

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2024
NAME OF PROVIDER OR SUPPLIER  Atrium Place Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Redman Road Saint Louis, MO 63136	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>32847</p> <p>Based interview and record review, the facility failed to ensure residents were treated with respect and dignity for one resident (Resident #8) who was left exposed in the hall with other residents present when Certified Nursing Assistant (CNA) F refused to get the resident a gown or blanket when he/she got finished in the shower. The census was 92. The sample was 8.</p> <p>The administrator was notified on 5/14/24, of the past non-compliance. Staff were in-serviced on resident rights, the resident's concerns were addressed, and the staff person responsible was terminated. The deficiency was corrected on 5/10/24.</p> <p>Review of the facility's Resident Rights policy, last revised 9/1/22, showed:</p> <ul style="list-style-type: none"> <li>-All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disabilities, socioeconomic status, sex, sexual orientation, or gender identity or expression;</li> <li>-The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents;</li> <li>-The resident has the right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside the facility;</li> <li>-The resident has the right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences;</li> <li>-The resident has a right to personal privacy and confidentiality of his or her personal and medical records: Personal privacy includes accommodations, medical treatments, written and telephone communication, personal care, visits, and meetings of family and resident groups.</li> </ul> <p>Review of Resident #8's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 5/7/24, showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> </ul> <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included anxiety disorder and depression;</p> <p>-Used a wheelchair;</p> <p>-Partial/moderate assistance required for shower/baths</p> <p>-Substantial/maximal assistance required for tub/shower transfers.</p> <p>Review of the facility's preliminary investigation report, showed:</p> <p>-Incident occurred on 5/4/24 during the day shift;</p> <p>-Summary of interview with person(s) reporting the alleged incident: Resident #8 stated that after CNA F assisted him/her with a shower, he/she was made to sit in the hallway butt naked.</p> <p>Review of the facility's finalized investigation report, showed:</p> <p>-Summary of interview with person(s) reporting the alleged incident: Resident #8 stated that after CNA F assisted him/her with a shower, he/she was made to sit in the hallway butt naked;</p> <p>-CNA E came out of a room and witnessed the resident in the hall naked and assisted with getting him/her covered and back to his/her room;</p> <p>-Per a telephone interview, CNA F said he/she did get the resident a gown, but it was still in the shower room because it got wet. Resident was already walking to the wheelchair which was outside the shower room door. Resident was asked to sit down in the wheelchair while the aide went to get a dry gown;</p> <p>-Outcome of the investigation: Upon completion of the investigation, it was concluded that there was a verbal disagreement between CNA F and the resident. CNA F removed him/herself from the situation and another aide continued to provide care. Through the investigation, it was determined as well that CNA F did have the resident sit in a wheelchair unclothed. At this time, the facility has made the decision to terminate employee for poor customer service and discourteous behavior.</p> <p>During an interview on 5/13/24 at 3:13 P.M., Licensed Practical Nurse (LPN) D said he/she was the nurse on the date of the incident, but he/she did not witness any of the incident. To his/her knowledge, the CNA who showering the resident and a CNA who was working on the hall were the two staff involved. The CNA who was giving the shower had an issue with the resident and did not give the resident a gown. The CNA working the hall noticed the resident undressed and got him/her covered.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/24 at 3:30 P.M., the resident said on the date of the incident, he/she had finished giving him/herself a shower. CNA F came in to get him/her and he/she placed a blanket on the floor to walk on since the floor was et. He/She started to slide as soon as he/she walked over the blanket and onto the part of the floor that was not covered. He/She explained to CNA F that he/she needed to get his/her wheelchair and bring it to the bathroom because he/she was not steady. CNA F said he/she was not going to do that and told him/her to just come on. He/She was skidding on the floor and did not feel secure. CNA F opened the door to the shower room and he/she noticed CNA F did not bring any linen or gown in with him/her. CNA F said he/she thought he/she had put the linen and gown there for the resident but he/she did not have time to do it now. He/She told CNA F that he/she was not going to go into the hall naked and the CNA started to call him/her difficult. He/She was still sliding and did not want to fall, so he/she continued toward the wheelchair that was sitting in the hall. CNA F called him/her rude, said he/she could not stand him/her and then walked off. The resident said he/she had no choice but to walk into the hall naked to sit in his/her chair or he/she would fall. The resident began to cry and said there were resident's in the hall, and at least one of them was of the opposite gender. Immediately following the incident, CNA E brought him/her a gown and covered him/her up. He/She was exposed about 10 seconds. CNA E then assisted him/her to his/her room. Once to his/her room, he/she cried for about 45 min over what had happened. Once calmed down, he/she called his/her parent for comfort because no one came back to check on him/her. After talking to his/her parent, he/she put his/her call light on and CNA E responded. This is when he/she asked to talk to a manager. CNA E got the administrator on the phone and the administrator said she was headed to the facility to address the issue. He/She never saw CNA F again.</p> <p>During an interview on 5/13/24 at 3:52 P.M., CNA E said on the date of the incident, he/she was in another room and heard a commotion in the hall. When he/she came out, he/she saw the resident sitting in the hall naked in his/her wheelchair. He/She ran real quick to get something to cover the resident up. Once the resident told him/her what had happened, he/she immediately called the administrator. When this happened, there was a group of resident of the opposite gender sitting in the hall, but they were not paying attention.</p> <p>During an interview on 5/3/24 at 2:56 P.M., the Director of Nursing said the resident was left exposed in the hall after a shower. The facility completed an investigation and CNA F was terminated due to the resident's rights violation.</p> <p>MO00236062</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>32847</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction) receives necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing, for two of three residents observed to receive pressure ulcer care (Residents #2 and #7). The census was 92. The sample was 8.</p> <p>Review of the facility's Wound Treatment Management policy, dated 9/1/22, showed:</p> <ul style="list-style-type: none"> <li>-Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;</li> <li>-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;</li> <li>-In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.</li> </ul> <p>1. Review of Resident #2's medical record, showed diagnoses included diabetes, morbid obesity, and need for assistance with personal care.</p> <p>Review of the facility's wound report, showed the resident with a left heel unstageable pressure ulcer (dead tissue (slough, wet yellowish stringy dead tissue) or eschar (black or dark brown dry dead tissue) present, the actual base and condition of the ulcer cannot be determined).</p> <p>Review of the resident's electronic physician order sheet (ePOS), showed no treatment orders for the left heel. No order for a barrier wipe to be applied. No order for a protective boot.</p> <p>Observation and interview on 5/13/24 at 7:50 A.M., showed blood on the resident's left heel. The resident's fitted sheet was bloody underneath the resident's left foot. The resident said an aide saw the blood yesterday and said he/she would get the nurse because it needed to be wrapped. The nurse never came. At 8:20 A.M., the resident continued to lay in bed with no bandage on the left heel and blood on the sheet.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/13/24 at 11:23 A.M., showed the Wound Nurse entered the resident's room. Bloody drainage was visible on the sheet under his/her left foot and no dressing present on the heel. The wound nurse lifted the heel off the bed. Blackened tissue covered the entire heel and the edges appeared reddened. Bloody drainage drained from the area. The Wound Nurse said the resident should have a protective boot on to prevent the area from opening. She said the wound was intact and only required a protective barrier wipe. The resident said yesterday there was blood on the sheet too, and the sheet was not changed. The Wound Nurse described the heel as opened and mushy, and said the wound clinic will be arriving tomorrow, so for now she will just place a bandage over it. The Wound Nurse applied a boarder foam dressing. The resident said the staff noticed it last night. The Wound Nurse said staff should have covered the heel open area and obtained treatment orders yesterday when first noticed.</p> <p>2. Review of Resident #7's medical record, showed diagnoses included pressure ulcer of the sacral region (tailbone area) stage III (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) and severe protein-calorie malnutrition.</p> <p>Review of the facility's wound report, showed the following for the resident:</p> <ul style="list-style-type: none"> <li>-Pressure ulcer stage IV (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed) to the coccyx (tailbone area);</li> <li>-Pressure ulcer stage III to the left ischial (area of the buttocks that meets the upper thigh);</li> <li>-Pressure ulcer unstageable to the right ischial.</li> </ul> <p>Review of the resident's ePOS, showed:</p> <ul style="list-style-type: none"> <li>-An order dated 4/25/24 to cleanse coccyx wound with Vashe (intended for cleansing wounds, available by prescription only), leave soaked gauze in place for 1 minute. Pat dry and pack open area in wound with packing strips, cover wound bed with calcium alginate (absorbent dressing that aides in wound healing) and ABD pad (large thick absorbent dressing), tape over to close. Every day shift;</li> <li>-An order dated 4/25/24 to cleanse the left and right ischial with Vashe, pat dry and apply Santyl (ointment used to remove dead tissue), calcium alginate and cover with border gauze. Every day shift for wound care.</li> </ul> <p>Observation on 5/13/24 at 11:50 A.M., showed the Wound Nurse completed the dressing change to the resident's coccyx, left ischial, and right ischial pressure ulcers. She set up the supplies and removed the coccyx and left ischial dressings. A foul odor was noted when the dressing was removed. The open area was reddened and deep and the old drainage had a large amount of brown drainage. Wound edges were irregular and loose on both wounds. The Wound Nurse cleansed the area to the coccyx and left ischial with wound cleanser spray (solution used to remove contaminates, foreign debris and drainage from the wound surface). The wound nurse said she could not find the resident's ordered Vashe, it was available on Friday when she worked, but must have gone missing during the weekend. She applied the new dressing to the left ischial and the coccyx, without the Vashe soaked gauze. The Wound Nurse then assisted the resident to reposition in bed and removed the dressing to the right ischial. She cleansed the area with wound cleanser and applied the ordered treatment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an interview on 5/13/24 at 2:56 P.M., the Director of Nursing (DON) said physician orders should be followed. Treatments should be completed as ordered. The Wound Nurse is responsible to reorder treatment supplies as needed. The correct wound cleanser formula should be used. If a resident's open to air wound opens and is draining fluid and blood, staff address this. They should notify the doctor first, get it cleaned, let the Wound Nurse know the area opened, and get new orders to address the wound. CNAs should tell the nurse if a wound opens up. It is not acceptable to leave a wound uncovered overnight until the Wound Nurse arrives the next day.</p> <p>MO00235117</p> <p>MO00235554</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>32847</p> <p>Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status for one resident with a diagnosis of severe protein-calorie malnutrition and who was categorized as severely underweight and who had a wound, when staff failed to accurately monitor the resident's weights, failed to timely document weights obtained, and failed to accurately document nutritional supplement administration, resulting in the registered dietician using inaccurate weights and inaccurate information to determine the resident's nutritional status and nutritional needs. In addition, the facility failed to provide the resident's physician and dietician ordered nutritional supplements to the resident (Resident #7). This resulted in weight loss of 3.9% from March to April 2024, and the resident's continued severely underweight status. The census was 92. The sample was 8.</p> <p>Review of the facility's Weight Monitoring policy, dated 9/1/22, showed:</p> <ul style="list-style-type: none"> <li>-Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutrition status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</li> <li>-Weight can be a useful indicator of nutritional status. Significant unintended weight changes or insidious weight loss (gradual unintended loss over a period of time) may indicate nutritional problems;</li> <li>-The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: <ul style="list-style-type: none"> <li>-Identifying and assessing each resident's nutritional status and risk factors;</li> <li>-Evaluating/analyzing the assessment information;</li> <li>-Developing and consistently implementing pertinent approaches;</li> <li>-Monitoring the effectiveness of interventions and revising them as necessary;</li> </ul> </li> <li>-Interventions will be identified, implemented, monitored, and modified as appropriate, consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status;</li> <li>-A weight monitoring schedule will be developed upon admission for all residents.</li> </ul> <p>Review of Resident #7's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 3/25/24, showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Dependent for eating and oral hygiene;</p> <p>-Signs and symptoms of possible swallowing disorder: Loss of liquids/solids from mouth when eating or drinking; holding food in mouth/cheek or residual food in mouth after meals; coughing or choking during meals or when swallowing medications; complaints of difficulty or pain with swallowing;</p> <p>-Height: 62 inches;</p> <p>-Weight 90 pounds;</p> <p>-Unknown if experienced weight loss or gain;</p> <p>-Nutritional approach: mechanically altered diet.</p> <p>During an interview on 5/16/24 at 10:31 A.M., the MDS Coordinator said the weight in the quarterly MDS was not accurate. She took that information from a prior hospitalization and it was not a weight obtained at the facility.</p> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <p>-Problem: The resident has nutritional problems or potential nutritional problems, has chronic wound, underweight;</p> <p>-Goal: No significant weight loss of 5% in 30 days or 10% in 180 days. The resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs and symptoms of malnutrition;</p> <p>-Interventions included: Provide assistance with dining, such as tray setup, cutting up food, identifying items on tray, and feeding resident as needed. Registered dietician to evaluate and make diet change recommendations as needed.</p> <p>Review of the resident's medical diagnosis list, showed diagnoses included unspecified severe protein-calorie malnutrition, diabetes, need for assistance with personal care, dysphagia (difficulty swallowing), and lack of coordination.</p> <p>Review of the resident's weight log, reviewed on 5/13/24 at 7:57 A.M., showed:</p> <p>-On 2/1/24, a weight of 78 pounds;</p> <p>-On 2/8/24, a weight of 83 pounds;</p> <p>-On 2/15/24, a weight of 84.2 pounds;</p> <p>-On 3/28/24, a weight of 78 pounds;</p> <p>-No weight documented in April 2024.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/14/24 at 10:00 A.M., the administrator said the weights documented on 2/8/24 as 83 pounds and 2/15/24 of 84.2 pounds, were incorrect and a new weight log will be provided.</p> <p>Review of the resident's electronic physician order sheet (ePOS), showed:</p> <ul style="list-style-type: none"> <li>-An order dated 2/19/24 and discontinued 3/10/24, for regular diet, pureed texture, nectar/mildly thick consistency;</li> <li>-An order dated 3/18/24 and discontinued 5/2/24, for regular diet, pureed texture, nectar/mildly thick consistency</li> <li>-An order dated 3/25/24, for frozen/thickened nutritional supplement (dietary) three times a day for severe protein malnutrition;</li> <li>-An order dated 4/24/24, for ice-cream with meals;</li> <li>-An order dated 5/2/24, for regular diet mechanical soft texture, nectar/mildly thick consistency.</li> </ul> <p>Review of the resident's nutritional assessment, dated 3/1/24, showed:</p> <ul style="list-style-type: none"> <li>-Regular diet, extra sauce, double meats with lunch and dinner;</li> <li>-Most recent weight 84.2 pounds on 2/15/24;</li> <li>-Pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction) stage III's (full thickness tissue loss, fat may be visible but bone, tendon or muscle is not exposed) to coccyx (tailbone area) and right buttocks, worse;</li> <li>-Resident is on a pureed diet with double meat lunch and dinner and extra sauce on meat. Fair to good oral intake reported. Has treatment to stage III wounds to right buttocks and coccyx areas. Weight up slightly since admission as desired but remains underweight. Nutritional interventions are appropriate and supportive of wound healing. Monitor weights, appetite, and wound healing.</li> </ul> <p>Review of the resident's weight log, provided by the facility on 5/14/24, showed:</p> <ul style="list-style-type: none"> <li>-On 1/30/24, a weight of 78 pounds;</li> <li>-On 2/1/24, a weight of 78 pounds;</li> <li>-On 3/28/24, a weight of 78 pounds;</li> <li>-On 4/4/24, a weight of 74.1 pounds (down 3.9% since 3/28/24);</li> <li>-On 5/13/24, a weight of 75.7 pounds.</li> </ul> <p>Review of the resident's nutritional assessment, dated 4/7/24, showed:</p> <ul style="list-style-type: none"> <li>-Regular diet, pureed, nectar/mildly thick liquids;</li> </ul> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Nutritional supplements included: Frozen nutritional treat three times a day;</p> <p>-Most recent weight 78 pounds on 3/28/24;</p> <p>-Pressure ulcer, coccyx stage IV (full thickness tissue loss with exposed bone, tendon or muscle);</p> <p>-See registered dietician (RD) note 4/7/24.</p> <p>Review of the resident's progress notes, showed the only nutrition/dietary note documented in the resident's record was an RD note, dated 4/7/24, which showed the resident as a treatment to a stage IV wound to the coccyx. On vitamin C, multivitamin, zinc fortified pudding, active liquid protein twice a day for healing. On a pureed diet with nectar thick liquids and frozen nutritional treat three times a day. Fair oral intake reported. Weight 78 pounds stable. Overall underweight. Body mass index (BMI) 14.3 (a BMI less than 18.5 indicates underweight, a BMI of less than 16 indicates severely underweight). Would discontinue fortified pudding since the facility does not offer. Continue nutritional interventions which remain appropriate.</p> <p>Review of the resident's diet order and communication sheet, dated 4/24/24, showed:</p> <p>-Diet change;</p> <p>-Diet regular, pureed, thickened liquids;</p> <p>-Start ice cream with meals.</p> <p>During an observation and interview on 5/13/24 at 7:10 A.M., the resident said his/her only concern with care is staff do not help him/her eat and he/she is hungry. Observation showed the resident lay in bed and appeared very thin.</p> <p>Review of the resident's meal ticket for the date of 5/13/24, showed:</p> <p>-Breakfast: Oatmeal for breakfast, only regular scrambled eggs. The meal ticket did not identify the resident to receive ice-cream or frozen nutritional supplement;</p> <p>-Lunch: Double meat, add ice-cream cup. The meal ticket did not identify the resident to receive a frozen nutritional supplement;</p> <p>-Dinner: Double meat, add ice-cream cup. The meal ticket did not identify the resident to receive a frozen nutritional supplement.</p> <p>Observation on 5/13/24 at 9:00 A.M., showed dietary staff delivered hall trays to the resident's hall. Nursing staff began to pass hall trays. At 9:07 A.M., nursing staff passed the resident a breakfast tray, a second staff member sat at the resident's side while the staff who passed the tray left the room and said they needed to get utensils. Staff served the resident scrambled eggs, an English muffin, oatmeal, and juice. No ice-cream or health shake provided. Staff returned with utensils. Both staff stayed in the room and closed the room door. At 9:23 A.M., staff exited the room. Observation of the resident's tray showed all food except the oatmeal consumed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2024
NAME OF PROVIDER OR SUPPLIER  Atrium Place Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2600 Redman Road Saint Louis, MO 63136	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the scheduled mealtimes, showed:</p> <ul style="list-style-type: none"> <li>-Breakfast: 7:45 A.M.;</li> <li>-Lunch: 11:45 A.M.;</li> <li>-Dinner: 5:45 P.M.</li> </ul> <p>Review of the resident's May 2024 medication administration record, showed:</p> <ul style="list-style-type: none"> <li>-Frozen/thickened nutritional supplement (dietary) three times a day for severe protein malnutrition. Scheduled administration times of 9:00 A.M., 2:00 P.M., and 9:00 P.M.: Documented as administered 31 out of 36 opportunities. Blank 5 opportunities. No documentation the supplement was not provided or why;</li> <li>-Ice-cream with meals. Scheduled administration times of 8:00 A.M., 12:00 P.M., and 5:00 P.M. Documented as administered during the 8:00 A.M. scheduled administration time 12 out of 12 opportunities.</li> </ul> <p>On 5/13/24 at 12:25 P.M., Certified Medication Technician (CMT) A confirmed he/she is the resident's CMT and said supplements come from dietary on their tray. He/She looked up the resident's order and said he/she was not sure why the order for the supplement three times a day says frozen supplement, because that is just his/her thickened liquids, and it would come from dietary. He/She had never given the resident supplements. He/She does not know what that is. If an order is ordered to come out from dietary, he/she will initial it as given, but does not give it him/herself.</p> <p>During an observation and interview on 5/13/24 at 12:45 P.M., showed Licensed Practical Nurse (LPN) B exited the resident's room with the mechanical lift scale. He/She said he/she is the resident's nurse, and he/she just weighted him/her and he/she is 75.7 pounds. CMTs give things like protein power supplements and dietary sends out the health shakes.</p> <p>Observation on 5/13/24 at 12:49 P.M., showed dietary staff delivered the hall trays to the resident's hall. Trays and a drink bin were on the cart. The drink bin contained no supplements.</p> <p>During an interview on 5/13/24 at 12:50 P.M., Dietary Aide C said health shakes are listed on the resident's meal tickets. That is how dietary staff know who gets them. Dietary staff make sure it is in the drink bucket on the hall tray carts and nursing staff pass the tray based on the ticket.</p> <p>Observation on 5/13/24 at 12:51 P.M., showed nursing staff passed the resident's food tray. The nursing staff served the resident ice-cream, but no health shake. At 12:55 P.M., the resident's nurse sat at the resident's side and served the resident mashed potatoes, ground meat, mixed vegetables, juice, and ice cream.</p> <p>During an observation and interview on 5/13/24 at 1:07 P.M., the resident's nurse exited the resident's room. The resident said he/she got enough to eat. Observation of the resident's tray showed approximately half of the mashed potatoes, approximately a quarter of meat, a small amount of veggies, and all of the ice cream consumed. The resident smiled and said he/she liked ice cream.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Atrium Place Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2600 Redman Road Saint Louis, MO 63136	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/24 at 1:13 P.M., the Staffing Coordinator said he/she is a Certified Nursing Assistant (CNA)/CMT and is working as the resident's CNA today. Regarding health shakes, in the order it will say if dietary gives the supplement. If there is an order for a health shake to be given, dietary puts it on their tray. Nursing staff just pass the trays.</p> <p>During an interview on 5/13/24 at 1:45 P.M., the Dietary Manager said he had been at the facility a little over a year. If a health shake is ordered, the dietician usually sends an email, or staff discuss it during the risk meeting. Then it is placed on the meal ticket so when the aides see the meal tickets, they know who gets them. The frozen/thickened supplement ordered for the resident is the magic shake. The facility had been out of that supplement for several months and they are still out at the distributor. He will give ice-cream until the magic cup is back in stock because the facility does not have anything else to give in place of the supplement. The resident is just getting the ice-cream for now, twice a day.</p> <p>During an interview on 5/13/24 at 1:54 P.M., the RD said she had not seen the resident, as the resident is not on the list of residents she follows. She normally will see everyone with weight loss on a weekly basis, but in the system, it looks like the most recent weight documented for the resident was 75.7 and his/her baseline is 78. The prior RD would have been the person who would have ordered the supplement because the prior RD was the last person to see the resident, but that RD is no longer with the company. April 7th was the last time the prior RD saw the resident. If the resident has an order for ice-cream three times a day, he/she should receive it three times a day and could even get more if he/she enjoyed it. She was aware the distribute was out of the magic cup supplement. It began to be difficult to get that supplement around the time of COVID. The facility converted to the frozen house supplements, which are health shakes. Frozen health supplements and magic cups are not the same thing. She just took over as the dietician for this facility the first week in May and she will need to educate the dietary manger regarding what residents should be receiving if they have a supplement ordered. The resident should be receiving the frozen health supplement.</p> <p>During an interview on 5/13/24 at 2:56 P.M., the Director of Nursing (DON) said physician orders should be followed. The CMTs will normally administer supplements if they are on the medication administration record to be given. Supplements should not be documented as administered if they were not. If a resident has weight loss, their weights should be obtained as ordered. She was aware that the resident had experienced some weight loss.</p> <p>During an interview on 5/15/24 at 10:05 A.M., the administrator said regarding the weight for April 2024 that was not on the weight log the day prior, the weights were being done by the restorative aide. The April 2024 weight for the resident was obtained and documented on a piece of paper and had not yet been entered into the system.</p> <p>During an interview on 5/14/24 at 4:34 P.M., the Medical Director said he would expect his orders to be followed. The resident is compromised due to his/her low BMI and wounds. He ordered the ice-cream because the resident loves ice-cream and he wanted to make sure he/she was given ice-cream 3 times a day. If the dietician ordered health shakes, those should be given as well. It is important for proper nutrition.</p> <p>MO00235554</p>		