| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265417 | A. Building<br>B. Wing | 09/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sherbrooke Village | 4005 Ripa Avenue<br>Saint Louis, MO 63125 |

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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46967<br><br>Based on interview and record review, the facility failed to immediately report an allegation of injury of unknown origin to the Department of Health of Senior Services (DHSS) within the required two-hour time frame, when Resident #1 wandered onto another unit, wearing only a brief, with a cord tied around his/her waist and a bloodied face. The sample was two. The census was 74.<br><br>Review of the facility's Abuse Prevention policy revised [DATE], showed:<br><br>Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are reported immediately, but not later than two hours after the allegation is made if the events that caused the allegation result in serious bodily injury. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, are reported immediately, but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency).<br><br>Review of Resident #1's medical record, showed:<br><br>-admitted [DATE];<br><br>-No documented diagnoses.<br><br>Review of the resident's progress notes, showed:<br><br>-On [DATE] at 6:40 P.M., the resident arrived from the hospital via stretcher with two emergency medical services (EMS) personnel. He/She was accompanied by his/her family member. His/her native language was Bosnian. His/her family member translated needs for him/her. He/She denied pain. No distress. Skin intact. No active bleeding noted. He/She was alert and oriented times zero. He/She was extremely confused. He/She was able to make needs known. No agitation was noted. Range of motion (ROM) was with in normal limits. He/She refused toileting and a shower. Safety precautions were put in place.<br><br>Review of the resident's admission fall risk evaluation dated [DATE] at 9:18 P.M., showed:<br><br>-Disoriented times three at all times;<br><br>(continued on next page) |



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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No falls in the past three months;<br><br>-Balance problem while standing and walking;<br><br>-Predisposing disease, blank;<br><br>-Fall risk score 4.<br><br>Review of the resident's Nursing Admission Evaluation and Baseline Care plan form dated [DATE] at 9:34 P. M., showed:<br><br>-Communication: Could not communicate with staff and required an interpreter;<br><br>-Exam: Well nourished, alert and confused;<br><br>-No skin issues;<br><br>-No presence of pain;<br><br>-ROM was within limits in all joints;<br><br>-Required partial to moderate assistance with mobility. Walking evaluation not attempted due to medical condition or safety concerns;<br><br>-Assistive device: Wheelchair;<br><br>-No history of falls;<br><br>-Behaviors: Agitated.<br><br>Review of the resident's progress notes, showed:<br><br>-On [DATE] at 4:50 A.M., Licensed Practical Nurse (LPN) B noted he/she was made aware the resident had bruising and blood on his/her face. Upon assessment the resident had blood to bridge of his/her nose and bruising under his/her right eye. The resident could not explain what happened due to a language barrier. LPN B called the resident's physician and left a voicemail. He/She notified the resident's family and on call nurse. He/She cleaned the areas of concern and applied a dressing. At 5:20 A.M. the resident was transported to the hospital.<br><br>Review of the facility's investigation summary date [DATE] (time unknown), showed:<br><br>-The resident was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart beat), paranoia, anxiety, restlessness, agitation, history of falling, closed head injury and dementia with behaviors;<br><br>-Staff noted a change of condition on [DATE] at approximately 4:00 A.M. The resident guarded his/her right arm, had discoloration near right eye and bleeding near the bridge of his/her nose;<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -An investigation was initiated with the following completed immediately;<br><br>-Physician, family, and Director of Nursing (DON) notified;<br><br>-Incident report reviewed;<br><br>-Pain/skin evaluation reviewed;<br><br>-Nurses notes reviewed;<br><br>-Physician orders reviewed;<br><br>-Staff interviewed;<br><br>-Residents interviewed;<br><br>-Staff denied witnessing any incidents/accidents or rough handling during care;<br><br>-Blood spatter noted on floor, near the closet in unoccupied resident room [ROOM NUMBER];<br><br>-Certified medication technician (CMT) A observed the resident walking down the hallway with an unsteady gait, wearing a brief and nonskid sock, with blood on his/her face and hands. He/She could not understand the resident. He/She contacted the nurse;<br><br>-Certified nurse assistant (CNA) C said he/she saw the resident lying in bed at approximately 3:15 A.M. Around 4:00 A.M., he/she went to get the resident and observed him/her with dried blood on his/her face. He/She transferred him/her back to 200 hall. The nurse assessed him/her;<br><br>-LPN B said he/she noted the resident was in bed asleep at 3:00 A.M. He/She received a call from CMT A at 4:00 A.M. informing him/her the resident was on 200 hall with blood on him/her. The resident's face showed some discoloration and he/she guarded his/her right arm. LPN B contacted the physician to request transfer to hospital;<br><br>-It was determined the resident's injuries most likely occurred due to a fall contributed by his/her unsteady gait;<br><br>-No documentation of injury of unknown origin reported to DHSS within two hours or 24 hours.<br><br>During an interview on [DATE] at 9:44 A.M., assisted living (AL) Director of Nursing (DON) said the resident was admitted on [DATE]. He/She fell around 4:00 A.M. on [DATE]. He/She was sent to the hospital. The AL DON was not notified of the fall. The resident's family said it was an assault. When asked how the fall occurred, the AL DON said he had not reviewed the resident's progress notes. A police officer called and said he/she interviewed the resident and he/she was extremely confused. The officer was not going to submit a report. The AL DON was told the incident was being treated as a fall.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 1:00 P.M., CMT A said around 4:00 A.M., he/she saw a resident pushing on the door of the 400 hall. He/She walked towards the resident and asked him/her to come closer. The resident was only wearing a brief, nonskid socks, and had a black, electrical wire wrapped around his/her waist. The resident's face was bloody. The resident had a laceration on his/her forehead and nose, and purple bruising on the right side of his/her face. The resident did not speak English. CMT A called LPN B and notified him/her of the situation. CNA C arrived to the 400 hall with a wheelchair and propelled the resident back to the 200 hall. The resident's injuries were serious. The resident was confused, and his/her gait was unsteady. He/She did not know how the resident sustained the injuries. Registered Nurse (RN) D asked him/her to submit a written statement on [DATE] at 3:50 P.M.<br><br>During an interview on [DATE] at 1:11 P.M., LPN B said he/she received a call from CMT A at 4:10 A.M. CMT A said the resident was standing in the hall with blood on him/her. CNA C brought the resident to the nurse's station on the 200 hall. The resident had a skin tear on his/her nose and discoloration under his/her right eye. LPN B did not notice a laceration on the resident's head. The resident could not raise his/her right arm. The resident did not have any injuries when he/she was admitted to the facility. LPN B did not know how the resident sustained the injuries. He/She assumed the resident fell . The resident was very confused and had an unsteady gait. LPN B reported the incident to RN D at approximately 4:34 A.M. He/She notified the physician and resident's family member. RN D asked him/her to submit a written statement on [DATE] at 3:00 P.M.<br><br>During an interview on [DATE] at 1:19 P.M., CNA C said the resident was assigned to him/her. The resident resided on the 200 hall. The resident was agitated and confused when he/she arrived at the facility. The resident wanted to go home. He/She put the resident to bed at 1:35 A.M. He/She was wearing a hospital gown. CNA C did rounds at 3:00 A.M. and the resident was still asleep. He/She received a call from LPN B stating the resident was on another hall. He/She did not know how the resident got on the other hall. The resident could barely walk. The resident must have gone out the door next to his/her room. He/She went to get the resident from the 400 hall. The resident was seated in a chair. He/She was only wearing a brief, with a black cord wrapped around his/her waist. His/Her face was bruised and bloody. Staff never found the resident's hospital gown. CNA C took the resident to the nurse's station. The resident's injuries looked serious. He/She did not know how the resident sustained his/her injuries. He/She assumed the resident fell . He/She was asked to submit a written statement on [DATE].<br><br>During an interview on [DATE] at 9:00 A.M., RN D said he/she was on call on [DATE]. He/She received a call from LPN B at 4:00 A.M. LPN B said the resident had a fall with some bruising. LPN B did not give specifics about the resident's injuries. RN D told LPN B to call the resident's family and physician and send the resident to the hospital. Staff did not see the resident fall or find him/her on the floor. The nurse found blood in an unoccupied resident room, near a closet. We assumed it was a fall. If we were not certain the resident fell , then it should have been an injury of unknown origin. When there is an injury of unknown origin, staff notify the Administrator and complete a state report. He/She notified the Administrator of the incident on [DATE] at 7:45 A.M. The Administrator said himself and the Regional Nurse would take care of it. The Administrator did not tell him/her to contact DHSS. RN D arrived at the facility on [DATE] at 10:09 A.M. He/She reached out to LPN B and CMT A for an explanation of what happened. He/She did not get a statement from CNA C.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 2:29 P.M., the Administrator said when a resident has an injury of unknown origin, the facility starts the investigation and reports it to the state agency within two hours. They concluded the incident was an unwitnessed fall. The Administrator would not expect staff to report a fall to DHSS. They found blood splatter in room [ROOM NUMBER], near the closet. He talked to the resident's family member on [DATE], and he/she said the resident fell .<br><br>MO00241705<br><br>MO00241708 |