STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265711	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Meramec Valley	#1 Arbor Terrace Fenton, MO 63026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on interview and record review, the facility failed to promote the resident's self-determination through support of resident choices when staff failed to follow a resident's choice to be a no code (do not resuscitate (DNR), no life prolonging methods are performed), when staff performed cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) when the resident was found not breathing and without a pulse (Resident #1). The sample size was 3. The census was 150. The Administrator was notified on [DATE] of the past non-compliance. The facility responded appropriately when the incident occurred. Staff were provided continuing education on where to locate a resident codes status. They updated their CPR/Code Status policy and added an additional system in which staff can access a resident's current code status. The deficiency was corrected on [DATE]. Review of the Code Status (refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) Guidelines, dated ,d+[DATE] showed: -Purpose: To assure the resident's code status is communicated to all direct care staff; -Procedure: -On admission a code status will be requested from the resident and/or the representative by the Social Worker or facility designee; -If the facility has not obtained resident's documented wishes on code status upon admission, the physician's orders will be entered as administer CPR; -The evening charge nurse will be responsible for printing the order report by category for code status DAILY and place on the divisions' code status clipboard. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CPR Initiation, When Indicated policy, dated ,d+[DATE], showed: Purpose: To assure we meet professional standards of quality and provide the necessary care and services to attain or maintain the highest practicable well-being of the residents according to their request and/or as stated in their advanced directives (a written statement of a person's wishes regarding medical treatment often including a living will made to ensure those wishes are carried out should the person be unable to communicate them to a doctor). Review of the Code Status procedure, dated [DATE], showed: -A licensed nurses will confirm a resident's code status before initiating CPR, by reviewing the resident's current orders in the Electronic Health Record (EHR); -A daily report of residents' code status is generated and placed in the STAT (emergency) carts for quick reference; -The administration of CPR is guided by the physician's documented orders in the resident's EHR. Review of Resident #1's medical record, showed an admitted [DATE], with a readmitted [DATE] Review of the resident's Outside the Hospital Do Not Resuscitate order (OHDNR, refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest), showed it was signed and dated by the resident's responsible party on [DATE] and signed by the physician on [DATE]. Review of the resident's progress notes, showed: -On [DATE] at 6:48 P.M., The resident was having a hard time breathing, audible crackles, lung sounds course and crackly. Orders received for a chest X-ray; -On [DATE] at 7:00 P.M., The resident appeared to be unresponsive at nurses' station. While confirming code status 911 was called and CPR was started, during this time a pulse was detected and emergency medical staff (EMS) transported the resident to the hospital. During an interview on [DATE] at 9:36 A.M., the Administrator said she was aware staff initiated CPR on a DNR resident. The resident had only been DNR for one week. The DNR paperwork had been completed on [DATE]. There was a binder at the nurse's station that staff could look through for residents that were DNR. Resident code status information was also available in the EHR. That evening, the nurse working said he/she looked through the DNR binder and could not find the purple DNR paperwork for the resident. He/She told staff to initiate CPR and call 911. At the same time, he/she was accessing the EHR and noted the resident was DNR, but since CPR had been initiated, it could not be stopped. EMS arrived on the scene and were able to get a pulse, the resident was transported to the hospital. The resident was dead on arrival to the hospital. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], Family Member (FM) A said he/she had received a phone call from the facility. The nurse said the resident had expired. The nurse reported the resident had been making gurgling sounds so the nurse had an X-ray ordered. FM A said he/she wanted additional information leading up to the resident's death. The nurse told FM A he/she would call him/her back. When the nurse called back, he/she said he/she had been mistaken, EMS was able to get a pulse. This concerned FM A as the resident was a DNR. While FM A was on the way to the hospital, the hospital called to confirm if the resident was DNR. FM A confirmed the resident was DNR. The resident expired in the emergency room . During an interview on [DATE] at 8:37 A.M., Registered Nurse (RN) B said he/she worked on the evening in question. He/She was not the nurse assigned to the resident's unit. RN B was called to the unit by the nurse working on the unit to come assess the resident for respiratory distress. When RN B arrived at the unit, the resident was seated in a wheelchair at the nurse's station. The resident was having some respiratory distress with audible (could hear it) wheezing. The nurse called the on-call physician to get orders for a chest X-ray. When RN B got back around the corner, the resident appeared to be not breathing. RN B checked the DNR binder, but did not see a signed DNR for the resident. He/She instructed staff to lower the resident to the floor and initiate CPR. He/She called 911. At around the same time RN A accessed the resident's EHR which indicated he/she was a DNR. Staff continued with CPR until EMS arrived at the facility. EMS was able to get a faint pulse. RN B provided the DNR paperwork to EMS, and EMS transported the resident to the hospital. RN B went back through the DNR binder and was able to locate the resident's DNR paperwork. He/She had missed it the first time he/she looked through the book. RN B was aware DNR meant do not start CPR. It was a crisis situation and RN B made the decision to start CPR on the evidence available at the time. During an interview on [DATE] at 9:43 A.M., RN G said the code status for every resident could be found in the resident's EHR. The information could also be found on a clip board on each crash cart. There was a binder at each nurse's station with the DNR paperwork for residents that were a DNR. Nurses were responsible for verifying code status prior to calling a code. During an interview on [DATE] at 12:21 P.M. Licensed Practical Nurse (LPN) F said the facility provided inservice training about code status. All residents code status could be found in their medical record. There was a binder on the desk with the signed DNR paperwork and now there was a clip board on each crash cart with every resident's name and code status. It was the responsibility of the nurse to check the chart for code status prior to CPR being initiated. During an interview on [DATE] at 12:37 P.M., LPN H said the facility provided additional inservice training regarding code status. The code status will be in each medial record. There was a list of all the residents' names on the crash cart. The DNR paperwork was kept in a binder at the nurse's station. It was the responsibly of the nurse to verify code status before a code was called. During an interview on [DATE] at 12:58 P.M., LPN I said the facility provided inservice training about code status and where to find and verify code status. The resident's medical record had their code status and each resident's name, with their code status on a clip board at each nurse's station. Each crash cart had a clip board with all the residents' names and their code status. A nurse was responsible to verify a resident's code status prior to initiating a CPR. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:23 P.M., LPN J said a resident's code status could be found in their medical record. For quick reference, each crash cart had a clip board with every resident's name and code status. There were binders at each nurse's station with the DNR paperwork available to review. A nurse must verify a code status in the medical record prior to CPR being initiated. During an interview on [DATE] at 2:35 P.M., the Administrator and Director of Nursing said there were two ways to check a resident's code status. There were binders at the nurse's station, clipboards with all residents' code status on the crash cart and always in the resident's EHR. Staff should check and double check a code status prior to starting CPR. If no DNR paperwork could be located, staff were to treat the resident as a full code. The code status paperwork should be signed by the resident or his/her responsible party, and the physician. The code status should be accessible, documented as a physician order and match in the electronic system and on paper forms. The resident's code status choice should be honored. MO00252205