STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265345	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Bridgeton	12145 Bridgeton Square Dr 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 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 ensure staff followed their abuse and neglect policy. Resident #4 informed Certified Nursing Assistant (CNA) K that CNA P was mean to him/her and twisted his/her right arm tightly. CNA K failed to notify his/her charge nurse of the accusation because he/she did not believe the resident. Due to CNA K's failure to report the resident's allegation, CNA P remained working until the Administrator was notified and suspended CNA P pending the facility's investigation. Ten residents were sampled. The census was 69. Review of the facility's Abuse and Neglect policy, issued on 1/3/22 and reviewed on 11/19/24, showed: -What: To minimize the threat of abuse and/or neglect, nursing homes must incorporate clear-cut policies and practices that demonstrate a hardline, zero-tolerance approach to resident abuse. Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type by anyone. Residents must not be subjected to abuse by anyone. This includes staff; -Why: The resident has the right to be free from abuse and neglect. The facility must not use verbal, mental, sexual, or physical abuse; -The facility must develop and implement written policies and procedures that: Establish policies and procedures to investigate any such allegations. Review of the facility's Abuse - Protection of Residents policy, issued on 10/4/22 and reviewed on 5/7/25, showed: -Policy: The facility will ensure that all residents are protected from physical and psychosocial harm during and after an investigation; -Procedure: The following methods to ensure the protection of residents during an investigation may include but are not limited to: -1. Responding immediately to protect the alleged victim and integrity of the investigation; -2. Examine the alleged victim for any sign of injury, including physical examination or psychosocial assessment if needed; -3. Immediate notification of the alleged victim's practitioner and the family/responsible party; (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4. Removal of access by the alleged perpetrator to the alleged victim and assurances that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents; -5. Notification of the alleged violation to other agencies or law enforcement authorities; -6. Evaluation of whether the alleged victim feels safe and if he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.; -a. Providing emotional support and counseling to the resident during and after the investigation, as needed; -b. Protection from retaliation; -7. Monitor the alleged victim and other residents at risk, such as conducting unannounced management visits at different times and shifts. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/28/25, showed: -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands, clear comprehension; -Cognitively intact; -Diagnoses of chronic obstructive pulmonary disease (a chronic lung disease) and anxiety. Review of the resident's care plan, located in the electronic healthcare record, showed: -10/19/23: Focus: activity of daily living (ADL) assistance. Goal: Resident wishes to maintain prior level of function. Interventions: Assist with mobility and ADLs as needed. Hoyer (a machine used to transfer residents unable to bear weight) lift for all transfers; -11/8/24: Focus: Resistive to care. Will make false assumptions towards staff and has manipulative perception of healthcare concerns and needs being met. Goal: Will participate in care. Interventions: Allow resident to make decisions about treatment regime to provide a sense of control. Cares in pair, two CNAs when care is being provided. Continued documentation of behaviors. During an interview on 5/29/25 at 10:00 A.M., the resident said a few weeks ago, he/she could not recall the exact date, CNA P was taking care of him/her. CNA P became mean and squeezed his/her right arm so hard it left a bruise which was not visible at the time of the interview. He/She told Licensed Practical Nurse (LPN) A, on the day it happened. LPN A was the only one he/she told and said he/she would take care of it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 10:25 A.M., LPN A said the resident never told him/her anything about CNA P getting mad at him/her and twisting his/her right arm. He/She has not seen any bruises on the resident's right arm. Had the resident told LPN A, and CNA P was in the building, he/she would have gotten the CNA's statement and sent him/her home immediately. He/She would have reported it to the Administrator or Director of Nursing (DON) immediately and started the investigation. During an interview on 5/29/25 at 10:44 A.M., the Administrator said he visits with the resident almost daily. The resident never told him anything about CNA P being mean to him/her and squeezing his/her arm. This was the first time he heard anything about it. He shakes the resident's hand every time after talking to him/her and he/she had not seen any bruising. During an interview on 5/30/25 at 7:22 A.M., CNA K said he/she took care of the resident every night he/she worked. On 5/8/25 or 5/10/25, he/she returned to work after being on vacation. The resident told him/her that CNA P had been mean and squeezed the resident's hand or wrist tightly and left a bruise. The resident did not say exactly when it occurred. The resident showed CNA K his hand/wrist, but CNA K did not see any bruises. Since there were no bruises and he/she had never seen CNA P be mean to anyone, CNA K thought the resident was making it all up. CNA K did not report the resident's allegations to anyone. Looking back now, he/she should have reported the resident's allegations to the charge nurse whether he/she believed the resident or not. Review of CNA K's written statement, dated 5/30/25, showed: One night he/she walked into the resident's room to do personal care. The resident said CNA P was mean and squeezed his/her arm. Don't you see the bruise? He/She told the resident no. The resident had no bruise or discoloration. Review of CNA K's time punches, showed he/she returned to work on the night shift of 5/6/25. He/She also worked on 5/8/25 and 5/9/25. During an interview on 5/30/25 at 9:15 A.M., CNA P denied being mean to the resident or squeezing the resident's arm. He/She had been nothing but nice to the resident, and could not understand why the resident would say something like that. Review of CNA P's time punches, showed he/she worked on the night shift on 5/1/25 through 5/5, 5/7 through 5/9, 5/12 through 5/14, 5/16 through 5/19, 5/21 through 5/23 and 5/26 through 5/28/25. The resident was in the CNA's group to care for on 5/4/25, 5/14, 5/19 and 5/22/25. During an interview on 5/30/25 at 8:00 A.M., the interim DON and Administrator said they expected staff to follow the facility's policies. Whether CNA K believed the resident or not, he/she should have followed the policy and reported the resident's allegation to the charge nurse. MO00254277

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to follow their policy and physician's orders by failing to notify the physician when one resident's blood sugar levels exceeded the physician's ordered parameters. In addition, the facility failed to obtain STAT (now/no delay) lab orders for the resident. The facility identified 22 residents with orders for routine blood sugar checks. Of the six that were sampled one, Resident #13, had blood sugar levels that exceeded the parameters to contact the physician. The census was 73. Review of the facility's Changes in Resident's Condition or Status, issued 11/26/25, and reviewed 9/5/24, showed:-Policy: This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status;-Notification of Changes: A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: -A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in life threatening conditions or clinical complications); -A need to alter treatment significantly (that is, a need to discontinue an existing form or treatment due to adverse consequences, or to commence a new form of treatment).Review of Resident #13's annual Minimum Data Set (MDS,) a federally mandated assessment instrument completed by facility staff dated 4/1/25, showed:-Makes Self Understood: Rarely/never understood;-Ability To Understand Others: Rarely/never understands;-Diagnoses of high blood pressure, diabetes mellitus (low/high blood sugar level), aphasia (a partial or total loss of language skills), stroke and respiratory failure;-Received insulin injections 7 of the last 7 days.Review of the resident's care plan, located in the electronic health record (EHR), showed:-Focus: 6/20/23: Diabetes Mellitus; --Goal: The resident will have no complications related to diabetes; --Interventions/Tasks: Blood sugar checks as ordered. Diet as ordered. Medication as ordered.Review of the resident's physician's order sheet (POS) and 6/1/25 through 6/30/25 medication administration record (MAR) located in the EHR, showed:-Ordered on 4/11/25, and discontinued on 6/29/25: Notify physician for blood sugar less than 60 or greater than 400;-Ordered on 4/11/25, and discontinued on 6/29/25: Monitor blood sugar four times a day at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. -Ordered on 4/11/25, and discontinued on 6/24/25: Lantus insulin (long-acting insulin) 6 units daily at 9:00 P.M.;-Ordered on 4/11/25, and discontinued on 6/5/25: Humalog (fast-acting insulin) 5 units every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.;-Ordered on 6/5/25, and discontinued on 6/29/25: Novolog fast-acting insulin) 5 units every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.;-Ordered on 6/24/25, and discontinued on 6/29/25: Lantus insulin 16 units daily at 9:00 P.M.Review of the resident's MARs, showed:-5/1/25 through 5/31/25: All of the resident's blood sugar levels were within the acceptable parameters;-6/1/25 through 6/21/25: All of the resident's blood sugar levels were within the acceptable parameters;-6/22/25 through 6/30/25, showed the following blood sugar level readings documented:-12:00 A.M.: 6/22 read 410, 6/23 read 439, 6/25 read 402, 6/26 read 406, 6/27 read 425, 6/28 read 466, and 6/29 read 475;-6:00 A.M.: 4/28 read 526;-12:00 P.M.: 4/28 read 444.Review of the resident's progress notes located in the EHR, showed:-No documentation the resident's physician was notified (at the time the blood sugar level was obtained) regarding the blood sugar levels on 6/22, 6/23, 6/26, 6/27, 6/28 (12:00 A.M. and 12:00 P.M.); -6/24/25 at 9:46 A.M.: Call placed to physician and informed him of multiple elevated BS readings (6/22 and 6/23). Orders received to increase Lantus by 10 units every day;-6/28/25 at 7:02 A.M.: Resident sugar level 526. Physician called and awaiting return call.Review of the nurse's report sheets for the resident, showed:-6/25/25: Blood sugar 402. New order: Increase Lantus to 16 units;-6/28/25: 6:10 A.M., Called physician. Obtain STAT CBC (complete blood count), CMP (comprehensive metabolic panel) and urine (obtain sample for urinalysis);-Review of the resident's EHR showed no documentation the facility obtained the STAT CBC, CMP and urinalysis. Review of the resident's progress note, showed:-6/29/25 at 8:34 A.M. (the next note after the 6/28/25 at 7:02 A.M. entry): 12:00 A.M., upon entering resident's room, he/she was noted to be tachypneic (rapid shallow breathing) with eyes closed. Opened eyes to name but drifted back immediately. Vitals obtained: 152/68 (blood pressure (BP) - normal 120/80), 98.8 (temperature (T) - normal 98.7), 121 (pulse (P) - normal 60-100), 86% on room air (oxygen saturation rate (O2 Sat) - normal 95-100). Blood sugar level 475. Insulin administered per orders. Resident is normally resistant to any touch to his/her abdomen, and he/she is not this time. Skin warm and dry. Cough noted: 12:13 A.M.: Call placed to EMS (emergency medical services) and departed to hospital. 12:16 A.M.: Call placed to physician. 7:15 A.M.: Director of Nursing (DON) informed. Review of the resident's SBAR (

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident #7 had fall mats in place and the resident's bed was kept in the lowest possible position when the resident was in bed and unattended by staff, and failed to include the fall mats and low bed as interventions on the resident's care plan. The facility also failed to ensure Resident #9's bed was kept in the lowest position when the resident was in bed and unattended by staff. Four residents were sampled. The census was 69. Review of the facility's Fall Management policy, issued on 6/4/20, and revised on 3/11/25, showed: -Policy: The facility will assess the resident upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls; -Federal Regulations: The facility must ensure that the resident remains as free of accident hazards as is possible. Each resident receives adequate supervision and assistance devices to prevent accidents; -Definitions: Accident - Refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident; -Avoidable Accident - This means that an accident occurred because the facility failed to: -1. Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; -2. Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; -3. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident; -4. Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice; -Fall - Refers to unintentionally coming to rest on the ground, floor, or other lower level. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred; -Risk - Refers to any external factor, facility characteristic or characteristic of an individual resident that influences the likelihood of an accident; -Hazards - Refer to elements of the resident environment that have the potential to cause injury or illness; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. Hazards over which the facility has control are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness; -2. Free of accident hazards as is possible refers to being free of accident hazards over which the facility has control; -Procedure: -1. Residents will be assessed for fall indicators upon admission, readmission, quarterly, change in condition and with any fall utilizing the Fall Risk Assessment; -2. During the admission and readmission process, a care plan will be developed and initiated by the admitting nurse on any residents assessed to be a risk for falls; -3. Upon completion of the other interdisciplinary team's admission and readmission assessments, the interdisciplinary team will review any additional fall risk indicators and revise the resident's care plan as indicated; -4. The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly Minimum Data Set (MDS), upon a fall event and as needed thereafter; -5. Residents and/or family members will receive education on the fall management care plan and will be provided opportunity for feedback; -6. The interventions to reduce the risk of falls should be individualized based on the resident risk factors and fall history; -Identifying Patients' Fall Potential; -1. All patients have fall indicators. Fall indicators are patient specific information that, when alone or combined with other fall indicators, create a potential for a patient to fall; -2. Accurate and thorough assessment of the patient is fundamental in determining indicators for potential falls; -a. Fall indicators may be identified by multiple disciplines, utilizing various assessments, and including but not limited to review of; physician orders, progress notes, environmental factors, caregiver conversations; -b. Patient conditions may vary throughout the day, week, month or other time period and the identification of patient fall indicators is an ongoing, interdisciplinary assessment process. 1. Review of Resident #7's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/25/25, showed: -Hearing: Minimal difficulty; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Adequate vision; -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands - clear comprehension; -Moderately impaired cognition; -Mobility Devices: [NAME] and wheelchair; -Substantial/maximal assistance required for: Roll left and right, lying to sitting on side of bed, sit to stand, chair/bed to - chair transfer, and walk 10 feet; -Diagnoses of heart failure, high blood pressure, diabetes mellitus and stroke; -Did the resident have a fall any time in the last month prior to admission? Yes; -Did the resident have a fall any time in the last 2 to 6 months prior to admission? Yes; -Any falls since admission? No. Review of the resident's care plan, located in the electronic healthcare records (EHR), showed: -5/20/25: Focus: activity of daily living (ADL) assistance and therapy services needed to maintain or attain highest level of function. Goal: Resident wishes to attain prior level of function. Interventions/Tasks: Assist with mobility and ADLs as needed. Therapy services as needed; -5/20/25: Focus: Decline in mobility and strength related to stroke and requires assist with all ADLs and transfer. Goal: Resident will not sustain serious injury requiring hospitalization. Interventions/Tasks: Assist with ADLs as needed. Call light within reach. Complete fall risk assessment. Mechanical lift (a machine used to transfer a resident who can bear partial weight or a machine used to transfer a resident who cannot bear weight). Orient resident to room; -5/27/25: Focus: Resident scored moderate (cognition) on Brief Interview for Mental Status (BIMS, a cognitive assessment completed by facility staff). Goal: Resident will be able to communicate basic needs. Interventions/Tasks: Allow extra time for resident to respond to questions and instructions. Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed; -The care plan did not address the resident's fall history, current fall risk or interventions specifically keeping the bed in the lowest position and fall mats on the floor when unattended. Review of the resident's Fall Risk Assessments located in the EHR, showed: -5/21/25: A score of 18 (a score of 10 or above indicates the resident is at risk of falling); (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/27/25: A score of 17. Review of the resident's progress notes, located in the EHR, showed: -5/21/25 at 12:14 A.M.: Resident arrived via ambulance and transferred to bed; -5/21/25 at 7:09 A.M.: Called to resident's room by Certified Nursing Assistant (CNA). Resident sitting on floor with back against bed. Bed in lowest position. Assisted back to bed with assist of 2. No apparent injuries noted; -5/21/25 at 12:31 P.M.: BIMS score of 12, revealing moderate cognitive impairment; -5/22/25 at 5:58 Alert and oriented x 2 (orientation is documented as one or more of the following: person, place, time, situation) although he/she wanders mentally at times. Weakness noted to left side. Resident is able to turn and reposition in bed with assist of 1. Call light within reach and bed in lowest position; -5/23/25 at 6:27 P.M.: Resident requires assistance to turn and reposition in bed. Call light within reach and bed in lowest position with floor mats on both sides for safety. Continues on observation related to fall on 5/21/25; -5/24/25 at 8:41 A.M.: Resident able to turn and reposition in bed independently. Call light within reach and bed in lowest position with floor mats on both sides for safety; -5/25/25 at 12:36 P.M.: Resident able to make needs known. Resident able to turn and reposition in bed independently. Call light within reach and bed in lowest position with floor mats on both side for safety; -5/27/25 at 5:54 A.M.: Resident able to turn and reposition in bed independently. Call light within reach and bed is in lowest position with floor mats on both sides for safety; -5/27/25 at 6:09 P.M.: Resident is able to turn and reposition in bed independently. Call light within reach and bed in lowest position with floor mats on both sides for safety. Awake at intervals during the night yelling out Jesus and Nurse; -5/27/25 at 9:45 A.M.: Resident observed in his/her room on the floor in front of wheelchair. When asked how he/she got on the floor resident stated he/she was trying to get up; -5/29/25 at 5:16 A.M.: Resident continues on observation related to unwitnessed fall on 5/27/25. Asleep in bed duration of night. Call light within reach and bed in lowest position with floor mats on both sides for safety; -5/29/25 at 10:21 P.M.: Resident continues on observation for unwitnessed fall on 5/27/25. Asleep in bed duration of the night. Call light within reach and bed in lowest position with floor mats on both sides for safety. Observation on 5/28/25, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:55 A.M., the resident lay in bed unattended by staff. Both of the resident's floor mats were leaned up against the wall near the window. The height of the resident's bed was 21 inches () from the floor to the top of the bed. The resident said he/she had fallen twice since his/her admission. He/She was not injured during the falls. One of the falls was from his/her bed. The facility put the fall mats down after his/her fall from the bed. Sometimes the mats are on the floor and sometimes they aren't. He/She does not mind having the fall mats down and the bed in the lowest position when unattended; -At 1:22 P.M., the resident lay in bed sleeping and unattended by staff. The fall mats remained leaning against the wall and the height of the resident's mattress from the floor to the top of mattress was 25. Observation on 5/29/25 from 9:36 A.M. to 9:44 A.M., showed the resident lay in bed with his/her eyes closed and unattended by staff. Both of the floor mats leaned against the wall. The height of the bed was 22 from the floor to the top of the bed. At 9:44 A.M., Licensed Practical Nurse (LPN) R entered the resident's room and said the resident had fallen twice since his/her admission. He/She verified the mats were leaning against the wall and there were no staff in the room attending to the resident. He/She said the floor mats should be on the floor, one on each side of the bed when staff are not in the room taking care of the resident. The bed should be in the lowest position possible. The LPN lowered the resident's bed to the lowest position at that time and the height of the bed was 13 from the floor to the top of the mattress. The resident said he/she did not mind the bed being in the lowest position or having the floor mats on each side of the bed. During an interview on 5/29/25 at 11:45 A.M., with the interim Director of Nurses (DON) and Administrator, the DON said she expected staff to keep the resident's floor mats on the floor next to the bed and the bed in the lowest position any time there are not staff in the room and the resident is in bed. The resident's care plan should identify the use of the fall mats and the bed in the lowest position possible when the resident is not being cared for. She will update the care plan. Review of the resident's updated care plan on 5/29/25, by the interim DON, showed: -Focus: Resident has had an actual fall with poor balance, he/she is at risk for future falls. Goal: The resident will resume usual activities without further incident. Interventions/Tasks: Ensure bed is in lowest position at all times when in bed. Floor mats to bilateral side of bed. Frequently used items within reach. 2. Review of Resident #9's admission face sheet, located in the EHR, showed an admission date of 9/24/25. Review of the resident's progress note, dated 1/5/25 at 9:27 A.M., showed: Resident observed sitting on the floor mat by his/her bedside. Resident was assessed back into bed. Review of the resident's Fall Risk Assessments located in the EHR, showed: -1/5/25 at 10:01 A.M.: A score of 20; -4/5/25: A score of 16. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265345	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Bridgeton	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE], showed: -Makes Self Understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability To Understand Others: Sometimes understands - responds adequately to simple, direct communication only; -Severely impaired cognition; -Mobility Devices: Wheelchair; -Substantial/maximal assistance required for: Sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to - chair transfer; -Diagnoses of high blood pressure and dementia; -Any falls since admission or prior assessment? No. Review of the resident's care plan, located in the EHR, showed: -10/4/24: Focus: ADL assistance and therapy services needed to maintain or attain highest level of function. Goal: Will maintain quality of life. Interventions/Tasks: Assist with mobility and ADLs as needed and 1 person assist with transfers. Resident has dementia and may participate in care with cueing and repeated verbal commands; -1/29/25: Focus: Resident has dementia and scored a BIMS assessment that suggest severe cognitive impairment. Goal: Resident will follow 1 to 2 step instructions. Interventions/Tasks: Allow extra time for resident to respond to questions and instructions. Ask yes/no questions to determine resident's needs; -9/27/24: Focus: At risk for falls. Has had falls prior to admission and is at risk for future fall. Goal: Will not sustain serious injury requiring hospitalization. Interventions/Tasks: Anticipate and meet the resident's needs. Assist with ADLs as needed. Call light within reach. Complete fall risk assessment. Ensure mats at bedside. Ensure that bed is in low position. Observation on 5/28/25, showed: -At 9:26 A.M.,: The resident lay in bed unattended by staff. One mat lay on the floor on each side of the bed. The height of the bed was 25 from the floor to the top of the mattress; -At 1:45 P.M.: The resident lay in bed unattended by staff. One mat lay on the floor on each side of the bed. The height of the bed was 27 from the floor to the top of the mattress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265345	A. Building B. Wing	05/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/29/25 at 8:15 A.M., showed the resident lay in bed unattended, eating breakfast. The height of the bed from the floor to the top of the mattress was 25. CNA F entered the room. He/She said he/she was not sure if the resident had a history of falls or not, but since there were fall mats down, he/she expected the bed to be in the lowest position when staff are not in the room. The CNA lowered the bed to the lowest position and the height of the bed was 13 from the floor to the top of the bed. During an interview on 5/29/25 at 11:45 A.M., the Administrator and interim DON said they expected the resident's bed to be in the lowest position when staff are not in the room attending to the resident. MO00254505 MO00254738