STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50366 Based on interview and record review, the facility failed to ensure one resident's right to be informed in advance of treatment and treatment alternatives or treatment options and to choose the alternative or option he/she preferred when staff did not inform the resident's representative prior to the resident having lung surgery (Resident #1). The sample was 4. The census was 80. Review of facility's Change in a Resident's Condition or Status policy, revised 8-24-24, showed: -The facility will assess and identify a change in condition to ensure the resident receives appropriate care; -Procedure: -The nurse supervisor/charge nurse will notify the resident's family or representative when: -There is a significant change in the resident's condition; -It is necessary to transfer the resident to a hospital; -Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status; -The nursing supervisor/charge nurse will document of changes in the resident's medical record, updating of resident and, family of change in status. Review of Resident#1 quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/17/25, showed: -Moderate cognitive impairment; -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD, progressive lung disease that makes it hard to breath), malignant neoplasm of right upper lobe of lung (cancer of right upper lung), bipolar disorder (mental health condition characterized by significant mood swing), personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems).in ways that cause problems). (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's care plan, in use during the survey, showed: -Problem: Responsible Party, Resident has a legal guardian, Public Administrator (PA); -Goal: The resident's guardian will continue to assist me in making informed decisions; -Approaches included: -Actively involve the resident's guardian in his/her care by inviting his/her guardian to meetings as needed; -Assist the resident in contacting his/her guardian about concerns that he/she may have. Review of the resident's physician orders, showed no orders for surgery. Review of resident's progress notes, showed: -A progress note dated 2/3/25 at 2:11 P.M., by Social Services The last note that showed requesting the PA to sign the consent forms for bronchoscope biopsy (a small cameral inserted into the airways to view the lungs); -A progress note dated 4/15/25 at 14:22 P.M., by Licensed Practical Nurse (LPN) A, nursing admission summary including message left on phone recording to the PA's Office with resident update and readmit to the facility; -A progress note dated 4/17/25 at 12:00 P.M. by the Administrator, late note on Friday 4/11/25, email came from PA's Office requesting referral pack sent to them. Called the following Monday, 4/14/25, to apologize if there was a problem relating to previous Director of Nursing (DON); -No other progress notes to show communication between the facility and PA in reference to resident's lung surgery to remove right upper lobe for cancer. During an interview, on 4/17/25 at 9:15 A.M., the resident's PA Deputy (PAD) said the PA's Office was unaware the resident was scheduled for lung cancer surgery or was admitted to the hospital for surgery until the resident called the office on 4/8/25, to give the PA an update on his/her surgery that took place on 4/2/25. After speaking with the resident, the PAD said he/she called the nursing facility and spoke with the Assistant Director of Nursing (ADON). The ADON said this had been in the works for a while, and didn't know why the PAD was not notified but would have someone get back with the PAD. The ADON also said the lack of communication was probably due to the change in administration during this time. The PAD did not hear back from the facility until 4/16/25 after the PA's office requested a referral package on 4/11/25 and again on 4/16/25. The PA's office was aware of the mass on 8/23/24 when they received a Magnetic Resonance Imaging (MRI, scan that produces detailed images of the inside of the body) report recommending a follow up Computed Tomography (CT, a diagnostic imaging procedure that produces images of the inside of the body). This scan was cancelled once due to insurance issues. The MRI scan was performed and on 1/8/2. The last contact the PA's Office had with the facility, about resident's lung cancer, was on 2/3/25 for consent to perform a bronchoscope with anesthesia. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/17/25 at 11:27 A.M., the resident said he/she was upset because he/she is going to have to move because the facility did not tell his/her PA about having lung surgery to remove his/her cancer. He/She denied telling the PA about the surgery and said they were aware of the lung mass. He/She said, I know (LPN A) called them about the surgery because he/she told me he/she did. The resident added, he/she used to talk to a different PAD prior to this one. The resident said he/she told the new PAD that from now on the resident would make sure they know about everything. The resident just didn't want to move because he/she likes it here and has been here for eight years. During an interview on 4/17/25 at 11:44 A.M. LPN A said he/she did not work the day the resident went to surgery and doesn't remember speaking with the PA's Office but if he/she did, it would be in the progress notes. During an interview on 4/17/25 at 2:26 P.M. the ADON said he/she did not work the day the resident went to surgery. When the PA's Office is notified, it will be in the progress notes. He/She received a call from the PAD on 4/8/25 and he/she would check into why they were not notified. He/She was not aware prior to the call that they were not notified. The old DON had been taking care of notifying next of kin, power of attorneys, families, and PAs about changes in conditions but he/she was no longer here on 4/8/25. He/She does not remember if he/she told anyone else, but he/she thinks the Administrator knew about it. There was a lot of things going on that day he/she does remember that. Certified Medication Technician (CMT) B took the resident to the hospital and stayed until after the surgery. During an interview on 4/17/25 at 2:43 P.M. CMT B said, he/she went with the resident to the hospital for the surgery and stayed until the resident was in recovery. They arrived to the hospital at 6:30 A.M. After surgery, he/she returned to the facility around 2:00 P.M. and gave the previous DON the resident's condition update. Resident returned to the facility on [DATE]. He/She did not speak with the PA's Office prior to or after surgery. The DON is responsible for that. During an interview on 4/17/25 at 1:50 P.M., LPN C, said when a resident leaves for medical treatment the facility sends a face sheet, medication list, and bed hold form. They notify the resident's PA whenever they are not aware of something or if the resident has a change in condition. It is the same type of notification for all residents to notify next of kin and/or responsible party. The charge nurse is responsible to notify the PA, next of kin or responsible party. If a resident has an appointment, LPN C calls the PA, next of kin, or responsible party (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25 at 1:40 P.M. the Administrator and DON said when a resident has a PA the facility is responsible to notify prior to treatment and the PA is responsible to speak with the resident and help guide them through the treatment plan, approve the treatment, and sign consent forms unless the resident is having an medical crisis and needs treatment. It is the responsibility of the nurse or charge nurse to reach out to the PA as soon as possible. The charge nurse or the nurse who is in charge at the time is responsible to put these forms together and give them to the resident and/or resident guardian. They do not know if this was completed for the resident. Progress notes should be written to show who was notified, what was sent, and who they spoke to. They did not know progress notes were not written, and they are unable to verify if the PA's Office knew about the resident's surgery prior to the resident calling them after the surgery. They should receive approval from the PA's Office prior to sending the resident for treatment unless it is an emergency. They have not been officially told by the PA that he/she was not notified. They suspected something was wrong when the transfer request came in on 4/11/25, They followed up on 4/14/25 but they have not heard back from them. They are assuming the previous DON did not notify the PA. They have not spoken with the PA about this issue but have left several messages for a return call. The Administrator said he/she was unaware the PA had called about not being notified. MO00252492