STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Care of St Joseph	3002 North 18th St Saint Joseph, MO 64505

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44993 Based on interviews and record review the facility failed to complete neurological assessment's for one resident (Resident #1), after the resident reported to Registered Nurse (RN) A on he/she had fallen the night prior and someone picked him/her off the floor. The resident was noted to have bruise to his/her torso and increased confusion. RN A did not initiate neurological assessment's. Additionally, the facility Certified Nurses Aide (CNA) A failed to notify the nurse immediately when he/she found the resident on the floor during the night of 12/4/24. CNA A and CNA B assisted the resident off the floor and back to bed. The facility census was 139. Review of the fall policy dated 2020 showed: - The staff were supposed to assess the resident after a fall; - The staff were supposed to complete a post-fall assessment. Review of the head injury policy dated 9/1/21 showed: - The staff were expected to assess if there is a known, suspected or verbalized head injury; - Perform neurological assessments as indicated. 1. Review of the Resident #1's Admission Minimum Data Set, (MDS, a federally mandated assessment completed by the facility staff), dated 11/5/24 showed: - Diagnoses included: Diabetes Mellitus (DM) type two (a disease in which the body does not process blood sugar properly), history of falls, anticoagulant (medicine to prevent blood clots) use, and heart failure. - Brief Interview for Mental Status (BIMS) score of 14, indicating the resident did not have a cognitive deficit; - The resident required assistance for staff to use the toilet, get dressed and shower; - The resident used a wheel chair for mobility; - The resident had a history of falls prior to admission. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's comprehensive care plan dated 11/1/24 showed: - 11/1/24 The resident was at risk for falls; - 11/30/24 The resident had an actual unwitnessed fall on 11/30/24; - 12/2/24 The staff were to anticipate the resident's needs; - 12/2/24 The staff were supposed to initiate neurological assessments for an unwitnessed fall and ensure the resident had a clear path; - 12/6/24 The resident had an unwitnessed fall with an intervention to obtain lab work. Review of the resident's record showed: - A fall assessment was completed on 11/30/24 with a score of eight, indicating the resident was at a low risk for falls; - A fall assessment was completed on 12/6/24 with a score of 48, indicating the resident was a high risk for falls; - Facility staff documented on 12/5/24 at 8:49 A.M. the resident was more confused than usual and was incontinent of urine; - LPN A documented on 12/5/24 at 9:47 A.M. he/she obtained an order for them resident's physician to check the resident for a Urinary Tract Infection (UTI); - Another staff member documented on 12/5/24 at 12:00 P.M. the resident was not feeling well and in bed sleeping; - Staff documented on 12/5/24 at 12:07 P.M. they attempted to obtain a urine sample from the resident and was unsuccessful; - RN A documented on 12/5/24 at 4:01 P.M. he/she saw new bruises to the resident's left hip, and flank (side/rib area). the resident reported to RN A he/she had fallen the night prior, he/she yelled and somebody lifted him/her off the floor; - The facility staff did not document the resident fall on 12/4/24; - RN A did not initiate neurological assessments; - X-ray was obtained on 12/6/24 and found the resident had a fractured right collar bone; - The resident was sent to the hospital on 12/7/24 due to increased confusion and a fractured collar bone. During and interview on 12/12/24 at 2:35 P.M. CNA A said: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- He/She was completing 5:00 A.M. rounds on 12/5/24 and heard the resident yelling help; - The resident was sitting on his/her bottom on the floor in front of his/her wheelchair; - The resident had a small open area to his/her left upper leg and bruising; - The resident said he/she needed to use the bathroom; - CNA A got CNA B and both CNA's picked the resident up off of the floor and placed him/her into his/her wheel chair; - The CNA's did not tell the charge nurse of the resident's fall before they got him/her up off the floor; - CNA A knew the nurse was supposed to assess the resident before getting the resident up; - CNA A notified the charge nurse of the fall once the resident was taken to the bathroom and placed back in his/her wheel chair. During an interview on 12/12/24 at 12:05 P.M. RN A said: - He/She was helping the charge nurse on 12/5/24 obtain a urine sample from the resident and he/she had his/her shirt off; - RN A saw bruises to the resident's right flank area and a bruise to the top of his/her right hand; - The resident reported to RN A he/she had fallen the night before and someone lifted him/her off the floor; - RN A documented the observation the nursing record, but did not start neurological assessments; - He/She should have initiated neurological assessments. During an interview on 12/12/24 at 12:28 P.M. Family Member A said: - The facility nurse called him/her on 12/6/24 and reported the resident needed more help with his/her cares; - He/She visited the resident the morning of 12/7/24 while the resident was at the breakfast table and saw a pool of blood under the resident's chair and discovered a skin tear; - The resident was not able to feed him/herself that morning and was able to on 12/5/24; - He/She saw a large bruise on the resident and the resident was confused; - The facility staff did not report a fall of any injuries to him/her; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident was sent to the hospital at that time. During an interview on 12/12/24 at 12:45 P.M. the Director of Nursing (DON) said: - He/she expected CNA A and CNA B to wait for the nurse to assess the resident before repositioning the resident after being found on the floor; - He/She expected neurological assessments to be completed on all falls that were not witnessed. During an interview on 12/12/24 at 1:25 P.M. The Administrator said: -The CNA's should not have picked the resident up before the charge nurse could assess the resident for injuries; - The staff should have initiated neurological assessments when the resident had an unwitnessed fall. During an interview on 12/13/24 at 9:15 A.M. the residents Primary Care Physician said: - He/She would have expected the nurses to complete neurological assessments on the resident once they discovered he/she had fallen; - It is his/her expectation that neurological assessments are completed on all falls that are not witnessed; - It would be his/her expectation CNA's would not pick up or reposition the resident until the nurse has assessed the resident for injuries. MO246258