE], showed: -admitted [DATE] from an acute care hospital; -One stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer, may also present as an intact or open blister); -Other ulcers, wounds and skin problems: None present; -Unstageable ulcer not indicated as present. 3. Review of Resident #56's medical record, showed: -On 8/23/19 159.2 pounds (Lbs) -On 9/9/19 161.2 Lbs; -A quarterly MDS, dated [DATE], showed: -Assessment reference date (ARD) 10/3/19; -Weight 159 Lbs; -No weight of 159 documented in the medical record in the seven day ARD look back period; -On 10/9/19 161.7 Lbs; -On 11/28/19 163.0 Lbs; -On 12/15/19 163.6 Lbs; -A quarterly MDS, dated [DATE], showed: -ARD 1/3/20; -weight 159 Lbs; -No weight of 159 documented in the medical record in the seven day ARD look back period. During an interview on 3/16/20 at 8:44 A.M., the MDS coordinator said the weights entered in the MDS are obtained from the vitals section of the resident's medical record. Weights should be accurate as they are used to determine if there had been a significant weight loss. 4. Review of the facility's wound report dated 11/20/19, showed the following for Resident #38: -Onset date: 11/14/19; -Stage: Full thickness; -Prior measurements: New. Current Measurements: 7.0 cm by 2.9 cm by 0.2 cm; -Site: Left posterior thigh; -Acquired: in house. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Does the resident have one or more unhealed pressure ulcers: No. 5. Review of Resident #60's medical record, showed: -A care plan, dated 7/9/18, showed will often refuse care; -An order dated 9/10/19, for wound care to the coccyx (tailbone area), refused on 1/2 and 1/5/20; -An order dated 9/10/19, for wound care to the right ischium (buttocks), refused on 1/2 and 1/5/20; -An order dated 9/25/19, for wound care to the left ischium, refused on 1/2 and 1/5/20; -An order dated 11/6/19, for wound care to the right medial foot, refused on 1/2 and 1/5/20; -An order dated 12/14/19, for skin prep (protective barrier) to right second toe, refused on 1/2 and 1/5/20; -A quarterly MDS, dated [DATE], showed rejection of care: Behavior not exhibited; 6. During an interview on 3/12/20 at 6:35 P.M., the DON and administrator said they would expect MDS be accurate, to include the presence of wounds and pressure ulcers. 7. During an interview on 3/16/20 at 8:44 A.M., the MDS coordinator said MDS should be accurate. She is currently the only MDS coordinator.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident for two of three sampled residents admitted within the past 30 days (Residents #143 and #498). The census was 143. 1. Review of Resident #143's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/20/20, showed: -admitted [DATE] from an acute care hospital; -Total dependence for bed mobility, dressing, eating, toilet use and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's medical record, reviewed on 3/11/20, showed: -No comprehensive care plan completed; -An order dated 2/13/20, cleanse gastrostomy ([DEVICE], tube inserted into the stomach to provide food, fluid and medication) site with soap and water, apply triple antibiotic ointment and drain sponge every night shift; -An order dated 2/13/20, #6 [MEDICAL CONDITION] (tube inserted into the airway for breathing) check placement and patency every shift for maintenance; -An order dated 2/13/20, for an indwelling urinary catheter (tube inserted into the bladder to drain urine) 16 French (FR, size); -An order dated 2/13/20, enteral feed order [MEDICATION NAME] (liquid nutrition) 1.5 continuous via [DEVICE]; -A skin/wound note, dated 2/13/20 at 4:30 P.M., showed: -Area to right and left buttocks observed as unstageable (depth unable to be determined due to wound covered by dead tissue) and measured 5.0 by 7.5 by 0.1; -Area to left gluteal (buttocks) fold observed as shearing measuring 0.5 x 1.0 x 0.1, with no drainage; -Area to left back observed as open area measuring 0.5 x 0.5 x 0.1, with no drainage present; -Area to right lateral (side) and plantar (bottom) foot observed as fluid filled blister with periwound (skin surrounding the wound) purplish in color; -Area to right back observed as open area measuring 2 x 3 x 0.1; -An order dated 2/14/20, oxygen 28% per [MEDICAL CONDITION] collar with 4 liters oxygen. Review of the resident's Admission Assessment: Nursing, provided as the baseline care plan, dated 2/13/20, showed: -Respiratory/chest: -Regular rate and rhythm; -[MEDICAL CONDITION] not indicated; -Oxygen use not indicated; -Bowel: Incontinent: -Not indicated as a focus area; -No goal related to incontinence; -No interventions; -Bladder: Catheter 16 FR: -Not indicated as a focus area; -No goals related to catheter use; -No interventions; -Skin assessment: No skin issues: -Pressure ulcers and wounds not indicated; -The use of a [DEVICE] or nutritional needs not indicated. Observation on 3/10/20 at 9:57 A.M., showed the resident in bed. Oxygen on at 4 liters per high humidity [MEDICAL CONDITION] collar at 28%. [MEDICAL CONDITION] suction machine at the bedside. Urinary catheter drained to gravity. Air mattress on the bed. Tube feeding, [MEDICATION NAME] 1.5 infused at 55 milliliters per hour. During an interview on 3/16/20 at 12:09 P.M., the Director of Nursing (DON) if a resident had a [MEDICAL CONDITION], [DEVICE], wound or oxygen use, she would expect this be listed on the baseline care plan. 2. Review of Resident #498's hospital records, showed the following: -admitted : 2/17/20; -discharge date : 3/9/20; -Chief Complaint: Abdominal pain; -History of Present Illness: [MEDICAL CONDITION], smoker, lung nodule (single mass on the lung) and rectal [MEDICAL CONDITION] (cancer in the epithelium or lining of the large intestine) not currently on [MEDICAL CONDITION]. Review of the resident's admission assessment, dated 3/9/20, showed the following: -The facility admitted the resident from the hospital on [DATE]; -Bowel: Ostomy (procedure that allows bodily waste to pass through a surgically created opening called a stoma on the abdomen into a prosthetic known as a 'pouch'). Bladder: continent. Observation on 3/10/20 at 9:52 A.M., showed the resident lay on his/her back, in his/her bed, with his/her stomach area exposed. The resident's [MEDICAL CONDITION] bag (a plastic bag that collects fecal matter from the digestive tract) was visible when the resident lifted his/her shirt and exposed his/her stomach area. A bedside urinal bottle sat on the resident's bedside table. During an interview on 3/10/20 at 9:52 A.M., the resident said he/she suffered from pain in his/her stomach due to [MEDICAL CONDITION]. The staff give him/her pain medication and it does help. He/she had a [MEDICAL CONDITION] and staff emptied the bag for him/her. The resident was not sure if staff were aware of how often to empty or change his/her [MEDICAL CONDITION] bag. Review of the resident's baseline care plan, dated 3/10/20, showed the following: -The care plan did not address the resident's bladder and bowel concerns and did not direct staff on how to care for the resident's [MEDICAL CONDITION]; -The care plan addressed resident's pain but did not specify any characteristics of the resident's pain such as location or conditions related to pain. During an interview on 3/16/20 at 12:40 P.M., the administrator and DON said the resident's [MEDICAL CONDITION] care and any other bladder/bowel concerns should have been documented on the resident's care plan. Pain should be addressed on care plans and care plans should be resident specific. 3. During an interview on 3/16/20 at 12:09 P.M., the DON said the admitting nurse completes the baseline care plan on admission. Documentation should be complete and accurate.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan regarding infections, nutrition/weight loss, and pain management for eight of 29 sampled residents (Residents #138, #56, #38, #60, #85, #123, #62 and #127). The census was 143. 1. Review of Resident #138's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, showed: -admitted [DATE] from an acute hospital; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use while a resident at the facility, showed: -Focus: The resident has infection of the (specify): -Goal: Be free from complications related to infection; -Interventions: (blank). Review of the resident's [DIAGNOSES REDACTED]. 2. Review of Resident #56's significant change MDS, dated [DATE], showed: -Moderate cognitive impairment; -Supervision required with eating; -Signs and symptoms of possible swallowing disorders: Loss of liquids/solids from mouth when eating or drinking; -Care area assessment summary: Nutritional status triggered and indicated as care planned by the facility. Review of the resident's care plan, updated 2/29/20, showed: -Focus: At risk for nutrition due to [DIAGNOSES REDACTED]. Has a swallowing problem, dementia, dysphagia (difficulty swallowing). Regular puree diet with nectar thick liquids for all meals. On 3/4/19 was reported the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) was pocketing food; -Goal: Free of complications related to nutrition; -Approach: New admit 3/30/18 initiate weekly weights. Review of the resident's weight record, showed: -On 8/23/19 159.2 pounds (Lbs) -On 9/9/19 161.2 Lbs; -On 10/9/19 161.7 Lbs; -On 11/28/19 163.0 Lbs; -On 12/15/19 163.6 Lbs; -On 1/10/20 142.6 Lbs; -On 1/16/20 142.6 Lbs; -On 2/3/20 143.1 Lbs; -No further weights documented; -A significant weight loss in 6 months, from August 2019 until February 2020 of 10.11%; -A significant weight loss in 3 months, from November 2019 until February 2020 of 12.21%; -A significant weight loss in 1 month, from December 2019 to January 2020 of 12.82%. During an interview on 3/16/20 at 12:09 P.M., with the Director of Nursing (DON), administrator and the nurse practitioner, they said residents are weighed monthly, and some residents are weighed more. The resident is not a resident weighed weekly. If the care plan directed staff to weigh the resident weekly, they would expect this be done. 3. Review of Resident #38's annual MDS, dated [DATE], showed: -Mild cognitive impairment; -Received as needed pain medication. Review of the resident's electronic physician order [REDACTED]. Review of the resident's narcotic sign out sheet, showed [MEDICATION NAME] HCL 50 mg administered nine times from 3/3/20 through 3/13/20. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Depends on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficit and physical limitations; -Focus: Activity of daily living (ADL) self-care performance deficit related to cognitive impairment and left side [MEDICAL CONDITION] (weakness or paralysis on one side of the body); -Focus: Limited physical mobility related to weakness; -Focus: Continued risk for impaired cognitive function and decision making related to stroke. Soft spoken but able to make needs known. Sometimes needs extra time to process information; -Focus: High blood pressure and [MEDICAL CONDITION]; -Focus: At risk for falls related to daily [MEDICAL CONDITION] drug use, limited mobility, impaired balance and cognitive impairment; -Pain not listed on the care plan as a care area with goals and/or interventions to minimize the effects of pain. During an interview on 3/11/20 at 2:00 P.M., the resident said his/her wound on his/her bottom hurt. Staff just changed his/her dressing on his/her bottom but he/she was in pain before they changed the dressing. Staff cleaned the wound and the pain stayed after they were finished. He/she was waiting on the nurse to come back and give him/her some pain medication. His/her pain was at a 25 on a scale of 0-10 (0 indicated no pain and 10 indicated the worse pain imaginable, a 25 would indicate pain off the chart). Staff administer him/her [MEDICATION NAME] because [MEDICATION NAME] was not doing anything to relieve the pain. He/she was up earlier in the day to go to therapy but he/she was not able to participate or do much because he/she was in pain and hurting. Observation on 3/13/20 at 8:46 A.M., showed the staffing coordinator provided wound care for the resident. The resident moaned and yelled out loud during the treatment. During an interview on 3/16/20 at 12:09 P.M., the DON said if a resident has pain, it should be listed on the care plan with interventions. 4. Review of Resident #60's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Rejection of care: Behavior not exhibited; -Total dependence for bed mobility, dressing and personal hygiene; -Bathing: Total dependence; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 7/9/18, showed: -Focus: ADL self-care performance deficit related to limited mobility and [MEDICAL CONDITION]. Required total assistance with ADLs. Prefers to have showers done at 10:00 A.M. on Mondays and Wednesdays: -Goal: Would like for staff to anticipate needs through next review period; -Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated; -Focus: Will often refuse care: -Goal: Fewer episodes of refusal of care behaviors; -Interventions: Monitor behavior episodes. During an interview on 3/10/20 at 9:43 A.M., the resident said he/she wanted a shower and he/she had not had his/her hair washed since August 2019. Observation, showed the resident's hair oily. The resident said his/her hair stinks, so he/she keeps it up in a ponytail so it stays out of his/her face. Observation on 3/10/20 at approximately 10:00 A.M., of the shower room located next to the resident's room, showed a roll in shower buddy (a shower chair used to meet the needs of those with disabilities by use of a tilting chair that offers core and extremity support for individuals unable to maintain their own positioning) available. During an interview on 3/13/20 at 9:57 A.M., the resident said he/she has still not been provided a shower. He/she has scabs on his/her head from not having a shower. Observation and interview on 3/13/20 at 9:58 A.M., showed Nurse R assessed the resident's scalp. Nurse R said the resident has flaky, itchy hair and he/she was just in the resident's room scratching the resident's head for him/her, per the resident's request. He/she did not know if the resident was receiving showers because he/she was switched from days to evenings for showers. The resident said he/she attended a care plan meeting in January and said he/she wanted to take showers. The staff in the care plan meeting said they would put it in the care plan. Observation during a skin assessment of the resident's hair and scalp, showed the resident's hair oily with chunks of dry skin in the scalp and flakes on the resident's pillow, bed and shirt. The resident's hair had a pungent odor and the hair appeared thick and oily. As the nurse brushed through the resident's hair, dandruff flaked off, all over the resident's shoulders. The resident said everyone says I refuse showers but they don't ask. During an interview on 3/16/20 at 12:09 P.M., the Director of Nursing (DON) and administrator said when the resident refuses a bath or shower, staff educate him/her. Refusing care is a normal behavior for the resident. He/she goes through cycles where he/she refuses care. They did not know when the resident's hair was last washed. Interventions for staff to attempt when the resident refused showers should be documented in the care plan. The facility does have a beauty shop. If it is determined it is safe for the resident to use the hair bowl in the beauty shop, staff could use this to wash the resident's hair. The DON said she believed this may have been attempted before and the resident could not be positioned properly to use the beauty shop. She thinks staff had issues with the tilt shower chair not being safe as well. The resident's hair can be washed during a bed bath. Further review of the resident's care plan, showed the care plan failed to provide interventions to attempt if the resident refuses a bath/shower, the resident's preference to receive a shower over a bath, the availability of a shower buddy shower chair, and failed to direct staff to wash the resident's hair as requested with alternative ways to wash his/her hair if a shower was not possible. The care plan did not identify the resident as a resident that could not have a shower due to inability to position self or that he/she was unable to go to the beauty shop to have his/her hair washed. 5. Review of Resident #85's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Supervision with eating; -[DIAGNOSES REDACTED]. Review of the resident's medical record, showed: -An order dated 1/9/19, for a regular diet, regular texture, regular consistency; -The last Registered Dietician assessment completed on 1/10/19; -No quarterly nutritional assessments. Review of the resident's care plan, dated 2/19/19, showed no documentation regarding the resident's nutritional needs. 6. Review of Resident #123's admission MDS, dated [DATE], showed the following: -Limited assistance with eating; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 2/27/20, showed the following: -Focus: Resident has potential nutritional problem with regards to [MEDICAL CONDITION], diabetes and high blood pressure; -Goal: The resident will comply with recommended diet for weight stability through review date; -Interventions: Provide and serve diet as ordered. Registered Dietician to make diet change recommendations as needed. Review of the resident's medical record, showed: -An order dated 3/8/20, for regular texture, regular consistency, renal (kidney) diet (no oranges/juice, bananas, limited potato). -No documentation regarding an assessment from the Registered Dietician; -No quarterly nutritional assessments. Further review of the resident's care plan, showed it did not address the resident's need for a renal diet and/or dietary restrictions to include no oranges/juice, bananas, limited potato. 7. Review of Resident #62's admission MDS, dated [DATE], showed: -Cognitively intact; -Supervision required with eating; -CAAS: Nutritional status triggered and indicated as care planned by the facility. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Potential nutritional problem related to therapeutic diet for [MEDICAL CONDITION] and diabetes; -Goal: Maintain adequate nutritional status as evidenced by maintaining stable weight no signs and symptoms of malnutrition, and consuming at least 50% meals daily; -Interventions: Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. RD to evaluate and make diet change recommendations as needed. Review of the resident's medical record, showed an order dated 2/21/20, for renal diet (no oranges/juice, bananas, limit potato), regular texture, regular consistency. Further review of the resident's care plan, showed it did not address the resident's need for a renal diet and/or dietary restrictions to include no oranges/juice, bananas, limited potato. 8. Review of Resident #127's annual MDS, dated [DATE], showed: -Cognitively intact; -Supervision required with eating; -CAAS: Nutritional status triggered and indicated as care planned by the facility. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: At risk for potential nutritional problems related to [MEDICAL CONDITION] (CKD); -Goal: Maintain adequate nutrition by consuming at least 75% of meals daily; -Interventions: Provide and serve diet as ordered. Registered Dietician to evaluate and make diet change recommendations as needed. Review of the resident's medical record, showed an order dated 3/3/20, renal diet (no oranges/juice, bananas, limit potato), regular texture, regular consistency. Further review of the resident's care plan, showed it did not address the resident's need for a renal diet and/or dietary restrictions to include no oranges/juice, bananas, limited potato. 9. During an interview on 3/16/20 at 12:09 P.M., with the DON, administrator and nurse practitioner, they said care plans should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) complete and accurate. The MDS coordinator is responsible for the care plans.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop the comprehensive care plan within 7 days after completion of the comprehensive assessment, for one of three sampled residents admitted within the past 30 days (Resident #143). The census was 143. Review of Resident #143's admission MDS, dated [DATE], showed: -admitted [DATE] from an acute care hospital; -Total dependence for bed mobility, dressing, eating, toilet use and personal hygiene; -[DIAGNOSES REDACTED]. underlying tissue). Review of the resident's medical record, reviewed on 3/11/20, showed: -No comprehensive care plan completed; -An order dated 2/13/20, to cleanse gastrostomy ([DEVICE], tube inserted into the stomach to provide food, fluid and medication) site with soap and water, apply triple antibiotic ointment and drain sponge every night shift; -An order dated 2/13/20, for #6 [MEDICAL CONDITION] (tube inserted into the airway for breathing) check placement and patency every shift for maintenance; -An order dated 2/13/20, for an indwelling urinary catheter 16 French (FR, size); -An order dated 2/13/20, for enteral feed order [MEDICATION NAME] (liquid nutrition) 1.5 continuous via [DEVICE]; -A skin/wound note, dated 2/13/20 at 4:30 P.M., showed: -Area to right and left buttocks observed as unstageable (depth unable to be determined due to wound covered by dead tissue) and measured 5.0 by 7.5 by 0.1; -Area to left gluteal (buttocks) fold observed as shearing measuring 0.5 x 1.0 x 0.1, with no drainage; -Area to left back observed as open area measuring 0.5 x 0.5 x 0.1, with no drainage present; -Area to right lateral (side) and plantar (bottom) foot observed as fluid filled blister with periwound (skin surrounding the wound) purplish in color; -Area to right back observed as open area measuring 2 x 3 x 0.1; -An order dated 2/14/20, oxygen 28% per [MEDICAL CONDITION] collar with 4 liters oxygen. Observation on 3/10/20 at 9:57 A.M., showed the resident in bed. Oxygen on at 4 liters oxygen per high humidity [MEDICAL CONDITION] collar at 28%. [MEDICAL CONDITION] suction machine at the bedside. Urinary catheter drained to gravity. Air mattress on the bed. Tube feeding, [MEDICATION NAME] 1.5 infused at 55 milliliters per hour. During an interview on 3/16/20 at 12:09 P.M., the Director of Nursing (DON) said the comprehensive care plan should be completed within 21 days of admission. It is the MDS coordinator's responsibility to ensure the care plan is completed timely.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a discharge planning process was in place which addressed discharge goals and needs, including an updated care plan, caregiver support and referrals to local contact agencies as appropriate, that involved the resident and interdisciplinary team in developing a discharge plan for four of 29 sampled residents (Residents #139, #398, #2, and #1). The census was 143. 1. Review of Resident #139's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/16/20, showed the following: -admitted to the facility on [DATE]; -Ability to understand others and to make him/herself understood; -Always continent of bowel and bladder; -Adequate speech, hearing and vision; -A Brief Interview for Mental Status (BIMS, a screening tool used to determine cognitive impairment) score of 15 out of 15 (cognitively intact); -No behaviors; -Independent with all activities of daily living (ADLs); -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at time of survey, showed the following: -Focus: The resident is very independent of his/her daily activities. He/she attends most activity of her/his choosing, there are times you find him/her sitting and chatting with his/her peers or playing bingo or attending music socials and socials of food. His/her sister visits a couple times per week. Sometimes the resident likes to spend time in his/her room coloring or watching television; -Goal: Staff to provide the resident with a monthly calendar. Ask resident about his/her preferences as it relates to daily group activities; -Intervention: Keep the resident encouraged daily although he/she is very independent of his/her daily activities; -Focus: The resident is at risk for a decline in his/her ADLs related to disease process [MEDICAL CONDITION] (a disorder of the central nervous system that affects movement, often including tremors) and major [MEDICAL CONDITION], impaired mobility related to [MEDICAL CONDITIONS] (numbness, pain or tingling in the extremities) and headaches; -Goal: The resident will maintain current level of function ADLs through the review date; -Intervention: Monitor the resident for impaired mobility related to unsteady gait and balance. Bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. He/she is able to shower and eat with setup assist. The resident is independent with all other ADLs; During an interview on 3/11/20 at 5:36 P.M., the Director of Social Services (DSS), said the 500 hall is a long-term care floor recently opened due to increased census. The resident may not need skilled nursing. He/she does not do well with roommates, was evicted from his/her house, is emotional since his/her spouse passed away and has pain in his/her shoulders. There is no discharge planning for the resident. At admission, he/she needed skilled nursing. The resident does not feel safe returning to community and does not want to participate with Money Follows the Person (a government program used to enable people with chronic conditions and disabilities transitioned from institutions back into the community). 2. Review of Resident #398's admission MDS, dated [DATE], showed the following: -admitted to the facility on [DATE]; -Ability to understand others and to make him/herself understood; -Always continent of bowel and bladder; -Adequate speech, hearing and vision; -A BIMS of 15; -No behaviors; -One-person physical assist with all ADLs; -Uses wheelchair for movement; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at time of survey, showed the following: -Focus: The resident is alert and oriented. He/she enjoys reading books on the western world and other great authors. He/she is always engaged in his/her favorite TV programs. He/she has been invited to activities but has not attended as of yet; -Goal: To have the resident attend at least one activity per week; -Interventions: The resident has been informed of activity programs. Encourage the resident to attend daily activities of choice. Although the resident is independent, monitor him/her for socialization; -Focus: The resident has an ADL self-care performance deficit due to having a [DIAGNOSES REDACTED]. He/she requires limited assist with all activities of daily living, bed mobility and personal hygiene tasks and is continent of bowel and bladder; -Goal: The resident will improve current level of function in ADLs through the review date; -Intervention: He/she uses a manual wheelchair to assist with mobility. The resident is able to propel self while in wheelchair. Assist as needed. The resident is continent of bowel and bladder and requires limited assist with toileting tasks and personal care. He/she transfers with one assist with a gait belt for all transfers. During an interview on 10/10/20 at 10:36 A.M., the resident said there is never any staff on his/her floor. He/she does his/her own showers and laundry. During an interview on 3/11/20 at 5:36 P.M., the DSS said the resident's goal is to enroll in Money Follows the Person. He/she was sick when he/she arrived at the facility. During an interview on 3/12/20 at 12:07 P.M., the resident said he/she just talked with DSS today and asked about Money Follows the Person this morning. He/she did not know of the program before. He/she would like to get his/her own place. He/she cannot walk right now but is working with therapy. Further review of the resident's care, showed no discharge planning or goals and documentation regarding the Money Follows the Person program. 3. Review of Resident #2's admission MDS, dated [DATE], showed the following: -admitted to the facility on [DATE]; -A BIMS of 9 out of 15 (moderate cognitive impairment); -Ability to understand others and to make him/herself understood; -Always continent of bowel and bladder; -Adequate speech, hearing and vision; -Independent with all ADLs; -Steady gait and balance with no limitations regarding all extremities range of motion; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at time of the survey, showed the following: -Focus: The resident is alert and oriented. He/she would like to watch TV in his/her room, take smoke breaks and attend socials with peers; -Goal: the resident will attend at least two activities of choice per week; -Intervention: Provide meaningful activities, provide access to channel 2 from his/her TV to see the daily activities. Monitor the resident for socialization and ask preference as it relates to activities; -Focus: The resident is a smoker and attends smoke breaks of choice; -Goal: The resident will not smoke without supervision; -Intervention: The resident is able to smoke independently with supervision; -Focus: The resident is at risk for falls due to being independently ambulatory; -Goal: The resident will be free of injury related to falls; -Intervention: Anticipate and meet the resident's needs as needed. Review of the resident's 3/10/20 nursing home referral form, signed and dated by the resident, showed the resident was referred to Money Follows the Person. During an interview on 3/12/20 at 11:15 A.M., the resident said he/she smokes and goes out on smoke breaks with staff. He/she has signed up for Money Follows the Person. During an interview on 3/11/20 at 5:36 P.M., the DSS said the resident signed up for Money Follows the Person and is waiting to be accepted. Further review of the resident's care plan, showed no discharge planning and no documentation related to Money Follows the Person. 4. Review of Resident #1's quarterly MDS, dated [DATE], showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) the following: -admitted to the facility on [DATE]; -A BIMS score of 11 out of 15 (moderate cognitive impairment); -Ability to understand others and to make him/herself understood; -Always continent of bowel and bladder; -Adequate speech, hearing and vision; -Steady gait and balance with no limitations regarding all extremities range of motion; -Requires supervision and oversight with all self-preformed activities of daily living; -[DIAGNOSES REDACTED]. Observation of the resident during survey, showed he/she walked free and independent throughout the building. Review of the resident's nursing home referral form, signed and dated by the resident, showed the resident was referred to Money Follows the Person on 12/27/19. During an interview on 3/11/20 at 5:36 P.M., the DSS said the resident is actively participating in Money Follows the Person program and must remain at the facility during this time. Review of the resident's care plan, in use at time of the survey, showed no documentation of the resident's participation in the Money Follows the Person program, nor any discharge planning. 5. During an interview on 3/11/20 at 5:36 P.M., the DSS said discharge goals should be part of the care plan. A care plan should be updated every three months. He is in the process of reviewing all of these residents, case by case. 6. During an interview on 3/12/20 at 12:52 P.M., the administrator said discharge planning starts at the moment the resident is admitted to the facility. The MDS coordinator is in charge of care plans, and they have two currently on staff. There is no discharge planning on these residents' care plans. She expected the discharge goals be discussed at admission, quarterly and asked with all MDS updates. Any and all discharge goals to include Money Follows the Person, should be addressed on the resident's care plan.
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 the necessary services to maintain good grooming and personal hygiene per resident wishes and standards of practice for two residents (Residents #60 and #135). The sample was 29. The census was 143. 1. Review of Resident #60's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/5/20, showed: -Cognitively intact; -Rejection of care: Behavior not exhibited; -Total dependence for bed mobility, dressing and personal hygiene; -Bathing: Total dependence; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 7/9/18, showed: -Focus: Activities of daily living (ADL) self-care performance deficit related to limited mobility and [MEDICAL CONDITION]. Required total assistance with ADLs. Prefers to have showers done at 10:00 A.M. on Mondays and Wednesdays: -Goal: Would like for staff to anticipate needs through next review period; -Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated; -Focus: Will often refuse care: -Goal: Fewer episodes of refusal of care behaviors; -Interventions: Monitor behavior episodes. Review of the resident's medical record, showed task list: Bathing preference: Specify frequency, as necessary. During an interview on 3/10/20 at 9:43 A.M., the resident said he/she wanted a shower and he/she had not had his/her hair washed since August 2019. Observation, showed the resident's hair oily. The resident said his/her hair stinks, so he/she keeps it up in a ponytail so it stays out of his/her face. Observation on 3/10/20 at approximately 10:00 A.M., of the shower room located next to the resident's room, showed a roll in shower buddy (a shower chair used to meet the needs of those with disabilities by use of a tilting chair that offers core and extremity support for individuals unable to maintain their own positioning) available. Observation on 3/10/20 at 10:09 A.M., showed Wound Nurse Q provided wound care to the resident. During care, the resident asked to get a shower and said he/she has been fighting staff to get a shower. The wound nurse did not respond to the resident's request. During an interview on 3/12/20 at 1:57 P.M., the resident said he/she still was not given a shower. Observation, showed his/her hair pulled in a ponytail and appeared oily. During an interview on 3/13/20 at 9:57 A.M., the resident said he/she has still not been provided a shower. He/she has scabs on his/her head from not having a shower. Observation and interview on 3/13/20 at 9:58 A.M., showed Nurse R assessed the resident's scalp. Nurse R said the resident has flaky, itchy hair and he/she was just in the resident's room scratching the resident's head for him/her, per the resident's request. He/she did not know if the resident was receiving showers because he/she was switched from days to evenings for showers. The resident said he/she attended a care plan meeting in January and said he/she wanted to take showers. The staff in the care plan meeting said they would put it in the care plan. Observation during a skin assessment of the resident's hair and scalp, showed the resident's hair oily with chunks of dry skin in the scalp and flakes on the resident's pillow, bed and shirt. The resident's hair had a pungent odor and the hair appeared thick and oily. As the nurse brushed through the resident's hair, dandruff flaked off, all over the resident's shoulders. The resident said everyone says I refuse showers but they don't ask. Review of the resident's documented bath/showers from 1/1/20 through 3/10/20, showed on 2/14/20, a skin monitoring shower review form completed. The form did not indicate if the resident received a bath or shower and/or if the resident had his/her hair washed. No skin concerns documented on the form, despite the resident having multiple skin issues. During an interview on 3/16/20 at 12:09 P.M., the Director of Nursing (DON) and administrator said when the resident refuses a bath or shower, staff educate him/her. Refusing care is a normal behavior for the resident. He/she goes through cycles where he/she refuses care. They did not know when the resident's hair was last washed. Interventions for staff to attempt when the resident refused showers should be documented in the care plan. The facility does have a beauty shop. If it is determined it is safe for the resident to use the hair bowl in the beauty shop, staff could us this to wash the resident's hair. The DON said she believed this may have been attempted before and the resident could not be positioned properly to use the beauty shop. She thinks staff had issues with the tilt shower chair not being safe as well. The resident's hair can be washed during a bed bath. Further review of the resident's care plan, showed the care plan failed to provide interventions to attempt if the resident refuses a bath/shower, the resident's preference to receive a shower over a bath, the availability of a shower buddy shower chair, and failed to direct staff to wash the resident's hair as requested with alternative ways to wash his/her hair if a shower was not possible. The care plan did not identify the resident as a resident that could not have a shower due to inability to position self or that he/she was unable to go to the beauty shop to have his/her hair washed. 2. Review of Resident #135's quarterly MDS, dated [DATE], showed the following: -Cognitive intact; -Ability to understand others and to make him/herself understood; -Always incontinent of bowel and bladder, with use of ostomy (allows bodily waste to pass through a surgically created stoma on the abdomen) and catheter (a sterile tube inserted into the bladder to drain urine); -Dependent on staff for all ADLs; -No behaviors of rejection of care; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at time of survey, showed the following: -Focus: The resident is dependent for ADL self-care performance related to [DIAGNOSES REDACTED]. Observe skin during care and report any changes to nurse. Avoid scrubbing over bony prominences. Check nail length, trim and clean on bath day and as needed. The resident is totally dependent on staff for repositioning and turning in bed, dressing and personal hygiene. The resident is totally dependent on staff for ostomy and incontinence care. Observation and interview on 3/13/20 at 9:18 A.M., showed the resident's nails approximately 1 inch long on all fingers and short facial hair. The resident said he/she wishes the staff would cut his/her nails and help him/her shave. During an interview on 3/16/20 at 12:09 P.M., the DON said she expects all residents to receive assistance with nail care and shaving during bathing, showers or as needed. MO 111 MO 377
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for four residents (#138, #141, #135, and #143), of six residents investigated for non-pressure wounds and wound care when the facility failed to assess and treat wounds per facility policy and standards of practice. Resident #138 had a delay in treatment orders after admission. The facility failed to routinely apply the ordered treatments and assess the wounds. The resident had a change in level of swelling and wound drainage and the facility failed to timely notify the physician after identifying the change. The resident had a change in mental status

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) after several days of increased swelling, drainage and pain; and was sent to the hospital. The resident required surgical debridement (removal of dead tissue) of a right heel wound and a [MEDICAL CONDITION] (BKA) of the left lower extremity due to the condition of the wounds. The sample was 29. The census was 143. Review of the facility's Facility Assessment Tool, updated 2/25/20, showed: -Purpose: To determine what recourses are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental and psychosocial well-being; -Services and care offered based on resident needs: Pressure injury prevention and care, skin care, wound care. Review of the facility's Skin Ulcer-Wound Policy, dated 8/15/18, showed: -All caregivers are responsible for preventing, caring for and providing treatment for [REDACTED]. It may also include an area of discoloration that is not open if the nurse identifies an area of concern that may potentially ulcerate and then confirms suspicion with a provider (physician/nurse practitioner/physician assistant/midlevel) for diagnosis; -Assessment: -Licensed staff will, upon admission, perform a head to toe body audit within 2 hours of admission. The findings will be documented in the resident's clinical record. Any items not documented in the admission assessment form will be charted in the nurse's notes; -Licensed staff will complete a head to toe skin assessment weekly and as needed. The skin assessment will be documented on a skin assessment form and become part of the resident's clinical record. Any unusual findings will be documented on the form with a follow-up note in the nurse's notes further describing the area of concern; -Treatment protocols: -Consult wound care providers when appropriate; -Until wound care providers can assess and order treatment, the following techniques may be employed: -Follow standard precautions and good hand hygiene techniques; -For non-open areas of concern or areas covered with stable eschar (dry dead tissue), apply skin prep (protective barrier wipe) daily and use preventative measures. On areas where skin prep is not appropriate (i.e. buttocks, etc.) moisture barrier cream is adequate. Skin prep may also be used for un-ruptured serous fluid (clear drainage) or blood-filled blisters; -For all other open areas, the treatment is determined based on tissue type and drainage; -All orders must be approved by a physician within 24 hours of discovering the open area or change in treatment; -Assessment protocols: -Nurses may not diagnose, just describe; -Measurements must be completed weekly; -At the time a skin issue is discovered, it must be measured. Wounds are three dimensional; therefore length, width and depth must be documented if using measuring instrument. It is acceptable to measure using common household objects (i.e. dime size, quarter size, half dollar) until actual measurements can be obtained per facility protocol; -Length of wound should always be measured in head to toe alignment. Width should always be measured in hip to hip or side to side alignment. Depth should always be the deepest part of the wound in perpendicular alignment; -If a reddened area is identified, the nurse should assess if the area is blanching (when skin color fades when pressure is applied and returns when pressure is released). If it is no blanching, then it should be captured on the licensed body audit report. 1. Review of the facility's Notification Changes in Condition policy, revised 1/28/20, showed: -It is the responsibility of licensed staff to contact the physician and the resident's responsible party whenever there is a change in the resident's physical, mental or psychosocial status; -Acute change in condition: A sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional status that, without intervention, may result in complications or death; -Upon identification of any change in condition, licensed nursing personnel will contact the resident's attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition; -All notification should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions; -All notifications should be documented and should include: -The date and time of the notification; -The name of the individual contacted; -The specific reason for the notification; -And any specific responses that were given by the person contacted; -All changes in condition require follow-up assessment and documentation of resident condition which should include, at a minimum: Vital signs, pain, orientation, any change from baseline status, and status of any pending labs/diagnostics. Review of Resident #138's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, showed: -admitted [DATE] from an acute hospital; -Clear speech, understood and understands; -Moderately impaired cognition; -Rejection of care: Behavior not exhibited; -Limited assistance required for dressing; -Supervision required for personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use while a resident at the facility, showed: -Focus: The resident has [MEDICAL CONDITION]: -Goal: Remain free of complications; -Interventions: Elevate legs when sitting or sleeping. Monitor extremities for signs and symptoms of injury, infection or ulcers. Monitor/document/report as needed any signs and symptoms of skin problems related to [MEDICAL CONDITION]: Redness, swelling, blistering, itching, burning, bruises, cuts or other [MEDICAL CONDITION]; -Focus: The resident has diabetes: -Goal: Have no complications related to diabetes; -Interventions: Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails; -Focus: The resident has infection of the (specify): -Goal: Be free from complications related to infection; -Interventions: (blank); -Focus: The resident has potential/actual impairment to skin integrity: -Goal: The resident will maintain intact skin. Skin breakdown will show to be improved; -Interventions: Avoid scratching and keep hands and body parts from excessive moisture. Educate of causative factors and measures to prevent skin injury. Monitor/document location, size and treatment of [REDACTED]. to the physician. Treatment per physician orders. Weekly treatment documentation. Review of the resident's [DIAGNOSES REDACTED].M., the resident admitted for observation/assessment of condition. The resident is alert and oriented to person, place, time and situation. The resident has no changes in mood or behavior noted. The resident has no notable changes in skin integrity. The following wounds are currently being treated: Coccyx (tailbone area), left buttocks. (No documentation of a treatment to the left or right lower extremities). [MEDICAL CONDITION] (swelling) both lower extremities 1+ (based on the [MEDICAL CONDITION] scale, used to determine the severity of the [MEDICAL CONDITION]. 1+ has 2 millimeter (mm) depression or barely visible that disappears rapidly and is the lowest severity grade. The [MEDICAL CONDITION] scale goes up to 4+); -On 2/7/20 at 5:30 A.M., admission assessment: Skin issues present, refer to assessment for more information. Review of the resident's Nursing Admission Assessment, dated 2/7/20 at 5:30 A.M., showed: -Date and approximate time of arrival: 2/6/20 at 5:20 P.M.; -Skin condition: -Top of left foot, red circle area, weeping (draining fluid) noted; -Right toes, missing some great toe. Review of the resident's progress notes, dated 2/7/20 at 10:05 P.M. through 2/11/20 at 6:52 A.M., showed: -On 2/7/20 at 10:05 P.M., there are no wounds currently noted. [MEDICAL CONDITION] 1+ both lower extremities. Infection details: (blank); -On 2/8/20 at 7:50 P.M., the resident has notable changes in skin integrity. The following wounds are currently being treated: left buttocks. [MEDICAL CONDITION] 1+ both lower extremities. Infection details: [MEDICAL CONDITION]; -On 2/9/20 at 1:54 A.M., the resident has notable changes in skin integrity. The following wounds are currently being treated: left buttocks. [MEDICAL CONDITION] 1+ both lower extremities. Infection details: [MEDICAL CONDITION]; -On 2/9/20 at 1:30 P.M., the resident has notable changes in skin integrity. The following wounds are currently being treated: Both lower extremity dressing changed per treatment order. [MEDICAL CONDITION] 3+ (5-6 mm depression) both lower extremities and arms. Infection details: [MEDICAL CONDITION]; -On 2/9/20 at 10:00 P.M., the resident has notable changes in skin integrity. The following wounds are being treated: Left buttocks. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [DIAGNOSES REDACTED]; -On 2/10/20 at 2:12 A.M., the resident has notable changes in skin integrity. The following wounds are being treated: Left buttocks. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [MEDICAL CONDITION]; -On 2/10/20 at 2:49 P.M., the resident has no notable changes in skin integrity. There are no wounds currently noted. Both lower extremity feet dressings changed per treatment order. [MEDICAL CONDITION] present, both feet. Infection details: [DIAGNOSES REDACTED]; -On 2/11/20 at 6:52 A.M., resident alert, pleasant, skin with dressing; -No further documentation of the wounds to the lower extremities, documentation the physician was notified of the wounds, increased [MEDICAL CONDITION], or descriptions/measurements of the wounds. Review of the resident's electronic physician order [REDACTED].M., cleanse area to left anterior (front side) foot with wound cleanser, pat dry, apply triple antibiotic ointment (TAO) and ABD pad (absorbing dressing), wrap with Kerlix (gauze wrap) and secure with tape daily; -An order dated 2/11/20 at 7:00 A.M., cleanse area to right lower extremity with wound cleanser, pat dry, apply ABD pads, wrap with Kerlix and secure with tape daily, every day shift for third spacing drainage (occurs when too much fluid moves from the intravascular space (blood vessels) into the interstitial or third space-the nonfunctional area between cells. This can cause potentially serious problems such as [MEDICAL CONDITION]); -An order dated 2/12/20, for weekly skin assessments; -No treatment order for the lower extremities prior to 2/11/20. Review of the resident's treatment administration record (TAR), for February 2020, showed: -An order dated 2/11/20 at 7:00 A.M., cleanse area to left anterior foot with wound cleanser, pat dry, apply TAO and ABD pad, wrap with Kerlix and secure with tape daily: -Documented as not administered, see progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) note, on 2/11/20 and 2/18/20; -Not documented as refused or administered on 2/12, 2/13, 2/15, 2/20 and 2/21/20; -An order dated 2/11/20 at 7:00 A.M., cleanse area to right lower extremity with wound cleanser, pat dry, apply ABD pads, wrap with Kerlix and secure with tape daily, every day shift for third spacing (occurs when too much fluid moves from the intravascular space (blood vessels) into the interstitial or third space-the nonfunctional area between cells. This can cause potentially serious problems such as [MEDICAL CONDITION], reduced cardiac output, and low blood pressure); -Documented as refused on 2/11/20; -Not documented as refused or administered on 2/12, 2/13, 2/15, 2/20 and 2/21/20; -Documented as not administered, see progress note, on 2/18/20; -No documentation of any treatment orders for the left lower or right lower extremity prior to 2/11/20. Review of the facility's wound reports, dated 2/12/20, 2/28/20 and undated and identified by the director of nursing (DON) as dated 2/21/20, showed the resident not listed on the wound report for any wounds. No tracking of wound progress, measurements or treatments. Review of the resident's progress notes, dated 2/11/20 at 5:32 P.M. through 2/12/20 at 11:07 P.M., showed: -On 2/11/20 at 5:32 P.M., orders administration note: Cleanse area to left anterior foot with wound cleanser, pat dry, apply TAO and ABD pads, wrapped with Kerlix and secure with tape daily. Refused, resident stated every time I get ready to do something, someone comes in; -On 2/11/20 at 10:58 P.M., the resident has no notable changes in skin integrity. The following wounds are currently being treated: left buttocks. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [MEDICAL CONDITION]; -On 2/12/20 at 10:25 A.M., weeping [MEDICAL CONDITION] to both lower extremities; -On 2/12/20 at 10:45 P.M., the resident has no notable changes in skin integrity. There are no wounds currently noted. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [MEDICAL CONDITION]; -On 2/12/20 at 11:07 P.M., weekly skin observation. Skin color is normal. Skin temperature is dry and warm. Skin issues present. Refer to assessment for more information. Review of the resident's weekly skin observation, dated 2/12/20 at 11:07 P.M., showed: -Skin condition: Reddened area top of left foot. On antibiotic therapy. Review of the resident's progress notes, dated 2/13/20 at 2:43 A.M. through 2/19/20 at 3:35 P.M., showed: -On 2/13/20 at 2:43 A.M., the resident has no notable changes in skin integrity. There are no wounds currently noted. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [MEDICAL CONDITION]. Additional comments: Resident is on antibiotics related to [MEDICAL CONDITION] to both lower extremities and feet; -On 2/13/20 at 10:07 P.M., the resident has no notable changes in skin integrity. There are no wounds currently noted. [MEDICAL CONDITION] 3+ both lower extremities and feet. Infection details: [MEDICAL CONDITION]. Additional comments: Resident completed antibiotics; -On 2/17/20 at 11:30 A.M., infection note: On antibiotic for [MEDICAL CONDITION], noted weeping [MEDICAL CONDITION] to both lower extremities; -On 2/17/20 at 5:15 P.M., [MEDICATION NAME] administration for pain; -On 2/17/20 at 7:20 P.M., infection note: On antibiotic for [MEDICAL CONDITION], noted significant weeping and [MEDICAL CONDITION] to both lower extremities; -On 2/17/20 at 9:15 P.M., [MEDICATION NAME] administration for pain; -On 2/18/20 at 5:07 A.M., weeping [MEDICAL CONDITION] to both lower extremities; -On 2/18/20 at 3:04 P.M., cleanse are to left anterior foot. Resident declined wound care today; -On 2/18/20 at 3:05 P.M., cleanse area to right lower extremity. Resident declined wound care today; -On 2/18/20 at 4:03 P.M., [MEDICATION NAME] administration for pain. Resident complained of throbbing pain in feet; -On 2/18/20 at 5:50 P.M., [MEDICATION NAME] administration for pain; -On 2/19/20 at 3:35 P.M., weekly skin observation: Skin issues present. Refer to assessment for more information. Review of the resident's Weekly Skin Observation, dated 2/19/20 at 3:35 P.M., showed: -Reddened area great toe/antibiotic therapy. Review of the resident's progress notes, dated 2/19/20 at 7:47 P.M. through 2/23/20 at 4:00 P.M., showed: -On 2/19/20 at 7:47 P.M., roommate called nursing staff to room stating the resident is on the floor. Upon arrival to room, the resident was lying on the floor stating he/she tried to stand up and fell on the floor. DON, physician and facility supervisor informed; -On 2/19/20 at 11:02 P.M., weekly skin observation: No skin issues present; -On 2/22/20 at 1:37 P.M., [MEDICAL CONDITION] 4+ (8 mm depression, or a very deep indentation, the most severe type of [MEDICAL CONDITION]) weeping to both lower extremities. Dressings changed; -On 2/22/20 at 9:38 P.M., [MEDICAL CONDITION] 4+ weeping to both lower extremities. Dressing changed; -On 2/23/20 at 3:00 P.M., resident has signs and symptoms of altered mental status and weakness noted. Very poor appetite this shift. Resident asking for juice and water with juice and water sitting on table within reach of resident. Resident appears very weak. Unable to sit on side of bed without falling to side. [MEDICAL CONDITION] and drainage to both lower extremities seems to be getting worse, legs wrapped x2 this shift and draining continues to come though wraps, on bed and floor. Drainage is yellow and very foul smelling. Toes to right leg have dark discoloration noted. Verbal, but not making sense (less sense than normal). Family at bedside stating that the resident is not responding to them the way that the resident normally does. Call placed to physician, notified of assessment and change in condition noted. New orders noted to send to hospital. Call placed to ambulance for non-emergency transfer; -On 2/23/20 at 4:00 P.M., ambulance arrived. Further review of the resident's ePOS, showed an order dated 2/23/20, send resident to hospital. Review of the resident's hospital surgical report, dated 2/23/20, showed: -Date of surgery 2/23/20; -Preoperative Diagnosis: [REDACTED]. there is a need for free drainage from the operative site. A second surgical procedure involving stump (or residual limb) revision or closure is needed after the guillotine procedure. This is done only after the infection has been eliminated); -Findings: Grossly ischemic left lower leg that appeared unsalvageable, left great toe completely dusky/black, desquamation (sheading of skin) and dependent blood pooling the into soft tissues of the left foot and lower leg up to mid-calf. Left lower leg cool to the touch and pale with moderate soft tissue [MEDICAL CONDITION]. Sluggish bleeding from amputation site, muscle dusky but appeared viable; -Indications for surgery/procedure: The resident arrived to the hospital emergency department with altered mental status from a nursing facility. He/she was brought to the hospital by a family member who was concerned about the care that the resident was receiving at the nursing facility and noted acute changes to the left lower extremity. On arrival, the resident was found to have significant ischemic changes to the left foot and lower leg up to the mid-calf including a completely black left great toe, pallor (paleness) of the lower leg and desquamation. The patient was unable to provide medical history due to altered mental status and was admitted to the intensive care unit with an urgent surgical consult. Due to the appearance of the left lower extremity and concerns for critical limb ischemia, urgent surgical intervention was discussed with family, involving a left lower extremity below-knee guillotine amputation. Review of the resident's hospital surgical report, dated 2/26/20, showed: -Date of surgery: 2/26/20; -Preoperative Diagnosis: [REDACTED]. Revision of left lower extremity amputation, left knee disarticulation (amputation of a limb through a joint, without cutting of bone); -Findings: Ischemic changes of left lower extremity below the knee stump that appears unsalvageable; -Indication for surgery/procedure: Left lower extremity ischemia,[MEDICAL CONDITION]/shock; -Condition at discharge: Critical. During an interview on 3/16/20 at 12:09 P.M., with the DON, Administrator, and nurse practitioner, the DON said care plans should be complete. The DON and nurse practitioner said if a resident is admitted with a wound, treatment orders should be obtained on admission. Staff should follow the wound policy and document assessments of wounds. Changes in wounds should be reported to the physician. Treatments should be applied as ordered. 2. Review of Resident #141's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Extensive assistance required for bed mobility, dressing, toilet use and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 11/1/18, showed: -Focus: Open area noted to left buttock non-pressure related. Updated 2/26/20: The wound seems to be deteriorating as he/she continues to spend long periods of time in his/her wheelchair. Skin is also staying moist due to constant sweating on bottom, fold and creases; -Goal: Wound will exhibit signs of healing and/or be healed without any signs/symptoms of infection; -Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Review of the resident's medical record, showed: -An order dated 11/10/19, for skin prep wipes to left gluteal (buttocks) two times day; -The order not documented as completed as ordered or refused, 11 of 62 opportunities in December 2019; -An order dated 12/5/19, for skin prep to left buttocks daily; -The order not documented as completed as ordered or refused, six of 27 opportunities in December 2019; -A weekly skin observation, dated 12/9/19: left buttocks, treatment in place; -A weekly wound observation tool, dated 12/10/19: Left buttocks moisture associated skin damage (MASD) measured 1.8 x 2 x 0.1; -A weekly skin observation, dated 12/16/19: Left gluteal fold, skin prep and cream applied; -A weekly wound observation tool, dated 12/17/19: Left buttocks MASD measured 1.8 x 2 x 0.1; -A weekly skin observation, dated 12/23/19: Left gluteal fold open area; -A weekly wound observation tool, dated 12/24/19: Left buttocks MASD measured 2 x 1.8 x 0.1; -A weekly skin observation, dated 12/30/19: Left gluteal fold with current treatment in place; -The order for skin prep wipes to left gluteal two times a day not documented as completed as ordered or refused, seven of 43 opportunities in January 2020; -The order for skin prep to left buttocks daily not documented as completed as ordered or refused, seven of 22 opportunities in January 2020; -A weekly skin observation, dated 1/6/20: Left buttocks treatment in place; -A weekly wound observation tool, dated 1/8/20: Left medial thigh MASD 5 x 4 x 0.2; -A weekly skin observation, dated 1/13/20: Left gluteal fold open area with treatment in place; -A weekly skin observation, dated 1/20/20: Left gluteal fold open area with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) treatment in place; -An order dated 1/22/20, to discontinue both orders for skin prep; -No treatment for [REDACTED]. to left buttocks topically two times a day for left buttocks abrasion; -Not documented as applied as ordered or refused, three of 12 opportunities in February 2020; -A weekly skin observation, dated 2/17/20: Left buttocks treatment in place; -An order dated 2/18/20, for Venelex ointment, apply to right buttocks topically every day and evening shift for right buttocks abrasion; -Not documented as applied as ordered or refused, 13 of 24 opportunities in February 2020; -A weekly skin observation, dated 2/24/20: Left buttocks dressing intact; -A weekly skin observation, dated 3/2/20: Right gluteal fold buttocks, treatment nurse aware; -A weekly skin observation, dated 3/9/20: Right gluteal fold wound to area beefy red; -An order dated 3/9/20, for the wound care clinic to evaluate and treat; -No further wound measurements since 1/8/20. No further descriptions of wound appearance or drainage. No clarification if the wound was on the left or right buttock. Further review of the resident's medical record, showed an order, dated 3/11/20 at 7:00 A.M., to clean wound with wound cleaner, pat dry, apply calcium alginate (used to absorb moisture) to wound bed, cover with ABD and secure with tape daily; Observation on 3/11/20 at 7:43 A.M., showed Wound Nurse O provided wound care for the resident with the nurse from the wound clinic. The wound was located on the resident's left posterior thigh/buttocks area. A dressing dated 3/10/20 was in place. The wound was large and beefy red. An area with loose grey tissue visible. The wound care nurse measured the wound. Review of the wound care clinic note, dated 3/11/20, showed the following for the resident: -Wound assessment: Left thigh acute full thickness (extend past the two layers of skin (dermis and epidermis) and extend into the subcutaneous (fat) tissue). Measurements 7.5 centimeter (cm) length (L) by 8.3 cm width (W) by 0.2 cm depth (D), there is a moderate amount of serosanguineous (thin, watery, pale red to pink drainage) drainage noted. Wound bed has 51-75% slough (moist dead tissue), 26-50% granulation (new tissue growth). The wound is deterioriating. Review of the facility's wound report, dated 2/28/20 and the most recent wound report provided by the facility, showed the resident listed with a new wound onset date of 3/2/20. During an interview on 3/12/20 at 6:35 P.M., with the DON, Administrator and Wound Nurse O, they said the documentation in the wound report and documentation in the medical record should be accurate. The wound on the resident is MASD and not pressure. Nurses are not trained to stage wounds and should not be staging wounds. The nurse practitioner or wound company are the only ones who can stage a wound. If staff observe a wound, they should describe the wound and measure the wound. Staff should be knowledgeable with anatomical locations of wounds. The resident has had the wound healed out and then comes back, as well as having other wounds that have healed. Documentation should clearly identify wounds and show the progression of the wounds. Wound assessment and measurements should be obtained immediately upon admission and the wound nurse will assess any reported wounds to determine if the wound company needs to be consulted. The wound policy should be followed and measurements obtained weekly. The resident's wound was just added to the February 28th wound report, which is why the onset date shows March 2nd. The facility is currently transitioning from one wound nurse to another. Treatments should be administered as ordered and current wounds should have orders for treatments. 3. Review of Resident #135's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Total dependence for bed mobility, transfer, dressing and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Chronic pressure ulcers present on admission due to limited mobility. Open areas to Coccyx/sacral, medial back, both gluteal fold, right lateral leg distal and open areas to left and right hip, left lateral foot: -Goal: Pressure ulcers/other wounds will show signs of healing and remain free from infection; -Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Review of the resident's medical record, showed: -A skin/wound note, dated 10/25/29: Resident seen by wound care: -Area to right distal lateral lower leg presents as a chronic full thickness arterial ulcer measuring at 37.8x2.5x0.4, with moderate serosanguineous drainage. Tendon and bone are exposed. Wound bed has 51-75% bright red granulation; -Area to medial abdomen presents as an acute full thickness surgical wound measuring at 01.3x0.8x0.2, with moderate serosanguineous drainage. Wound bed has 76-100% granulation; -Area to left anterior ankle presents as an acute full thickness arterial ulcer measuring at 1.4x2.4x0.2, with moderate serosanguineous drainage. Wound bed has 76-100% bright red granulation; -A weekly skin observation, dated 10/26/19: Skin issues present. Right lower leg treatment in place, left lower leg treatment in place (no mention of abdomen wound); -A weekly skin observation, dated 11/2/19: Skin issues present. Right lower leg treatment in place, left lower leg treatment in place (no mention of abdominal wound); -A weekly skin observation, dated 11/9/19: Skin issues present. Right lower leg treatment in place, left lower leg treatment in place (no mention of abdominal wound); -A weekly skin observation, dated 11/16/19: No skin issues present; -A weekly skin observation, dated 12/17/19: No skin issues present; -A weekly skin observation, dated 12/24/19: No skin issues present; -A weekly skin observation, dated 12/31/19: No skin issues present; -A weekly skin observation, dated 1/7/20: No skin issues present; -A weekly skin observation, dated 1/14/20: Skin issues present. Treatment in progress left leg dressing dry and intact (no mention of abdominal wound or right leg wound); -A weekly skin observation, dated 1/21/20: Skin issues present. Treatment in progress right lower extremity dressings dry and intact (no mention of abdominal wound or left ankle wound); -A weekly skin observation, dated 1/28/20: Skin issues present. Treatment in progress right lower extremity dressings dry and intact (no mention of abdominal wound or left ankle wound); -A skin/wound note, dated 1/31/20: Area to abdomen observed as open area measuring 1.0x1.0x0.2, with pink granulation tissue present. Moderate serosanguineous drainage. Area reopened. Physician notified with new order for calc
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care to prevent pressure ulcers and ensure residents with pressure ulcers receive the necessary treatment and services to promote healing, for five of seven residents investigated for pressure ulcers (Residents #56, #135, #60, and #143). The facility failed to assess wounds per facility policy and standards of practice and provide treatments as ordered. Resident #56 had a delay in identification of a pressure ulcer. When first identified by the facility, the pressure ulcers was a stage III. This resulted in a delay of treatment. After identified, the facility failed to assess and monitor the wound and failed to provide treatments as ordered consistently, which resulted in the wound developing into a stage IV pressure ulcer. The wound became infected and the resident required hospitalization [MEDICAL CONDITION] and surgical wound debridement. The sample was 29. The census was 143. Review of the facility's Centers for Medicare and Medicaid (CMS) form 802, showed: -The facility identified five resident's as having pressure ulcers (any lesion caused by unrelieved pressure that results in damage to the underlying tissue); -Residents #56 and #143 were not identified as having pressure ulcers. Review of the facility's Facility Assessment Tool, updated 2/25/20, showed: -Purpose: To determine what recourses are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental and psychosocial well-being; -Services and care offered based on resident needs: Pressure injury prevention and care, skin care, wound care. Review of the facility's Skin Ulcer-Wound Policy, dated 8/15/18, showed: -All caregivers are responsible for preventing, caring for and providing treatment for [REDACTED]. It may also include an area of discoloration that is not open if the nurse identifies an area of concern that may potentially ulcerate and then confirms suspicion with a provider (physician/nurse practitioner/physician assistant/midlevel) for diagnosis; -Assessment: -Licensed staff will, upon admission, perform a head to toe body audit within 2 hours of admission. The findings will be documented in the resident's clinical record. Any items not documented in the admission assessment form will be charted in the nurse's notes; -Licensed staff will complete a head to toe skin assessment weekly and as needed. The skin assessment will be documented on a skin assessment form and become part of the resident's clinical record. Any unusual findings will be documented on the form with a follow-up note in the nurse's notes further describing the area of concern; -Treatment protocols: -Consult wound care providers when appropriate; -Until wound care providers can assess and order treatment, the following techniques may be employed: -Follow standard precautions and good hand hygiene techniques; -For non-open areas of concern or areas covered with stable eschar (dry dead tissue), apply skin prep (protective barrier wipe) daily and use preventative measures. On areas where skin prep is not appropriate (i.e. buttocks, etc.) moisture barrier cream is adequate. Skin prep may also be used for un-ruptured serous fluid (clear drainage) or blood-filled blisters; -For all other open areas, the treatment is determined based on tissue type and drainage; -All orders must be approved by a physician within 24 hours of discovering the open area or change in treatment; -Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) protocols: -Nurses may not diagnose, just describe; -Measurements must be completed weekly; -At the time a skin issue is discovered, it must be measured. Wounds are three dimensional; therefore length, width and depth must be documented if using measuring instrument. It is acceptable to measure using common household objects (i.e. dime size, quarter size, half dollar) until actual measurements can be obtained per facility protocol; -Length of wound should always be measured in head to toe alignment. Width should always be measured in hip to hip or side to side alignment. Depth should always be the deepest part of the wound in perpendicular alignment; -If a reddened area is identified, the nurse should assess if the area is blanching (when skin color fades when pressure is applied and returns when pressure is released). If it is no blanching, then it should be captured on the licensed body audit report. 1. Review of Resident #56's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/3/19, showed: -Moderate cognitive impairment; -Extensive assistance required for bed mobility, toilet use and personal hygiene; -[DIAGNOSES REDACTED]. ulcers (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed): 0; -Number of stage IV pressure ulcers (full thickness tissue loss with exposed bone, tendon or muscle): 0; -Number of unstageable pressure ulcers (depth unable to be determined due to coverage of wound bed by slough (moist dead tissue) or eschar). Review of the resident's care plan, updated 2/29/20, showed: -Focus: Incontinent of bowel and bladder which increases risk for pressure related injuries: -Goal: Will remain free from skin breakdown; -Interventions: Check resident every two hours and assist with toileting as needed; -Focus: Impaired skin integrity, pressure injuries to left lower leg, coccyx (tailbone area) and left heel; -Goal: Be free of complications related to skin breakdown; -Interventions: Treatments per physician orders, low air loss mattress, weekly treatment documentation, wound clinic to treat. Review of the resident's medical record, showed: -No ordered treatment to the buttocks area from 11/1/19 through 11/26/19; -A weekly skin observation, dated 11/11/19: Skin issues present. Right buttocks open areas moisture associated skin damage. Moisture barrier cream applied to areas on buttocks, referred to wound nurse; -A weekly skin observation, dated 11/18/19: Skin issues present (the buttocks area not documented as an area of concern); -A weekly skin observation, dated 11/25/19: Skin issues present (the buttocks area not documented as an area of concern); -A weekly wound observation tool, dated 11/26/19: Left buttocks pressure ulcer, acquired stage III. First observation, no reference. Granulation tissue (new tissue growth) present, slough tissue present. Percent of necrosis and/or slough in wound bed, 26-50%. Moderate amount of serosanguineous (thin, watery, pale red to pink) drainage. Measurement: Length (L) 3.8 centimeter (cm) by width (W) 5.5 cm by depth (D) 0.2 cm; -An order dated 11/27/19, to cleanse area to left buttocks with wound cleanser, pat dry, apply hydrogel (gel used to keep the wound bed moist and aid in healing) and calcium alginate (absorbent product) daily. Order discontinued on 11/27/19, after the first application of the treatment; -An order dated 11/28/19, to cleanse area to left buttocks with wound cleanser, pat dry and apply Santyl (ointment used to remove dead tissue) and calcium alginate daily; -A weekly skin observation, dated 12/2/19: Skin issues present. Left buttocks dressing intact to area. Treatment done per wound nurse; -A weekly skin observation, dated 12/9/19: Skin issues present. Left buttocks open area with granulation and slough tissue present; -A weekly wound observation, dated 12/12/19: Left buttocks pressure ulcer, acquired stage III, improving. Granulation tissue present, slough tissue present. Percent of necrosis and/or slough in wound bed, 26-50%. Moderate amount of serosanguineous drainage. Measurement (LxWxD): 2.8 by 0.5 by 0.2; -A weekly wound observation, dated 12/12/19: Right buttocks partial thickness wound acquired 12/12/19. First observation, no reference. Granulation tissue present. Scan serosanguineous drainage. Measurements (LxWxD): 3.0 cm by 1 cm by 0.1 cm; -The prior treatment order to the left buttocks discontinued on 12/13/19; -An order dated 12/14/19, skin prep to right buttocks daily: -The treatment not documented as completed five of 18 opportunities in December 2019; -No treatment for [REDACTED]. Area to buttocks with current treatment in place; -A weekly wound observation, dated 12/18/19: Left buttocks pressure ulcer, acquired stage III, unchanged. [MEDICATION NAME] (new tissue growth) and granulation tissue present. Measurement (LxWxD): 6.0 cm by 4.0 cm by 0.2 cm: -Further review of prior wound measurements for the left buttocks, showed the wound grew in size and was not unchanged as indicated on the assessment; -A weekly wound observation, dated 12/18/19: Right buttocks acute full thickness wound, unchanged. [MEDICATION NAME] and granulation tissue present. Moderate amount of serosanguineous drainage. Measurement (LxWxD): 6 cm by 4 cm by 0.2 cm; -Further review of prior wound measurements for the right buttocks, showed the wound grew in size and was not unchanged as indicated on the assessment; -An order dated 12/23/19, to cleanse area to coccyx with wound cleanser, pat dry, apply Santyl and cover with dry dressing daily: -The treatment not documented as completed as ordered three of nine opportunities in December 2019 and four of 16 opportunities in January 2020; -A weekly skin observation, dated 12/23/19: Skin issues present. Area to coccyx with current treatment order in place; -A weekly skin observation, dated 12/31/19: No skin issues; -A weekly skin observation, dated 1/6/20: Right buttocks with current treatment in place; -A weekly skin observation, dated 1/13/20: Area to coccyx with current treatment in place; -The prior treatment order to the coccyx discontinued on 1/16/20; -An order dated 1/17/20, to cleanse area to coccyx with wound cleanser, pat dry, mix [MEDICATION NAME] (antibiotic) ointment with Santyl and cover with dry dressing daily: -The treatment not documented as completed as ordered two of 15 opportunities in January 2020 and three of nine opportunities in February 2020; -A weekly skin observation, dated 1/20/20: No skin issues present; -A weekly skin observation, dated 2/3/20: Sacrum (buttocks area) stage IV pressure ulcer, treatment in place; -No measurements documented from 12/18/19 through the resident being sent to the hospital on [DATE]; -A transfer to hospital summary, dated 2/9/20: Resident stated to writer he/she did not feel good and wanted to go to hospital. Vital signs taken at that time were blood pressure 132/77 (normal 90/60 through 120/80), heart rate 88 (normal 60 through 100), respirations 20 (normal 12 through 22), temp 101.0 temporal (taken on the skin over the temple, normal 97.8 through 99.1). Call placed to resident's doctor to inform doctor of resident's condition. New order given to send resident out to hospital for evaluation and treatment. Resident left building via ambulance transport at 5:55 P.M. Review of the resident's hospital records, showed resident admitted to the hospital on [DATE] with [MEDICAL CONDITION] (systemic infection) related to infected sacral decubitus ulcer (pressure ulcer). General surgery consulted for wound debridement (surgical removal of dead tissue) at bedside on 2/10/20 and operating room on 2/11/20 for further debridement. Further review of the resident's medical record, showed: -The resident readmitted to the facility on [DATE]; -A readmission assessment, dated 2/20/20: admitted from hospital on [DATE] at approximately 5:45 P.M. Skin issues present (skin assessment blank); -An order dated, 2/21/20 for [MEDICATION NAME] ointment (an enzyme that helps promote healthy tissue growth), apply to affected area topically daily; -The treatment not documented as completed as ordered six of nine opportunities; -A weekly skin observation, dated 2/24/20: Area to coccyx with treatment in place; -A skilled charting note, dated 2/29/20: Total care, no resident participation for bed mobility. Skin integrity: No new changes to skin integrity noted. Resident has treatable wounds, pressure to coccyx. Dressing change not required; -The ordered treatment for [REDACTED]. Observation of the resident on 3/11/20 at 6:32 A.M., showed the resident lay in his/her bed, asleep. Wound vac attached. During an interview on 3/12/20 at 6:35 P.M., with the Director of Nursing (DON), Administrator and Wound Nurse O, they said the resident came back to the facility today after leaving to have a second scheduled surgical debridement of the wound. He/she had originally gone to the hospital to have surgical debridement of the wound to the coccyx in February. Wound Nurse O said when the resident returned from the hospital in February, he/she had an order for [REDACTED]. Once the site was ready, the order for the wound vac was entered in the system and the wound vac was applied. He/she did not document any of this. The administrator said any treatment changes, treatments applied and communication with the physician should be documented. Wounds should be identified, assessed and documented with treatment orders obtained. People do not just wake up one day with a stage III wound. The wound should have been identified and treated prior to becoming a stage III. They would expect the documentation regarding the location of the wound be accurate. The wound was on the buttocks. Staff will use different locations interchangeable and this is not the correct way to do it. Staff would benefit from training on locations of wounds. Documentation should be accurate. Treatments should be applied as ordered. Staff should follow the wound policy and obtain measurements weekly. 2. Review of Resident #135's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors; -Total dependence for bed mobility, transfer, dressing and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Chronic pressure ulcers present on admission due to limited mobility. Open areas to coccyx/sacral, medial back, both gluteal fold, right lateral leg distal and open areas to left and right hip, left lateral foot: -Goal: Pressure ulcers/other wounds will show signs of healing and remain free from infection; -Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Review of the resident's medical record, showed: -A skin/wound note, dated 10/25/29: Resident seen by wound care: -Area to left ischium presents as a chronic stage III pressure injury measuring at 2.0x2.5x0.6 with moderate serosanguineous drainage. Wound bed is 1-25% slough 76-100% granulation; -Area to medial coccyx presents as a chronic stage IV pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 9) injury measuring at 6.0x11.0x1.0 with moderate serosanguineous drainage. Wound bed has 76-100% bright red granulation; -A weekly skin observation, dated 10/26/19: Skin issues present. Vertebrae (upper middle) treatment in place (no mention of the left ischium or medial coccyx wound); -A weekly skin observation, dated 11/2/19: Skin issues present. Left gluteal fold treatment in place, coccyx treatment in place, vertebrae (upper middle) treatment in place; -A weekly skin observation, dated 11/9/19: Skin issues present. Left gluteal fold treatment in place, coccyx treatment in place, vertebrae (upper middle) treatment in place; -A weekly skin observation, dated 11/16/19: No skin issues present; -A weekly skin observation, dated 12/17/19: No skin issues present; -A weekly skin observation, dated 12/24/19: No skin issues present; -A weekly skin observation, dated 12/31/19: No skin issues present; -A weekly skin observation, dated 1/7/20: No skin issues present; -A weekly skin observation, dated 1/14/20: Skin issues present. Treatment in progress buttocks (no mention of the ischium or back wound); -A weekly skin observation, dated 1/21/20: Skin issues present. Treatment in progress buttocks (no mention of the ischium or back wound); -A weekly skin observation, dated 1/28/20: Skin issues present. Treatment in progress buttocks (no mention of the ischium or back wound); -A weekly skin observation, dated 2/5/20: Skin issues present. Treatment in progress abdomen, buttocks, right lower extremity dressings dry and intact; -A weekly skin observation, dated 2/11/20: Skin issues present. Treatment in progress buttocks (no mention of the ischium or back wound); -A weekly skin observation, dated 2/18/20: Skin issues present. Treatment in progress buttocks (no mention of the ischium or back wound); -A weekly skin observation, dated 2/25/20: Skin issues present. Treatment in progress coccyx, left ischium (no mention of the back wound); -A weekly skin observation, dated 2/25/20: Treatment in progress coccyx, left ischium (no mention of the back wound); -A weekly skin observation, dated 3/3/20: Treatment in progress coccyx, back (no mention of the ischium wound); -No further weekly wound observations from September 2019 through March 2020; -No further pressure ulcer measurements or descriptions from September 2019 through March 2020. Review of the resident's wound clinic notes, dated 3/11/20, showed: -Medial back acute stage III pressure ulcer. Measurement (LxWxD): 2 cm by 4.1 cm by 0.2 cm. Scant amount of drainage. Wound is improving; -Left ischial chronic stage III pressure ulcer. Measurement (LxWxD): 2 cm by 2.5 cm by 0.7 cm, moderate amount of serosanguineous drainage. The wound is deteriorating; -Coccyx chronic stage IV pressure ulcer. Measurement (LxWxD): 6 cm by 11 cm by 1.4 cm, moderate amount of serosanguineous drainage. Wound is deteriorating. Further review of the resident's medical record, showed: -An order dated 1/9/20: Cleanse area to right mid back with wound cleanser, pat dry, apply calcium alginate and dry dressing daily; -An order dated 2/7/20: Cleanse area to left ischium with wound cleanser, pat dry, apply [MEDICATION NAME] (antibacterial foam dressing), ABD and secure with tape, every day shift Mondays, Wednesdays, and Fridays; -An order dated 2/7/20: Cleanse area to coccyx with wound cleanser, pat dry, apply [MEDICATION NAME], ABD and secure with tape, every day shift Mondays, Wednesdays, and Fridays; -No order for a right medial back wound treatment. Observation of the resident's pressure ulcer treatments, on 3/13/20 at 9:18 A.M., showed Nurse A entered the resident's room with the treatment cart. Nurse A washed his/her hands and applied gloves. A Certified Nurse Aide (CNA) M assisted the nurse in turning the resident on his/her left side by using the turning sheet. The resident did not have anything covering his/her back, ischium, or coccyx wounds. Bloody wound discharge was visible on the bed. Nurse A returned to his/her cart removed a spray bottle of wound cleanser, returned to the resident's bed side, sprayed all open wound areas on the resident's back, coccyx and ischium. He/she did not pat the wounds dry. Two wounds located on the resident's back. One to the right medial side of the back and one to the medial back: -Nurse A applied a piece of calcium alginate to the right medial back wound. The wound bed beefy red. He/she placed a piece of gauze 4 by 4 on top (there was no treatment order for this wound); -Nurse A took two precut pieces of [MEDICATION NAME] from clean area on cart and placed it on the medial back wound. The wound bed appeared beefy red (calcium alginate not applied as ordered and [MEDICATION NAME] applied and was not ordered for this wound); -Nurse A applied an ABD pad over both back wounds and secured with tape; -Nurse A placed a large piece of [MEDICATION NAME], shaped like a half moon, on the resident's coccyx wound, covered with an ABD pad and secured with tape; -Nurse A used an applicator and applied collagen powder to the left ischium wound, placed gauze over the area and secured with tape ([MEDICATION NAME] not applied as ordered and collagen powder applied and was not ordered for this wound). During an interview on 3/13/20 at 10:13 A.M., CNA M said the pad was visibly soiled with wound drainage and dirt from the resident. During an interview on 3/13/20 at 10:13 A.M., Nurse A said all dressings were removed earlier when the resident was cleaned up from a large bowel movement. He/she has no way to measure the wounds and does not know the size. The wound nurse normally does the treatments and measurements. The resident's wounds are very time consuming. 3. Review of Resident #60's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Rejection of care: Behavior not exhibited; -Total dependence for bed mobility, dressing and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 7/9/18, showed: -Focus: Will often refuse care: -Goal: Fewer episodes of refusal of care behaviors; -Interventions: Monitor behavior episodes; -Focus: Has open areas throughout his/her body. Remains at risk for further decline and/or new open areas as he/she remains dependent on staff for bed mobility, transfers and incontinent care: -Goal: Will show signs and symptoms of healing without infection; -Interventions: Pressure relieving mattress, pressure relieving cushion to protect the skin while up in chair. Monitor/document location, size and treatment of [REDACTED]. Review of the resident's medical record, showed he/she frequently refused wound care and skin assessments. Review of the resident's medical record, reviewed on 3/11/20, showed: -An order dated 2/29/20, cleanse area to coccyx with wound cleanser, pat dry, apply Santyl nickel thick, apply calcium alginate over Santyl, cover with ADB pads (absorbent dressing), secure with tape daily: -Not documented as completed as ordered or refused three of 10 opportunities; -An order dated 2/29/20, cleanse area to left ischium (lower buttocks) with wound cleanser, pat dry, and apply Santyl nickel thick. Apply calcium alginate over Santyl, cover with ABD pads and secure with tape daily: -Not documented as completed as ordered or refused three of 10 opportunities; -An order dated 2/29/20, cleanse area to right ischium with wound cleanser, pat dry, apply Santyl nickel thick, apply calcium alginate over Santyl, cover with ABD pads and secure with tape daily: -Not documented as completed or refused three of 10 opportunities; -An order dated 2/29/20, cleanser area to right medial foot with wound cleanser, pat dry, protect peri-wound (skin surrounding wound bed) with skin protectant, apply Santyl nickel thick, apply dry dressing and secure with tape: -Not documented as completed or refused three of 10 opportunities; -An order dated 2/29/20, use skin prep to left back, and do not wash skin around wound. Apply dry dressing and secure with tape every day shift: -Not documented as completed or refused three of 10 opportunities; -An order dated 3/2/20, cleanse area to left lower lateral leg with cleanser, pat dry, apply Santyl nickel thick, cover with ABD pads and secure with tape daily: -Not documented as completed or refused two of nine opportunities; -No order for treatment to a left outer thigh wound. Review of Drugs.com, showed Santyl: Apply this medication only to the affected skin wound. Try not to get any ointment on the healthy skin around the wound. Observation on 3/10/20 at 10:09 A.M., showed Wound Nurse Q said he/she used to be the wound nurse and is currently filling in until the facility can find a different full time wound nurse. He/she prepped the treatment cart, obtained supplies. He/she had two whole ABD pads and several pieces of ABD pad cut into various sizes. He/she obtained Santyl ointment from cart, and the tube of Santyl not labeled with a resident's name. The tube appeared new and unused. He/she squirt a large amount of Santyl in a swirling motion on three of the small and one of the whole ABD pads. He/she entered the resident's room with the treatment cart and supplies. As the wound nurse repositioned the resident, a fowl wound odor permeated the room. The resident complained about the smell. The wound nurse cut more ABD pads and applied the remainder of the tube of Santyl onto the dressings. Each dressing had a large amount of Santyl piled up on the dressing: -The buttocks/coccyx dressing saturated and the date unable to be read. The wound nurse removed the dressing and exposed an approximate basketball sized wound. When removing this dressing, the dressing to the left and right ischium also came off. The wound nurse cleansed the buttocks/coccyx area with wound cleanser, patted dry, applied ABD dressings with the Santyl ointment already applied, over the wound. The Santyl on the ABD pads more than a nickel thick and pushed into the wound when the dressing was applied (no calcium alginate applied as ordered); -An elongated wound to the left ischium, extended vertical in relation to the resident's body. The wound nurse cleansed the area with wound cleanser, patted dry, applied ABD dressings with the Santyl ointment already applied, over the wound. The Santyl on the ABD pads more than a nickel thick and pushed into the wound when the dressing was applied (no calcium alginate applied as ordered); -An elongated wound to the right ischium, extended vertical in relation to the resident's body. The wound nurse cleansed the area with wound cleanser, patted dry, applied ABD dressings with the Santyl ointment already applied, over the wound. The Santyl on the ABD pads more than a nickel thick and pushed into the wound when the dressing was applied (no calcium alginate applied as ordered); -The left back/shoulder area dressing had peeled off, the date could not be read and the area surrounding the wound red and inflamed. The wound nurse cleansed the wound with wound cleanser spray (the order indicated not to cleanser the skin around the wound), patted dry, and applied an ABD dressing with the Santyl ointment already applied, over the wound. The Santyl on the ABD pads more than a nickel thick and expanded outside the wound edges and onto healthy tissue when the dressing was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) applied; -The left lateral lower leg/knee dressing, dated 3/9. The dressing removed and exposed an approximate quarter sized wound. The wound nurse removed a second tube of Santyl from the treatment cart. He/she applied the Santyl to an ABD pad and placed the Santyl on the treatment cart. He/she cleansed the wound to the leg/knee, patted dry, applied the ABD pad with Santyl. The Santyl on the ABD pad more than a nickel thick and expanded outside the wound edges and onto healthy tissue. The dressing secured with tape. Observation of the tube of Santyl used on the leg/knee wound, showed a different resident's name labeled on the tube; -The left outer thigh dressing removed and exposed an approximate dime size wound. No dressing or treatment applied to thigh wound. The wound remained open to air; -The right inner foot dressing removed and exposed a wound approximately larger than quarter size. The wound nurse cleansed the area with wound cleanser, patted dry, applied ABD dressings with the Santyl ointment already applied and applied over the wound. The Santyl on the ABD pads more than a nickel thick and expanded outside the wound and onto healthy tissue when the dressing was applied (no skin protectant applied to the wound edges as ordered). During an interview on 3/16/20 at 12:09 P.M., with the DON, Administrator and nurse practitioner, they said physician orders [REDACTED]. 4. Review of Resident #143's admission MDS, dated [DATE], showed: -admitted [DATE] from an acute care hospital; -Total dependence for bed mobility, dressing, eating, toilet use and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's medical record, reviewed on 3/11/20, showed no comprehensive care plan completed. Review of the resident's baseline care plan, dated 2/13/20, showed for his/her skin assessment: Normal color, skin temperature dry and warm, no skin issues. Review of the resident's medical record, showed: -An Admission Assessment Nursing, dated 2/13/20, showed no skin conditions; -A weekly skin observations progress note, dated 2/13/20, showed: -Resident admitted on [DATE]; -Refer to assessment for more information; -An Admission Weekly Skin Observation assessment, dated 2/13/20, showed: -Skin issues: yes; -Sacrum (buttocks) wound to bottom, treatment nurse did assessment; -No measurement or description of the sacrum wound documented; -A progress note, showed a skin/wound note, dated 2/13/20 at 4:30 P.M., showed an area to right and left buttocks observed as unstageable and measured 5.0 by 7.5 by 0.1, moderate drainage with [MEDICATION NAME] tissue to periwound (skin around wound edges); -The ePOS, showed an order dated 2/14/20, to cleanse area to buttocks with wound clenser, pat dry, apply calcium alginate and dry dressing daily: -Treatment not documented as applied or refused five of 16 opportunities in February 2020; -Treatment not documented as applied or refused three of 10 opportunities in March 2020; -A weekly skin observation assessment, dated 2/18/20, showed no skin issues; -Further review of progress notes, showed a skin/wound note, dated 2/25/20 and 3/3/20, showed skin color normal, skin temperature dry and warm. Skin issues present. Refer to assessment for more information; -A weekly skin observation assessment, dated 2/25/20 and 3/3/20, showed: Area to buttocks with current treatment in place; -A weekly skin observation assessment, dated 3/10/20, showed: -No skin issues; -Notes: No new skin issues. Dressings intact. Further review of the resident's medical record, showed no further documentation of pressure wound assessments, measurements or description. Review of the resident's wound clinic note, dated 3/11/20, showed: -Wound assessment: Coccyx is an acute stage III pressure ulcer. Initial wound encounter measurements (LxWxD) are 2 cm by 7 cm by 0.3 cm, moderate amount of serosanguineous drainate. Observation of the residen
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to properly monitor residents nutritional status to ensure early identification of residents with, or at risk for, impaired nutrition or hydration status. This would allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. The facility failed to obtain weights as directed by the resident's care plan for one resident (Resident #56) and failed to ensure the dietician monitored residents nutritional status quarterly for four of eight residents reviewed for nutritional needs (Resident #56, #85, #123, and #144). The sample was 29. The census was 143. Review of the facility's Nutrition and Unplanned Weight Loss/Gain policy, dated 6/28/19, showed: -The facility will assess and monitor the nutritional status of residents to assist the resident in maintaining adequate nutritional status, to the extent possible, giving careful consideration to the following: The residents choice to make informed decisions, the residents nutritional and hydration needs and by considering any pomological or functional impairment which may need to be addressed; -Definitions: -One month: 5% weight loss = significant loss. Greater than 5% = severe loss; -Three months: 7.5% weight loss = significant loss. Greater than 7.5% = severe loss; -Six months: 10% weight loss = significant loss. Greater than 10% = severe loss; -All residents shall be weighed upon admission, monthly and as required by their clinical condition and/or as ordered by nursing and/or physician orders; -Routine weight measurements will occur at least monthly unless otherwise noted in the resident's plan of care; -The physician and the resident's responsible party will be notified of any significant weight changes and the need for modifications of the resident's nutritional regimen within 72 hours of identification of a significant loss or gain; -The registered dietician (RD) is responsible to complete an assessment; estimating calorie, nutrient and fluid needs of all residents upon admission, annually and as needed; -Residents with significant weight loss will be referred to their physician/practitioner for orders or additional diagnostic testing; -The policy failed to identify who would be responsible to complete resident's quarterly nutritional assessments. 1. Review of Resident #56's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/2/19, showed: -Moderate cognitive impairment; -Supervision required with eating; -Signs and symptoms of possible swallowing disorders: Loss of liquids/solids from mouth when eating or drinking; -Care area assessment summary (CAAS): Nutritional status triggered and indicated as care planned by the facility. Review of the resident's electronic physician order [REDACTED]. Review of the resident's care plan, updated 2/29/20, showed: -Focus: At risk for nutrition due to [DIAGNOSES REDACTED]. Has a swallowing problem, dementia, dysphagia (difficulty swallowing). Regular puree diet with nectar thick liquids for all meals. On 3/4/19 was reported the resident was pocketing food; -Goal: Free of complications related to nutrition; -Approach: New admit 3/30/18 initiate weekly weights. Review of the resident's medical record, showed: -A Registered Dietician Assessment, dated 4/16/19, showed: -Nutritional risk factors: Below desired weight range, potential for poor intake, current history of pressure ulcers, difficulty chewing/swallowing/dysphagia, altered texture diet, thickened liquids, risk for dehydration; -No further Registered Dietician Assessments completed as of 3/16/20; -No quarterly nutritional assessments; -No dietary progress notes. Review of the resident's weight record, showed: -On 8/23/19 159.2 pounds (Lbs) -On 9/9/19 161.2 Lbs; -On 10/9/19 161.7 Lbs; -On 11/28/19 163.0 Lbs; -On 12/15/19 163.6 Lbs; -On 1/10/20 142.6 Lbs; -On 1/16/20 142.6 Lbs; -On 2/3/20 143.1 Lbs; -No further weights documented; -A significant weight loss in 6 months, from August 2019 until February 2020 of 10.11%; -A significant weight loss in 3 months, from November 2019 until February 2020 of 12.21%; -A significant weight loss in 1 month, from December 2019 to January 2020 of 12.82%. Further review of the resident's medical record, showed no documentation the physician and the resident's responsible party were notified of any significant weight changes and the need for modifications of the resident's nutritional regimen within 72 hours of identification of a significant loss or gain, per the facility's policy. During an interview on 3/16/20 at 10:23 A.M., the RD said he/she became aware of the resident's significant weight loss in February and ordered double portions. Further review of the resident's medical record, showed no order for double portions. During an interview on 3/16/20 at 12:09 P.M., with the Director of Nursing (DON), administrator, and the nurse practitioner, they said residents are weighted monthly, and some residents are weighed more. The resident is not a resident weighed weekly. If the care plan directed staff to weight the resident weekly, they would expect this be done. 2. Review of Resident #85's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Trouble concentrating on things; -No behaviors; -Supervision with eating; -[DIAGNOSES REDACTED]. Review of the resident's medical record, showed: -An order dated 1/9/19, for a regular diet, regular texture, regular consistency; -The last Registered Dietician Assessment completed on 1/10/19; -No quarterly nutritional assessments. Review of the resident's care plan, dated 2/19/19, showed no documentation regarding the resident's nutritional needs. 3. Review of Resident #123's admission MDS, dated [DATE], showed the following: -No cognitive impairment; -Feeling depressed and down at times; -Limited assistance with eating; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 2/27/20, showed the following: -Focus: Resident has potential nutritional problem with regards to [MEDICAL CONDITION], diabetes and high blood pressure; -Goal: The resident will comply with recommended diet for weight stability through review date; -Interventions: Provide and serve diet as ordered. Registered Dietician to make diet change recommendation as needed. Review of the resident's medical record, showed: -An order dated 3/8/20, for regular texture, regular consistency, renal (kidney) diet (no oranges/juice, bananas, limited potato). -No documentation regarding an assessment from the Registered Dietician; -No quarterly nutritional assessments. 4. Review of Resident #144's quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) MDS, dated [DATE], showed the following: -No cognitive impairment; -No moods; -No behaviors; -Supervision with eating; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised 5/15/19, showed the following: -Focus: Resident is frequently non complaint with recommend diet. Resident will order fast food on occasion and will frequently purchase snacks out of the vending machine; -Goal: Resident will have no complication relate to diabetes through the review date; -Interventions: Dietary consult for nutritional regimen and ongoing monitoring. Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Review of the resident's medical record, showed: -An order dated 1/24/17, for a regular diet, regular texture and regular consistency; -A Dietary Note/Nutritional Note, completed by the Dietary Manager, dated 2/25/20, showed the resident is currently on a regular diet. He/she does not complain about meals and as of 2/1/20, he/she weighed 230 lbs; -The last Register Dietician Assessment, completed on 2/19/19; -No quarterly nutritional assessments. 5. During an interview on 3/16/20 at 10:23 A.M., the RD said she visits the facility two times a month. She documents nutritional assessments on residents annually and on admission. She does not complete the quarterly assessments. That is the responsibility of the dietary manager. 6. During an interview on 3/16/20 at 10:30 A.M., the dietary manager said he has been in his position for 8 to 10 months. He recently found out he was supposed to be doing the quarterly nutritional assessments on residents and has started to do them. 7. During an interview on 3/16/20 at 12:27 P.M., the administrator said the RD comes in twice a month. The RD should be assessing and documenting quarterly, annually and for a significant change of the resident. She did not know why the RD was not assessing the resident quarterly. The assessments are important to address any nutritional concerns of the resident. The dietary manager is not qualified to complete the assessments.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to routinely assess, monitor and document on two residents receiving [MEDICAL TREATMENT] (process for removing toxins from the blood for individuals with kidney failure). The facility identified 6 residents as receiving routine [MEDICAL TREATMENT] treatments, three were sampled and problems were found with all three. (Residents #123, #62 and #127). The census was 143. Review of the facility's End Stage [MEDICAL CONDITION] [MEDICAL TREATMENT] Policy, dated 1/4/20, showed the following: -Purpose: To ensure a resident with End Stage [MEDICAL CONDITIONS], including [MEDICAL TREATMENT] care and treatment outside the facility, receive services by facility staff trained in the care and special needs of these residents; -Policy: Staff caring for residents with [MEDICAL CONDITION], including residents receiving [MEDICAL TREATMENT] care outside the facility shall be trained in the care and special needs of these residents; -Education and training of staff in the care of [MEDICAL CONDITION]/[MEDICAL TREATMENT] resident may be managed by the contracted [MEDICAL TREATMENT] facility or by the facility staff development coordinator or Director of Nursing (DON)/qualified designee; -Agreements between this facility and the contracted [MEDICAL CONDITION] facility include all aspects of how the resident's care will be managed, including how the care plan will be developed and implemented or how information will be exchanged between the facilities; -To prevent infection and/or clotting: -Check for signs of infection (warmth, redness, tenderness or [MEDICAL CONDITION]) at the access site when performing routine care and at regular intervals; -Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals; -Check patency of the site at regular intervals, palpate the site to fee the thrill (the vibration felt when blood flows through the [MEDICAL TREATMENT]) or use a stethoscope to hear the bruit (sound heard when blood flows through the [MEDICAL TREATMENT]) of blood flow through the access; -Additionally, all care instructions should be documented in the resident's plan of care; -Care of the central [MEDICAL TREATMENT] catheters: Check for signs of infection (warmth, redness, tenderness, [MEDICAL CONDITION], or drainage) every shift and document findings. 1. Review of Resident #123's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/5/20, showed the following: -Cognitively intact; -[DIAGNOSES REDACTED]. Review of the resident's care plan, revised 2/27/20, showed the following: -Focus: Resident is dependent upon [MEDICAL TREATMENT] three times weekly. He/she attends the [MEDICAL TREATMENT] center on Tuesday, Thursday and Saturday. He/she has a left upper extremity arterial/venous fistula (AV fistula, connection between an artery and vein); -Goal: The resident will have no signs or symptoms of complication from [MEDICAL TREATMENT]; -Interventions: Encourage resident to attend all scheduled [MEDICAL TREATMENT] appointments. Monitor vital signs. Notify physician of significant abnormalities. Monitor, document and report as needed any sign or symptoms of infection to access site, redness, swelling, warmth or drainage, renal (kidney) insufficiency, changes in level of consciousness, changes in skin turgor, oral mucous, changes in heart and lung sounds, bleeding, hemorrhage, bacterium or septic shock. Review of the resident's electronic POS, showed the following: -An order dated 3/8/20, [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday at 10:30 A.M.; -An order dated 3/9/20, access bruit and thrill every shift related to [MEDICAL CONDITION]; -An order dated 3/9/20, [MEDICAL TREATMENT] access left upper extremely AV Fistula. Review of the resident's medical record, showed no documentation of consistent monitoring during routine care and at regular intervals of the resident's [MEDICAL TREATMENT] and physical condition before and after visits to the [MEDICAL TREATMENT] center. Observation on 3/12/20 at 12:11 P.M., showed the resident up in his/her wheelchair in the dining room with the fistula in his/her left upper arm. 2. Review of Resident #62's admission MDS, dated [DATE], showed: -Cognitively intact; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Attends [MEDICAL TREATMENT] three times weekly on Tuesdays, Thursdays and Saturdays; -Goal: Have no signs or symptoms of complications; -Interventions: Check and change dressing daily at access site, right chest [MEDICAL TREATMENT] catheter. Encourage to go to [MEDICAL TREATMENT] appointments. Monitor/document/report as needed any signs and symptoms of infection to access site. Monitor/document/report as needed any signs and symptoms of [MEDICAL CONDITION]. Monitor/document/report as needed for signs and symptoms of the following: Bleeding, hemorrhage, bacteremia, septic shock. Review of the resident's ePOS, showed: -An order dated 2/23/20, for [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday at 11:30 A.M.; -An order dated 3/9/20, for a right chest [MEDICAL TREATMENT] catheter. Review of the resident's medical, showed no documentation of consistent monitoring during routine care and at regular intervals of the resident's [MEDICAL TREATMENT] and physical condition before and after visits to the [MEDICAL TREATMENT] center. 3. Review of Resident #127's annual MDS, dated [DATE], showed: -Cognitively intact; -[DIAGNOSES REDACTED]. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: The resident needs [MEDICAL TREATMENT], has a left upper extremity AV fistula; -Goal: Have no signs and symptoms of complications from [MEDICAL TREATMENT]; -Interventions: Assess bruit and thrill every shift and notify physician of any abnormalities. Do not draw blood or take blood pressure in arm with fistula. Encourage to attend all appointments on Mondays, Wednesdays and Fridays, pick up around 8:45 A.M. Vital signs per facility protocol. Monitor/document/report as needed any signs and symptoms of infection to the access site, [MEDICAL CONDITION], bleeding, hemorrhage, bacteremia, septic shock, new/worsening of [MEDICAL CONDITION]. Review of the resident's ePOS, showed: -An order dated 3/3/20, no blood pressure in the left arm; -An order dated 3/3/20, [MEDICAL TREATMENT] on Monday, Wednesday, Friday. Review of the resident's medical, showed no documentation of consistent monitoring during routine care and at regular intervals of the resident's [MEDICAL TREATMENT] and physical condition before and after visits to the [MEDICAL TREATMENT] center. 4. During an interview on 3/16/20 at 12:21 P.M., the Director of Nursing (DON) said she would expect the [MEDICAL TREATMENT] policy to be followed as written. The charge nurse should assess the resident before and after [MEDICAL TREATMENT]. This would include obtaining and documenting vital signs, general appearance and assessing the [MEDICAL TREATMENT] fistula.

F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services. The facility relied on staffing agencies to provide nursing services for the residents. The facility did not train the agency staff on facility policies and procedures. In addition, the facility staff failed to demonstrate competency in care provided to treat wounds. The census was 143. Review of the facility assessment, revised 12/9/19, showed: -Staff: -Registered Nurses (RN); -Licensed Practical Nurses (LPN); -Direct care staff; -Nurse educator; -(Agency staff not indicated as staff utilized) -Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) training/education and competencies: -All employees participate in a series of competencies upon hire and again quarterly and as needed. Education needs are also identified through performance observation, resident/family concerns and regulation changes; -Certified Nursing Assistants (CNAs) are given core in-service to ensure completion of mandatory 12 hours of training in conjunction with facility identified training needs. During an interview upon entrance to the facility, on 3/10/20 at 8:30 A.M., the administrator said the facility utilizes staff from nursing agencies to fulfill staffing needs. Observations during the survey, showed: -The facility failed to ensure residents receive care to prevent pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction) and ensure residents with pressure ulcers receives necessary treatment and services to promote healing, for five of seven residents investigated for pressure ulcers (Resident #56, #135, #60, and #143). The facility failed to assess wounds per facility policy and standards of practice and provide treatments as ordered. Resident #56 had a delay in identification of a pressure ulcer. When first identified by the facility, the pressure ulcers was a stage III (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed). This resulted in a delay of treatment. After identified, the facility failed to assess and monitor the wound and failed to provide treatments as ordered consistently, which resulted in the wound developing into a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle). The wound became infected and the resident required hospitalization [MEDICAL CONDITION] (systemic infection) and surgical wound debridement (removal of dead tissue); -The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for four residents (#138, #141, #135, and #143), of six residents investigated for non-pressure wounds and wound care when the facility failed to assess and treat wounds per facility policy and standards of practice. Resident #138 had a delay in treatment orders after admission. The facility failed to routinely apply the ordered treatments and assess the wounds. The resident had a change in level of swelling and wound drainage and the facility failed to timely notify the physician after identifying the change. The resident had a change in mental status after several days of increased swelling, drainage and pain; and was sent to the hospital. The resident required surgical debridement of a right heel wound and a [MEDICAL CONDITION] (BKA) of the left lower extremity due to the condition of the wounds; -The facility failed to implement procedures for the provision of infection prevention and control utilizing current standards of practice for three of four residents observed during wound care (Resident #135, #60 and #38). During an interview on 3/12/20 at 6:35 P.M., with the Director of Nursing (DON), administrator and Wound Nurse O, they said the facility just got a new nurse educator a couple weeks ago. Prior to that, the facility would have blitz days and competency exams. Staff should be competent in their ability to know how to determine the onset of a wound and have the ability to know if a wound is getting better, worse or unchanged. Staff are trained on the facility's wound policy. No other specialized training is provided at this time. The DON was asked to provide the most recent training provided to facility staff on wound care, to include what staff were educated on during the training. During an interview on 3/16/20 at 8:29 A.M., the Quality Assurance (QA) nurse said she was also hired as the infection preventionist and the nurse educator, but she has only been at the facility for a couple of weeks and has only been trained in the QA part of her job, as of this point. The DON said the facility is going to reach out to the wound clinic to see if they will provide training on wounds. The former QA nurse left in January. When asked about the documentation of the most recent training provided to facility staff on wound care, the DON said the only documentation of training the facility has is the logs. The former QA nurse was also responsible for staff training. No information is provided to agency staff when they come to work for the facility and the do not receive orientation. They get report during rounds from the off-going staff. The facility depends on the agency training their own staff. Usually, before agency staff come, the facility will tell them where manuals are. The facility utilizes both licensed nurses and CNAs from the nursing agency weekly.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility failed to ensure each nurse aide had no less than 12 hours of in-service education per year based on their individual performance review, calculated by hire date. The facility identified 68 certified nursing assistants (CNAs) employed at the facility for more than a year. Seven CNAs were sampled and five of the seven did not have the required 12 hours of in-service training. The census was 143. Review of the facility assessment, revised 12/9/19, showed: -Staff training/education and competencies: -All employees participate in a series of competencies upon hire and again quarterly and as needed. Education needs are also identified through performance observation, resident/family concerns and regulation changes; -CNAs are given core in-service to ensure completion of mandatory 12 hours of training in conjunction with facility identified training needs. 1. Review of CNA S's employee file and training log, showed: -Date of hire (DOH) 8/27/17; -Training hours reviewed from 8/2018 through 7/2019 = 0. 2. Review of CNA V's employee file and training log, showed: -DOH 3/30/16; -Training hours reviewed from 3/2019 through 2/2020 = 7. 3. Review of CNA W's employee file and training log, showed: -DOH 11/22/16; -Training hours reviewed from 11/2018 through 10/2019 = 6.5. 4. Review of CNA X's employee file and training log, showed: -DOH 10/18/17; -Training hours reviewed from 10/2018 through 9/2019 = 0 hours. 5. Review of CNA Y's employee file and training log, showed: -DOH 6/25/18; -Training hours reviewed from 6/2018 through 5/2019 = 0 hours. 6. During an interview on 3/16/20 8:29 A.M., the Quality Assurance (QA) nurse said she was also hired as the infection preventionist and the nurse educator, but she has only been at the facility for a couple of weeks and has only been trained in the QA part of her job, as of this point. The former QA nurse left in January. The DON said the only documentation of training the facility has are the logs. The former QA nurse was also responsible for staff training. The QA nurse said she was not sure how training was tracked.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility are stored and labeled in accordance to current acceptable professional standards for two of three observed medication carts and two of three observed nurse treatment carts. The census was 143. 1. Observation on [DATE] at 6:36 A.M., of the second floor treatment cart, showed the following: -A tube of protective ointment cream labeled with a resident's name, the lid opened, and the tube lay directly in the drawer of the cart; -A tube of hydrogel wound cream (ointment used to keep wounds moist and promote healing) with vitamin E, the lid opened and the tube lay directly in the drawer of the cart. No resident name labeled on the tube; -A tube of itch relief cream, opened and lay directly in the drawer of the cart. No resident name labeled on the tube; -A 30 gram tube of Santyl cream (used to treat wounds), opened and lay directly in the drawer of the cart. No resident name labeled on the tube; -A tube of [MEDICATION NAME] propionate (used to treat skin conditions such as [MEDICAL CONDITION]) cream, opened and lay directly in the drawer of the cart. No lid for the tube in the cart. The tube soiled on the outside, no resident name labeled on the tube; -A bottle of eye drops opened, no name or pharmacy label. No resident name labeled on the bottle and no box to identify the medication. 2. Observation on [DATE] at 1:34 P.M., of the third floor medication cart, showed the following: -Outside pharmacy bottle of [MEDICATION NAME] (antibiotic) 100 milligram (mg) with 6 tablets inside, filled on [DATE]; -Outside pharmacy bottle of imatinib 100 mg ([MEDICAL CONDITION] drug), filled on [DATE]. During an interview on [DATE] at 1:53 P.M., Nurse P said these drugs are no longer being used and should be disposed of. 3. Observation on [DATE] at 1:53 P.M., of the third floor nurse treatment cart, showed the following: -A tube of triple antibiotic cream with an expiration date of [DATE]; -A tube of [MEDICATION NAME] (antibiotic cream) with an expiration date of [DATE]. 4. Observation on [DATE] at 3:00 P.M., of the 100 hall medication cart, showed the following: -Two weeks of individually packaged medications for a resident who was discharged to the hospital; -Three unknown loose pills at the bottom of the last drawer; -A sharps container in use, connected to the side of the cart, filled with sharps past the safety full line. 5. During an interview on [DATE] at 3:30 P.M., the Director of Nursing (DON) said she expected all carts to be neat and organized. All medications that have expired and old prescriptions should be discarded and not stored in the cart. If a resident is no longer at the facility, their medication should be returned to pharmacy and not stored in the cart. On [DATE] at 12:09 P.M., the DON said medications should be labeled with the resident's name and have a pharmacy label.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13)
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation and interview, the facility failed to ensure hot foods were at least 120 degrees Fahrenheit (F) when served to residents for one of one test trays sampled on the 100 hall. The census was 143. Observation of the 100 hall meal service on 3/11/20, showed the following: -At 8:30 A.M., during an interview, Nurse A said breakfast trays had not arrived to the hall; -At 8:35 A.M., observation of the main dining room showed five trays covered. During an interview, the Assistant Dietary Supervisor (ADS) said the meal trays were for 101 to 116 hall trays; -At 8:50 A.M., observation showed hall trays delivered to the hall; -At 9:00 A.M., hall trays passed out by staff. A test tray of a hall tray, completed with ADS, showed eggs at 100 degrees F and sausage at 80 degrees F. The sausage was cold to taste. During an interview at that time the ADS said the food should be served at 160 degrees F. During an interview on 3/12/20 at 10:06 A.M., seven of seven residents said there is too much of the same types of food and food can often be cold for most meals. During an interview on 3/16/20 at 9:59 A.M., the Dietary Manager said the food should be served at 165 degrees F. The hall was short staffed and the trays were not delivered in a timely manner.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to keep items labeled and dated in the kitchen storage rooms, to ensure the deep fryer was free of debris, microwaves and cabinets were free of dirt and debris and the vents above the preparation areas were free of dust buildup. This had the potential to affect residents who received food from the facility kitchen. The census was 143. Observation of the kitchen on 3/11/20, showed the following: -At 6:45 A.M., three large containers of dry cereal in the storage room did not have a label or date; -At 6:46 A.M., grease and debris on the top and sides of the deep fryer. The vents above the food preparation area covered with dust; -At 6:50 A.M., the microwave in the kitchenette of the main dining room had dried food and debris on the inside. Three dead bugs in the cabinets next to the microwave in the kitchenette of the main dining room; -At 7:15 A.M., the microwave in the mansion kitchenette had dried food and debris on the inside. Observation of the kitchen on 3/16/20 at 7:20 A.M., showed in the food storage and preparation areas in the kitchen, two large containers of chips and six large containers of bulk cereal did not have a label or a date. There was grease and debris on the top and sides of the deep fryer and the vents were covered with dust above the food preparation area. During an interview on 3/16/20 at 8:30 A.M., the Dietary Manager (DM) said the Dietary Aides (DA) should be cleaning the microwaves and the cooks should be cleaning the deep fryer. He did not realize they were not being done. The stock person should be labeling and dating the bulk items. He did not realize the items were not being labeled and dated. The DA should be cleaning the vents in the kitchen and the maintenance team cleans the vents in the dining room. There is no actual schedule for the cleaning of the vents.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented, for two resident (Residents #56 and #38). The sample was 29. The census was 143. 1. Review of Resident #56's hospital discharge transfer orders for the receiving facility, showed: -discharged to facility on 2/20/20; -Procedure site: Sacral/coccyx (buttocks/tailbone area): Wound vac (medical vacuum device used to apply light suction to pull excess fluid from wounds with drainage) to sacrum. Review of the resident's medical record, showed: -A readmission assessment, dated 2/20/20: admitted from hospital on [DATE] at approximately 5:45 P.M. Skin issues present; -An order dated, 2/21/20 for [MEDICATION NAME] ointment (an enzyme that helps promote healthy tissue growth), apply to affected area topically daily; -An order dated 3/2/20: Change wound vac (medical vacuum device used to apply light suction to pull excess fluid from wounds with drainage) to buttocks on Mondays, Wednesdays and Fridays: -Not documented as applied until 3/4/20; -No order for or documentation of the wound vac prior to 3/2/20. Observation of the resident on 3/11/20 at 6:32 A.M., showed the resident in his/her bed, asleep. The wound vac was attached. During an interview on 3/12/20 at 6:35 P.M., with the Director of Nursing (DON), Administrator and Wound Nurse O, they said the resident had gone to the hospital to have surgical debridement of the wound to the coccyx in February. Wound Nurse O said when the resident returned from the hospital in February, he/she had an order for [REDACTED]. Once the site was ready, the order for the wound vac was entered in the system and the wound vac was applied. He/she did not document any of this. The administrator said any treatment changes, treatments applied and communication with the physician should be documented. 2. Review of Resident #38's electronic physician order [REDACTED]. Review of the resident's March 2020 Medication Administration Record [REDACTED]. Review of the resident's narcotic sign out sheet, showed [MEDICATION NAME] HCL 50 mg administered nine times from 3/3/20 through 3/13/20. During an interview on 3/16/20 at 12:09 P.M., the DON staff should document in the MAR indicated [REDACTED]
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the quality assessment and assurance committee develop and implement appropriate plans of action to correct identified quality deficiencies. The facility received repeated deficiencies for the prior year's annual survey to the current year's annual survey. In addition, the facility failed to implement a performance improvement plan for an identified concern with pressure ulcer (injury to the skin and/or underlying tissue, as a result of pressure or friction) care that resulted in a citation at the isolated actual harm level, which is a higher grid level than the citation received the prior year for the same concern. The census was 143. Review of the facility's Quality Assurance Process Improvement and Compliance policy, last revised 4/30/18, showed: -This organization will implement and maintain an active quality assurance process improvement and compliance (QAPIC) program; -QAPIC efforts will be ongoing, comprehensive and will encompass the full range of services performed by the facility and its departments including but not limited to clinical care, quality of life, resident rights, safety, operations, billing human resources and management practices; -The QAPIC committee has been empowered to: Charter and oversee process improvement teams to accomplish its goals, perform system and process assessments; complete process improvement projects (PIPs) and to establish a structure of responsibility; -Feedback, data systems and monitoring: Monitoring performance through data collection is the foundation of all performance improvement and compliance activities. Data may be obtained from a variety of sources, including but not limited to: -Centers for Medicare and Medicaid services (CMS) Quality Measures; -hospitalization data; -Infection control data; -Survey and regulatory findings; -Nutrition reports; -PIPs: PIPs are conducted to examine and improve care or services in areas that have been identified by the QAIPC committee as areas that need attention or that demonstrate a clear opportunity for improvement. In order to provide a consistent approach to performance improvement, the organization has adopted the FOCUS-PDSA model: -Find a process/system to improve; -Organize a team that knows the process/system; -Clarify current knowledge of the process/system; -Understand the causes of process variation; -Select the process improvement; -Plan the improvement and continue data collection; -Do the improvement, data collection and analysis; -Study the results and lessons learned from the effort; -Act to standardize the improvement and continue to improve the process by reviewing what to do next; -Implementation of PIPs are generally expected to be conducted using teams. Some situation may dictate the use of other methodologies as deemed appropriate for the opportunity for improvement being addressed. 1. Review of form CMS-2567, dated 1/15/19, showed the facility cited the following deficiencies: -F656: Develop/implement Comprehensive Care Plan, cited at the isolated no actual harm with potential for more than minimal harm level; -F657: Care Plan Timing and Revision, cited at the isolated no actual harm with potential for more than minimal harm level; -F677: ADL Care Provided for Dependent Residents, cited at the pattern no actual harm with potential for more than minimal harm level; -F686: Treatment/services to Prevent/Heal Pressure Ulcers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) cited at the isolated no actual harm with potential for more than minimal harm level; -F692: Nutrition/Hydration Status Maintenance, cited at the isolated no actual harm with potential for more than minimal harm level; -F761: Label/Store Drugs and Biologicals, cited at the pattern no actual harm with potential for more than minimal harm level; -F812: Food Procurement, store/prepare/serve-Sanitary, cited at the pattern no actual harm with potential for more than minimal harm level. Review of form CMS-2567, dated 8/9/19, showed F684: Quality of Care, cited at the isolated actual harm level Review of the current CMS-2567, dated 3/16/20, showed: -F656: Develop/implement Comprehensive Care Plan, cited at the pattern no actual harm with potential for more than minimal harm level; -F657: Care Plan Timing and Revision, cited at the isolated no actual harm with potential for more than minimal harm level; -F677: ADL Care Provided for Dependent Residents, cited at the isolated no actual harm with potential for more than minimal harm level; -F684: Quality of Care, cited at the isolated actual harm level; -F686: Treatment/services to Prevent/Heal Pressure Ulcers, cited at the isolated actual harm level; -F692: Nutrition/Hydration Status Maintenance, cited at the pattern no actual harm with potential for more than minimal harm level; -F761: Label/Store Drugs and Biologicals, cited at the pattern no actual harm with potential for more than minimal harm level; -F812: Food Procurement, store/prepare/serve-Sanitary, cited at the widespread no actual harm with potential for more than minimal harm level. 2. Observation, interview and record review during the survey, showed: -The facility failed to ensure residents receive care to prevent pressure ulcers and ensure residents with pressure ulcers received necessary treatment and services to promote healing, for five of seven residents investigated for pressure ulcers (Resident #56, #135, #60, and #143). The facility failed to assess wounds per facility policy and standards of practice and provide treatments as ordered; -Review of Resident #56's medical record, showed the resident had skin issues identified on 11/11/19. No treatment order for the identified area obtained until 11/27/19, at which time the area was identified as acquired stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed). The facility failed to assess and monitor the wound per facility policy and failed to consistently provide treatments as ordered. On 2/3/20 the wound worsened to a stage IV (full thickness tissue loss with exposed bone, tendon or muscle). The resident had a change in condition and was sent to the hospital on [DATE] with a [DIAGNOSES REDACTED]. The resident required surgical wound debridement (surgical removal of dead tissue); -Review of Resident #135's medical record, showed on 10/25/29 the resident had a left ischium (lower buttocks area) stage III pressure ulcer and a medial coccyx (tailbone area) stage IV pressure ulcer. On 10/26/19, the resident had an area to the upper middle back, later staged as a stage III pressure ulcer by the wound clinic. The facility failed to assess and monitor the wound per facility policy. Observation during the survey, showed staff failed to apply the treatment per acceptable standards of practice and/or as ordered; -Review of Resident #60's medical record, showed a right ischial stage IV pressure ulcer, a coccyx stage IV pressure ulcer, a medial foot stage III pressure ulcer, a left ischial stage III pressure ulcer, a left lower leg stage II pressure ulcer and a left thigh stage III pressure ulcer. Observation during the survey, showed staff failed to apply the treatment per acceptable standards of practice and/or as ordered and failed to treat all area; -Review of Resident #143's medical record, showed the resident admitted on [DATE] with an unstageable pressure ulcer to the buttocks. The facility failed to assess and monitor the wound per facility policy. 3. During an interview on 3/12/20 at 6:35 P.M., the Administrator and Director of Nursing (DON) said the medical director, DON, Assistant DON, administrator, Minimum Data Set (MDS) coordinators, medical records department, social service, dietary and any other department needed regularly attend the quality assurance and performance improvement (QAPI) meetings. The Quality Assurance (QA) nurse is also the infection preventionist and she attends routinely as well. The last meeting was in March, the week prior to the start of the annual survey. Issues with pressure ulcers and wounds had been identified as an area of concern. 4. During an interview on 3/16/20 at 8:29 A.M., the DON said it was probably a month and a half ago that pressure ulcers were identified as a concern. The QAPI team discussed the issue on 3/13/20, and are going to assign the Assistant DONs to do the wounds. The PIP will start this week. The DON will be auditing the wounds. The PIP is all in the works, and not started yet.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement procedures for the provision of infection prevention and control utilizing current standards of practice for three of four residents observed during wound care (Resident #135, #60 and #38). In addition, the facility failed to ensure employee purified protein derivative (PPD) test (a test that helps diagnose (TB) [MEDICAL CONDITION]) results were documented completely for seven of 10 sampled employees. The sample was 29. The census was 143. Review of the facility's Skin Ulcer-Wound policy, dated 8/15/18, showed: -All caregivers are responsible for preventing, caring for and providing treatment for [REDACTED]. Review of the facility's Infection Control Program, dated 8/2017, showed: -The infection control preventionist (ICP) is a registered or licensed practical nurse who has received formal training in the prevention and control of infections; -The facility will maintain an infection control program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Review of Resident #135's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/12/20, showed: -Cognitively intact; -Total dependence for bed mobility, dressing and personal hygiene; -[DIAGNOSES REDACTED]./ruptured blister); -Two, stage III pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed); -One stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle); -One unstageable pressure ulcer (depth unable to be determined due to coverage of the wound bed); -Total number of venous and arterial ulcers, one; -Surgical wound care not indicated. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: Chronic pressure ulcers present on admission due to limited mobility. Open areas to Coccyx/sacral (tailbone/buttocks area), medial back, both gluteal (buttocks) fold, right lateral (side) leg distal and open areas to left and right hip, left lateral foot: -Goal: Pressure ulcers/other wounds will show signs of healing and remain free from infection; -Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED]., and Fridays; -An order dated 2/7/20: Cleanse area to coccyx with wound cleanser, pat dry, apply [MEDICATION NAME], ABD and secure with tape, every day shift Mondays, Wednesdays, and Fridays; -An order dated 3/2/20: Cleanse area to right distal lower leg with wound cleanser, pat dry, apply calcium alginate, ABD pad, wrap with Kling (gauze wrap) and secure with tape, every day shift Mondays, Wednesdays, and Fridays; -An order dated 3/2/20: Cleanse area to left anterior (front) ankle with wound cleanser, pat dry, apply collagen powder and dry dress daily; -An order dated 3/2/20: Cleanse area to mid abdomen with wound cleanser, pat dry, apply collagen powder and dry dressing daily. -No order for a right medial back wound treatment. Observation on 3/13/20 at 9:18 A.M., showed Nurse A provided wound care for the resident. He/she entered the room with the treatment cart and placed it against the wall near the foot of the resident's bed. He/she created a clean area on the cart with a paper barrier between the cart and treatment supplies. The barrier covered approximately half of the top of the treatment cart. Nurse A washed his/her hands and applied gloves. The resident lay in bed, dressed in a hospital gown, opened to the back. A chuck pad (disposable pad) lay on top of a turn sheet (a sheet that is folded to provide support to the weight bearing parts of the body, used to assist in repositioning). The turn sheet placed under the resident and on top of a low air loss mattress that appeared dirty with dry skin flakes and a brown substance. The chuck pad and turn sheet under the resident from approximately 4 inches from shoulders to just below buttocks. Certified Nursing Assistant (CNA) M assisted the nurse to turn the resident on his/her left side by using the turning sheet. The resident did not have treatments or bandages over his/her back, ischium, or coccyx wounds. As the resident was turned, a foul wound odor permeated the room. The turn sheet and chuck pad appeared soiled with large black/brown stains, brown substance, bloody wound discharge and a substance that appeared to be fresh and old bowel feces. Nurse A returned to the treatment cart and removed a spray bottle of wound cleanser from the top of the cart. He/she returned to the resident's bed side, sprayed all of the resident's wound areas on the resident's back, coccyx and ischium and placed the wound cleaner back on cart. With same gloved hands, he/she obtained a clean piece of calcium alginate and placed it in the right medial back wound and then placed a piece of gauze 4 by 4 on top. He/she failed to sanitize his/her hands and change gloves after cleansing the wounds and before applying a clean treatment. Nurse A returned to the treatment cart with the same gloved hands, grabbed two precut pieces of [MEDICATION NAME] from the top of the cart and placed it on the middle back wound. He/she opened the drawer of the treatment cart, that had not been sanitized prior to the dressing changes, with same gloved hands, removed a single packet of skin prep (protective barrier wipe), and closed the cart drawer. Nurse A failed to sanitize his/her hands and apply new gloves. He/she returned to the resident and opened the skin prep. He/she placed the trash created from opening the skin prep on the resident's bed and then applied the skin prep on the wound edges. He/she then picked up the trash from off the bed and placed it in the trash can. He/she removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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** - Some	(continued... from page 15) his/her gloves and without sanitizing his/her hands, opened the treatment cart drawer and pulled out an ABD pad. He/she applied new gloves without sanitizing his/her hands, returned to the resident and opened the ABD pad. He/she placed the ABD pad over both back wounds. He/she returned to the treatment cart with the same gloved hands and opened cart drawer. He/she retrieved a yellow handled scissors from the drawer and without sanitizing the scissors, cut a piece of adhesive gauze tape. With the same gloved hands, Nurse A returned to the resident and secured the ABD pad with tape. He/she removed one of his/her gloves, reached into his/her shirt pocket and removed a marker. He/she initialed and dated tape on resident's back treatment. He/she then removed his/her other glove and washed his/her hands for the first time since starting the treatments. He/she returned to the treatment cart and looked at the resident's wound orders in computer. He/she used the mouse and keyboard on cart that had not been sanitized. At this time the resident verbalizes pain in his/her back, CNA M asked the nurse if the resident could be turned to his/her back to help relieve his/her pain. Nurse A said yes. The CNA assisted the resident to roll onto his/her back any lay, with no barrier or bandage on his/her coccyx and ischium wounds, on the soiled chuck pad, turn sheet and mattress. The nurse finished the computer review, applied new gloves without sanitizing his/her hands after touching the computer, and stood at the foot of the bed. He/she removed a bandage from the resident's left foot, removed his/her gloves and placed them into the trashcan. He/she washed his/her hands and puts on new gloves. He/she opened cart drawer with his/her gloved hands, looked inside, and closed drawer. The nurse walked behind the privacy curtain and returned with the wound cleanser bottle. With the same gloved hands, he/she sprayed the wound cleanser onto the resident's left foot and then placed wound cleanser bottle back on to the top of the treatment cart. With same gloved hands, picked up the yellow handed scissors and cut a piece of calcium alginate and tape. He/she placed the calcium alginate and a piece of gauze over left foot wound, and secured it with tape. He/she removed one glove, reached into his/her shirt pocket, pulled out a marker, initialed and dated the tape over the wound, and placed the marker back into his/her pocket. He/she removed the other glove and without sanitizing his/her hands, placed on new gloves. He/she pulled the resident's hospital gown down, past his/her stomach and removed the old dressing from the resident's abdomen area. With the same gloved hands, he/she grabs the same wound cleanser bottle and sprayed the wound on the resident's stomach, that appeared red with slight drainage and beefy red wound base. He/she applied new gloves without sanitizing his/her hands, cut tape with the yellow handed scissors, and pick up a piece of calcium alginate with the same gloved hands. He/she applied the calcium alginate directly to the wound bed, covered it with gauze and secured it with tape. He/she removed a glove, reached into his/her pocket, pulled out a marker, initialed and dated the tape over wound. The nurse then picked up bandage wrapper trash from the mattress and sheet and placed it in the trash can. With the same gloved hands, opened the cart drawer, looked inside, reached in his/her shirt pocket and removed a pair of bandage scissors. He/she pulled out a single use alcohol wipe from the top of the cart, opened package and cleansed the scissors. He/she placed the scissors on the clean barrier on the cart. He/she placed new gloves on without sanitizing his/her hands. He/she used the bandage scissors and cut the old dressing off the resident's right leg, from ankle to knee. With the same gloved hands, removed another alcohol pad from the cart drawer and wipes down the bandage scissors. He/she placed the scissors next to the computer keyboard. Nurse A and CNA M grabbed the soiled turn sheet and turned the resident back onto his/her left side. The nurse returned to the treatment cart, opened the drawer and threw a hand towel from the cart onto the bed. He/she closed the cart drawer, returned to the resident, and placed the hand towel on top of the resident's urine collection bag, which lay on the mattress. The nurse collected the old bandages from off the resident's right leg and revealing a large open wound from knee to ankle, with bloody drainage and a beefy red wound base. He/she placed the old dressing in the trash can. Without sanitizing his/her hands; the nurse applied new gloves, grabbed the same wound cleanser from the cart, and sprayed it down the leg wound, from knee to ankle. He/she then applied square 4x4 gauze pads to the right leg wound, one by one, starting at the knee and working towards the ankle until the wound was covered by 10 gauze pieces. With the same gloved hands, the nurse removed the gauze pads he/she had just applied. He/she placed the gauze and gloves in the trash, applied new gloves without sanitizing his/her hands, picked up several pieces of [MEDICATION NAME] from the clean area on the cart and the yellow handed scissors and moves towards the resident's back side. He/she placed the yellow handled scissors on the resident's soiled chuck pad. Nurse A failed to re-clean the coccyx wound, potentially contaminated with feces. While holding all pieces of the [MEDICATION NAME], the nurse placed a few pieces of the [MEDICATION NAME] into the open left leg wound. With the same gloved hands, he/she returned to the coccyx area and placed a large piece of [MEDICATION NAME] shaped like a half moon, into the resident's coccyx wound and packed it under the wound edges. He/she returned to the right leg wound, and with the same gloved hands, placed a few more pieces of precut [MEDICATION NAME] into the open leg wound. He/she returned again to the coccyx wound with the same gloved hands, removed the piece of [MEDICATION NAME] that had been placed on the coccyx wound, and repositioned it. Without sanitizing his/her hands or changing gloves, Nurse A held up a separate piece of [MEDICATION NAME] to the coccyx wound, picked up the yellow handled scissors off of the soiled bed and cut the [MEDICATION NAME]. He/she returned the scissors to the bed and took the cut piece of [MEDICATION NAME] and packed it under the wound edges of the coccyx wound. Nurse A then removed both the cut piece and half-moon shaped piece of [MEDICATION NAME] from the coccyx wound, repositioned the pieces again and placed them back into the wound. Then, with same gloved hands, returned to the resident's left leg and placed the remaining cut pieces of [MEDICATION NAME] into the open leg wound, one by one, till it reached the resident's ankle. He/she collected the trash and placed it into the trash can. Nurse A changed his/her gloves without sanitizing his/her hands and took an ABD pad from the treatment cart. He/she placed the ABD pad on the resident's coccyx wound, returned to the cart, opened the cart drawer, pulled out a large precut piece of adhesive gauze tape and secured the dressing onto the coccyx. He/she removed one glove, reached into his/her shirt pocket, pulled out a marker, and initialed and dated the tape over wound. Nurse A applied new gloves, without sanitizing his/her hands, removed a package of collagen powder (used to promote healing) and an applicator, opened the package and applied the collagen powder to ischium wound with the applicator. Nurse did not re-clean the ischium wound, potentially contaminated with feces. Nurse A then placed gauze on the area and secured with precut tape. He/she removed a glove, reached into his/her shirt pocket, pulled out a marker, and initialed and dated the tape over wound. Collected the trash and placed it in the trash can and removed his/her gloves. He/she removed an ABD pad from the top of the treatment cart, tossed it onto the resident's bed, and pulled a large piece of precut adhesive bandage tape out of the cart. He/she applied new gloves without sanitizing his/her hands, took the adhesive tape to the resident, opened the ABD pad, places the ABD pad on top of the completed dressings on residents back, and secured with another large piece of adhesive tape. He/she removed a glove, reached into his/her shirt pocket, pulled out a marker, and initialed and dated the tape over the wound. The nurse collected the bandage trash, threw it in the trashcan and removed his/he gloves. Without sanitizing his/her hands, he/she tossed four ABD pads in and several packages of rolled gauze onto the resident's soiled bed, near left leg wound. He/she applied new gloves without sanitizing his/her hands. At the bed side, the nurse picked up and opened the ABD pads and placed them on the resident's right leg wound, on top of the [MEDICATION NAME]. He/she opened the rolled gauze, held up the resident's right leg at the ankle with his/her left hand, and rolled the gauze around the leg (starting at ankle and working up towards the knee). The nurse would wrap the gauze around the leg, allow it to drop on the bed and rolled the gauze under the leg, over the soiled hand towel (now soiled with bloody wound drainage) before picking it up from the other side and repeating the process until the leg was wrapped. Nurse A reached into his/her shirt pocket, pulled out bandage scissors, took an alcohol pad from the cart and cleansed the scissors. He/she then removed his/her gloves and washed his/her hands, returned to the cart, applied new gloves, took the scissors and cut the tape. He/she used the tape to secure the rolled gauze on resident's left leg. Nurse A announced he/she was then completed with the resident's treatments. During an interview 3/13/20 at 10:13 A.M., CNA M said the chuck pad was visibly soiled with wound drainage and dirt from resident. During an interview 3/13/20 at 10:13 A.M., Nurse A said all dressings were removed earlier when the resident was cleaned up from a large bowel movement. He/she had no way to measure the wounds and does not know the sizes. The wound nurse normally does the treatments and measurements. The resident's wounds are very time consuming. During an interview on 3/16/20 at 12:09 P.M., the Director of Nursing (DON), administrator and nurse practitioner said if the wound bed becomes contaminated after the dressing was removed and site cleaned, it should be re-cleaned. 2. Review of Resident #60's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Total dependence for bed mobility, dressing and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 7/9/18, showed: -Focus: Has open areas throughout his/her body. Remains at risk for further decline and/or new open areas as he/she remains dependent on staff for bed mobility, transfers and incontinent care: -Goal: Will show signs and symptoms of healing without infection; -Interventions: Pressure relieving mattress, pressure relieving cushion to protect the skin while up in chair. Monitor/document location, size and treatment of [REDACTED]. Review of the resident's medical record, reviewed on 3/11/20, showed: -An order dated 2/29/20, cleanse area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265699	A. BUILDING _____ B. WING _____	03/16/2020

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

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** - Some	(continued... from page 16) to coccyx with wound cleanser, pat dry, apply Santyl (used to remove dead tissue from the wound bed) nickel thick, apply calcium alginate over the Santyl, cover with ADB pads, secure with tape daily; -An order dated 2/29/20, cleanse area to left ischium with wound cleanser, pat dry, and apply Santyl nickel thick. Apply calcium alginate over Santyl, cover with ABD pads and secure with tape daily; -An order dated 2/29/20, cleanse area to right ischium with wound cleanser, pat dry, apply Santyl nickel thick, apply calcium alginate over Santyl, cover with ABD pads and secure with tape daily; -An order dated 2/29/20, cleanse area to right medial foot with wound cleanser, pat dry, protect peri-wound (skin surrounding wound bed) with skin protectant, apply Santyl nickel thick, apply dry dressing and secure with tape; -An order dated 2/29/20, use skin prep to left back, and do not wash skin around wound. Apply dry dressing and secure with tape every day shift; -An order dated 3/2/20, cleanse area to left lower lateral leg with cleanser, pat dry, apply Santyl nickel thick, cover with ABD pads and secure with tape daily: -No order for treatment to a left outer thigh wound. Review of Drugs.com, showed Santyl: Apply this medication only to the affected skin wound. Try not to get any ointment on the healthy skin around the wound. Observation on 3/10/20 at 10:09 A.M., showed Wound Nurse Q cleansed the top of the treatment cart with bleach and placed down a plastic wrap barrier, sanitized his/her hands with alcohol gel and placed gloves on. He/she obtained an ABD pad x 3, removed scissors directly from the treatment cart and without cleansing the scissors, cut an ABD pad into multiple pieces. He/she placed the scissors on the clean barrier of the cart. He/she precut tape with the same scissors and placed them directly on the treatment cart, off to the side of the clean barrier. He/she entered the resident's room, washed his/her hands and placed gloves on. The Nurse repositioned the resident and applied wound treatments using the dressings cut with the potentially soiled scissors. When applying the treatment to the right medial foot, the nurse obtained a partially used tube of Santyl from the treatment cart, labeled with a different resident's name, and used it on the resident. During an interview on 3/16/20 at 12:09 P.M., with the DON, Administrator and nurse practitioner, they said physician order [REDACTED]. 3. Review of Resident #38's annual MDS, dated [DATE], showed: -Extensive assistance required for bed mobility, toilet use, and personal hygiene; -Other problems: moisture associated skin damage (MASD); -[DIAGNOSES REDACTED]. Observation on 3/13/20 at 8:46 A.M., showed the staffing coordinator provided wound care for the resident. He/she cleaned the treatment cart with bleach and set up a clean area, washed his/her hands with soap and water and applied gloves.The scissors were cleaned with bleach wipes. The staffing coordinator removed the dressing from the coccyx, changed his/her gloves but did not sanitize his/her hands. He/she cleansed the wound with wound cleanser, changed his/her gloves but did not sanitize his/her hands. He/she applied Santyl with an applicator, changed his/her gloves but did not sanitize his/her hands. He/she cut a piece of calcium alginate, packed it into the wound with his/her gloved hand and changed his/her gloves but did not sanitize his/her hands. He/she placed gauze over the site, covered it with an ABD pad and secured it with tape. He/she remove his/her gloves, labeled the dressing and sanitized his/her hands. 4. During an interview on 3/12/20 at 6:35 P.M., with the DON, administrator and Wound Nurse O, they said hands should be sanitized when going from clean to dirty. Supplies should be placed on a clean barrier and clean supplies should be used. 5. Review of the facility's Physical Examinations and Health Requirements policy, dated 6/2017, showed: -This policy will provide the health requirements which apply to employee and volunteers at the time of hire and annually thereafter; -A licensed nurse will conduct the first step of a two-step TB skin test. The test must be read within 48 to 72 hours after the administration. Failure of the employee to return for the reading will delay his/her date of hire until the testing is completed. A second test must be administered seven to 21 days after the first test was given. Review of employee files, showed: -Registered Nurse C date of hire 8/7/19: First step PPD administered 8/7/19 (after start of employment), read as negative. The date read not indicated. Second step PPD administered 8/21/19, read as negative. The date read not indicated; -Activity Aid D date of hire 4/11/19: First step PPD administered 4/9/19, read as negative. The date read not indicated. Second step PPD administered 4/20/19, read as negative. The date read not indicated; -Assistant Director of Nursing E date of hire 2/6/20: First step PPD administered 2/6/20, read as negative. The date read not indicated. Second step PPD administered 2/20/20, read as negative. The date read not indicated; -Certified Medication Technician F date of hire 6/25/19: First step PPD administered 6/20/19, read as negative. The date read not indicated. Employment terminated before the second step PPD was due; -Certified Nursing Assistant G date of hire 1/8/20: First step PPD administered 1/6/20, read as negative. The date read not indicated. Employment terminated before the second step PPD was due; -Cook H date of hire 9/26/19: First step PPD administered 9/24/19, read as negative. The date read not indicated. Second step PPD administered 10/28/19, read as negative. The date read not indicated; -Laundry Aide K date of hire 2/21/20: First step PPD administered 2/28/20, read as negative. The date read not indicated. Employment terminated before the second step PPD was due. During an interview on 3/16/20 at 7:57 A.M., the Human Resource Director said the date the PPD is read should be documented to ensure it was read within the required timeframe. The first PPD should be completed prior to employment.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on interview and record review, the facility failed to implement a training program to provide training to agency staff tasked with the responsibility to care for residents to include abuse, neglect, exploitation, misappropriation of resident property, dementia management and resident abuse prevention. The census was 143. Review of the State Operations Manual, showed staff includes for the purposes of the training guidance, all facility staff, (direct and indirect care and auxiliary functions) contractors, and volunteers. Review of the facility assessment, revised 12/9/19, showed: -Staff: -Registered Nurses (RN); -Licensed Practical Nurses (LPN); -Direct care staff; -Nurse educator; -(Agency staff not indicated as staff utilized); -Staff training/education and competencies: -All employees participate in a series of competencies upon hire and again quarterly and as needed. Education needs are also identified through performance observation, resident/family concerns and regulation changes; -Abuse, neglect and exploitation: Training that at a minimum educates staff on 1) activities that constitute abuse, neglect, exploitation and misappropriation of resident property; 2) Procedures for reporting incidents of abuse, neglect, exploitation or the misappropriation of resident property; 3) Care/management for persons with dementia and resident abuse prevention. During an interview on 3/16/20 at 8:29 A.M., the Quality Assurance (QA) nurse said she was also hired as the infection preventionist and the nurse educator, but she has only been at the facility for a couple of weeks and has only been trained in the QA part of her job, as of this point. The DON said there is no information provided to agency staff when they come to work for the facility and they do not receive orientation. They get report during rounds from the off-going staff. The facility depends on the agency training their own staff. Agency staff are not trained on the facility abuse and neglect policy. The facility utilizes both licensed nurses and CNAs from the nursing agency weekly.