STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265586	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Place Health and Rehabilitation	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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have physician orders for the resident's immediate care when staff failed to transcribe one resident's surgical wound treatments from the hospital discharge orders into the facility physician orders and failed to obtain a treatment order for the coccyx (tailbone) wound, which was present on admission, which resulted in the treatment not being provided/documented for four days after admission (Resident #111). The sample size was 24. The census was 102. The administrator was notified on 6/26/25, of past non-compliance. When the facility identified the issue, they immediately assessed the resident's current condition, notified the physician/Nurse Practitioner (NP). Treatment orders were put in place per provider's order. The admitting nurse and wound nurse received corrective actions. Nurses were educated on ensuring all orders were transcribed properly and obtaining wound orders upon notification of admission and/or new skin issues and on documentation. The deficiency was corrected on 5/27/26. Review of the facility's Documentation in Medical Record policy, dated revised 8/1/25, showed:-Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation;-Licensed staff and interdisciplinary team members shall document all assessments, pertinent observations. and services provided in the resident's medical record in accordance with state law and facility policy;-Documentation shall be completed at the time of service. but no later than the shift in which the assessment, observation, or care service occurred. Review of the facility's Documentation of Wound Treatments and Assessments policy, dated revised 8/21/25, showed:-Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. Weekly wound assessments are completed on wounds such as pressure, and surgical;-The following elements are documented as part of a weekly wound assessment:--Type of wound (pressure injury, surgical, etc.) and anatomical location;--Stage of the wound, if pressure injury or the degree of skin loss if non-pressure (partial or full thickness);--Measurements: height, width, and depth;--Description of wound characteristics:--Color of the wound bed;--Type of tissue in the wound bed;--Condition of the peri-wound skin;--Presence, amount, and characteristics of wound drainage/exudate;--Presence or absence of odor;--Presence or absence of pain;--Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing should be documented each shift. Review of Resident #111's After Visit Summary, dated 4/14/26 through 5/1/26 and printed on 5/1/25, showed:-Wound care instructions: post-discharge dressing care, apply moist to wet Vashe (sterile medical gauze moistened with solution) gauze to midline and thigh wound twice a day (BID); change more frequently for drainage as needed;-A check mark was placed in front of the order. Review of the resident's Weekly Wound Assessment, dated 5/1/26, showed:-Date of onset was 5/1/26;-Was admitted with Stage II pressure ulcer (partial-thickness skin loss where the outer layer of skin and part of the underlying layer are damaged) on sacrum (triangular bone that sits at the end of the spine);-Size: three centimeters (cm) length X two cm width, no depth, wound bed was pink and yellow with no drainage;-Electronically signed on 5/4/26. Review of the resident's progress notes, dated 5/1/26 (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 5/5/26, showed:-On 5/1/26 at 2:59 P.M., Full body assessment performed by the nurse, resident noted to have open areas to right thigh, abdomen- eight staples noted, open coccyx (tailbone) wound. Resident will continue with current plan of care per discharge (d/c) paperwork. Referral to wound physician completed;--At 8:22 P.M., Areas noted to coccyx, anal/peri area (located between the genitals and the anus), right thigh and midline which included eight staples. Wound team aware of resident's arrival and skin condition. All orders verified by nurse practitioner (NP).-On 5/5/26 at 11:11 A.M., admitted with abdominal surgical wound, tight surgical wound and pressure ulcer on sacrum.-There was no documentation showing the treatment was on hold. Review of the resident's care plan, dated 5/5/26, showed:-Focus: Residents had actual impairment to skin integrity;-Goal: Resident will maintain or develop clean intact skin by next review date;-Intervention: Weekly treatment documentation to include measurement of each area of skin breakdown width, length, depth, type of tissue and exudate and any other notable changes or observations. Date initiated 5/4/26. Review of the resident's active Order Summary Report, showed:- A physician order to cleanse abdomen with Normal Saline (NS)/wound cleanser (DWC). Pat dry pack with Vashe (medical grade wound cleanser) moisten gauze and dry dressing daily and prn if soiled/dislodged everyday shift for wound healing. Start date 5/4/26;-A physician order to cleanse right thigh with NS/DWC. Pat dry with Vashe moisten gauze and dry dressing daily and prn if soiled/dislodges everyday shift for wound healing; Start date was 5/4/26;-A physician order to cleanse with NS/DWC. Pat dry apply calcium alginate with silver (highly absorbent wound dressing) and dry dressing daily and prn if soiled/dislodged everyday shift for wound healing; Start date was 5/4/26. Review of the resident's Treatment Administration Record (TAR), dated 5/1/26 through 5/ 14/26, showed:-A physician order to cleanse abdomen with Normal Saline/wound cleanser (NS/DWC). Pat dry and pack with Vashe moisten gauze and dry dressing daily and as needed (PRN) if soiled/dislodged everyday shift for wound healing. Start Date: 5/5/26;--Documentation showed treatment started on 5/5/26;-A physician order to cleanse right thigh with NS/DWC. Pat dry pack with Vashe moisten gauze and dry dressing daily and PRN if soiled/dislodged everyday shift for wound healing. Start date 5/5/26;--Documentation showed the treatment started on 5/5/26;-A physician order to cleanse with NS/DWC, Pat dry apply calcium alginate w/silver and dry dressing daily and PRN if soiled/dislodged everyday shift for wound healing. Start date 5/5/26;--Documentation showed the treatment started on 5/5/26. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/5/26, showed:-admitted [DATE];-Moderately impaired cognition;-Functional limitation in range of motion in both lower extremities;-Substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for personal and toilet hygiene, bathing, dressing and rolling in bed.-Dependent for transfers;-Diagnoses include cancer, atrial fibrillation (irregular heart rhythm) heart failure, diabetes and depression;-At risk for developing pressure ulcers/injuries;-No unhealed pressure ulcers;-Had surgical wounds. Review of the Medical Doctor's progress note, dated 5/5/26, showed midline incision to be packed twice daily with wet to dry dressings. Thigh dressing to be changed twice daily with wet to dry dressings. During an interview on 6/23/26 at 12:30 P.M. and at 2:14 P.M., Licensed Practical Nurse (LPN) E said when a resident was admitted to the facility, the nurse on the floor was responsible for completing the admission. The nurse reviewed the paperwork sent from the hospital and entered the orders into the computer. If the Medical Doctor (MD)/NP was at the facility LPN E, would take the orders to her and she would review the paperwork. If the MD/NP was not at the facility, LPN E would call the physician to verify orders. Skin assessments were part of the admission process. If a resident had a wound but did not have a treatment order, LPN E would notify the in-house wound nurse and obtain a treatment order. The wound nurse would assess the resident, obtain treatment orders and enter them into the computer. LPN E said the resident had several wounds on admission, but he/she could not recall the location of the wounds. During an interview on 6/24/26 at 9:20 A.M., LPN A said when a resident was admitted (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility, he/she used the discharge paperwork from the hospital for the orders. The nurse who was admitting the resident was responsible for entering the orders into the computer. Orders were verified the with MD/NP. If an order was changed, it should be documented in the progress notes. If a resident had a wound, it would be documented in the progress notes and on the skin assessment. The assessment should include the location of the wound, size and description of the wound. If there were no treatment orders for the wound, he/she would notify the MD/NP and obtain an order. During an interview on 6/24/26 at 9:45 A.M., the NP said the facility used the discharge summary for orders. If the NP was in house when a resident was admitted , the nurse would give her the paperwork, and she would review it. The nurses entered the orders into the computer. The nurse should do a skin assessment on admission. Most of the time, the residents would come to the facility with wound care orders. If they did not, the nurse would obtain a treatment order until the resident could be seen by the wound doctor. During an interview 6/24/26 at 11:47 A.M., the Wound Nurse said if the resident had a wound and no treatment order, the nurse should notify the MD/NP and obtain orders. The resident admitted with surgical wounds on his/her abdomen and thigh. The resident also had a wound on his/her sacral area and heel. The resident's orders should have been entered into the computer when he/she was admitted . When the NP came that Monday on 5/4/26, the facility obtained treatment orders, and they were entered into the computer. During an interview on 6/24/26 at 12:22 P.M., The Director of Nursing (DON) said the nurse could only go by the After Visit Summary or Discharge Summary for the orders. If a resident was admitted with a wound and had no treatment orders, the nurse should call and obtain treatment orders and document it in the progress notes. The resident's wound care should have been put in at the time of the admission and the nurse should have obtained a treatment order for the wound on the coccyx. The admitting nurse said he/she completed the resident's treatments over the weekend. During an interview on 6/26/26 at 1:12 P.M., the Administrator said when a resident was admitted to the facility, she would expect staff to print off a copy of the discharge summary/after visit summary and give a copy to the NP if she was in the building and to the Minimum Data Set (MDS) nurse. If the NP was not in the building, she would expect staff to call them to verify orders. The Administrator expected staff to follow the facility's policies and procedures. 30189133018448

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed the Nurse Practitioner's (NP) order for intravenous (IV) fluids following critical laboratory results for one of 24 sampled residents (resident #68). The NP order for IV fluids was entered into the electronic physician's order sheet (ePOS). There was no documentation the IV fluids were administered. The resident continued to decline and was transferred to the hospital for treatment. The census was 102. Review of the medical provider order policy, reviewed 5/4/26, showed:-Policy: use uniform guidelines for the ordering and following of medical provider orders;-Explanation and guidelines:--Medications and/or treatments should be administered upon signed order;--Verbal orders should be received only by nurses, pharmacist or verified in writing by the medical provider;-Following of medication/treatment orders:--Medical provider orders should be reviewed prior to administration of medication and/or treatment to validate the order contains all required elements;--Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order. Review of Resident #68's medical record, showed:-re-admitted : 3/26/26;-Diagnoses included brain hemorrhage, stroke, respiratory failure, Parkinson's (progressive brain disorder when brain nerve cells die or become impaired), epilepsy (seizures), difficulty swallowing, gastrostomy status (GT, hollow tube inserted into the stomach to provide food and fluids);-Unable to make needs or wants clearly known;-Staff provided full care needs. Review of the laboratory results, dated 4/17/26, showed:-Sodium: 154 high (normal 136-145). Review of the progress notes, showed:-On 4/18/26 at 6:30 P.M., a nurse note: the NP called and notified writer that the resident's blood test results had a critical sodium level. NP ordered IV fluids, and if IV could not be administered, send the resident to the hospital for placement;-On 4/18/26 at 8:53 P.M., a nurse note: a critical sodium level reported. New order received to place a hypodermoclysis (a technique used to administer fluids directly into the fat layer below the skin) and administer one liter of 0.45 percent fluids and recheck the sodium level once infusion is completed. Review of the April treatment administration record (TAR), dated 4/1/26-4/30/26, showed:-An order, dated 4/19/26: Sodium Chloride solution 0.9 %. Administer 50 milliliters (ml) IV one time a day for increased sodium level. Noted as blank on the TAR on 4/19/26. Review of the progress notes, showed:-On 4/20/26 at 5:53 A.M., a change in condition note: the resident had a change in vital signs. High pulse rate. New orders to send to the emergency room (ER) for evaluation and treatment;-On 4/20/26 at 6:14 A.M., a nurse note: the resident experienced a change in condition. The resident's symptoms included rapid breathing and lethargy. Vital signs were within normal ranges except for an elevated heart rate. The physician was notified and new orders received to send the resident to the ER. Review of the hospital Discharge summary, dated [DATE], showed:-admitted : 4/20/26;-discharged : 4/28/26;-Hospital problems:--admitted from a different hospital to current hospital for a pulmonary embolism response team ([NAME]) action for a large pulmonary embolism (medical emergency, blood clot within the lungs) with right sided heart strain;--Hypernatremia (high sodium): presented initially with Na (sodium) 156 and Chloride (Cl) 122, indicated severe hypernatremia and elevated osmolality. May have contributed to the reported acute mental status. The patient is bedbound, nonverbal and G-tube dependent.-Patient initially had a 0.6 x 90 kilogram (kg) x (150/140-1) = 6.4 Liters free water deficit;-Plan: may have enteral route (preferred) vs. IV;-Acute kidney injury (AKI): initial creatine was 1.33, improved to 1.15 on the same day after aggressive fluid resuscitation. AKI likely from hypoperfusion and currently improving;-Flush G-tube with 150 ml of water every six hours. Review of the Nurse Practitioner progress note, dated 4/30/26, showed:-Resident readmitted to the facility;-Plan: physical therapy evaluation, staff assist with all care. During an interview on 6/24/26 at 9:41 A.M., the NP reviewed the resident's medical record and said it appeared the resident did not receive the ordered IV fluid medications. She ordered the fluids due to the laboratory results and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wanted to ensure hydration. Not receiving the fluids could have contributed to the continued decline in the resident's health status. The resident also developed a pulmonary embolism that was discovered upon admission into the hospital. If the ordered fluids could not be administered, he/she would have sent him/her to the hospital for fluids. She expected staff to document when care or treatments were administered to residents. If it was not documented, the order was considered not completed. The facility was working on education on documentation and ensuring orders were completed. During an interview on 6/24/26 at 12:40 P.M., the Director of Nursing (DON) said when an order was received, she expected the nurses to administer the order. The NP had ordered subcutaneous fluids due to elevated sodium levels. The resident received the ordered fluids. The nurses did not document the administration in the medical record. At the hospital, the resident was diagnosed with a pulmonary embolism that likely contributed to the increased heart rate and rapid breathing. The nurses were newer graduates, and the facility was continuing to provide education regarding administration of ordered fluids. During an interview on 6/25/26 at 8:32 A.M., Licensed Practical Nurse (LPN) A said the resident relied on the G-tube for food and fluids. The resident had an order for free water flushes when re-admitted to the facility. LPN A was a new nurse and had received in-servicing regarding the importance of administering water to resident's who were ordered NPO. The resident did not have a kangaroo water bag in place and relied on nurses to administer the water. During an interview on 6/25/26 at 9:33 A.M., the resident's physician said, the resident had an irregular fast heartbeat for a day or two. Staff notified the NP, and the NP ordered stat labs which showed the hypernatremia. There was concern that resident had not been getting ordered free water flushes through the g-tube. Not getting the fluids would have kept the sodium levels elevated. The resident continued to experience a change in condition, and he/she was sent to the hospital for treatment. Upon admission to the hospital, it was discovered he/she had developed a pulmonary embolism that needed treatment. The resident also received fluid resuscitation which helped lower the sodium level. She discussed thoughts with nursing management and determined since many of the nurses were new, in-servicing began immediately for training to ensure water flushes were administered to residents with g-tubes. The facility had ordered and implemented kangaroo water bags and pumps to ensure accurate administration of fluids. Resident #68 should have a kangaroo bag in place next week; several were on order for facility residents. Since the resident was readmitted , his/her laboratory values have been within range. 2994027

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided were consistent with professional standards when one resident (Resident #111) was admitted to the facility with a physician's order for a regular diet with Total Parenteral Nutrition (TPN, a nutrient solution, including lipids, that is administered through a central venous access device. This solution usually consists of proteins. carbohydrates, electrolytes, vitamins. trace minerals, and lipids (as indicated)); and staff failed to transcribe the order into the medical record and/or failed to document communication with the hospital showing the physician order was changed. The sample was 24. The census was 102.The Administrator was notified on 06/26/26, of the past non-compliance. When the facility identified the issue, they immediately assessed the resident's current condition for decline or complications related to nutrition or treatment interruption. Staff reviewed the resident's admission records and available hospital transfer documentation was reviewed for TPN orders and discontinuation information. The facility Notified the Nurse Practitioner (NP). Communicated with the hospital case manager regarding their concerns with TPN. The resident's current care plan was discussed with the Interdisciplinary Team (IDT). Treatment orders were put in place per the provider's order. Staff were educated on auditing new admissions for treatments in a timely manner, all orders are transcribed properly and clarification received for any discontinued medication, documentation of order clarifications, notification of change in condition. The care plan was reviewed and updated. The event was referred to Quality Assurance Performance Improvement (QAPI) due to the identified admission order communication gap. The admitting nurse received corrective action. The deficiency was corrected on 5/27/26. Review of the facility's Documentation in Medical Record policy, date revised 08/01/25, showed:- Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation;-Licensed staff and IDT members shall document all assessments, pertinent observations. and services provided in the resident's medical record in accordance with state law and facility policy;-Documentation shall be completed at the time of service. but no later than the shift in which the assessment, observation, or care service occurred. Review of the facility's Medical Provider Orders policy, date revised 04/07/25, showed:-Validate newly prescribed medications and/or treatments in the electronic medication administration record (MAR)/treatment administration record (TAR);-Written Transfer Orders (sent with a resident by a hospital or other health care facility) Implement a transfer order without further validation, if it is signed and dated by the resident's current attending medical provider, unless the order is unclear or incomplete, or the date signed is different from the date of admission. If the order is unsigned. or signed by another medical provider, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending medical provider before medications are administered. The nurse should document verification on the admission order record, by entering the time, date, and signature. Example: Order verified by the phone with Dr. [NAME]/M. [NAME], R.N. Review of the facility's TPN policy, date revised 04/01/25, showed:-The nurse will verify the practitioner's order for the TPN. The order should include, at a minimum, the dextrose (sugar) concentration, the component names and dosages, route, rate, duration of use and any test results that require monitoring;-Consult the dietitian for assessment and monitoring. Review of Resident #111's After Visit Summary from the hospital, dated 04/14/26 through 05/01/26, showed:-Call Provider for any other concerns or questions. Please call the colorectal office and phone number was provided for any questions or concerns;-Diet instructions: Regular diet with TPN. A question mark was handwritten in front of the order. Review of Resident #111's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 05/05/26, showed:-Moderately impaired cognition;-No rejection of care;-Set up or clean up assistance (helper (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sets up or cleans up, resident completes the activity. Helper assists only prior to the activity): Eating;-Diagnoses include cancer, atrial fibrillation (irregular heart rhythm) heart failure, diabetes and depression;-Intravenous access (IV, (a medical technique that administers fluids, medications and nutrients directly into a person's vein) was blank. Review of the Order Summary Report, dated active orders as of 05/01/26, showed:-Clear liquid diet, date ordered 05/01/26. Start date was 05/04/26;-There was no physician order for TPN. Review of the progress notes dated 05/01/26 through 05/13/26, showed:-On 05/01/26 at 8:22 P.M., resident arrived at facility via ambulance from hospital. Consumed a regular diet, able to feed self. Devices Left Upper Arm (LUA) double lumen (catheter contains two completely separate internal channels, allowing healthcare providers to deliver two different medications or fluids simultaneously without them mixing) Peripherally Inserted Central Catheter (PICC, is a flexible, long medical tube inserted into a vein in the upper arm and advanced toward the heart) PICC with a Clean Dry and Intact (CDI) dressing. All orders verified by NP;-On 05/07/26 at 8:45 A.M., dual lumen IV access removed from Left Upper Extremity (LUE) per physician order;-On 05/11/26 at 7:47 P.M., the nurse looked at resident's vitals and noted blood pressure (B/P, normal 120/80 through 90/60) to be very low at 55/30. NP made aware, new order received for 0.9 % Normal Saline (NS, salt concentration that closely mirrors the natural balance of fluids and salts found in human blood) 1000 milliliters (mL) at 75 mL/hour (hr) through hypodermoclysis (the administration of fluids or medications directly into the subcutaneous tissue). Infusion started without difficulty. New order received for PICC to be placed. LUA double lumen PICC successfully placed. Temperature 98.8 (T, normal 97.9 through 99.1), Pulse 85 (P, normal 60 through 100), Respirations 16 (R, normal 12 through 20), B/P 60/42, NS @ 75 ml/hr to be infused via PICC, started as ordered. B/P 66/42, P84, R18 T 98.1. Resident appears more alert post start of infusion. B/P 70/50 P88 R 18 T 97.8. NP updated on resident's condition;-On 05/12/26 at 5:58 A.M., double lumen PICC to LUE noted. Completed a 1000 mL bag of fluids about 4:00 A.M., resident alert and oriented but slow to respond. Vitals obtained and documented B/P still running low at 86/56;-On 05/12/26 at 7:01 P.M., Resident reviewed via IDT related to TPN orders not being sent from the hospital upon initial admission, and facility staff receiving verbal confirmation from hospital staff that TPN had been discontinued at the time of admission. Resident had a doctor's appointment on 05/06/26 and returned to the facility the same day. On 05/06/26, the facility received a message from the hospital case manager inquiring about the resident. A return call was placed to the case manager on 05/07/26, and a message was left requesting clarification regarding discharge medications and TPN orders; however, no return call was received. On 5/11/26, another call was placed to the case manager requesting a return call. NP also contacted the case manager and received an answer. The nurse spoke with the case manager for clarification of orders but did not receive clarification at that time. The nurse then contacted the surgeon's office and spoke with Office Staff D, who confirmed that the resident was supposed to continue TPN upon admission to the facility. Upon review of the discharge orders, Office Staff D confirmed that the TPN order had not been properly transcribed into the after-visit summary by hospital staff. Upon the resident's arrival to the facility on [DATE], orders indicated a regular diet with TPN; However, there were no specific orders for TPN administration, mixture, laboratory monitoring, or initial formula. The nursing staff contacted the hospital discharging nurse at that time and was informed that TPN had been discontinued;-On 05/12/26 at 7:02 P.M., the nurse contacted the pharmacy which confirmed that no medication or TPN orders had been received from the hospital. On 05/11/26, a new PICC line was inserted Resident was started on IV fluids and remained on IV fluids pending clarification and initiation of TPN orders. Call placed to surgeon, and resident has a follow-up appointment scheduledfor 5/13/26 at 10:00 A.M. Labs were ordered, drawn via PICC line, and sent to the laboratory. Resident condition noted stable at that time. Resident states he/she felt better this shift. Vital signs: BP 99/64, P84, R 18, T 98.2;.-On 5/13/26 at 11:02 A.M., resident went to scheduled appointment this shift, and call received from Office Staff D to inform facility that resident will be direct admitted to the hospital. Review of the Outpatient Parenteral Nutrition Orders, located in the (continued on next page)

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Atrium Place Health and Rehabilitation	2600 Redman Road Saint Louis, MO 63136

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	miscellaneous section of the medical record, dated 04/30/26, showed: the form was dated 04/30/26 and faxed to the facility on [DATE]. Written on the top of the form was for discharge possibly on 05/01/26. The form had Lab monitoring weekly: Comprehensive Metabolic Panel (CMP, lab test for electrolytes) Magnesium and phosphorus (electrolytes), Complete Blood Count (CBC, lab test for measurement the cells) and Triglycerides (type of lipid (fat) circulating in the blood) and weekly weight. Infuse the formula over 12 hours seven days a week. Review of the Medical Doctor's (MD) progress note, dated 05/05/26, showed patient was discharged to the facility on a regular diet with bowel regimen and TPN. Patient was stable for discharge on [DATE]. discharged on regular diet. During interviews on 06/23/26 at 12:30 P.M. and 2:14 P.M., Licensed Practical Nurse (LPN) E said when the resident admitted , he/she had a line (PICC line) but the resident did not have an order for TPN. LPN E called the hospital and spoke with the nurse who gave him/her report, and the nurse told LPN E the TPN had been discontinued, and he/she verified the order with the NP. The NP also gave an order to discontinue the PICC line. Someone discontinued the line a few days later. LPN E did not recall if he/she verified the TPN orders with the surgeon or not. The resident was still being followed by the surgeon. When the resident went out for the follow up appointment, the resident took his/her order sheet with him/her. The doctor could look at the orders and see the resident was not on TPN. During an interview on 06/23/26 at 4:55 P.M., the Pharmacy Office Manager said they received a referral for TPN on 05/27/26. The pharmacy did not send the TPN out because the resident was admitted to a skilled nursing facility (SNF). If the pharmacy was unable to provide the service, the pharmacy would notify whoever sent the referral. During an interview on 06/24/26 at 9:45 A.M., the NP said the resident was admitted to the facility on Thursday or Friday. The NP visited the facility on Monday or Tuesday, and she was told staff called the hospital and the TPN was discontinued, and the resident was eating. A few days later, staff reported they had been trying to reach the outside Register Dietician (RD) for a few days, and she was not returning their call. The NP said she placed a call to the RD and left a message, and about 20 minutes later the RD called back. The RD claimed the hospital faxed the orders for TPN to the facility and claimed the information should have come in the hospital discharge paperwork. After speaking to the RD, the NP said she placed an order for a new PICC line to be placed. The plan was to start TPN. The day she clarified the order with the RD, the resident's blood pressure was low. The resident initially refused care, fluids and to go to the hospital. After speaking with the resident and his/her family, the resident agreed to receive fluids by hypodermoclysis until the PICC line was placed. The resident ate for about a week, then his/her blood pressure began trending low. Not receiving TPN could possibly cause the blood pressure to trend low. During an interview on 06/24/26 at 12:22 P.M., The Director of Nursing (DON) said when a resident is admitted to the facility the admitting nurse should verify the orders and transcribe the orders into the computer. If an order is clarified, it should be documented in the progress notes and in the order and communicated. The nurse can only go by what is on the After Visit Summary/Discharge Summary for the orders. The nurse should document any communication they had with the MD/NP. During the last conversation the facility had with the hospital, the hospital was not sure if the resident would be admitted with TPN or not. When a resident is admitted with TPN, the hospital should send a sheet with the TPN information, dated the day the resident is discharged and the TPN order should be included in the medication list. The TPN sheet shows what labs need to be monitored and how often they should be drawn, along with the script for the TPN and how to administer it. When the admitting nurse received the paperwork, TPN was not listed under the medication list and there was no sheet for the TPN. The admitting nurse saw the order for regular diet with TPN; that's why there was a question mark placed in front of the order. The admitting nurse said he/she called the hospital and spoke with the nurse who discharged the resident to obtain clarification for the TPN. The hospital nurse told the admitting nurse the TPN was discontinued. The admitting nurse did not document the conversation. The facility needs TPN orders to be clear. The TPN sheet must be dated when the resident was discharged . On 05/06/26, the resident went out for his/her follow up appointment with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265586	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Place Health and Rehabilitation	2600 Redman Road Saint Louis, MO 63136

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surgeon, but the appointment was rescheduled for 05/08/26. The case manager called around 05/06/26 or 05/07/26 asking about the TPN, and they found out the surgeon was managing the TPN. The surgeon was okay with the resident not receiving TPN. The facility and the NP were monitoring the resident. The facility attempted to call the RD several times regarding the TPN and left several messages over a few days, but the RD did not call back. When the NP came to the facility, staff notified her they were trying to reach the RD but she did not call back. The NP called the RD and spoke with her. When the resident had a change in condition, the facility contacted the surgeon's office and received orders for labs and fluids. When the resident went out for his/her follow up appointment, the resident was admitted to the hospital. During an interview on 06/25/26 at 9:02 A.M., the Medical Director said TPN is ordered by dietary. There was a breakdown between the RD and the pharmacy. The RD said she sent the script to the pharmacy. There was possible communication between the pharmacy, hospital, etc. that was not documented. The Medical Director expected staff to document any communication. During an interview on 06/26/26 at 1:12 P.M., the Administrator said if orders are clarified it should be documented in the progress notes. The Administrator expected staff to follow the facility's policies and procedures. 301993130189133018448