

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Bridgeton		STREET ADDRESS, CITY, STATE, ZIP CODE 12145 Bridgeton Square Dr 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394</p> <p>Based on observation, interview, and record review the facility failed to ensure a kitchen exit door was locked and armed after one resident (Resident #1) eloped from the facility through the kitchen door during the early morning hours, and was out of the facility for approximately 30 minutes. The resident was found on the facility's premises, approximately 30 feet from the exit door. The facility census was 74.</p> <p>The facility was notified of past non-compliance on 12/31/24. Facility staff immediately searched for the resident, reported the incident, and began their investigation. The investigation consisted of written statements and interviews. The investigation showed the kitchen door was not locked and armed. Staff were in-serviced on elopement policy, and abuse and neglect. A second alarm was added to the kitchen door. The deficiency was corrected on 12/27/24.</p> <p>Review of the facility's Elopement policy, revised 11/19/24, showed:</p> <ul style="list-style-type: none"> -Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle; -Upon completion of the other interdisciplinary team's admission and readmission assessments, the interdisciplinary team will review any additional unsafe wandering and/or elopement risk indicators and revise the resident's care plan as indicated; -The interdisciplinary team will review and revise the resident's unsafe wandering management care plan, if indicated, upon completion of each comprehensive, significant change and quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) and upon an unsafe wandering or elopement event; -A specific system will be implemented to notify staff that exit doors have been opened in areas accessible to residents and may include but not be limited to: <ul style="list-style-type: none"> -Documented and routine testing of door alarms; -Documented and routine testing of staff's response to alarms; <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitoring practices when door alarms are disabled or during instances of higher traffic such as holidays, special events, or tours;</p> <p>-Monitoring practices for exits that are not visible to staff but readily accessible to residents;</p> <p>-Residents will be assessed for unsafe wandering and elopement indicators upon admission, readmission, change in condition, quarterly and with any unsafe wandering or elopement event utilizing the Elopement Risk Evaluation;</p> <p>-During the admission and readmission process a care plan will be initiated by the admitting nurse on any residents assessed with unsafe wandering or elopement behaviors;</p> <p>-Associates will be provided unsafe wandering and elopement training upon hire, annually and as indicated by the Unsafe Wandering and Elopement Performance Improvement Plans (PIPs);</p> <p>Elopement drills will be conducted at least quarterly.</p> <p>Review of Resident #1 admission MDS, dated [DATE], showed:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnoses included high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), renal failure, diabetes, hyperlipidemia (high lipids in the blood), stroke, dementia, seizure disorder, and malnutrition;</p> <p>-Substantial/maximum assistance required for mobility;</p> <p>-Uses walker and wheelchair;</p> <p>-No physical or verbal behaviors;</p> <p>-Wandering behavior not exhibited.</p> <p>Review of the resident's admission elopement assessment, dated 11/28/24, showed the resident was not an elopement risk.</p> <p>Review of the resident's care plan, updated 12/17/24, showed:</p> <p>-Focus: Resident risk for elopement. Disoriented to place, impaired safety awareness, stroke with cognitive deficits, does understand others and is able to make self-understood;</p> <p>-Goal: The resident's safety will be maintained;</p> <p>-Interventions: Assess for fall risk; Complete elopement risk assessment; Encourage to participate in activities to divert from exiting seeking behavior.</p> <p>Review of the facility's investigation, dated 12/17/24, showed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Approximately 6:44 A.M., Registered Nurse (RN) A contacted the Administrator regarding Resident #1. He/She informed the administrator that Resident #1 had been cared for by his/her aide at approximately 6:20 A.M. He/She performed Activity of Daily Living (ADL) care and got resident dressed for breakfast and assisted him/her to the wheelchair next to his/her bed;</p> <p>-RN A stated approximately 6:30 A.M. he/she noted the resident was not in his/her room so they began to search other residents rooms, and the entire facility staff continued to search. Administrator contacted Director of Nursing (DON) approximately 6:47 A.M. to update on Resident #1. DON phoned Licensed Practical Nurse (LPN) B to search the outside premises. Charge nurse observed the patient adjacent to the building near generator area. LPN B stated no acute distress noted, patient was fully clothed, and current temp of 35 degrees Fahrenheit (F) outdoors on 12/17/24. Vital signs taken and skin assessment completed with no injuries noted at this time. Patient stated he/she was trying to get back home;</p> <p>-Through additional investigation, it was determined that the resident had walked down the hall while the aide and nurses were performing care. Resident #1 entered the dining room area which is closed due to COVID-19 restrictions. He/She then proceeded to enter the exit corridor area by the kitchen where he/she exited the building. He/She was observed roughly 30 feet from the building away from this door near the generator area on the ground;</p> <p>-Approximately 10:35 A.M., upon assessment noted a hematoma (collection of blood under the skin caused by trauma) developing called to physician orders to send patient to hospital for Computed Tomography (CT) scan of the head. Daughter here at bedside. Transferred to for evaluation.</p> <p>Review of the resident's progress notes, showed:</p> <p>-On 12/17/24 at 8:57 A.M., while doing another resident's care, he/she came out, he/she noticed the resident's door was open and his/her door was to be kept closed because of residents' being COVID positive. Resident was last seen at the 6:00 A.M. round in his/her room. He/She went in to look and saw that the resident was not in the room and he/she immediately called for the Certified Nurse Aide (CNA) to begin looking for the resident. He/She thought he/she was in the bathroom but he/she was not. His/herself and the CNA began to search for resident and then the staff on the other hall. The nurse went outside in his/her car to cover the area, along with his/herself and several of the staff. LPN B got out of his/her car and saw something and realized it was the resident on the ground around 20 feet from the building. Rest of the staff was notified, a wheelchair was brought, and resident was assisted after active range of motion was applied. Inside resident was assessed for any bruising, skin tears, etc. none noted at this time. Family made aware. Physician made aware and DON made aware;</p> <p>-At 9:30 A.M., Nurse Practitioner (NP) here today to see resident. A full assessment was completed with normal findings, skin intact, no bruising, no scratches, no bumps, no open areas noted. Resident in room resting at this time. Vital signs within normal limits;</p> <p>-At 10:32 A.M., Writer place call to physician to report that a hematoma has raised on top of forehead. New order to send to emergency room (ER) for CT of head. Writer placed call to ER spoke to staff, gave report of resident, and he/she stated he/she will inform staff and await for his/her arrival.</p> <p>(continued on next page)</p>		

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