

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Brooking Park		STREET ADDRESS, CITY, STATE, ZIP CODE  307 South Woods Mill Road Chesterfield, MO 63017	
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)		
<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34926</p> <p>Based on interview and record review, the facility failed to assess one of four sampled residents (Resident #1) for risk of entrapment from a bed rail and failed to ensure the bed rail did not pose a risk of entrapment when staff installed bed rails with a low air loss mattress. The resident was at risk for a serious adverse outcome when staff failed to assess the use of bed rails with the addition of a new low air loss mattress. On [DATE] at 9:40 P.M., staff found the resident on the floor with his/her head stuck between the rail and the mattress. The resident's buttocks were on the floor, his/her neck was stuck between the rail and the mattress, and his/her face was blue. The resident expired at the hospital. The census was 58.</p> <p>The Administrator was informed on [DATE] of an Immediate Jeopardy (IJ) past non-compliance, which occurred on [DATE]. Facility staff were inserviced and a system was immediately put in place to evaluate and remove bed rails. The IJ was corrected on [DATE].</p> <p>Review of the facility's Adaptive/Assistive Device and Potential Restraints Policy, review date ,d+[DATE], showed:</p> <p>-Policy Statement: To ensure that physical restraints and adaptive/assistive device will be used only when it has been determined through an evaluation process that it is necessary to treat a resident's medical condition or as a therapeutic intervention to enhance the resident's functional abilities to promote the resident's highest level of wellbeing and after evaluation of risks;</p> <p>-Procedure:</p> <p>--A physical restraint and adaptive/assistive device will be used only when it has been determined through an evaluation process that it is necessary to treat a resident's medical condition or as a therapeutic intervention to enhance the resident's functional abilities;</p> <p>(continued on next page)</p>		

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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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Adaptive/assistive devices such as geri-chairs (large padded chairs with wheeled bases, and are designed to assist seniors with limited mobility), Broda chairs (tilt-in-space positioning wheelchairs), siderails and assist bars, low air loss mattresses (made up of many inflatable air tubes that inflate and deflate in an alternating pattern. This mimics the movement of a patient shifting in bed, and relieves pressure on the body, especially in areas like the hips, shoulders, elbows, and heels), canoe/scoop mattresses (designed with raised edges or contoured sides that 'scoop' upward, creating a barrier to help prevent users from rolling off the bed), alarms and other devices and/or combination of devices that are not assessed as a restraint will be evaluated for necessity and risk prior to being placed, quarterly, upon significant change of condition, and when a mattress is changed;</p> <p>--Siderail(s) and assist bars will be evaluated in combination with the mattress prior to placement of a mattress or siderail(s) upon admission, quarterly, upon significant change in condition, and each time the mattress is changed;</p> <p>--A low air loss mattress will not be routinely placed by hospice. Low air loss mattresses will only be used when conventional pressure reduction mattresses are inadequate to heal or prevent pressure ulcers, or when other means of providing comfort and pain control have proven inadequate;</p> <p>--Low air loss Mattresses that are not the communities' stock conventional pressure reduction mattress will only be placed after approval by the Director of Nursing (DON) or his/her designee and only after evaluation if the device (low air loss mattress or non-stock conventional pressure reduction mattress) using Adaptive/Assistive Device and Potential Restraint Evaluation form. The resident will not be placed on the mattress until it has been examined by the DON or his/her designee stated above;</p> <p>--Consent will be obtained from the resident (when appropriate) or responsible family member/legal guardian/durable power of attorney (DPOA) for adaptive devices such as siderails and assist bars, low air loss mattresses and other devices and/or combination of devices placed near, next to, or in contact with the resident's body (excluding braces, splints, casts, canes, walkers, and other devices that pose minute risk of harm) prior to placement if the device assessed to be a restraint. Consent will be obtained for siderails and bed-assist bars whether or not they serve as restraints;</p> <p>--For residents who have been newly admitted to the community and deemed appropriate for the implementation of assist/mobility bars, nursing will provide frequent monitoring for the first 48 hours the resident has the assist bars in place to ensure safety and proper utilization. This will include monitoring the resident every hour for the first 24 hours, then every two hours thereafter for the next 24 hours. If after 48 hours, there is no evidence of possible injury/negative outcome and resident is utilizing assist bars appropriately, then monitoring will cease unless otherwise indicated;</p> <p>-Clarification:</p> <p>--The DON or designee must evaluate restraints, low air loss mattresses, and non-stock pressure reduction mattresses used in combination with side rails;</p> <p>--Licensed nurses who have been educated in evaluation may evaluate other adaptive/assistive devices including side rails when used in combination with non low air loss and stock community pressure reduction mattresses, as approved by the DON.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's medical record, showed:</p> <ul style="list-style-type: none"> <li>-admitted to the facility on [DATE];</li> <li>-Weight 301 pounds on [DATE].</li> </ul> <p>Review of the resident's baseline care plan, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Vision and hearing adequate;</li> <li>-Understands and can easily communicate with staff;</li> <li>-Required substantial/maximal assist with toileting hygiene, showering and upper body dressing, rolling left to right in bed, moving from a sitting position to a lying positions, moving from a lying position to a sitting position, and moving from a sitting position to a standing position;</li> <li>-Dependent on staff for lower body dressing, putting on and taking off footwear, chair to chair and chair to bed transfers, toilet transfers, and tub/shower transfers;</li> <li>-Required a walker and/or wheelchair;</li> <li>-Alert but cognitively impaired with fluctuations with moderate cognitive impairment;</li> <li>-Had a history of falls within the previous month prior to admission:</li> <li>-Used a positioning assistance bar.</li> <li>-Had a fall on [DATE] without injury.</li> <li>-Offer to assist the resident with toileting every two hours.</li> </ul> <p>Review of the resident's Fall Risk Assessment, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-One to two falls in the past three months;</li> <li>-Alert and oriented times three (alert and oriented to person, place and time);</li> <li>-Chair bound and incontinent;</li> <li>-No noted drop in blood pressure between lying and standing;</li> <li>-Vision adequate;</li> <li>-Did have a change in condition in the last 14 days;</li> <li>-Recent hospitalization in the last 30 days;</li> <li>-Balance problems while standing and walking;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Therapist G and Therapist H were in the room with the resident, saw the mattress on the floor and decided to help out and put it on the bed.</p> <p>Review of the resident's progress notes, showed:</p> <p>-[DATE] at 7:37 A.M.: On [DATE] at 6:24 A.M., upon staff making rounds, patient was found on the floor lying in side-lying position. No new wounds. Nurse tried to reach out to resident's responsible party, but hasn't got ahold of them. Nurse reached out to fire department to pick the resident up and put him/her back in the bed. Resident is in stable condition, bed in the lowest position, patient is non-compliant with using the call light. Nurse asked the resident what he/she was trying to do. The resident said he/she was trying to take himself/herself to the bathroom. Nurse notified telehealth. Staff will continue to monitor resident for safety and activities of daily living (ADLs). Call light within reach. Vital signs are in stable condition;</p> <p>-[DATE] at 8:03 A.M.: Resident's physician and family made aware of the fall.</p> <p>Review of the resident's progress notes, showed:</p> <p>-[DATE] at 10:40 P.M.: At 8:20 P.M., this writer gave the resident his/her Lipitor (treats high cholesterol). At 9:40 P.M., the Certified Nursing Assistant (CNA) came to this Licensed Practical Nurse (LPN) for assistance due to resident fall out of bed. Upon arrival, the resident was found with his/her legs on the floor and head stuck between the rails. Attempted to get his/her head out of the rail. Staff could not completely get it out. RN called 911 at 9:55 P.M. At 10:00 P.M., the Emergency Medical Technicians (EMTs) and police arrived. CPR was performed. After performing CPR, at 10:15 P.M., pulse was responding. This writer called the Administrator at 10:12 P.M. At 10:23 P.M., the resident was sent out to the hospital. At 10:28 P.M., the resident's family was called and informed;</p> <p>-No progress note that the resident was assessed/evaluated for the use/placement of an assistive grab bar and/or the use of a LAL mattress with the assistive grab bar.</p> <p>Review of CNA B's Witness Statement, dated [DATE], showed:</p> <p>-Reported to the facility for the evening shift at 2:30 P.M., on [DATE];</p> <p>-Went to find the aide on duty to get report and do rounds;</p> <p>-Aide was in the resident's room changing his/her brief and putting him/her into bed;</p> <p>-The call light was in reach, his/her head was elevated at a 45 degree angle and he/she was watching TV;</p> <p>-He/She went back into the room at approximately 5:15 P.M., to deliver his/her evening dinner tray;</p> <p>-The resident stated that he/she was not hungry;</p> <p>-Asked resident if he/she would like a soda and he/she said yes;</p> <p>-He/She didn't talk much, just yes or no answers;</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She had a faint pulse;</p> <p>-Staff attempted to get his/her neck out of the rail, but could not get it completely out;</p> <p>-Staff moved the mattress to get his/her neck out as much as possible. RN C called 911;</p> <p>-The police and EMT arrived around 10:00 P.M.;</p> <p>-The police got his/her neck free and started CPR;</p> <p>-The Administrator was called around 10:12 P.M.;</p> <p>-At 10:15 P.M., the EMT got a pulse;</p> <p>-At 10:23 P.M., the EMTs took the resident to the hospital.</p> <p>Review of RN C's Witness Statement, dated [DATE], showed:</p> <p>-He/She was sitting at the nurse's station completing his/her charting and round 9:40 - 9:45 P.M., the CNA came to the nurse's station saying there was a resident stuck in the bedrail by his/her neck. The resident was blue in color and hanging off the bed;</p> <p>-The nurse on that assignment ran to the resident's room with the assigned aide to assist the resident;</p> <p>-Based off the statement the aide made about the resident being blue in color, he/she called 911 and was attempting to obtain a code status;</p> <p>-After that, he/she called the police at 9:50 P.M.;</p> <p>-He/She called the resident's physician and the administrator after that.</p> <p>During an interview on [DATE] at 2:44 A.M., CNA E said:</p> <p>-The agency aide came out of the resident's room and asked for assistance getting the resident off the floor;</p> <p>-Upon entering the room, it was noted that the resident was sitting on the floor with the bed rail over his/her head and holding his/her throat on the bar. Only his/her nose and mouth was sticking through. He/She was still breathing and his/her eyes were open, but not moving. CNA E got in the resident's face and yelled the resident's name. They tried to undo the mattress and get him/her out, but was unable to get him/her out due to his/her size;</p> <p>-The nurse entered the room;</p> <p>-The EMTs came into the room and got the resident out and resuscitated him/her. The EMTs said he/she still had a pulse when they left with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The bed was not in the low position when he/she entered the room, but it should have been.</p> <p>During an interview on [DATE] at 3:33 P.M., RN C said:</p> <p>-The aide came down to the nurse's station close to 9:50 P.M. and said the resident was blue and not breathing, and his/her head was stuck in the bed rail;</p> <p>-RN C called 911 while the resident's nurse went down to the resident's room with the aide. By the time he/she hung up, the police and EMS were running in the door;</p> <p>-The police and EMS were able to get the resident out from between the bed and the rail and started CPR.</p> <p>Review of the EMS run sheet, dated [DATE], showed:</p> <p>-The 911 call was received on [DATE] at 9:45 P.M.;</p> <p>-Resident's level of distress was severe;</p> <p>-Signs and symptoms were cardiac arrest;</p> <p>-While responding to the scene, 911 dispatch advised that the patient was unconscious with breathing status unknown, possibly in cardiac arrest;</p> <p>-Assessment time was 10:08 P.M.;</p> <p>-The resident was found in cardiac arrest on the floor with CPR being performed by the police department;</p> <p>-The resident had no spontaneous breaths and no pulses;</p> <p>-The resident was still warm and his/her color was pale;</p> <p>-No lividity (discoloration of the skin that occurs after death, caused by blood pooling in the body's veins and capillaries) or pooling was noted;</p> <p>-Nursing home staff reported that the resident was wedged between the bed and the wall when he/she fell , and it is believed that he/she asphyxiated;</p> <p>-Nursing home staff was unable to provide a detailed history reporting the resident was new to the facility;</p> <p>-Due to the resident having high ET/CO2 (a measurement of the amount of carbon dioxide in exhaled breath) readings and periods of an organized rhythm with a pulse confirmed with ultrasound the decision was made to transport to the closest hospital;</p> <p>-A pulse was regained at 10:13 P.M. and lost at 10:25 P.M., with CPR initiated and pulse regained at 10:31 P.M., and maintained throughout transport;</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Pupils were reactive;</p> <p>--Overbreathing the ventilator (the patient and the ventilator are not in sync and the patient breathing faster than the rate set on the ventilator);</p> <p>--Would occasionally, spontaneously open eyes.</p> <p>Review of the resident's Unwitnessed Fall Report, dated [DATE], showed:</p> <p>-Incident description: Resident found on the floor in his/her room. Resident found with his/her buttocks on the floor with his/her neck stuck in the rail. His/Her head was lying to the left. Resident had a faint pulse. Two aides and the nurse attempted to get the resident to the floor but were unsuccessful. Staff was able to get the resident's neck out of the assist rail by pushing the mattress back;</p> <p>-Immediate action taken: Resident sent to the hospital;</p> <p>-Injuries note at the time of the incident: No injuries noted at the time of the incident;</p> <p>-Level of consciousness: Comatose (a state of deep unconsciousness for a prolonged or indefinite period, especially as a result of severe injury or illness);</p> <p>-Mobility: Wheelchair bound;</p> <p>-Injuries reported post incident: No injuries observed post incident;</p> <p>-Predisposing environmental factors: Other (no description);</p> <p>-Predisposing physiological factors: Confused, impaired memory, and weakness/fainted;</p> <p>-Predisposing situation factors: admitted in the last 72 hours and siderails up;</p> <p>-Other information: Resident was lethargic;</p> <p>-Statements: No statements found;</p> <p>-Agencies/People notified: Physician and family.</p> <p>Review of the resident's medical record, showed:</p> <p>-No Assistive Device Audit tool;</p> <p>-No Adaptive Device/Potential Restraint form;</p> <p>-No assessment or evaluation of the resident for the use of assistive devices or assistive devices with the use of a LAL mattress.</p> <p>During an interview on [DATE] at 10:11 A.M., the CPSO/CCO said:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Brooking Park		STREET ADDRESS, CITY, STATE, ZIP CODE  307 South Woods Mill Road Chesterfield, MO 63017	
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)		
<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-At approximately 9:40 P.M., last Thursday, [DATE], the resident was found sitting on the floor with his/her head stuck between the mattress and the assist bar on the bed;</p> <p>-The resident had a pulse but was not breathing;</p> <p>-Staff attempted to dislodge his/her head, but was unable to due to the resident's size;</p> <p>-911 was called and the police were here within ,d+[DATE] minutes;</p> <p>-The police and EMS were able to get the resident dislodged and began CPR;</p> <p>-He/She arrived at the facility at approximately 10:30 to 10:40 P.M.;</p> <p>-The Administrator was also there;</p> <p>-Witness statements were obtained from all pertinent staff;</p> <p>-Investigation began;</p> <p>-Friday, [DATE], they started to evaluate what happened and analyze the incident;</p> <p>-They pulled four critical pathways they feel may be involved in the incident;</p> <p>-The resident had a bed with a U shaped grab bar and a LAL mattress was put on the bed without an assessment/evaluation performed;</p> <p>-They found the facility needed a process for assessing the need for specialty devices and mattresses and for assessing the safety and fit after the mattress is placed;</p> <p>-They are also looking at the mattress and overlay placement process;</p> <p>-The investigation showed that some assessments, mattress checks after placement and consent form were not getting done;</p> <p>-The facility kept in contact with the hospital and the first couple of reports showed the resident to be in critical but stable condition, then moved to ICU and told he/she was stable. On Sunday, they were told he/she was on a ventilator. They were informed the resident passed away on [DATE].</p> <p>During an interview on [DATE] at 3:09 P.M., the Therapy Director said:</p> <p>-At the time of the incident, he/she was not aware of any protocol related to placing mattresses on beds with side rails.</p> <p>During an interview on [DATE] at 11:13 A.M., the CPSO/CCO said:</p> <p>-There was a break in protocol on assessing residents before equipment placement and equipment after placement.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 8:40 A.M., the Administrator said:</p> <ul style="list-style-type: none"> <li>-The resident had a history of falling at home;</li> <li>-The resident was found on the floor earlier that day without injury;</li> <li>-The resident would try to get up and take him/herself to the bathroom without asking for assistance;</li> <li>-At approximately 10:00 P.M., on [DATE], nursing called him and said the resident had fallen and was trapped between the mattress and the assist rail;</li> <li>-The staff where unable to dislodge the resident due to his/her size;</li> <li>-Staff had already called 911 and they arrived within approximately three minutes;</li> <li>-EMS were able to dislodge the resident and start CPR;</li> <li>-The Administrator went to the facility immediately to check on the residents and begin the investigation;</li> <li>-Based on the investigation, it was approximately 40 minutes from the last time the resident was checked to when the resident was found trapped;</li> <li>-He does not feel staff followed policy/procedure when placing the LAL mattress on the bed with the assist rails;</li> <li>-He does feel nursing staff followed policy/procedure and acted responsibly when the resident was found trapped;</li> <li>-The CNA and nurse were both agency staff;</li> <li>-Agency staff are provided a binder with all policy and procedures in it for review and must sign a document that they were provided the information and read it;</li> <li>-He called the hospital several times and got updates on the resident. One day he was informed they were going to extubate (removal of an endotracheal tube (or ETT) from the throat and windpipe. An ETT is used to help breathe when one can't breathe on their own either due to surgery, injury or illness) and turn off all machines. The next time he called back, the resident had expired (died );</li> <li>-It was a terrible situation and they tried to be proactive and quickly get procedures in place so it would never happen again.</li> </ul> <p>MO00245555</p>