STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265565	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Health and Rehabilitation Center	1300 Broadway Pleasant Hill, MO 64080

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 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** 33409 Based on interview and record review, the facility failed to ascertain the resident's code status before initiating cardiopulmonary resuscitation (CPR, refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased) for one sampled resident (Resident #5) who was a do not resuscitate (DNR) status out of 5 sampled residents. On [DATE], Registered Nurse (RN) A found the resident without spontaneous respirations and pulse and started CPR. The resident was resuscitated after CPR was performed and was taken by Emergency Medical Services (EMS) to the hospital and subsequently died [DATE] after he/she was placed on comfort care. The facility census was 79 residents. The Administrator was notified on [DATE] at 11:25 A.M., of the Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's Cardiopulmonary Resuscitation Policy, dated [DATE], showed: -Code Status (refers to the level of medical interventions a person wishes to have started if their heart or breathing stops). -Original Do Not Resuscitate (DNR) Order (refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest) should be handwritten by a physician and then entered in the order system as these are not allowed to be telephone orders. -A faxed handwritten order by physician is acceptable. The original order should be maintained in the hard copy record in a plastic sleeve. -The DNR order is entered as a specific order type in electronic record as advance directive for quick reference in case of an emergency. Review of the facility's undated Protocol for Emergent care showed: -Call Stat to or Code Blue to location. -Do not leave the resident unattended. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff member should call for assistance. -Make sure enough staff members to assist with the resident and to make all necessary phone notifications and obtain crash cart, emergency equipment. -A staff member should access the electronic record immediately and verify the identification of the resident by electronic photograph and if there is an order for DNR. This order will appear as one of the first orders when sorting by order type. (Note does not indicate has to be a nurse or CMT). -In electric outage a hard copy photograph used for identification and hard copy DNR order on the chart. -The staff member (preferably nurse) that remains with the resident should get the resident prepared for resuscitation pending the determination of whether or not the resident has a current DNR order so that CPR can be immediately started if no DNR found. 1. Review of Resident #5's Admission Face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses of surgical wound, low back pain, paraplegia (an impairment in motor or sensory function of the lower extremities), history of pulmonary embolism (blood clot in lung), and seizures (is a sudden body or limb jerks that can involve the arms, head and neck). Review of the resident's Admission Data Collection, dated [DATE] at 3:50 P.M., showed the resident was oriented to person, time, and situation. Review of the resident's Base Line Care Plan, dated [DATE] at 2:04 P.M., showed the resident was a DNR, wishes no CPR. Review of the resident's Outside the Hospital DNR Order Sheet showed the form had been signed on [DATE] by the resident and his/her physician. Review of the resident's Physician Order Sheet (POS) showed the resident had a physician order dated [DATE] for DNR code status. Review of the resident's Care Plan for Living Will/Do Not Resuscitate status, dated [DATE], showed: -Goal for the resident was end of life wishes to be honored for 90 days (started [DATE]). -Respect the resident decision and assure that he/she may change his/her mind at any time concerning terms of living will/DNR. -Provide comfort measure and provide pain management as needed. -Inform other healthcare providers caring for the resident of his/her living will/DNR status. -Physician will review and uphold the resident's wishes stipulated in the living will. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's facility Nursing Note, dated [DATE] at 2:56 P.M. which was documented by RN B, showed: -Around 11:30 A.M. on [DATE], the resident went unresponsive while in the bath house. -RN B arrived to see resident already lowered to ground from wheelchair and RN A performing CPR. -When RN B arrived at bath house at 11:32 A.M., he/she took command of recording the event. -At 11:34 A.M., the resident had a return of spontaneous circulation (ROSC, is the resumption of sustained perfusion cardiac activity associated with significant respiratory effort after cardiac arrest). -The resident was placed on oxygen (O2) at a rate of 15 liters via a non-rebreather mask, oxygen saturation (O2 stats- measures how much oxygen is carried by the hemoglobin in your blood) were at 95% with O2 in place, and a heart rate of 105. -EMS arrived at 11:39 A.M., the resident was sent to the hospital for evaluation and treatment. -The resident's family member was notified of the event. -Note: There was no documentation the resident was a DNR status. Review of the resident's facility Summary of Events, dated [DATE], showed: -The resident was in the shower/bath house with two Certified Nursing Assistants (CNA) when the resident went unresponsive. -CNA A instructed CNA B to go get the charge nurse. -The nurse arrived at the bath house and a Code Blue (activated if a patient or individual is found unconscious, without a pulse, or not breathing) was called overhead. -The resident was lowered to the ground and the nurse began performing CPR and staff called the emergency phone number (911). -The facility summary timeline of the events: --Approximately at 11:28 A.M. the resident became unresponsive. --At 11:32 A.M., one round of chest compressions with Ambu-bag (refers to a type of device known as a bag valve mask, which is used to provide respiratory support to patients). --At 11:34 A.M., the resident's DNR status found in orders in his/her electronic record. --At 11:34 A.M., the resident chest compressions stopped due to ROSC achieved. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--The resident's O2 sats 66% at room air (the average O2 sats level are from 95 to 100%.) and heart rate of 121 (the normal heart rate between 60 and 100 beats/minute). --At 11:38 A.M., resident placed on oxygen at rate 15 liters per minute via a non-rebreather mask (a special medical device that helps provide resident with oxygen in emergencies) --At 11:39 A.M., O2 sats 95% with oxygen in place and heart rate of 105. --At 11:39 A.M., Emergency Medical Services (EMS) arrived at the facility. Review of the resident's EMS report, dated [DATE] at 11:34 A.M., showed. -EMS received call from the facility related to a resident in cardiac arrest-death. -EMS, fire and rescue arrived at the facility at 11:37 A.M. -At 11:40 A.M., the resident vital signs were taken with findings of heart rate (pulse) of 100 beats per minute, respiratory rate of 11 (an average normal rate of ,d+[DATE] per minute), O2 sats 96% with oxygen in place, the resident had oxygen administered at flow rate of 15 liters per minute, and the resident had improved with use oxygen. --The resident had no eye movement when assessed by EMS staff, no motor response and no verbal/vocal response. -At 11:52 A.M., the resident departed the facility by EMS. --At 11:58 A.M., the resident opened his/her eyes to verbal stimulation, obeys commands appropriate response to stimulation. -At 12:06 P.M., the resident arrived at the hospital. Narrative: dispatched to facility in regard to a cardiac arrest with CPR in progress. -EMS unit in route and updated on the patient, he/she had regained a pulse and now spontaneously breathing. Update no longer breathing, -An update the resident DNR status had been located. -EMS unit arrived on scene. Resident found lying supine on the floor in the shower room. Located off the 500 hallways under the care of facility staff. --Facility staff reports that while attempting to shower the resident, he/she became unresponsive and slumped over. --Facility staff initiated CPR when resident was found with no pulse and no breathing observed. --CPR was being performed by facility staff until the resident's DNR code status was located. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--The resident was unconscious and unresponsive with a Glasgow Coma Scale (GCS, is a system to score or measure how conscious you are at) of 3, he/she had a patent airway with apparent agonal (uneven) respiration at a rate of approximately ,d+[DATE] breaths per minute. --The resident skin pink, warm and moist. The resident pupils equal and reactive to light. -While attempting to contact online medical control for orders to transport determination, the resident began to have normal respiration and began to open his/her eyes and look around the room. -Due to sudden increase in GCS and Level of Consciousness (LOC) transport decision were made for hospital. -The resident was moved to a stretcher and secured in semi-Fowler (head elevated laying down) then moved to the ambulance and secured. Review of the resident's Hospital History and Physical Assessment (H&P), dated [DATE], showed: -The hospital received a copy of the resident's DNR status signed on [DATE]. -Family members were ok with comfort care only for the resident, to include use of a Bilevel Positive Airway Pressure (known as BPAP, or BiPAP, is a machine that helps you breathe) machine. -Had a diagnosis of cardiac arrest (heart attack) which was witnessed while he/she was in shower room at the nursing home. -CPR started by facility staff, even though the resident was a DNR status. Automated External Defibrillator (AED, a portable device that analyzes the heart's rhythm and delivers an electric shock to restore a normal heartbeat in cases of sudden cardiac arrest) was used. -The resident was transferred to Emergency Department (ED) from the care facility. -The resident had purposeful movement, but not yet following staff commands. -The resident had Acute Hypoxic (lack of oxygen to brain) and respiratory failure (a serious condition makes it difficulty to breath on your own). Review of the resident's hospital Physician Discharge Record, dated [DATE], showed: -The resident was admitted to the hospital on [DATE]. -The resident had a witnessed cardiac arrest at his/her skilled facility on [DATE]. He/She had signed Outside the Hospital DNR form, but was resuscitated regardless. He/she arrived at our facility requiring BiPAP. -He/she had a cardiac arrest event, witnessed while he/she was in the shower at nursing home. -CPR was started, though the resident was an DNR. The facility also used an AED. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-While at the hospital, Resident #5 was able to speak for himself/herself and clearly asserted that he/she did not want any further care. -The hospital plan was to transition the resident to hospice care, but he/she passed away prior to this occurring. -On [DATE], the resident passed away at the hospital. During an interview on [DATE] at 11:07 A.M., CNA B said: -On [DATE] at around 11:30 A.M., CNA A was about to shower the resident. -He/she had gone into the shower room to grab supplies for another resident. -CNA A and he/she had noted the resident's head had dropped to his/her chest. -He/she said something to CNA A that there was something wrong with the resident. -CNA A called out the resident's name, with no response. -CNA A then instructed CNA B to go get a nurse and he/she left to notify RN A. -Other nursing staff also arrived at the shower house to assist in the medical emergency. -He/she left the area to attend to another resident after he/she notified the nurse. During interview on [DATE] at 12:27 P.M., RN A said: -He/she was CPR certified. -On the morning of [DATE] the resident was feeling well enough and wanted to take a shower. He/she went to the shower room with CNA A, where the resident then become unresponsive. -RN A was notified by CNA B, and immediately went to assess the resident in the shower room. -The resident was found unresponsive to sternal chest rub and shaking shout. -He/she requested staff members (LPN B and CNA A) to call Code Blue and to obtain the AED and Crash cart (contains the equipment and medications that would be required to treat a patient in the first thirty minutes or so of a medical emergency). -With assist of three other staff members lowered the resident to ground and he/she started performing chest compressions, CPR. -Another nurse (LPN C) went to check the resident's code status and informed RN A and other nursing staff present the resident was a DNR. -He/she stopped performing CPR after the resident had spontaneous breathing and pulse return. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Legally he/she could not stop performing CPR once he/she started CPR. He/she could only stop CPR if the resident became responsive or EMS arrived to take over resident care. -He/she was aware after performing CPR for a resident with a DNR, that he/she was going to be sent home until further investigation. -His/her immediate thought was not about the resident's code status or wishes, only his/her response to an unresponsive resident and the emergency room nurse reaction kicked in and he/she started chest compressions after finding the resident had no breathing and no pulse. -He/she should have checked for the resident's code status before performing CPR. -The residents' code status were located in residents electronic record under POS and could also be found in the resident's medical hard chart, documented on the POS and usually a purple form with the resident's DNR form signed and dated by the physician and resident. During an interview on [DATE] at 11:15 A.M., Licensed Practical Nurse (LPN) A said: -On [DATE] he/she heard the Code Blue and responded to the shower house. -RN A assessed the resident, found he/she was unresponsive, not breathing and had no pulse. -He/she assisted RN A ad LPN B with lowering the resident to the ground. -RN A had already started chest compressions. -RN A was the resident's assigned nurse for that day. -Another nurse (LPN C) entered the shower house and said the resident was DNR, stop CPR. -The resident had started to breathe and had a pulse. -He/she would expect the resident code status be checked prior to initiation of CPR. Review of the facility Witness Statement by LPN B dated [DATE] showed: -At approximately 11:30 A.M. on [DATE], he/she was informed by LPN C the facility had a Code Blue to the shower house on 500 hallway. -As he/she was heading to the shower house, the administrator and LPN C were grabbing the crash cart. -When he/she arrived to the shower house, he/she noted LPN A , Registered Nurse RN A and the CNA A were already on scene and RN A had already started chest compressions. -The nursing staff transferred the resident to the ground. -The Administrator called EMS while RN A continued chest compressions. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she attached the AED pads to the resident's chest. -At around that time I heard LPN C stating the resident was a DNR and looked up to see LPN C showing us the hard chart with the DNR order paper work. -At around the same time the resident started breathing again, we got a set of vital signs, and then EMS arrived. -Paramedics took over the resident's care and transported the resident to the hospital. During an interview on [DATE] at 11:38 A.M., LPN B said: -On [DATE] at around 11:30 A.M. he/she was informed by LPN C of a Code Blue and heard Code Blue shower room. -The Administrator and LPN C grabbed a crash cart and headed toward the shower house by 500 hallway. -When he/she arrived CNA A, RN A, and LPN A were in the shower room and RN A had started chest compressions while the resident was in his/her wheelchair. -He/she and other nursing staff lowered the resident to ground with the use of a mechanical lift. -The Administrator went to call EMS, while RN A continued CPR. -He/she attached the pad for the AED. The resident had oxygen placed and then started using the Ambu bag. -The Assistant Director of Nursing (ADON) was the timekeeper for the event and called out times as needed. -At that time, he/she heard LPN C say the resident was a DNR. -Around this time the resident started breathing again and the nursing staff obtained a set of vital signs as EMS staff arrived and took over the resident's care. -He/she would expect the resident code status to be verified prior to performing CPR. -The resident code status could be found by looking in his/her electronic record and then in the hard chart. -The facility SSD had a binder with all resident DNR forms signed by the physician. Review of the facility Witness Statement by LPN C dated [DATE] showed: -At approximately 11:30 A.M. on [DATE], he/she was standing at the Nursing desk when he/she heard Code Blue to the shower house called overhead. I repeated the page to LPN B. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN B headed to the shower house and LPN C headed to get the crash cart with the Administrator. -Upon reaching the shower house on the 500 hallway, a crash cart was on site. -The 500 hall charge nurse and multiple staff members were already present. -He/she looked into the shower house to see staff lowering the resident to floor and the nurse (RN A) had started chest compressions. -Someone called for oxygen, so I assisted unwrapping tubing and handed the to tubing to another nurse. -He/she then heard someone ask if code status was confirmed. -At that time, he/she sent Certified Medication Technician (CMT) A to grab the resident's hard chart. -Another staff member called EMS while another staff attempted to reach the resident's spouse. -CMT A returned with the resident code status, he/she called out that the resident was a DNR to the rest of nursing staff present. -The resident had then began breathing on his/her own with noted pulse. -CPR was stopped. EMS arrived to facility and transported the resident out of the facility. During an interview on [DATE] at 11:22 A.M., LPN C said: -On [DATE], heard Code Blue overhead. -He/she had grabbed the crash cart heading to the shower house. -Had plenty of nursing staff in the room assisting the resident. -He/she handed the O2 tubing and then sent the CMT to get the resident's medical record. -He/she reviewed the resident's hard chart for a physician order for DNR status, and found the resident's purple DNR order in the chart. -He/she notified nursing staff the resident was a DNR and to stop chest compressions. -RN A stopped CPR when the resident began to breath on his/her own and have a pulse. -EMS arrived about the same time. -He/she left the area to gather transfer paperwork to send with the resident to hospital. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident's DNR status should have been found in his/her electronic medical record under physician orders and could also be found in the resident's hard chart, located in current printed POS. -Located in the hard chart, should be the resident's purple DNR form, signed by the resident and his/her physician. During an interview on [DATE] at 2:03 P.M., the Admission Coordinator said: -He/she had gone to visit the resident at the hospital on [DATE]. -The resident was found on the Intensive Care Unit (ICU) unit at the hospital. -The resident did not have O2 in place during the visit. He/she was alert and talkative at the time the visit. -He/she did not ask the resident about his/her feeling related to CPR being performed. -The resident had been referred to Hospice Care Services and hospital Social Service Worker (SSW) was assisting family with finding care. -He/She received a call about ,d+[DATE] minutes after he/she left the hospital, that the resident had passed away. During an interview on [DATE] at 2:25 P.M., the Hospital SSW said: -He/she was talking with the hospital physician who said the resident came to the hospital after cardiac resuscitation was successful. -The physician and hospital had received the resident current DNR status, and the resident was placed on cardiac care monitoring only. -The hospital Physician reported he/she had talked with the resident and he/she said Why am I here, I should not be here. (Related to his/her wishes of DNR status.) -The resident did not want to return back to the facility, due to the facility initiated CPR not following the resident's end of life wish. During an interview on [DATE] at 11:56 A.M., Hospital Physician B said: -The resident expressed his/her intent of not wanting CPR performed while at the hospital. -The resident came in with the Out of Hospital DNR form. -The resident was admitted to the hospital to provide comfort care only. -He/she was made aware the facility had initiated CPR even though the resident had a code status of DNR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident passed away at the hospital on [DATE]. During an interview on [DATE] at 2:18 P.M., Physician A said: -He/she was the resident's physician. -He/she was made aware of the change of condition and the incident related to not following the resident's wishes for DNR. -It was reported the facility staff could not find the resident DNR status right away and started chest compressions, CPR. -He/she felt it could have been worse, if the facility found out the resident was full code and did not start CPR. -He/she felt the facility should ensure a better system was in place for obtaining or access resident code status. -The resident passed away at the hospital. During an interview on [DATE] at 3:09 A.M., Director of Nursing (DON) said: -He/she would expect the nursing staff to follow facility policy for verifying DNR status by checking the resident's electronic record first for current DNR physician order. -The resident DNR status can also be found in the residents' hard chart under current printed physician order sheet and front of the chart purple form, signed by resident and the resident physician. -He/she would expect the nursing staff to obtain the resident code status before initiation of CPR chest compression. -He/she would expect nursing staff to complete initial assessment of the resident by checking for responsiveness, pulse and breathing, while another nurse would obtain and check code status before initiation of CPR. -RN A was aware of Resident #5's code status. He/she entered the resident's DNR code status physician order into his/her electronic record on [DATE]. -RN A's instincts were to ensure he/she immediately addressed the resident's medical emergency which the resident was without a pulse, not breathing, and was unresponsive. -RN A's thought was the resident not breathing and had no pulse, he/she needed start chest compressions (CPR). During interview on [DATE] at 11:36 A.M., CMT A said: -He/she was not aware if CMTs had access to the resident physician orders to review the resident code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she would have obtained the resident's hard chart for the resident code status and given to the nurse to review. -He/she was not shown how to find the resident code status in physician orders in the electronic records. During an interview on [DATE] at 11:40 A.M., LPN D said: -He/she would assess the resident and have another nurse or CMT find the resident code status. -To find a resident DNR status he/she would go into the electronic charting to find the DNR orders. -He/she not sure if the CMTs had access. After review of the facility electronic records, the CMT was able to access the resident physician orders. During an exit interview on [DATE] at 12:20 P.M., the DON said: -Licensed nursing staff was required to be CPR certified and would be responsible for initiating CPR after nursing staff had checked and verified the resident code status. -CPR should not be initiated until verified the resident end of life wishes or DNR status. -CMTs and nursing staff should have access to check code status in the resident electronic record under physician orders. -CNAs would be instructed to grab the hard chart for the nursing staff to find and verify the resident's code status. -He/she would expect CMTs and nursing staff to have the capability and knowledge to know how to locate the resident code status in the electronic medical record, to find printed copy signed DNR form and the physician order located in the resident medical hard chart. During an interview on [DATE] at 12:30 P.M., the Administrator said: -He/she would expect nursing staff to follow the facility policy and verify the resident code status before initiation of chest compressions or CPR. -The first nurse assessing the resident while the second nurse checked the resident code status. -RN A did not verify the resident code status prior to initiation of CPR. -RN A was not thinking about having to check the resident's code status first. -RN A's first reaction when he/she responded to residents' emergency, was to be assessed, the resident required immediate emergency care and he/she initiated CPR due to the resident was unresponsive, not breathing and had no pulse. He/she was not thinking about checking code status first. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265565	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Health and Rehabilitation Center	1300 Broadway Pleasant Hill, MO 64080

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note: At the time of the 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. The facility put measure in place to ensure the deficient practice with CPR would not recur. 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 D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). Complaint# MO 00233192