STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265236	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving neglect were reported immediately, but not later than two hours after the allegation is made, to the State Survey Agency for one resident (Resident #1) after the facility was made aware staff started cardiopulmonary resuscitation (CPR) and stopped before Emergency Medical Services (EMS) arrived. The sample was 3. The census was 71. Review of the facility's Abuse, Neglect and Exploitation Policy, revised 6/24, showed: -Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property; -Definitions: Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; -Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: -Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; -Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions; -Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Avenir at Mark Twain		STREET ADDRESS, CITY, STATE, ZIP CODE 11988 Mark Twain Lane Bridgeton, MO 63044	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Identification of Abuse, Neglect and Exploitation: The facility shall have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services; -Reporting/Response: The facility will have written procedures that include: -Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: -Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or; -Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of the facility's Medical Emergency Response policy, revised [DATE], showed: -Policy: It is the policy of this facility to respond to medical emergencies for residents, staff and visitors; -Policy Explanation and Compliance Guidelines: - 1. The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance; -2. CPR will be initiated unless: -a. There is a DNR (Do Not Resuscitate) order in place. -b. There are obvious signs of clinical death (rigor mortis (stiffening of the joints and muscles of a body a few hours after death), dependent lividity (the pooling of blood in the lower parts of the body after death. This causes the skin to appear discolored, usually in a shade of purple), decapitation (head removed from the body), transection (horizontal cross-section that divides the body into two parts), or decomposition (gradual process that begins at death and continues until the body is reduced to a skeleton)); -c. Initiating CPR could cause injury or peril (being in danger of injury) to the rescuer; -3. A nurse will: -a. Assess the situation and determine the severity of the emergency; -b. Stay with the resident; -c. Designate a staff member to announce emergency code, if necessary, notify the physician and call 911 as needed; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4. A Code will be announced, if necessary; -5. All available staff will respond to the emergency accordingly; -6. A nurse will bring the Emergency Cart to the code site, ensure accurate documentation of the event and delegate any other duties or tasks needed; -7. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and: -a. In accordance with the resident's advance directives, or; -b. In absence of advance directives or a Do Not Resuscitate order, and; -c. If the resident does not show obvious signs of clinical death; -8. The Charge Nurse or designee will ensure emergency medications and equipment are inventoried and restocked after the event; -9. The emergency carts and equipment shall be checked daily; -10. The facility will ensure that CPR certified staff are always available; -11. Current certified staff must maintain CPR-Certification for Healthcare Providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills. Online certification is not acceptable; -12. This facility will not implement a No CPR policy. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Severe cognitive impairment; -Lower extremity impairment on one side; -Diagnosis included chronic obstructive pulmonary disease (COPD), emphysema (a chronic lung disease that damages the lungs, making it difficult to breathe), dependence on supplemental oxygen, and high blood pressure. Review of the resident's most recent care plan, showed: -Focus: Advanced directive care; -Goal: Advanced directive will be honored through the end of review period; -Interventions: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Call 911 immediately; -Code status: Full code; -Initiate CPR immediately; -Notify family immediately; -Notify physician immediately; -Review advanced directives quarterly and with any change in condition. Resident to be asked about any desired changes to current advanced directives or whether they wish to execute any. Review of the resident's physician orders, showed an order as a full code (in the event of no pulse, initiation of CPR and summoning 911), dated [DATE]. Review of the resident's progress notes, dated [DATE] at 8:50 A.M., showed Licensed Practical Nurse (LPN A) went into the resident's room to pass early morning medication. After calling out the resident's name without response, LPN A proceeded to apply tactile queue (uses physical touch) as well as higher calling sound but found the resident was not responding. The resident was cold to touch. The nurse contacted another nurse, LPN B, in the building who responded promptly. Both nurses attempted resuscitation per protocol to no avail. LPN A and LPN B concluded the resident had no heartbeat, zero oxygenation, and no further resuscitation could revive the resident. LPN A called the resident's family and physician to notify them what happened. The family member was not available on phone, the physician was called via exchange message was left that there was an emergency news and requested a call back. While waiting for the physician to call back, the family called back and gave the name of the funeral home to collect the body. After learning the patient had passed, LPN A called 911 to assess. Administration was notified early after the incidence, and they assisted in making contacts. During an interview on [DATE] at 12:46 P.M., the Administrator said he received a call from the Assistant Fire Chief (AFC) on [DATE] around 1:00 P.M. in the afternoon. AFC stated that when they arrived, nobody was doing CPR on the resident. The Administrator said once the nurses started CPR, they should not have stopped until EMS arrived and took over. At 3:15 P.M., the Administrator said the reason he did not report the incident was because the AFC said he was going to report it to the hotline. During an interview on [DATE] at 10:28 A.M., the Administrator said any abuse, neglect or exploitation should be reported to state. When CPR was stopped prior to EMS arriving, it should have been reported for neglect within two hours of the incident. The Administrator expected staff to be knowledgeable of and follow the facility policies. The Administrator expected physician orders to be followed. MO00247107

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three residents (Residents #3, #1, and #5) received care in accordance with acceptable standards of practice when staff failed to complete progress notes when a resident had a fall (Residents #3 and #5), was sent to the hospital, and returned from the hospital (Resident #3). The facility failed to complete post fall follow up for 72 hours that included, progress notes per shift (Residents #3, #1 and #5), vital signs per shift (Resident #3), and neurological checks (neuro check - pulse rate, respiration rate, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength) (Resident #1) in accordance with facility policies. Additionally, the facility failed to update the care plan with interventions for each fall (Resident #1), and to follow interventions previously listed in the care plan (Resident #3). The facility also failed to document notifications to the physician (Residents #3 and #5) and residents' family in the progress notes when the resident had a fall (Residents #3 and #1), and failed to document notifications when a resident was sent to the hospital and when the resident returned from the hospital (Resident #3). The sample was 3. The census was 71. Review of the facility's Fall Prevention Program Policy, revised 1/25, showed: -Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; -Definitions: -A "fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere; -A near miss which is also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so; -Policy Explanation and Compliance Guidelines: -1. The facility utilizes a standardized risk assessment for determining a resident's fall risk; -a. The risk assessment categorizes residents according to low, moderate, or high risk; -b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment; -2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk; -3. The interdisciplinary team (IDT) will indicate on the resident's plan of care fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions; -5. Low/Moderate Risk Protocols: -a. Implement universal environmental interventions that decrease the risk of resident falling, examples to include, but not limited to: -i. A clear pathway to the bathroom and bedroom doors; -ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed; -iii. Call light and frequently used items are within reach; -iv. Adequate lighting; -v. Wheelchairs and assistive devices are in good repair; -b. Implement routine rounding schedule; -c. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance; -d. Encourage residents to wear shoes or slippers with non-slip soles when ambulating; -e. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating; -f. Monitor vital signs in accordance with facility policy; -g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes; -6. High Risk Protocols: -The resident will be provided with appropriate individualized interventions the following list is intended as examples for guidance and is not all inclusive; -a. The resident will be placed on the facility's Fall Prevention Program; -i. Indicate fall risk on care plan; -ii. Place Fall Prevention Indicator (such as star, color coded sticker) on the name plate to resident's room; -iii. Place Fall Prevention Indicator on resident's wheelchair; -b. Implement interventions from Low/Moderate Risk Protocols; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. -d. Provide additional interventions as directed by the resident's assessment, including but not limited to: -i. Assistive devices; -ii. Increased frequency of rounds; -iii. Sitter, if indicated; -iv. Medication regimen review; -v. Low bed; -vi. Alternate call system access; -vii. Scheduled ambulation or toileting assistance; -viii. Family/caregiver or resident education; -ix. Therapy services referral; -7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program; -8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care; -a. Interventions will be monitored for effectiveness; -b. The plan of care will be revised as needed; -9. When any resident experiences a fall, the facility will: -a. Assess the resident; -b. Complete a post-fall assessment; -c. Complete an incident report; -d. Notify physician and family; -e. Review the resident's care plan and update as indicated; -f. Document all assessments and actions; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-g. Obtain witness statements in the case of injury. Review of the facility's Falls Clinical Protocol Policy, revised 1/25, showed: -Assessment and Recognition: -1. The physician will help identify individuals with a history of falls and risk factors for falling; -a. Staff will ask the resident and the caregiver or family about a history of falling; -b. The facility will document in the medical record a history of one or more recent falls (for example, within 90 days); -c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause; -2. In addition, the nurse shall assess and document/report the following: -a. Vital signs; -b. Recent injury, especially fracture or head injury; -c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; -d. Change in cognition or level of consciousness; -e. Neurological (neuro) status; -f. Pain; -g. Frequency and number of falls since last physician visit; -h. Precipitating factors, details on how fall occurred; -i. All current medications, especially those associated with dizziness or lethargy; and; -j. All active diagnoses; -3. The staff and practitioner will review each resident's risk factors for falling and document in the medical record; -a. Examples of risk factors for falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy (a condition where the nerves outside of the brain and spinal cord (peripheral nerves) become damaged, leading to symptoms like numbness, tingling, pain, or weakness, usually in the hands and feet), gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension (low blood pressure), and medical conditions affecting the central nervous system; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-b. After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur; -4. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness or hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis (bones become brittle and fragile) or increased risk of bleeding in someone taking an anticoagulant (used to prevent and treat blood clots, also called blood thinner); -a. Falls often have medical causes; they are not just a nursing issue; -5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc; -6. Falls should be categorized as: -a. Those that occur while trying to rise from a sitting or lying to an upright position; -b. Those that occur while upright and attempting to ambulate; and; -c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor; -7. Falls should also be identified as witnessed or unwitnessed events; -Cause Identification: -1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall; -a. Often, multiple factors contribute to a falling problem; -2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. -a. After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling; -b. Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of foiling; -3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Treatment/Management; -1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling; -a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing); -2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance); -Monitoring and Follow-Up; -1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma. have been ruled out or resolved; -a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall; -2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling; -a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls; -b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented; -3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause; -4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions; -5. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes. Review of the facility's Notification of Changes Policy, revised 3/3/22, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's medical provider; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification; -Circumstances requiring notification include: -1. Accidents; -a. Resulting in injury; -b. Potential to require medical provider intervention; -2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status; -This may include: -a. Life-threatening conditions, or; -b. Clinical complications; -3. Circumstances that require a need to alter treatment. This may include: -a. New treatment; -b. Discontinuation of current treatment due to: -i. Adverse consequences; -ii. Acute condition; -iii. Exacerbation of a chronic condition; -4. A transfer or discharge of the resident from the facility; -Additional considerations: -1. Competent individuals: -a. The facility must still contact the resident's medical provider and notify resident's representative, if known; -b. A family that wishes to be informed would designate a member to receive calls; -c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's face sheet, showed the resident had an emergency contact listed and two next of kin (NOK) listed. Review of the resident's hospital visit, dated 11/30/24, showed: -Clinical impressions: fall initial encounter, left buttocks pain, neck pain; -4:59 A.M.: Arrived; -5:42 P.M.: X-ray to pelvis with bilateral (both sides) hip; -6:40 P.M.: Computed tomography (CT, a noninvasive medical imaging procedure that uses x-rays to create cross-sectional images of the body) head without contrast (performed without an injected dye); 6:41 P.M.: CT cervical (top section of the spine) spine without contrast; -9:09 P.M.: Discharge, condition stable; -Medication changes: None. Review of the resident's progress notes, showed: -11/30/24, no note regarding the resident's fall on 11/30/24; -No progress note regarding of notification of fall on 11/30/24 to the physician or the emergency contact/NOK; -No progress note regarding resident being sent out to hospital on [DATE] for evaluation or treatment after fall; -No progress note regarding of notification of resident being sent out to hospital on [DATE] after fall to the physician or the emergency contact/NOK. Review of the resident's fall risk data collection, dated 12/1/24, showed low risk with a score of 8. Review of the resident's care plan, during the survey, showed: -Focus: The resident has actual/potential for falls, 11/30/24 fall due to unavoidable environmental hazards; -Goal: The resident will be free of falls through the review date; -Interventions: -Call Don't Fall sign, date initiated 8/22/24; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avenir at Mark Twain		STREET ADDRESS, CITY, STATE, ZIP CODE 11988 Mark Twain Lane Bridgeton, MO 63044	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed, date initiated 8/22/24; -IDT Review of fall dated: 11/30/24 maintenance to conduct inspection for all facility toilets, date initiated 12/2/24. Observation on 1/13/25 at 11:00 A.M., showed no Call Don't Fall sign in the resident's room. Review of the resident's progress notes, showed: -No progress note regarding resident returning from hospital on [DATE] or notifications to physician or the emergency contact/NOK; -12/1/24, no incident follow up note for night shift (7:00 A.M. to 7:00 P.M.); -12/2/24, no incident follow up note day shift or night shift (7:00 P.M. to 7:00 A.M.); -12/3/24, no incident follow up note day shift or night shift. Review of the resident's vital signs, showed: -No oxygen saturation (Sp02, measures amount of oxygen in the blood, normal SpO2 is between 90 and 100 percent (%)) documented for 11/30/24, 12/1/24, 12/2/24, 12/3/24; -No temperature, (T, normal range, 98.6 degrees Fahrenheit (F)) documented for 11/30/24, 12/1/24, 12/2/24, 12/3/24; -No respiratory rate (RR, breaths per minute, normal range, 12-18) documented for 11/30/24, 12/1/24, 12/2/24, 12/3/24. (The facility did not monitor/document the resident's vital signs for 72 hours post fall.) 2. Review of Resident #1's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Lower extremity impairment on one side; -Dependent with oral hygiene, toileting, bathing, dressing, and personal hygiene; -Dependent with rolling, sitting to lying, lying to sitting, and transfers; -Always incontinent of urine; -Frequently incontinent of bowel; -Number of falls since admission or prior assessment, whichever is more recent: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No injury: One; -Injury: None; -Major Injury: None; -Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema (a chronic lung disease that damages the lungs, making it difficult to breathe), dependence on supplemental oxygen, and high blood pressure. Review of the resident's face sheet, showed the resident had an emergency contact listed. Review of the resident's fall risk data collection, dated 11/27/24, showed low risk with a score of 7. Review of the resident's care plan, during the survey, showed: -Focus: Resident has actual/potential for falls: -4/23/24, reaching for something on table and fell out of bed; -8/28/24, resident fell out of bed; -11/27/24, blank; -Goal: Resident will be free of falls through the review date; -Interventions: -Be sure the call light is within reach and encourage the resident to use it for assistance as needed, date initiated 8/4/23; -Educate the resident about calling for assistance prior to cares and what to do if a fall occurs, date initiated 8/4/23; -Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: moving and grooving, initiated 8/4/23; -Ensure resident is wearing appropriate footwear nonskid socks or shoes when ambulating or mobilizing in wheelchair, date initiated 8/4/23; -No interventions listed for fall on 11/27/24. Review of the resident's neurological checklist, dated 11/27/24, showed: -Eye Responses: A. Eyelid movement: -4 = Opens eyes spontaneously and purposely; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3 = Opens eyes only in response to speech; -2 = Opens eyes in response to pain; -1 = Does not open eyes when painfully stimulated; -U = Untestable; -11/27/24 at 3:45 A.M., blank, no eye response documented. Review of the resident's progress notes, showed: -No note showing the resident's emergency contact notified of fall on 11/27/24; -No incident follow up note on 11/28/24 day shift. 3. Review of Resident #5's annual MDS, dated [DATE], showed: -Cognitively intact; -Independent rolling, lying to sitting, sit to stand, transfers, and eating; -Partial assistance with bathing; -Supervision for dressing and personal hygiene; -Always continent of bowel and bladder; -Number of falls since admission or prior assessment, whichever is more recent: -No injury: Two or more; -Injury, None; -Major injury, None; -Diagnoses included high blood pressure, dementia, seizure disorder, and respiratory failure. Review of the resident's face sheet, showed the resident had no emergency contact listed. Review of the resident's fall risk data collection, dated 12/10/24, showed high risk with a score of 24. Review of the resident's care plan, showed: -Focus: The resident is at risk for falls and has a history of falls; -7/17/24, fell while getting out of bed; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/10/24, resident fell out of bed tripped over blankets; -Goal: The resident will be free of falls through the review date; -Interventions: -10/14/24 therapy provided resident reacher and educated to utilize, date initiated 10/14/24; -Encouraged the resident to participate in activities that promote exercise, physical activity for strengthening an improved mobility such as: (specify), date initiated 5/17/24; -Ensure personal items are within reach, date initiated 5/17/24; -Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair, date initiated 5/17/24; -IDT review of fall dated: -Short term interventions placed: -7/7/23, blank; -9/15/23, reposition bed and floor mat placed; -12/27/23, social services to declutter; -7/17/24, resident reminded to use call light for needs; -12/10/24, resident educated to keep feet from wrap in blankets when transferring self; -Provide reacher/grabber device, date initiated 5/17/24. Review of the resident's progress notes, showed: -12/10/24, no note regarding the resident's fall on 12/10/24; -No progress note regarding of notification of fall on 12/10/24 to the physician; -12/11/24, no incident follow up note day shift or night shift; -12/12/24, no incident follow up note day shift or night shift; -12/23/24, no incident follow up note day shift or night shift. Observation on 1/13/25 at 11:00 A.M., showed no fall prevention indicator

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate basic life support, including cardiopulmonary resuscitation (CPR, a lifesaving technique that's used in emergencies in which someone's breathing or heartbeat has stopped) for one (Resident #1) of three sampled residents, who was found by staff without a pulse. Staff started CPR on a resident with full code orders but stopped before Emergency Medical Services (EMS) arrived. The Certified Nurse Aides (CNAs) on duty said they did not know how to determine code status. EMS was not notified timely, the resident was discovered without pulse at 5:10 A.M. and EMS was not contacted until 6:14 A.M. The resident expired. Additionally, the facility failed to provide CPR qualified staff for 14, full eight hour shifts between [DATE] through [DATE]. The Staffing Coordinator (SC) did not know he/she was responsible to ensure one CPR certified staff person was available on each shift. Fifty-four residents were listed as full code residents. The census was 71. The Administrator was notified on [DATE] at 12:45 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's Medical Emergency Response policy, revised [DATE], showed: -Policy: It is the policy of this facility to respond to medical emergencies for residents, staff and visitors; -Policy Explanation and Compliance Guidelines: -1. The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance; -2. CPR will be initiated unless: -a. There is a DNR order in place. -b. There are obvious signs of clinical death (rigor mortis (stiffening of the joints and muscles of a body a few hours after death), dependent lividity (the pooling of blood in the lower parts of the body after death. This causes the skin to appear discolored, usually in a shade of purple), decapitation (head removed from the body), transection (horizontal cross-section that divides the body into two parts), or decomposition (gradual process that begins at death and continues until the body is reduced to a skeleton)); -c. Initiating CPR could cause injury or peril (being in danger of injury) to the rescuer; -3. A nurse will: -a. Assess the situation and determine the severity of the emergency; -b. Stay with the resident; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-c. Designate a staff member to announce emergency code, if necessary, notify the physician and call 911 as needed; -4. A Code will be announced, if necessary; -5. All available staff will respond to the emergency accordingly; -6. A nurse will bring the Emergency Cart to the code site, ensure accurate documentation of the event and delegate any other duties or tasks needed; -7. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and: -a. In accordance with the resident's advance directives, or; -b. In absence of advance directives or a Do Not Resuscitate order, and; -c. If the resident does not show obvious signs of clinical death; -8. The Charge Nurse or designee will ensure emergency medications and equipment are inventoried and restocked after the event; -9. The emergency carts and equipment shall be checked daily; -10. The facility will ensure that CPR certified staff are always available; -11. Current certified staff must maintain CPR-Certification for Healthcare Providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills. Online certification is not acceptable; -12. This facility will not implement a No CPR policy. Review of the facility's CPR policy, revised [DATE], showed: -Policy: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR); -Policy Explanation and Compliance Guidelines: -1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR; -2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: -a. In accordance with the resident's advance directives, or; -b. In the absence of advance directives or a Do Not Resuscitate order; and; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition); -3. CPR certified staff will be available at all times; -4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable. 1. Review of Resident #1's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung), emphysema (a chronic lung disease that damages the lungs, making it difficult to breathe), dependence on supplemental oxygen and high blood pressure. Review of the resident's current care plan, showed: -Focus: Advanced directive care; -Goal: Advanced directive will be honored through the end of review period; -Interventions: -Call 911 immediately; -Code status: Full code; -Initiate CPR immediately; -Notify family immediately; -Notify physician immediately; -Review advanced directives quarterly and with any change in condition. Resident to be asked about any desired changes to current advanced directives or whether they wish to execute any. During an interview on [DATE] at 2:11 P.M., the Social Worker (SW) said the resident was alert and oriented. He/She wanted to be a full code (in the event of no pulse, initiation of CPR and summoning 911) and told the SW to bring (him/her) back. They had a clear conversation, and this was maybe in October, 2024. It is the resident's right to choose to have everything done. Review of the resident's physician orders, dated [DATE], showed a full code order. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's progress notes, dated [DATE] at 8:50 A.M., showed, Licensed Practical Nurse (LPN A) went into the resident's room to pass early morning medication. After calling out the resident's name without response, LPN A proceeded to apply tactile queue (uses physical touch) as well as higher calling sound but found the resident was not responding. The resident was cold to touch. The nurse contacted another nurse (LPN B) in the building who responded promptly. Both nurses attempted resuscitation per protocol to no avail. LPN A and LPN B concluded with no heartbeat and zero oxygenation further resuscitation could not revive the resident. LPN A called the resident's family and physician to notify them what happened without any signs/symptoms of sudden death. The family member was not available on phone, the physician was called via exchange, message was left that there was emergency news and requested a call back. While waiting for the physician to call back the family called back and gave the name of the funeral home to collect the body. After learning the patient had passed, LPN A called 911 to assess. Administration was notified early after the incidence, and they assisted in making contacts. Review of the 911 phone call placed on [DATE] at 6:14 A.M., showed: -911 Operator: Tell me exactly what happened; -SC: They found a full code resident passed away and 911; -911 Operator: OK, so are you guys doing CPR or?; -SC: Yes, they are doing CPR in there, they was yes; -911 Operator: Ok alright, and I just have to ask he/she is not awake is that correct? -SC: No; -911 Operator: And he/she is not breathing is that correct?; -SC: No, no (he/she) is not; -911 Operator: Ok, do you guys need any further assistance? We are sending the ambulance. Do you need CPR instructions or anything like that?; -SC: No. Review of the EMS report, dated [DATE], showed: -Call type: Cardiac arrest/death; -Disposition: Patient dead at scene no resuscitation attempted; -Dispatch notified: 6:14 A.M.; -Unit dispatched: 6:15 A.M.; -Enroute: 6:17 A.M.; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At scene: 6:21 A.M.; -At patient: 6:22 A.M.; -Depart: 6:34 A.M.; -Narrative: Upon arrival resident was found unresponsive, no CPR in progress, and resident lying supine (lying face up) in bed. Staff stated they had last seen the resident awake and breathing at approximately 2:00 A.M., when giving the resident his/her night medication. Staff came back into the room at approximately 5:10 A.M., to find the resident unresponsive and not breathing. LPN A preceded to state the resident was a full code, they did 10 minutes of manual CPR, no automated external defibrillator used (AED, device designed to analyze the heart rhythm and deliver an electric shock). After the 10 minutes they stopped with compressions stating, there was no signs of life so we stopped. Staff then left the room waiting to call EMS at 6:14 A.M. 4 lead electrocardiogram (EKG, four electrodes to record the heart's electrical activity) was placed showing asystole (heart not beating), extremities and jaw were rigor (stiffening of the joints and muscles of a body after death). Review of the Fire Department's After-Action Report, dated [DATE], showed: -Alarm: 6:15 A.M.; -Arrival: 6:19 A.M.; -Remarks: Responded for report of cardiac arrest, CPR in progress. First to arrive on scene and make patient contact. No CPR was being performed upon arrival at the patient and two workers appeared to be cleaning the patient's body and bedding space. A nurse of the facility was present in the patient's room. The nurse stated that when he/she came into the room this morning at 5:10 A.M. to administer the patient's morning medications the patient was found unresponsive and not breathing. He/She then went to get another nurse and began CPR. Upon arrival in the room, the nurse stated, we have given up, stating the patient had no response to CPR and he/she felt cold. The nurse stated the patient was a full code and that he/she was last seen alive at 2:00 A.M. Performed an initial assessment. Patient was unresponsive, pulseless, not breathing, skin tone very pale, and pupils were fixed and dilated to the extent the patient's iris was almost entirely covered by the size of pupils. Applied a 4-lead EKG showing asystole in lead 2 which was confirmed in lead 3. Another emergency service ambulance arrived on scene and assumed the lead role in patient care. The patient was pronounced deceased on the scene and was not transported. The police department was on the scene and conducting an investigation of the incident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:27 A.M., LPN A said early in the morning on [DATE], he/she went into the resident's room to give him/her medication. LPN A said when he/she called out the resident's name, the resident didn't respond. LPN A said he/she called the resident's name out loud several times and received no response. LPN A checked on the resident because the resident normally responded when spoken to. LPN A said he/she knew the resident was a full code so he/she started doing CPR for approximately 10 minutes. LPN A did CPR on the resident in bed. When asked if a back board was placed behind the resident, LPN A then said he/she got the crash cart and placed the back board behind the resident while he/she was in bed before starting CPR. LPN A said the resident was on continuous oxygen at two liters and LPN A turned the concentrator up to the highest level, at five liters on the nasal cannula. After doing 10 minutes of CPR, LPN A said he/she verbally called to LPN B who came immediately. LPN A and LPN B both performed CPR on the resident until approximately 5:30 A.M. When LPN A and LPN B found no response to the CPR, they stopped performing CPR. LPN A said he/she called out for CNA C and CNA D and they came into the room. LPN B left and went back to his/her nurse's station because they had given up on resuscitation of the resident. CNA C began chest compressions on the resident and CNA D was giving breaths with the ambu bag. LPN A called the family, the physician, and the Assistant Director of Nurses, who instructed LPN A to contact 911. When EMS came in, everyone had given up and staff were not doing CPR. Staff gave up because the body had no life and was cold and kind of stiff. LPN A said the resident's body was not discolored except some blue discoloration to the lips. LPN A said he/she called 911 to let EMS know what happened and that the resident was a full code. LPN A said he/she removed the back board before EMS arrived. LPN A said when a resident is found unresponsive, start CPR immediately if full code, if the resident starts breathing again then LPN A would call 911. LPN A said the reason for the delay in calling 911 was because in this case, a bit of time passed because there were doubts all along if this was going to be positive effect. During an interview on [DATE] at 9:48 A.M., LPN B said around 5:30 A.M. on [DATE], CNA C ran over to his/her nurse's station and was yelling for him/her and said resident in distress. LPN B said he/she grabbed the crash cart and saw CNA C standing at the door of the resident's room. LPN A and CNA D were doing CPR on the resident. LPN A was doing compressions and CNA D was standing over the resident's head. LPN B pushed CNA D out of the way and hooked the ambu bag up. LPN B put the ambu bag over the resident's mouth and hooked it up to the concentrator. LPN B said he/she did not know how many liters the concentrator was set to. LPN B said CNA C and CNA D took over CPR until 911 showed up. LPN B said another resident needed something so LPN B left the room. LPN B did not know when LPN A called 911. LPN B was not in the room when 911 showed up. LPN B said he/she did not see any color difference in the resident's skin or rigor mortis. The resident was cool to the touch. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:59 A.M., CNA D said the last time he/she saw the resident was at 12:00 A.M. on [DATE]. CNA D said CNA C was assigned to the resident because the CNA who would have been assigned to the resident did not show up for the shift. On the morning of [DATE], LPN A called that he/she needed help because the resident was unresponsive around 5:30 A.M. CNA D called for CNA C and they went into the resident's room. The resident was lying on his/her back on the bed. CNA D said CNA C started doing chest compressions while LPN A started making phone calls. CNA D said he/she did not do chest compressions or do any type of rescue breaths. CNA D said he/she was clearing stuff out of the way. CNA D said nobody ever said to move the resident to the floor, CNA D said LPN B came in the room and made the comment that the resident should have been moved to the floor and said CNA C was not doing the compressions hard enough. CNA C stopped doing compressions when EMS came into the building. CNA D said the resident was between cold and warm and was not freezing cold. CNA D said he/she did not remember if the crash cart was in the resident's room. CNA D said an artificial manual breathing unit (ambu) bag was not used when CNA C did compressions. CNA D said he/she was not CPR certified. CNA D did not know how to access a resident's code status. During an interview on [DATE] at 7:15 A.M., CNA D said he/she saw LPN A and LPN B talking in the hallway around 5:00 A.M. LPN A had two carts in the hallway near the resident's room. One cart was the nurse's medication cart, and the other cart was the Certified Medication Technician's (CMT) medication cart. The nurses do not have CMTs on the night shift, so the nurses have to use both carts when passing medication. LPN A was standing next to the medication cart and LPN B was standing on the back side of the medication cart. CNA D did not see LPN B in the resident's room. Around 5:30 A.M. LPN A was standing outside the resident's doorway and called out for that he/she needed assistance. CNA D called out for CNA C and both went to the resident's room. LPN A started making phone calls and was stepping in and out of the resident's room. CNA C started doing chest compressions on the resident in the bed and CNA D moved the pillows that were propped around the resident and grabbed the bed controller and moved the bed up because it was in a low position. CNA D did not remember if there was a back board behind the resident. During an interview on [DATE] at 5:38 A.M., CNA C said he/she was not assigned to the resident the morning of [DATE]. CNA C said he/she did not see the resident that night, [DATE] or the morning of [DATE] until he/she overheard LPN A say the resident passed away while standing at the nurse's station making phone calls. CNA C said he/she went into the resident's room and CNA D followed. CNA C started doing chest compressions because nobody was doing anything on the resident. CNA C said someone said he/she was not doing chest compressions hard enough. CNA C did chest compressions for 15 to 20 minutes and stopped because LPN A said stop, and asked why he/she was doing CPR. LPN A said the resident was gone so CNA C stopped doing compressions. CNA C said when he/she was doing chest compressions, nobody was giving breaths to the resident. CNA C said it was around 30 minutes after he/she stopped doing compressions before EMS arrived. When EMS arrived, he/she left the room. CNA C said the resident did not have any discoloration to his/her skin that looked like mottling (discoloration on the skin that can appear red, purple, blue, or brown). CNA C did not know if the resident was a full code or a DNR and CNA C did not know how to access a resident's code status. CNA C said he/she was not CPR certified. CNA C said he/she did not see LPN A or LPN B do CPR on the resident. CNA C said there was no backboard under the resident or in the resident's room. CNA C said the crash cart was not in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Avenir at Mark Twain		STREET ADDRESS, CITY, STATE, ZIP CODE 11988 Mark Twain Lane Bridgeton, MO 63044	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:19 A.M., the Staffing Coordinator (SC) said he arrived at the facility around 6:15 A.M. on [DATE]. SC said when he arrived, LPN A, LPN B, CNA C and CNA D were in the resident's room. SC said he thought LPN B was doing CPR, but he was not sure. The SC asked LPN A if he/she called 911 and LPN A said he/she was getting ready to call and SC said he needed to call. SC told LPN A he/she needed to call 911 from the nurse's station. SC said the person on the phone could not understand LPN A, so he got on the phone and spoke with 911. During an interview on [DATE] at 9:00 A.M., Emergency Medical Technician (EMT) F said he/she was the first on the scene. EMT F said he/she was dispatched to the facility for CPR in progress. When he/she arrived at the resident's room, three staff members were in the room, LPN A and 2 other staff members. EMT F said CPR was not in progress. The two staff members appeared to be rolling the resident around and cleaning the resident. EMT F told LPN A they were dispatched for a CPR in progress. LPN A told EMT F that he/she found the resident unresponsive at 5:10 A.M. LPN A got another nurse, and they started CPR together. LPN A told EMT F they gave up because the resident had no response to CPR and felt cold. During an interview on [DATE] at 9:09 A.M., EMT E said they were the second on scene. When he/she arrived, no CPR was being performed. LPN A told EMT E he/she found the resident unresponsive at 5:10 A. M. LPN A got another nurse, and they started CPR together. LPN A said CPR was administered for 10 minutes and when the resident showed no signs of life, they stopped CPR. EMT E asked LPN A what they did between 5:10 and 6:00 A.M. LPN A began yelling and said he/she did CPR for 10 minutes and the resident showed no signs of life, so they stopped. EMT E asked why they waited to call 911, but could not get an answer from LPN A. EMT E said if LPN A would have called in a reasonable time, even if the resident had signs that he/she had deceased , EMS could have gone through the CPR protocol and the life saving measures. However, with the amount of time that passed before 911 was called, EMS was unable to do the life saving measures. During an interview on [DATE] at 11:23 A.M., the Assistant Fire Chief (AFC) said he spoke to the Administrator on [DATE]. The AFC was concerned that CPR was not in progress when they arrived. He was also concerned regarding the large time lapse in calling 911 after the resident was found unresponsive. The AFC said once the staff started CPR, it should have been continued until EMS arrived. Once CPR is started, it cannot be stopped until someone more qualified arrives to take over or pronounce the resident. During interview on [DATE] at 12:46 P.M., the Administrator said he received a call from the AFC on Thursday [DATE] around 1:00 P.M. in the afternoon. AFC stated when they arrived, nobody was doing CPR on the resident. The Administrator said once the nurses started CPR, they should not have stopped until EMS arrived and took over. On [DATE] at 10:28 A.M., the Administrator said he expected physician orders to be followed. During an interview on [DATE] at 2:27 P.M., the resident's Primary Care Physician (PCP) said the nurse should start CPR immediately with a full code patient and have someone call 911 immediately. Anyone can call 911. Compressions should continue until EMS arrives. LPNs need to follow the supervision of EMS and not pronounce death, and they should continue CPR until EMS arrives and takes over care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:22 A.M., the Medical Director (MD) said the purpose of CPR is to resuscitate the patient. The patient code status wishes should be followed. If a patient is found unresponsive, verify code status if full code, 911 should be called immediately and CPR should be initiated immediately. CPR should be continued until EMS arrives and takes over CPR. 2. Review of the facility's staffing sheets from [DATE] through [DATE], showed: -14 out of the 30 days the facility did not have a CPR certified staff member on the night shift (11:00 P.M. - 7:00 A.M.): -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift; -[DATE]: No CPR certified staff member on night shift. During an interview on [DATE] at 9:57 A.M., the SC said he did not know which staff members were CPR certified. He thought all the nurses were CPR certified. During an interview on [DATE] at 10:12 A.M., Human Resources (HR) said she does orientation with new employees and asks for CPR cards at that time. HR said the previous Director of Nursing (DON) used to keep the CPR cards and when they didn't have a DON around [DATE], HR started keeping the CPR cards. HR had not given the SC a list showing what staff were CPR certified. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:19 A.M., the SC said he did not know what staff members where CPR certified. He was not aware he was supposed to have one CPR certified staff member on each shift until [DATE], after talking with state. When the SC spoke to the Administrator, he told the SC there needed to be one on each shift. Currently there is nothing on the staffing sheets to identify what staff members are CPR certified. During an interview on [DATE] at 5:20 A.M., LPN G said he/she does not know who is CPR certified and he/she would not have time to ask in an emergency. The resident would be LPN G's top concern at that time. During an interview on [DATE] at 6:45 A.M., LPN H said the facility did not have LPN H's CPR certification at the facility. During an interview on [DATE] at 3:15 P.M., the Administrator said he expected a CPR certified staff member to be on staff at all times. The Administrator said the SC knows that all nurses are CPR certified. He expected the facility to have the current, up-to-date CPR certifications for staff who are CPR certified. Staff would be considered not CPR certified if the facility did not have the staff members current up-to-date CPR certification. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the E level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00247107