| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265589 | A. Building<br>B. Wing | 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St Peters Rehab and Healthcare Center | 230 Spencer Road<br>Saint Peters, MO 63376 |

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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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189<br><br>Based on interview and record review, the facility failed to clarify and obtain physician orders for two residents (Resident #1 and #2), in a review of 18 sampled residents, who sustained fractures and had surgery to repair, for assessment and treatment of each residents' surgical incisions when they admitted to the facility from the hospital. The facility failed to complete neurological checks per facility policy following a fall for one resident (Residents #2), in a review of 18 sampled residents. The facility census was 87.<br><br>Review of the facility's policy, Physician Orders, revised October 24, 2022, showed the following:<br><br>-Purpose: This will ensure that all physician orders are complete and accurate;<br><br>-Treatment orders will include a description of the treatment, including the treatment site, if applicable, the frequency of treatment and duration of order (when appropriate) and the condition/diagnosis for which the treatment is ordered.<br><br>Review of the facility policy, Response to Falls, revised October 24, 2022, showed the following:<br><br>-Post fall assessment and monitoring: Following each resident fall, the licensed nurse will complete an incident report and perform a post-fall assessment and investigation. A licensed nurse will also complete a neurological flow sheet for any un-witnessed fall, or witnessed fall with known head injury for 72 hours following the fall;<br><br>-Complete a neurological flow sheet for 72 hours following an unwitnessed fall or fall with known head injury.<br><br>1. Review of Resident #1's face sheet showed admission to the facility on [DATE].<br><br>Review of the resident's admission diagnosis list showed the resident had diagnoses that included other fracture of left lower leg, closed fracture with routine healing with a clinical category of orthopedic surgery (broken bone of left lower leg that did not puncture the skin but required surgical repair) and varus deformity, not elsewhere classified, left knee (happens when your tibia/larger bone in shin turns inward instead of aligning with your femur/the large bone in your thigh).<br><br>Review of the resident's hospital discharge summary, dated 10/16/24, showed the following:<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Discharge diagnoses: type I or type II open fracture to left ankle and closed displaced fracture of left patella (knee cap);<br><br>-Operations/procedures: left hindfoot fusion (surgical procedure to fix a fractured left ankle) and open reduction and internal fixation of left patella (surgical procedure to correct fractured knee cap);<br><br>-Patient instructions: non-weight bearing left lower extremity, wear knee immobilizer when up and out of bed. Wound care: keep wound clean and dry. Sutures/Staples: recheck in 2 weeks;<br><br>-Treatment: wound/skin care: keep wound clean and dry.<br><br>Review of the resident's nursing progress notes, documented by Licensed Practical Nurse (LPN) E, dated 10/16/24 at 7:07 P.M., showed the following:<br><br>-The resident admitted from the hospital/emergency room via stretcher at 7:00 P.M.;<br><br>-Resident was alert and oriented to person, place, time and situation;<br><br>-Resident was bedfast;<br><br>-Skin color was noted as other, refer to assessment for more information;<br><br>-Skin issues present, refer to assessment for more information.<br><br>Review of the resident's nursing progress noted, documented by LPN E, dated 10/16/24 at 7:16 P.M., showed the following:<br><br>-Resident admitted from local hospital after a stay with an admitting diagnosis of motor vehicle accident with open fracture (bone puncture of the skin related to a broken bone) of the left ankle and closed displaced fracture of the patella (kneecap);<br><br>-Resident had a left lower extremity immobilizer on and was non-weight bearing.<br><br>Review of the resident's October 2024 physician's orders (POS), showed the following:<br><br>-Admit to facility with admitting diagnosis of fractures;<br><br>-Left knee immobilizer on when up out of bed every shift, with an order start date of 10/17/24;<br><br>-Non-weight bearing left lower extremity every shift, with an order start date of 10/17/24;<br><br>-Wound care specialist to evaluate and treat if indicated, with an order start date of 10/17/24;<br><br>-No specific order to leave the immobilizer on at all times before the next appointment;<br><br>-No specific order to monitor surgical site on left ankle or left knee.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's baseline care plan, dated 10/17/24, showed the following:<br><br>-Skin: Problem - at risk for alteration in skin integrity;<br><br>-Interventions to complete a skin assessment on admission and weekly, observe for signs and symptoms of skin breakdown/infection, treatments as ordered, treatment orders;<br><br>-Orthopedic: Problem - at risk for orthopedic complications;<br><br>- Interventions to observe for signs/symptoms of deep vein thrombosis (blood clots), weight bearing status: non-weight bearing left lower extremity;<br><br>-Custom Problems: Custom problem 1 - resident has an immobilizer;<br><br>-Interventions to remove immobilizer from left lower extremity and check for impaired skin integrity (there was no order for this intervention).<br><br>Review of the resident's weekly skin observation assessment, dated 10/17/24, showed the following:<br><br>-Skin color normal; (no indication of location of skin assessment);<br><br>-Skin issues: yes; (no indication of location);<br><br>-Skin condition: other - left lower extremity surgical, immobilizer in place, do not remove before follow-up appointment;<br><br>-Skin condition: other - bilateral upper extremity, scattered bruising;<br><br>-Note text: The resident was admitted on [DATE]; Skin color is normal. Skin temperature is dry. Skin turgor is normal as skin returns promptly. Skin issues present. Refer to assessment for more information. Refer to full assessment for more information;<br><br>-The weekly skin observation assessment showed no documentation staff observed and assessed the actual surgical site/dressings on the left knee or ankle.<br><br>Review of the resident's skilled nursing note, dated 10/18/24, showed the following:<br><br>-Alert and oriented to person, place, time and situation;<br><br>-No new changes to skin integrity noted;<br><br>-Wound care section: resident has treatable wounds, dressing changed as per treatment orders, dressing change not required, changes noted to wound were all left blank.<br><br>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 10/21/24, showed the following:<br><br>-Cognitively intact;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No behaviors or rejection of cares;<br><br>-Lower extremity impairment one side only;<br><br>-Dependent on staff for shower/bathing self, upper and lower body dressing, putting on/taking off footwear and chair/bed-to-chair transfers;<br><br>-Substantial/maximum assistance staff for personal hygiene, sit-to-lying transfers and lying/sitting on side of bed;<br><br>-Partial/moderate staff assistance for rolling right and left in bed;<br><br>-Recent surgery requiring active skilled nursing facility care;<br><br>-Orthopedic surgery to repair fracture to pelvis, hip, leg, knee or ankle (not foot);<br><br>-Surgical wounds, surgical wound care, application of non-surgical dressings other than to feet, application of ointment/medications other than to feet.<br><br>Review of the resident's October 2024 POS, showed an order for weekly skin observation assessments every evening shift on Wednesday for skin assessment, with an order start date of 10/23/24.<br><br>Review of the resident's progress notes, documented by the wound care nurse (LPN C), dated 10/23/24 at 11:53 A.M., showed the following:<br><br>-Type: weekly skin observation assessments;<br><br>-Skin color is normal;<br><br>-Skin temperature is dry;<br><br>-Skin turgor is normal as skin returns promptly;<br><br>-Skin issues present; (no indication of location);<br><br>-Refer to assessment for more information.<br><br>Review of the resident's weekly skin observation assessment - full assessment, dated 10/23/24, showed the following:<br><br>-Skin issues: yes;<br><br>-Skin condition: other - left lower extremity surgical, immobilizer in place, do not remove before follow-up appointment;<br><br>-Skin condition: other - bilateral upper extremities scattered bruising;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The weekly skin observation assessment showed no indication staff observed and assessed the actual surgical site/dressings for the left knee or ankle.<br><br>Review of the resident's progress notes, documented by LPN C, dated 10/30/24 at 2:57 P.M., showed the following:<br><br>-Type: weekly skin observation assessments;<br><br>-Note text: the resident was admitted on [DATE] and room identified;<br><br>-Skin color is normal;<br><br>-Skin temperature is dry;<br><br>-Skin turgor is normal as skin returns promptly;<br><br>-Skin issues present; (no indication of location);<br><br>-Refer to assessment for more information.<br><br>Review of the resident's weekly skin observation assessment - full assessment, dated 10/30/24, showed the following:<br><br>-Skin issues: yes;<br><br>-Skin condition: other - left lower extremity surgical, immobilizer in place, do not remove before follow-up appointment;<br><br>-The weekly skin observation assessment showed no indication staff observed and assessed the actual surgical site/dressings for the left knee or ankle.<br><br>Review of the resident's October 2024 Treatment Administration Record (TAR), dated 10/17/24 - 10/31/24, showed the following:<br><br>-Weekly skin observation assessment every evening shift on Wednesday, documented as completed as ordered 10/23/24 and 10/30/24;<br><br>-Left knee immobilizer on when up out of bed every shift, documented as completed every shift 10/17/24 through 10/31/24;<br><br>-The TAR showed no indication of an assessment to the left lower extremity surgical sites or surgical dressings.<br><br>Review of the resident's skilled nursing note, dated 11/02/24, showed the following:<br><br>-Alert and orientated to person, place and situation, not orientated to time;<br><br>-No new changes to skin integrity noted;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Wound care section: resident has treatable wounds, dressing changed as per treatment orders, dressing change not required, changes noted to wound were all left blank.<br><br>Review of the resident's skilled nursing note, dated 11/04/24, showed resident has treatable wounds, dressing changed as per treatment orders, dressing change not required, changes noted to wound were all left blank.<br><br>Review of the resident's November 2024 Treatment Administration Record (TAR), dated November 1st to November 6th showed the following:<br><br>-Weekly skin observation assessment every evening shift on Wednesday for skin assessment; documented as completed as ordered 11/01/24 through 11/06/24;<br><br>-Left knee immobilizer on when up out of bed every shift; documented as completed as ordered on 10/23/24 and 10/30/24;<br><br>-The TAR showed no indication of an assessment to the left lower extremity surgical sites or surgical dressings.<br><br>During an interview on 11/27/24 at 1:58 P.M., LPN E said the following:<br><br>-If his/her name was on the admission nursing note or assessment, he/she admitted Resident #1 but he/she could not remember for sure;<br><br>-He/She does not recall Resident #1 specifically and could not say if he/she removed the left knee immobilizer and dressing to do a skin assessment;<br><br>-A new resident should have a full skin assessment on admission;<br><br>-If there were no orders for surgical wound care on an admission/readmission, the physician should be called for an order clarification;<br><br>-He/She was not 100% sure if the physician was called for orders for Resident #1's surgical site care.<br><br>During an interview on 11/27/24 at 1:42 P.M. and 2:09 P.M., the wound care nurse (LPN C), said the following:<br><br>-A full skin assessment should be completed on every new admission or each time a resident returns from the hospital;<br><br>-If a full skin assessment is not completed on admission or with a hospital return, she will do a complete assessment her next scheduled working day;<br><br>-If a resident is admitted with a surgical wound, the dressing should be checked, and if no specific orders to not remove, the dressing should be removed to assess the surgical site;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -If a dressing cannot be removed, due to physician orders not to remove, a surgical dressing should be checked every shift to determine if the wound was bleeding or had drainage;<br><br>-If a surgical resident comes to the facility without dressing change orders or directions, the physician should be called for clarification of orders;<br><br>-Resident #1 was adamant about not removing the left knee immobilizer or dressing to left ankle as he/she said the surgeon said not to remove it until follow-up appointment;<br><br>-She did not document that Resident #1 would not let her remove the left knee immobilizer or left ankle dressing so she could assess the surgical site;<br><br>-If a resident refused a complete skin assessment, the refusal should be documented;<br><br>-Resident #1 did not have any physician orders to check his/her left knee and left ankle dressing every shift, and should have had those orders;<br><br>-If a resident was admitted without wound care orders, the admitting nurse should call and get orders.<br><br>2. Review of Resident #2's nursing progress notes, dated 10/12/24, showed the resident was heard yelling for help from the shower room. Staff found the resident on the floor. The resident said he/she fell on to the floor because he/she was attempting to pull his/her pants up and was not able to do it without losing his/her balance. He/She fell on his/her left hip.<br><br>Review of the resident's neurological form, started on 10/12/24, showed the following:<br><br>-Neurological assessment to be completed after a fall every 15 minutes for four checks, every 30 minutes for two checks, every hour for two checks, every two hours for two checks, every two hours for two checks, every four hours for four checks and every shift for a combined total of 72 hours;<br><br>-Noted four - 15-minute checks, two - 30-minute checks, two - one-hour checks, two - two-hour checks and one - four-hour check;<br><br>-The facility had not followed their policy for neurological assessments; staff completed no neurological assessments after the one four-hour check and did not complete the 72-hour combined total per facility policy for neurological checks.<br><br>Review of the facility provided investigation of the resident's 10/12/24 fall showed the following:<br><br>-Date of incident: 10/12/24;<br><br>-Type of incident: fall with major injury;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Injury: physician ordered an x-ray of the right hip. X-ray completed and results reported to physician. Order to send the resident to hospital for evaluation due to acute subcapital right femoral neck fracture (fracture that occurs in the neck of the big thigh bone, where the femoral head meets the femoral neck - the most common type of hip fracture). The resident was hospitalized from 10/15/24 - 10/18/24 and had a right hip arthroplasty (hip replacement).<br><br>Review of the resident's report notes from the hospital, dated 10/18/24, showed the resident would be returning with a diagnosis of fall with right hip fracture with surgery. Right hip silver dressing (a type of dressing used for acute wounds and used to treat infected wounds). Right dressing per surgeon with no specific orders listed.<br><br>Review of the resident's record showed no contact with the surgeon or physician to clarify orders for the resident following his/her readmission to the facility until 10/31/24.<br><br>Review of the resident's October 2024 POS showed an order to complete a weekly skin assessment upon admission and then weekly thereafter; order start date of 10/18/24.<br><br>Review of the resident's nursing progress notes, dated 10/18/24, showed the resident returned from the hospital. Skin color is normal. Skin temperature is warm. Skin turgor is normal as skin returns promptly. Skin issues present. Refer to assessment for more information. No specific assessment of the condition of the resident's incision /surgical dressing.<br><br>Review of the resident's weekly skin observation assessment, dated 10/18/24, showed a right trochanter (hip) surgical incision, bandaged post-surgery. There was no documentation of an assessment of the resident's surgical wound dressing.<br><br>Review of the resident's care plan, revised on 10/22/24, showed the following:<br><br>-hospitalized from 10/15/24 - 10/18/24, had right hip arthroplasty (surgical repair), returned on physical therapy and occupational therapy services with a date of 10/22/24 as initiated;<br><br>-The resident has actual impairment to skin integrity: surgical incision to right hip with date initiated 10/18/24;<br><br>-Treatment per physician orders with a date of 10/18/24 as initiated.<br><br>Review of the resident's annual MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Clear speech, makes self understood and understands others;<br><br>-No behaviors or rejection of cares;<br><br>-Diagnosis of fracture other than multiple trauma and hip fracture;<br><br>-Recent surgery requiring skilled nursing facility care, surgical procedure hip replacement - partial or total;<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Surgical wounds and surgical wound care.<br><br>Review of the resident's weekly skin observation assessment, dated 10/22/24, showed a right trochanter (hip) surgical incision, bandaged post-surgery. There was no documentation of an assessment of the resident's surgical wound dressing.<br><br>Review of the resident's weekly skin observation assessment, dated 10/29/24, showed a right trochanter (hip) surgical incision. There was no documentation of an assessment of the resident's surgical wound dressing.<br><br>Review of the resident's October 2024 POS showed the following:<br><br>-Right hip (surgical incision): monitor surgical dressing for two weeks. Do not remove surgical dressing. Notify wound nurse with concerns as needed for surgical incision and every shift for surgical incision. Order start date of 10/31/24, (14 days after return to the facility after hospitalization ).<br><br>During an interview on 11/27/24 at 1:42 P.M. and 2:09 P.M., the wound care nurse (LPN C), said the following:<br><br>-Resident #2 returned to the facility after a hip surgery;<br><br>-She was not sure if Resident #2 returned from the hospital with wound care orders, but should have had a check dressing every shift order at a minimum;<br><br>-If there were no orders related to surgical site care on readmission, the physician should be called for orders.<br><br>During an interview on 11/27/24, at 2:15 P.M., the Assistant Director of Nursing (ADON) said the following:<br><br>-A skin assessment should be done within two hours of admission or return from the hospital;<br><br>-A surgical dressing should be removed on admission/readmission to determine the condition of the wound underneath, unless specifically contraindication by physician orders;<br><br>-If there were no orders related to surgical site care on admission or readmission, the physician should be called for orders;<br><br>-If a wound could not be evaluated due to specific physician orders not to remove, at a minimum the surgical dressing should be checked every shift to ensure there were no issues like bleeding or excessive drainage;<br><br>-A resident that has an unwitnessed fall should have at least every shift documentation for a minimum of 72 hours.<br><br>During an interview on 11/27/24, at 2:42 P.M., the Director of Nursing (DON) said the following:<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -She would expect a full skin assessment to be performed on all new admissions or re-admissions;<br><br>-If a surgical dressing could not be removed, she would expect at a minimum for the dressing to be checked each shift to monitor for bleeding or drainage;<br><br>-A full skin assessment was performed for Resident #1, with the exception of the surgical site, as it was her understanding the dressing was not to be removed until follow-up with the surgeon;<br><br>-Resident #1 and #2 should have had their surgical sites assessed and documented if able to remove the dressing, if orders were to not to remove the dressing, the dressings should have been checked every shift;<br><br>-She would expect nursing to get wound care orders from the physician if a resident was admitted and did not have wound care orders;<br><br>-For an unwitnessed fall, neurological checks should be completed for 72 hours and a resident assessment should be documented every shift for 72 hours.<br><br>During an interview on 11/27/24, at 3:10 P.M., the administrator said she expected staff to follow the policy for skin assessments on all admissions and readmissions. She expected staff to follow the policy for unwitnessed falls.<br><br>MO243484<br><br>MO244336<br><br>MO244813 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189<br><br>Based on observation, interview, and record review the facility failed to provide oversight and prevent injury for one resident (Resident #2), in a review of 18 sampled residents, when staff left the resident unattended in the shower room, resulting in the resident falling and sustaining a fracture. The facility census was 87.<br><br>On 11/27/24 at 4:15 P.M., the administrator was notified of the past noncompliance which occurred on 10/12/24. On 10/12/24, the administrator became aware of the violation of resident safety when Resident #2 was left alone in the shower room by staff. Resident #2's care plan directed he/she required one staff assist for bathing, hygiene and dressing. Resident #2 attempted to dress him/herself and had a fall that resulted in a right hip fracture. Upon discovery, the facility conducted an investigation, notified appropriate parties and all facility staff were educated on assistance with showers, to provide assistance with showers per care plan. The deficiency was corrected on 10/22/24 after all staff had been inserviced.<br><br>Review of the facility policy, Fall Management Program, revised October 24, 2022, showed the following:<br><br>-Purpose: To prevent resident falls and minimize complications associated with falls through the development of a fall management program;<br><br>-Policy: The facility will provide the highest quality care in the safest environment for the residents residing in the facility. The facility has developed a fall management program that strives to prevent resident falls through meaningful assessments, interventions, education and reevaluation;<br><br>-The nursing staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls.<br><br>1. Review of Resident #2's care plan, with an initiation date of 12/13/22 showed to keep the resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.<br><br>Review of the resident's care plan initiated 5/23/23 showed the following:<br><br>-The resident has an activities of daily living self-care performance deficit related to impaired balance;<br><br>-The resident required limited assistance by one staff with bathing/showering two times weekly and as necessary, to dress, with personal hygiene and to move between surfaces as necessary.<br><br>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 07/02/24, showed the following:<br><br>-Functional limitations in range of motion; upper extremity impairment on one side;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265589 | A. Building<br>B. Wing | 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Peters Rehab and Healthcare Center | 230 Spencer Road<br>Saint Peters, MO 63376 |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Substantial to maximal assistance to shower/bathe; helper does more than half of the effort;<br><br>-Partial to moderate assistance for upper body dressing; helper does less than half of the effort;<br><br>-Partial to moderate assistance for lower body dressing; helper does less than half of the effort;<br><br>-Substantial to maximal assistance for tub/shower transfers; helper does more than half of the effort;<br><br>-Substantial to maximal assistance to walk 10 feet;<br><br>-Uses a wheelchair.<br><br>Review of the resident's nursing progress notes, dated 10/12/24, showed the resident was heard yelling for help from the shower room. The resident was found on the floor and said he/she fell because he/she was attempting to pull his/her pants up and was not able to do it without losing his/her balance. The resident said he/she fell on to her left hip and was sore. There were no open areas or bruising noted from fall.<br><br>Review of the facility's investigation of the resident's 10/12/24 fall showed the following:<br><br>-Date of incident: 10/12/24;<br><br>-Type of incident: fall with major injury;<br><br>-Incident: on 10/12/24 at 2:31 P.M., the resident was heard yelling for help from the shower room and was found on the floor. The resident said he/she fell because he/she was attempting to pull his/her pants up and was not able to do it without losing his/her balance. No open areas or bruising noted and the resident said he/she was sore from the fall. The resident was seen by the physician on 10/14/24 and noted to have pain with internal and external rotation of the right hip as well as tenderness over the greater trochanter (hip). The resident said staff took him/her to the shower room to give a shower and left the resident in the shower by himself/herself. The staff member gave the resident the call light and instructed him/her to press the light if he/she needed help and that the staff member would be right back;<br><br>-Injury: physician ordered an x-ray of the right hip. X-ray completed and results reported to physician. Order to send the resident to the hospital for evaluation due to acute subcapital right femoral neck fracture (fracture that occurs in the neck of the big thigh bone, where the femoral head meets the femoral neck - the most common type of hip fracture). The resident was hospitalized from 10/15/24 - 10/18/24 and had a right hip arthroplasty (hip replacement);<br><br>-Initial interventions: 2. Staff interview completed. 3. Resident interview completed. 6. Education with facility staff;<br><br>-Root Cause Analysis: Resident attempting to dress himself/herself without assistance;<br><br>-Conclusion: Resident experienced a fall with major injury due to weakness while getting dressed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident's medical record showed x-ray was obtained on 10/14/24 with results provided on 10/15/24 and noted a right humeral neck fracture.<br><br>Review of the resident's nursing progress notes, dated 10/15/24, showed x-ray reports were reported to the physician with orders received to send the resident to the local hospital for evaluation and treatment.<br><br>Review of the resident's nursing progress notes, dated 10/18/24, showed the resident returned from the hospital.<br><br>Review of the resident's annual MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Clear speech, makes self understood and understands others;<br><br>-Diagnosis of fracture other than multiple trauma and hip fracture;<br><br>-Recent surgery requiring skilled nursing facility care, surgical procedure hip replacement - partial or total;<br><br>-Surgical wounds and surgical wound care.<br><br>During an interview on 11/26/24 at 3:37 P.M., and 11/27/24 at 11:08 A.M., the resident said the following:<br><br>-He/She had fallen on a Thursday in the shower room after a fall;<br><br>-He/She fell in the shower room after staff (Nurse Aide (NA) D) had left him/her alone in the shower and said he/she would be right back;<br><br>-He/She turned on the call light but got cold and decided to get dressed by himself/herself; he/she did not know how long he/she had waited for help;<br><br>-When trying to put on his/her pants, he/she lost his/her balance and fell to the floor;<br><br>-Initially he/she thought he/she was okay and was able to walk back to his/her room after staff checked him/her out;<br><br>-He/She had pain all weekend but did not tell anyone until Monday after his/her fall;<br><br>-He/She fractured his/her hip, was sent to the hospital and returned to the facility on [DATE] after surgery.<br><br>During an interview on 11/27/24 at 1:53 P.M., Nurse Aide (NA) D said the following:<br><br>-He/She was the staff member assigned to give the resident a shower the day the resident fell ;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -He/She was assisting the resident with a shower and another staff member asked for his/her assistance to help with another resident;<br><br>-He/She gave the resident the call light an instructed him/her to push the call light when finished with the shower;<br><br>-He/She assumed Resident #2 was independent and could be in the shower alone;<br><br>-He/She was unaware the resident needed assistance to shower and dress;<br><br>-He/She found out later that the resident was not a self-assist and should not have been left alone;<br><br>-The resident care plans are in the computer and staff have access to them for review;<br><br>-He/She should not have left the resident alone in the shower;<br><br>-He/She has been in-serviced on how to care for the resident and not leaving residents alone in the shower since the incident.<br><br>During an interview on 11/27/24 at 2:15 P.M., the Assistant Director of Nursing (ADON) said the following:<br><br>-Resident #2 should not have been left alone in the shower room;<br><br>-If a care plan shows a resident needs assistance by one staff for a shower, they should not be left alone.<br><br>During an interview on 11/27/24 at 2:42 P.M., the Director of Nursing (DON) said the following:<br><br>-Resident #2 should not have been left alone in the shower room;<br><br>-All nursing staff have been in-serviced related to the incident.<br><br>During an interview on 11/27/24 at 3:10 P.M., the administrator said the following:<br><br>-The care plan should be followed to direct the care a resident receives;<br><br>-The care plan says one assist for hygiene/bathing/dressing at least one staff member should be present for those tasks and should not be left alone.<br><br>MO244794 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189<br><br>Based on observation, interview, and record review, the facility failed to respond to call lights in a timely manner for three residents (Resident #12, #3 and #8), in a review of 18 sampled residents. The facility census was 87.<br><br>Review of the facility's policy, Communication - Call System, revised 10/24/22, showed the following:<br><br>-The facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities;<br><br>-Nursing staff will answer call lights promptly;<br><br>-Call lights located within resident bathrooms are considered emergency calls due to the potential for falls and injury and must be answered promptly.<br><br>1. Review of Resident #12's admission record showed the resident's diagnoses included dementia, arthritis, muscle weakness, cognitive communication deficit, and other abnormalities of gait and mobility.<br><br>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/02/24, showed the following:<br><br>-Moderate cognitive impairment;<br><br>-Supervision or touching assistance for toileting;<br><br>-Partial to moderate assistance with dressing and bed mobility;<br><br>-Partial to moderate assistance with sit to stand transfers and chair/bed/toilet transfers;<br><br>-Supervision or touching assistance with ambulation;<br><br>-Occasionally incontinent of urine and frequently incontinent of bladder.<br><br>Review of the resident's Care Plan, revised on 10/29/24, showed the following:<br><br>-The resident was at risk for falls;<br><br>-Ensure the call light is within reach and encourage the resident to use it for assistance as needed.<br><br>Review of the resident's call light log for 11/01/24 through 11/26/24 showed the following:<br><br>(continued on next page) |

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| | 265589 | A. Building<br>B. Wing | 11/27/2024 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 11/1/24 at 3:58 P.M., call light activated for 15 minutes. Call light reactivated at 4:15 P.M.; call light activated for 17 minutes;<br><br>-On 11/2/24 at 8:10 A.M., call light activated for 47 minutes;<br><br>-On 11/2/24 at 10:24 A.M., call light activated for 20 minutes;<br><br>-On 11/2/24 at 3:03 P.M., call light activated for 43 minutes;<br><br>-On 11/2/24 at 6:15 P.M., call light activated for 23 minutes;<br><br>-On 11/3/24 at 8:13 P.M., call light activated for 18 minutes;<br><br>-On 11/4/24 at 5:59 A.M., call light activated for 1 hour and 21 minutes;<br><br>-On 11/4/24 at 4:36 P.M., call light activated for 21 minutes;<br><br>-On 11/4/24 at 8:33 P.M., bathroom call light activated for 18 minutes. Call light reactivated at 9:06 P.M.; call light activated for 16 minutes;<br><br>-On 11/5/24 at 6:45 A.M., call light activated for 58 minutes;<br><br>-On 11/5/24 at 2:18 P.M., call light activated for 29 minutes;<br><br>-On 11/7/24 at 8:57 P.M., call light activated for 37 minutes. Call light reactivated at 9:27 P.M.; call light activated for 18 minutes;<br><br>-On 11/8/24 at 12:37 P.M., call light activated for 23 minutes;<br><br>-On 11/8/24 at 9:28 P.M., call light activated for 57 minutes;<br><br>-On 11/9/24 at 8:00 P.M., call light activated for 1 hour and 3 minutes;<br><br>-On 11/10/24 at 7:07 A.M., call light activated for 30 minutes;<br><br>-On 11/15/24 at 7:33 P.M., call light activated for 47 minutes;<br><br>-On 11/17/24 at 4:29 A.M., call light activated for 26 minutes;<br><br>-On 11/17/24 at 4:35 A.M., call light activated for 21 minutes;<br><br>-On 11/25/24 at 9:50 P.M., call light activated for 24 minutes.<br><br>During an interview on 11/26/24 at 11:46 A.M., the resident said it took staff a while to answer his/her call light. Sometimes he/she had to push the call light two or three times before staff would come help.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Review of Resident #3's admission record showed the resident's diagnoses included multiple sclerosis, polyneuropathy (a condition that occurs when multiple peripheral nerves malfunction at the same time, causing weakness, numbness, and burning pain), repeated falls, muscle wasting and atrophy (a decrease in size or effectiveness of an organ or tissue), need for assistance with personal care, muscle weakness, and cognitive communication deficit.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Impairment in range of motion in both lower extremities;<br><br>-Utilized a wheelchair for mobility;<br><br>-Substantial to maximum assistance for toileting;<br><br>-Substantial to maximum assistance for all dressing;<br><br>-Substantial to maximum assistance with most mobility needs, including bed to wheelchair transfer;<br><br>-Dependent for toilet transfers;<br><br>-Occasionally incontinent of urine and frequently incontinent of bladder.<br><br>Review of the resident's Care Plan, revised on 10/14/24, showed the following:<br><br>-He/She had an activities of daily living (ADL) self-care deficit related to generalized weakness, poor coordination, and multiple sclerosis;<br><br>-Encourage the resident to use the call light for assistance. Please answer call light promptly;<br><br>-He/She was at risk for falls related to gait and balance problems and unaware of safety needs;<br><br>-Ensure the resident's call light is within reach. Encourage the resident to use his/her call light and respond to all requests for assistance promptly.<br><br>Review of the resident's call light log for 11/01/24 through 11/26/24 showed the following:<br><br>-On 11/1/24 at 3:56 P.M., call light activated for 19 minutes;<br><br>-On 11/2/24 at 7:01 A.M., call light activated for 36 minutes;<br><br>-On 11/2/24 at 9:27 A.M., call light activated for 25 minutes;<br><br>-On 11/2/24 at 2:13 P.M., call light activated for 18 minutes;<br><br>-On 11/3/24 at 6:51 A.M., call light activated for 19 minutes;<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 11/4/24 at 5:58 P.M., call light activated for 34 minutes;<br><br>-On 11/6/24 at 7:04 P.M., call light activated for 30 minutes;<br><br>-On 11/6/24 at 7:39 P.M., call light activated for 25 minutes;<br><br>-On 11/7/24 at 6:55 A.M., call light activated for 31 minutes;<br><br>-On 11/9/24 at 5:02 A.M., call light activated for 1 hour and 27 minutes;<br><br>-On 11/12/24 at 10:03 A.M., call light activated for 38 minutes;<br><br>-On 11/16/24 at 7:00 A.M., call light activated for 1 hour and 40 minutes;<br><br>-On 11/16/24 at 12:45 P.M., call light activated for 24 minutes;<br><br>-On 11/18/24 at 12:13 P.M., call light activated for 40 minutes;<br><br>-On 11/19/24 at 9:05 A.M., call light activated for 32 minutes;<br><br>-On 11/19/24 at 6:25 P.M., call light activated for 39 minutes;<br><br>-On 11/20/24 at 9:45 A.M., call light activated for 43 minutes;<br><br>-On 11/20/24 at 12:29 P.M., call light activated for 32 minutes;<br><br>-On 11/22/24 at 6:37 A.M., call light activated for 1 hour and 1 minute.<br><br>During an interview on 11/25/24 at 12:34 P.M., the resident said the following:<br><br>-Staff's response time to call lights was not very good;<br><br>-Sometimes he/she had to wait up to 30 minutes for help;<br><br>-Sometimes staff could not help right away, so they shut off the call light and left. It could take a while for staff to return or staff forget and did not return.<br><br>3. Review of Resident #8's Face Sheet showed the resident's diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block air flow and make it difficult to breathe), hearing loss, osteoarthritis of right knee (a type of arthritis that occurs when flexible tissue at the ends of bones wears down) and spinal stenosis (the narrowing of the spaces inside of the spine that can cause pain, numbness or weakness of the arms and legs).<br><br>Review of the resident's Care Plan, revised on 07/06/24, showed the following:<br><br>-The resident had an activities of daily living self-care performance deficit related to confusion, generalized weakness and spinal stenosis;<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The resident required extensive assistance with bed mobility, dressing, toilet use, transfers with assist of one staff, and ambulation with a walker.<br><br>-Encourage the resident to use call light to call for assistance.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Highly impaired hearing;<br><br>-Clear speech, makes self understood and usually understands others;<br><br>-Limited range of motion one side upper extremity;<br><br>-Partial/moderate staff assist for upper body dressing, sit to stand transfer and chair/bed-to-chair transfer;<br><br>-Substantial/maximum staff assist for toileting hygiene, personal hygiene, and toilet transfers;<br><br>-Dependent on staff for lower body dressing and putting on/taking off footwear;<br><br>-Frequently incontinent of bowel and bladder.<br><br>Review of the resident's call light log for 11/01/24 through 11/26/24 showed the following:<br><br>-On 11/02/24 at 9:33 A.M., call light activated for 18 minutes;<br><br>-On 11/03/24 at 6:30 A.M., call light activated for 1 hour and 27 minutes;<br><br>-On 11/03/24 at 4:07 P.M., call light activated for 32 minutes;<br><br>-On 11/05/24 at 10:42 A.M., call light activated for 18 minutes;<br><br>-On 11/05/24 at 3:01 P.M., call light activated for 24 minutes;<br><br>-On 11/06/24 at 7:26 A.M., call light activated for 18 minutes;<br><br>-On 11/06/24 at 6:17 P.M., call light activated for 24 minutes;<br><br>-On 11/07/24 at 7:20 A.M., call light activated for 1 hour and 19 minutes;<br><br>-On 11/07/24 at 1:06 P.M., call light activated for 22 minutes;<br><br>-On 11/07/24 at 2:48 P.M., call light activated for 36 minutes;<br><br>-On 11/08/24 at 2:25 P.M., call light activated for 49 minutes;<br><br>(continued on next page) |

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|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 11/09/24 at 8:18 A.M., call light activated for 21 minutes;<br><br>-On 11/09/24 at 3:33 P.M., call light activated for 18 minutes;<br><br>-On 11/10/24 at 4:17 P.M., call light activated for 25 minutes;<br><br>-On 11/11/24 at 9:06 A.M., call light activated for 20 minutes;<br><br>-On 11/11/24 at 1:09 P.M., call light activated for 20 minutes;<br><br>-On 11/11/24 at 2:01 P.M., call light activated for 27 minutes;<br><br>-On 11/12/24 at 2:07 P.M., call light activated for 59 minutes;<br><br>-On 11/13/24 at 5:20 P.M., call light activated for 30 minutes;<br><br>-On 11/13/24 at 7:08 P.M., call light activated for 1 hour and 16 minutes;<br><br>-On 11/15/24 at 11:45 A.M., call light activated for 24 minutes;<br><br>-On 11/15/24 at 1:00 P.M., call light activated for 29 minutes;<br><br>-On 11/15/24 at 3:49 P.M., call light activated for 1 hour and 17 minutes;<br><br>-On 11/16/24 at 7:03 A.M., call light activated for 35 minutes;<br><br>-On 11/17/24 at 8:37 A.M., call light activated for 50 minutes;<br><br>-On 11/18/24 at 7:35 A.M., call light activated for 18 minutes;<br><br>-On 11/18/24 at 9:10 A.M., call light activated for 33 minutes;<br><br>-On 11/18/24 at 6:36 P.M., call light activated for 20 minutes;<br><br>-On 11/19/24 at 7:37 A.M., call light activated for 26 minutes;<br><br>-On 11/19/24 at 8:56 A.M., call light activated for 46 minutes;<br><br>-On 11/20/24 at 7:10 A.M., call light activated for 25 minutes;<br><br>-On 11/21/24 at 7:41 A.M., call light activated for 25 minutes;<br><br>-On 11/21/24 at 3:48 A.M., call light activated for 32 minutes;<br><br>-On 11/22/24 at 6:14 A.M. call light activated for 29 minutes;<br><br>-On 11/22/24 at 7:18 A.M., call light activated for 18 minutes;<br><br>(continued on next page) |

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| St Peters Rehab and Healthcare Center | 230 Spencer Road<br>Saint Peters, MO 63376 |

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 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 11/22/24 at 6:15 P.M., call light activated for 18 minutes;<br><br>-On 11/23/24 at 7:36 P.M., call light activated for 31 minutes;<br><br>-On 11/24/24 at 8:34 A.M., call light activated for 18 minutes;<br><br>-On 11/24/24 at 2:39 P.M., call light activated for 21 minutes;<br><br>-On 11/25/24 at 6:56 A.M., call light activated for 40 minutes.<br><br>During an interview on 11/26/24, at 3:15 P.M., the resident said the following:<br><br>-At times it took staff 45 minutes to an hour to answer his/her call light;<br><br>-He/She felt like it was worse on the weekends, but it was bad all of the time;<br><br>-Sometimes staff turned off his/her call light and said they would be right back, and they did not return;<br><br>-If staff do not return within 15 or so minutes, he/she reactivated the call light.<br><br>During an interview on 11/27/24 at 12:10 P.M., Licensed Practical Nurse (LPN) A said he/she expected staff to answer a call light to be answered in five minutes or less, if there were no emergent calls or activities occurring.<br><br>During an interview on 11/27/24, at 10:53 A.M., Registered Nurse (RN) F said staff should answer a call light in less than five minutes if they were not taking care of an emergent situation.<br><br>During an interview on 11/27/24, at 2:15 P.M., the Director of Nursing (DON) said she expected staff to answer a call light as quickly as possible and within 15 minutes barring no emergent situation. It was not acceptable for it to take 30 to 45 minutes or longer before staff answer a resident's call light.<br><br>During an interview on 11/27/24, at 3:10 P.M., the Administrator said she expected staff to answer a call light within 15 minutes or as soon as possible as long as there was not an emergency occurring. It was not acceptable to her for staff to take 30 minutes to an hour to answer a call light.<br><br>MO243484<br><br>MO243898<br><br>MO244336 |