

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on interview and record review, the facility failed to ensure staff consistently provided residents with two showers per week as scheduled. Of the 9 residents sampled, problems were identified with 8 (Residents #3, #2, #1, #7, #5, #9, #10 and #11). Seven of those 8 were interviewed, and they all said they preferred to have their showers as scheduled. One resident (Resident #2) was not interviewable, but his/her shower record showed he/she did not receive his/her showers as scheduled. The census was 90.</p> <p>Review of the Facility Assessment (an assessment used to determine what resources are necessary to care for residents competently), dated 9/20/23, and completed by the Administrator, Director of Nurses (DON), Assistant Director of Nurses (ADON), Director of Rehabilitation, Maintenance Supervisor, Dietary Supervisor, and Medical Director, showed:</p> <ul style="list-style-type: none"> -Average daily census: 90; -Residents independent for dressing, bathing, transfers, eating, toileting: 5; -Residents requiring assist of 1-2 staff for dressing, bathing, transfers, eating, toileting: 70; -Residents dependent for: Dressing: 9, bathing: 14, transfers: 12, eating: 7, toileting: 15; <p>-Staff Type/Plan: The following contains the facility's budgeted staffing plan. Staff will be adjusted based on resident needs and the skill levels of available staff. Certified Nursing Assistants (CNAs) to residents: 1:12 ratio on days, and 1:15 on nights.</p> <p>1. Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/19/24, showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability To Understand Others: Usually understands, misses some part/intent of message but comprehends most conversation; <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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Moderate cognitive impairment;</p> <p>-Rejection of Care - Presence and Frequency: Behavior not exhibited;</p> <p>-Dependent - Helper does all of the effort: Toileting hygiene, shower/bathing;</p> <p>-Mobility Device: Wheelchair;</p> <p>-Frequently incontinent of bowel;</p> <p>-Diagnoses of hemiplegia (paralysis affecting one side of the body) or hemiparesis (muscular weakness affecting one side of the body) , and multiple sclerosis (a potentially disabling disease of the brain and spinal cord.</p> <p>Review of the resident's care plan, located in the electronic healthcare record (EHR), showed:</p> <p>-Focus: Date Initiated 1/14/24: Psychosocial/Daily Routine. Resident perceives that daily routine is very different from prior pattern in the community. Resident prefers to choose clothing to wear, doing things with groups, and receiving shower;</p> <p>-Goal: Will express satisfaction with the routines of daily living;</p> <p>-Interventions/Tasks: Allow to express feelings. Allow to make decisions, set schedules, and to participate in self-care to the extent possible.</p> <p>During an interview on 3/5/24 at 8:05 A.M., the resident said he/she preferred showers as opposed to bed baths. He/She felt so much cleaner after a shower. He/She did not recall the last time he/she received a shower. The staff told him/her they do not have enough staff to give a shower.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Wednesday and Saturday on the day shift.</p> <p>Review of the resident's Skin Monitoring: CNA Shower Review Forms (completed by CNAs and reviewed by Nurses when a resident receives a shower), from 1/12/24 (admitted) through 3/5/24, showed:</p> <p>-The resident received 9 of 15 scheduled showers;</p> <p>-The last shower the resident received was on 2/26/24.</p> <p>2. Review of Resident #2's annual MDS, dated [DATE], showed:</p> <p>-Persistent vegetative state/no discernible consciousness: Yes.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Dependent-Helper does all of the effort: Toileting hygiene, shower/bathe self, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfers;</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Always incontinent of bowel/bladder;</p> <p>-Diagnoses of seizure disorder or Epilepsy (a brain disorder that cause recurring, unprovoked seizures, traumatic brain injury, usually caused by a blow or traumatic injury to the head or body), and respiratory failure.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>-Focus: Date Initiated 10/25/22: Impaired cognitive ability related to traumatic brain injury (usually caused by a blow or other traumatic injury to the head or body);</p> <p>-Focus: Date Initiated 10/25/22: Bowel incontinence;</p> <p>-Goal: Resident will have no skin breakdown related to bowel incontinence;</p> <p>-Interventions/Tasks: Assist with perineal care (washing the buttocks/genitalia) with each incontinence episode;</p> <p>-Focus: Date Initiated 10/26/22: Resident is dependent on staff with all activities of daily living (ADLs, cleaning, turning and repositioning, grooming, hygiene, etc.);</p> <p>-Interventions/Tasks: Assist with mobility and ADLs as needed.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Tuesday and Friday on the day shift.</p> <p>Review of the resident's progress notes, showed the resident was hospitalized from 2/6/24 through 2/21/24.</p> <p>Review of the resident's Skin Monitoring Comprehensive CNA Shower Review forms from 2/1/24 through 3/5/24, showed the resident received four of six scheduled showers.</p> <p>3. Review of Resident #1's admission MDS, dated [DATE], showed:</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands, misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care, Presence and Frequency: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment of the lower extremity;</p> <p>-Mobility Devices: [NAME] and wheelchair;</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dependent: Helper does all of the effort: Toileting and personal hygiene;</p> <p>-Partial/moderate assistance: Roll left and right, sit to lying, toilet transfer and tub/shower transfer;</p> <p>-Always continent of bowel and bladder;</p> <p>-Diagnosis of hip fracture.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>-Focus: Date Initiated 2/21/24, Psychosocial Daily Routine: Resident perceives that daily routine is very different from prior pattern in the community. Resident prefers choosing clothes to wear, keeping up with the news, listening to music and receiving showers.</p> <p>During an interview on 3/5/24 at 8:23 A.M., the resident said he/she preferred showers over bed baths. Showers made him/her feel better and cleaner.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Monday and Thursday on the day shift.</p> <p>Review of the resident's Skin Monitoring Comprehensive CNA Shower Review forms from 2/12/24 (admitted) through 3/5/24, showed the resident received five of six scheduled showers.</p> <p>4. Review of Resident #7's admission MDS dated [DATE], showed:</p> <p>-Adequate hearing and vision;</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To understand Others: Usually understands, misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Shower/bath: Independent;</p> <p>-Always continent of bowel;</p> <p>-Diagnoses of arthritis, multiple sclerosis and depression.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 3/5/24 at 9:35 A.M., the resident lay in bed. His/Her hair appeared oily. The resident said he/she did not receive two showers a week. Most of the time staff did not ask him/her if he/she wanted a shower. He/She said his/her hair felt like someone sprayed WD-40 on it. He/She would like to have his/her showers as scheduled.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Monday and Thursday on the evening shift.</p> <p>5. Review of Resident #5's quarterly MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -Ability to shower/bathe self: Blank; -Occasionally incontinent of bowel and bladder; -Diagnoses of anxiety and depression. <p>During an interview on 3/5/24 at 10:40 A.M., the resident said he/she did not receive two showers weekly most of the time. He/She did not receive his/her shower last Tuesday, but did receive one last Thursday because he/she kept asking for one. When there were only two staff working on the unit, which happened frequently, he/she never asked for a shower because staff told him/her three CNAs were needed to get showers done. He/She preferred to have showers. The resident said, When you get a shower you feel cleaner, especially when you get your hair washed.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Tuesday and Friday on the night shift.</p> <p>6. Review of Resident #9's annual MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands; <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognition not assessed;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Substantial/maximal assistance required for bathing;</p> <p>-Frequently incontinent of bowel;</p> <p>-Diagnoses of arthritis, dementia and asthma (a condition that causes inflammation and narrowing of the airways/lungs).</p> <p>During an interview on 3/5/24 at 9:40 A.M., the resident said there were weeks that he/she did not get two showers. The CNAs told him/her they couldn't give showers because there were not enough staff.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday on the day shift.</p> <p>7. Review of Resident #10's annual MDS dated [DATE], showed:</p> <p>-Adequate hearing and vision;</p> <p>-Speech Clarity: Clear speech - distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands;</p> <p>-Moderately impaired cognition;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Physical impairment of one upper and one lower extremity;</p> <p>-Ability to shower/bathe self: Blank;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Diagnoses of stroke and dementia.</p> <p>During an interview on 3/5/24 at 9:42 A.M., the resident said he/she was supposed to get a shower yesterday (Monday 3/4/24) but he/she did not get one. The CNAs did not ask him/her if he/she wanted a shower yesterday. Had they asked, he/she would have said yes. He/She felt better after a shower.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday.</p> <p>8. Review of Resident #11's quarterly MDS dated [DATE], showed:</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Adequate hearing;</p> <p>-Vision impaired, sees large print, but not regular print in newspapers/books;</p> <p>-Speech Clarity: Unclear speech, slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood;</p> <p>-Ability To Understand Others: Usually understands;</p> <p>-Moderate cognitive impairment;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Ability to shower/bathe self: Blank;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Diagnoses of hemiplegia or hemiparesis, and depression.</p> <p>During an interview on 3/5/24 at 9:44 A.M., the resident said he/she was supposed to get a shower yesterday, but did not. Yesterday, the CNAs never asked him/her if he/she wanted a shower. He/She preferred a shower. He/She felt nasty when he/she did not receive a shower.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday on the day shift.</p> <p>9. During an interview on 3/5/24 at 10:00 A.M., CNA A said there were about 44 residents on that unit. The facility tried to schedule three CNAs, but a lot of the time they did not end up with three CNAs. When there were just two CNAs that was over 20 residents apiece. Something had to give, which were the showers. His/Her shift began at 7:00 A.M. Today there were just two of CNAs until a few minutes ago when a third CNA came in. He/She was able to get two showers done today, but that's only because they really needed them. He/She did not know if he/she would be able to get any more showers done today.</p> <p>10. During an interview on 3/5/24 at 10:08 A.M., Licensed Practical Nurse (LPN) B said today there were 42 residents on that unit. When there were two CNAs the residents did not get their showers. He/She tried to help the CNAs when he/she could, but he/she had his/her own responsibilities as well. More often than not, that unit ended up with two CNAs.</p> <p>11. During an interview on 3/5/24 at 12:10 P.M., the facility Staffing Coordinator/CNA said the 100 hall had over 40 residents. She scheduled three CNAs on the 100 hall, but it was not uncommon for someone to call in or not show up. Yesterday she had three CNAs scheduled. One called off and one went home sick shortly after coming in. That left one CNA until about 11:00 A.M., when she went to the 100 hall and worked as a CNA. She did not give any assigned showers yesterday because she did not have time. She did not think the other CNA was able to give any showers yesterday.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12. During an interview on 3/6/24 at 2:30 P.M., the DON said she expected residents to receive their showers as scheduled. Two CNAs with 20 plus residents each would not be enough to get everything done. The Administrator said the facility tried to schedule three CNAs on the 100 hall, but it didn't always work out.</p> <p>MO00231775</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to develop a care plan that identified interventions to prevent falls after one resident's Fall Risk Assessment completed on [DATE], identified the resident to be a high risk to fall. In addition, on [DATE], the facility developed a care plan identifying the resident as having cognitive impairment and exhibited cognitive loss related to impaired decision making skills and impulsivity with a goal of avoiding complications that included falls and injuries. On [DATE], the resident was placed in his/her room in a wheelchair with no supervision. The resident leaned forward in the wheelchair reaching for a blanket on his/her bed causing the resident to fall out of the wheelchair onto the floor with the wheelchair resting against his/her back and his/her left leg was caught underneath the wheelchair. After staff assisted the resident back into the wheelchair, the resident had a seizure and then went into cardiac arrest (the heart suddenly stops beating). Facility staff initiated cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) and sent the resident to the hospital where the resident was pronounced dead (Resident #22). The census was 85.</p> <p>Review of the facility Fall Risk Assessment, undated, showed:</p> <ul style="list-style-type: none"> -Policy Statement: The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information; -Policy Interpretation and Implementation; <ul style="list-style-type: none"> 1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time; 2. The nursing staff will ask the resident and/or family about any history of the resident falling; 3. The nursing staff, attending physician, and consultant pharmacist will review for medications or medication combinations that could relate falls or falls risk, such as those that have side effects of dizziness, ataxia (a neurological sign consisting of a lack of voluntary coordination of muscle movements), or hypotension (low blood pressure); 4. The staff will look for evidence of a possible link between the onset of falling (or an increase in falling episodes) and recent changes in the current medication regimen; 5. The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness) or sensory impairments (such as decreased vision and peripheral neuropathy (damage or disease affecting the nerves) that may predispose to falls; <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis (low bone mass));</p> <p>7. The staff with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living capabilities, activity tolerance, continence, and cognition;</p> <p>8. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout;</p> <p>9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.</p> <p>Review of Resident #22's hospital discharge form dated [DATE] at 10:15 A.M., and found in the resident's electronic healthcare records (EHR) records, showed:</p> <p>-Admission (to the hospital): [DATE];</p> <p>-High Risk Falls: Yes;</p> <p>-Diagnosis: Stroke (poor blood flow due to blood vessels being blocked or due to bleeding in the brain);</p> <p>-The resident had some left sided tremors while in the hospital, he/she was tested and seizures were ruled out as a cause;</p> <p>-Hospital Course: Right decompressive hemicraniectomy (a brain surgery removing a portion of the skull to alleviate brain swelling).</p> <p>Review of the facility's handwritten report between the facility and the hospital, undated, but prior to the resident's admission, showed:</p> <p>-Left sided weakness. Went to the emergency room and had a heart attack and had a stroke;</p> <p>-Right hemicraniectomy. No bone (part of the skull had been removed), has a helmet.</p> <p>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed:</p> <p>-admitted [DATE];</p> <p>-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability to Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Cognitively intact;</p> <p>-Physical, verbal, or other behavioral symptoms: Behaviors not exhibited;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment of one upper and one lower extremity;</p> <p>-Mobility Device: Wheelchair;</p> <p>-Self Care: Dependent for shower/bathing, upper and lower body dressing, and putting on/taking off footwear;</p> <p>-Mobility: Dependent for sit to lying, lying to sitting, sit to stand, and chair/bed to chair transfer;</p> <p>-Walk 10 Feet and Picking Up Object: Not attempted due to medical condition or safety concerns;</p> <p>-Wheel 50 and 150 feet: Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity;</p> <p>-Diagnoses: Coronary artery disease (the reduction of blood flow to the heart), arthritis (joint pain or joint disease), stroke, hemiplegia (one sided paralysis) or hemiparesis (one sided weakness), and respiratory failure. A history of seizures was not indicated;</p> <p>-At any time in the past 5 days, has the resident been on a scheduled pain medication regimen?: Yes. Pain frequency: Blank;</p> <p>-Does the resident have a condition or chronic disease that may result in a life expectance of less than 6 months?: No;</p> <p>-Did the resident have a fall any time in the lat month prior to admission?: No;</p> <p>-Did the resident have a fall any time in the last ,d+[DATE] months prior to admission?: No;</p> <p>-Has the resident had any falls since admission?: No;</p> <p>-Receiving Speech Therapy (ST), Occupational Therapy (OT), and Physical Therapy (PT).</p> <p>Review of the resident's physician order sheet (POS), located in the EHR, showed:</p> <p>-Full Code (if the resident is found unresponsive with no signs of life CPR will be initiated);</p> <p>-Wear helmet when out of bed as tolerated.</p> <p>Review of the resident's Nursing Fall Risk Observation/Assessment form, dated [DATE], showed:</p> <p>-History of Falls: No falls;</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Vision Status: Moderately impaired - limited vision, but can identify objects;</p> <p>-Balance: Non-ambulatory (cannot walk)/wheelchair for locomotion;</p> <p>-Age: Resident is 85 or older: No;</p> <p>-Continence: Elimination with assistance;</p> <p>-Mobility: Non-ambulatory/wheelchair for locomotion;</p> <p>-Mobility: Confined to chair?: Yes;</p> <p>-Cognitive Status/Behavioral Symptoms: Has the resident's cognitive status changed in the last 90 days?: No;</p> <p>-Does the resident display any of the following behaviors: easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders, abusive and resists care: No;</p> <p>-Health Conditions/Risk Factors: Circulatory/Heart, Neuromuscular/Functional, Orthopedic, Perceptual, Psychiatric or Cognitive, Other, Lab Tests: 3 or more present;</p> <p>-Medications: 3 or more medications taken currently or within the last 7 days;</p> <p>-Scoring: The resident had a score of 18, indicating the resident was at a high risk to fall;</p> <p>-The assessment did not identify how the facility should utilize the high risk assessment score.</p> <p>Review of the resident's care plan, located in the EHR, initiated on [DATE] and revised on [DATE], showed:</p> <p>-Focus: Cognitive Impairment: Resident exhibits cognitive loss related to impaired decision making skills and impulsivity. Resident is status post hemispherectomy and should wear helmet at all times;</p> <p>-Goal: Date: Will avoid complications (i.e., falls, injury, impaired nutrition/hydration, decline in activities of daily living) related to cognitive deficits to extent possible;</p> <p>-Interventions: Encourage routine daily decision making as indicated;</p> <p>-On [DATE]: Medication as ordered;</p> <p>-On [DATE]: Resident is often non-compliant with wearing his/her helmet and takes it off at his/her own free will. Resident will continue to be reminded to keep helmet on;</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The care plan did not address the resident's high risk for falls, or interventions staff should implement to prevent falls such as leaving the resident in a highly visible area for close monitoring while in the wheelchair and/or for monitoring to ensure the resident did not remove his/her protective helmet, or assisting the resident to bed after therapy, meals or activities.</p> <p>Review of the resident's progress notes, located in the EHR, showed:</p> <p>-[DATE] at 12:25 P.M.: Resident admitted . Resident has his/her helmet on ad no signs or symptoms of distress;</p> <p>-[DATE] at 7:22 A.M.: Resident alert and oriented x 2 (orientation is referred to as one or more of the following: person, place, time, situation);</p> <p>-[DATE] at 11:52 A.M. and documented by the facility Social Worker (SW): Resident is alert x 4 with some confusion at times. Resident's spouse said the resident is a fall risk and would like the resident's bed at the lowest setting closer to the floor. Discharge goal is to return home with spouse;</p> <p>-[DATE] at 8:53 A.M.: Resident is closely monitored, bed in low position, resident up most of the night;</p> <p>-[DATE] at 1:06 P.M. and documented by Licensed Practical Nurse (LPN) C, showed: Resident observed in a kneeling position by his/her bed with the wheelchair tipped forward. Resident is non-compliant with wearing helmet and helmet was not on at that time. Resident stated that he/she was reaching for the blanket when his/her wheelchair tipped forward. Resident denies hitting his/her head and stated his/her back was hurting. Resident's helmet placed on and resident was helped back into wheelchair. Once in wheelchair resident continued to deny hitting his/her head. As he/she proceeded with normal conversation, resident began having seizure like activity. This nurse proceeded to call physician while nursing staff timed seizure, when this nurse was instructed to call 911 because resident appeared to go into arrest. This nurse overhead paged Code Blue (code to alert staff a resident is in cardiac arrest) and proceeded to call 911. All nursing staff present for code until paramedics arrived on scene and at that time care was transferred over to paramedics. Resident taken to hospital for further care. Spouse and Nurse Practitioner notified;</p> <p>-[DATE] at 3:46 P.M.: This SW sent the update to case manager to let her know that resident was sent to hospital and passed away.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:12 A.M., LPN C said on [DATE], a visitor alerted him/her to the resident being on the floor in his/her room. He/She and Certified Nursing Assistant (CNA) D entered the resident's room and found him/her on his/her knees with both elbows on the bed. The resident's wheelchair had tipped forward and was resting on the resident's back with his/her left leg caught beneath the wheelchair. The resident was not wearing his/her helmet. The helmet was laying on top of the bedside table. He/She and the CNA assisted the resident back into his/her wheelchair. Almost immediately after being placed back into the wheelchair, the resident had a seizure. He/She left the room to call the physician about the fall and seizure, but before he/she could call the physician the resident coded (cardiopulmonary arrest) and a Code Blue was called and they initiated CPR. This was about the third time he/she had taken care of the resident. The resident had not had any previous falls he/she was aware of and there was no reason why the resident could not be alone in his/her room while in the wheelchair. He/She was not aware the resident's assessment showed he/she was a high risk for falls. He/She had noticed the resident taking off his/her helmet in the past, but if you asked him/her to put the helmet back on he/she would. He/She was not sure if the resident had a history of seizures. He/She thought the resident's spouse took him/her back to the room that day but was not sure.</p> <p>During an interview on [DATE] at 10:25 A.M., CNA D said he/she had taken care of the resident several times and he/she had been assigned to care for the resident on [DATE]. The resident had not had any previous seizures or falls he/she was aware of. The resident had a history of taking his/her helmet off because he/she did not like it, but the resident's spouse said no matter what, make sure the resident wore his/her helmet. If you asked the resident to put the helmet back on he/she would. The resident was confused at times. He/She would think he/she could take himself/herself to bathroom, but he/she had not seen the resident try to get up from the wheelchair unassisted. The resident used a tilt wheelchair and they would tilt it back some so he/she could not get up without assistance. He/She did not know of the resident falling previously. On [DATE], the resident had just finished lunch in the dining room. His/Her spouse was in the dining room but left. He/She thinks an agency staff member took the resident back to his/her room. A short time later, he/she and Nurse C entered the room and found the resident on his/her knees with his/her arms on the bed and his/her wheelchair leaning against his/her back. The resident's leg was caught underneath the wheelchair. He/She was not wearing the helmet, although he/she had it on earlier in the dining room. The nurse asked the resident if he/she hit his/her head and he/she said no. The resident said he/she was reaching for the bed and the wheelchair tipped over. They put the resident back into the wheelchair and he/she began to have a seizure. A couple of seconds later he/she coded. He/She had not seen the resident have a seizure before.</p> <p>During a telephone interview on [DATE] at 1:34 P.M., the resident's spouse said the resident had an unprotected area on his/her head that required a helmet for safety. He/She had told facility staff the resident was a fall risk in the past. On [DATE], he/she visited the resident and was in the dining room when he/she had to leave for an appointment. Staff told him/her the resident was going to be taken back to his/her room after eating and they would lay him/her down in bed. Later that day, the spouse received a call from the facility and was told the resident coded and was taken to the hospital where he/she was pronounced dead. He/She did not understand why the resident was left alone in the wheelchair in his/her room, why staff did not put the resident back to bed or why he/she did not have his/her helmet on when he/she fell out of the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:04 A.M., the Rehabilitation Manager reviewed the resident's therapy notes and said on [DATE], the resident could go from lying down to sitting on the side of the bed with maximum assistance. Once sitting on the side of the bed, the resident could sit for approximately 5 minutes with verbal and tactile cues before losing his/her balance. The resident used a tilt wheelchair for mobility.</p> <p>During an interview on [DATE] at 12:00 P.M., ST J said as of [DATE], the resident was alert and oriented to person, place and situation. He/She worked with the resident in his/her room several times. The resident would be up in his/her wheelchair and he/she did not see any problems with the resident's sitting balance. The resident would have his/her helmet off at times. The resident's spouse wanted the resident to wear the helmet, but the resident said it itched. The resident was aware he/she should wear it due to the missing bone in his/her skull. The resident would put the helmet back on when asked to. He/She did not see a reason why the resident could not be left alone in his/her room in the wheelchair due to his/her sitting balance.</p> <p>During an interview on [DATE] at 12:00 P.M., OT I said the resident had good sitting balance in the wheelchair. He/She had not seen the resident leaning or fidgeting in the wheelchair. He/She had not seen the resident sliding out of the wheelchair or trying to get out of the wheelchair before.</p> <p>During an interview on [DATE] at 10:50 A.M., the Director of Nurses said the fall risk assessment was designed to give the facility a baseline for the resident, and alerted staff the resident was more likely to fall. There were no general guidelines on what the facility should do as far as care planning and implementing interventions based on the assessment score. However, she could see, based on a high risk score, a care plan should have been added for falls. Based on the resident's high risk score, she would have expected staff to make rounds past the resident's room more frequently to ensure the resident was wearing his/her helmet while up in the wheelchair.</p> <p>MO00234249</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to ensure staff checked residents for incontinence at least every two to three hours. This resulted in residents left urine saturated for extended periods of time. Seven residents were sampled and problems were identified with two (Residents #37 and #5). The census was 94.</p> <p>1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/24, showed:</p> <ul style="list-style-type: none"> -Vision: Impaired - sees fine detail, including regular print in newspapers/books; -Hearing: Adequate; -Speech Clarity: Unclear speech - slurred or mumbled words; -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -Functional Limitation in Range of Motion: One upper and one lower extremity; -Mobility Devices: [NAME] and wheelchair (manual or electric); -Toileting hygiene: Dependent - Helper does all of the effort. Resident does none of the effort to complete activity; -Shower/bathe self: Not attempted due to medical condition or safety concerns; -Personal hygiene: Partial/moderate assistance - Helper does less than half the effort; -Urinary Continence: Always incontinent; -Bowel Continence: Always incontinent; -Diagnoses of hemiplegia (paralysis of one side of the body)/hemiparesis (weakness of one side of the body), anxiety and depression. <p>Review of the resident's care plan, located in the electronic medical record (EMR), showed:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7/30/23, Focus: Requires extensive assistance with Activities of Daily Living. Goal: Will have needs anticipated and met by staff. Interventions: A.M. and P.M. care with assistance of one staff. Assist with perineal care (genitalia/buttocks) and apply barrier cream after each incontinent episode;</p> <p>-7/30/23, Focus: Incontinent of bladder and bowel. Goal: Will have decreased frequency of incontinent episodes. Intervention: Apply preventative skin care as ordered.</p> <p>Observation on 5/6/24 at 11:40 A.M., showed the resident lay in bed. The wound care company Nurse Practitioner and facility Wound Nurse removed the resident's covers to complete a treatment on the resident's right buttock. There was a strong odor of urine once the covers had been removed. The resident's incontinence brief was saturated with urine. The urine had also saturated the incontinence pad beneath the resident and there was visible wetness from the resident's buttocks up his/her back to just beneath the resident's shoulder blades.</p> <p>During an interview on 5/10/24 at 1:40 P.M., the Director of Nurses (DON) said she can't be sure, but if the resident was that wet with urine, it does not sound as though staff checked the resident within the last two to three hours.</p> <p>2. Review of Resident #5's quarterly MDS, dated [DATE], showed:</p> <p>-Adequate hearing and vision;</p> <p>-Speech Clarity: Clear speech - distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability to Understand Others: Understands - clear comprehension;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Mobility Devices: Wheelchair (manual or electric);</p> <p>-Urinary Continence: Occasionally incontinent of urine.</p> <p>Review of the resident's diagnoses, located in the EMR, included chronic respiratory failure, muscle wasting and atrophy (muscle wasting), lack of coordination, contracture (rigidity or contracture of the muscles) of right and left ankles and [NAME] Disease (a genetic condition that causes severe muscle weakness and wasting).</p> <p>During an interview on 5/7/24 at 9:40 A.M., the resident said he/she had not been checked or changed since 9:00 P.M. last night. He/She turned on his/her call light at 4:23 A.M., because he/she was wet with urine. The night Certified Nursing Assistant (CNA), an agency CNA, never answered his/her call light. It was not until this morning at 9:00 A.M., when CNA D changed him/her.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/7/24 at 2:40 P.M., CNA D said he/she works 7:00 A.M. to 7:00 P.M. The first time he/she checked the resident for incontinence today was around 9:00 A.M. The resident was completely saturated with urine. The urine had soaked through the resident's incontinence brief and into the incontinence pad beneath the resident. He/She had taken care of the resident before, and it would have taken longer than two to three hours for the resident to be that wet.</p> <p>3. During an interview on 5/10/24 at 1:40 P.M., the DON said she expected incontinent residents to be checked for incontinence every two to three hours.</p> <p>MO00234970</p> <p>MO00235730</p> <p>MO00235933</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to ensure wound treatments were completed as ordered. Residents #31 and #28 had physician ordered wound treatments to be completed daily. On Saturday 5/4/24 and Sunday 5/5/24, neither resident had there wound treatments completed. Two residents with wounds were sampled and problems were found with both. The census was 94.</p> <p>Review of the facility Wound Care policy, undated, showed:</p> <ul style="list-style-type: none"> -Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing; -Documentation: The following information should be recorded in the resident's medical record: <ul style="list-style-type: none"> -The type of wound care given; -The date and time the wound care was given; -The name and title of the individual performing the wound care; -Any change in the resident's condition; -If the resident refused the treatment and the reason why; -The signature and title of the person recording the data; -Reporting: <ul style="list-style-type: none"> -Notify the supervisor if the resident refuses the wound care; -Report other information in accordance with the facility policy and professional standards of practice. <p>1. Review of Resident #31's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/27/24, showed:</p> <ul style="list-style-type: none"> -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to Understand Others: Usually understands - misses some part/intent of messages but comprehends most conversation; -Moderately impaired cognition; -Rejection of Care: Behavior not exhibited; <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Functional Limitation in Range of Motion: Impairment on one side;</p> <p>-Diagnoses of stroke, hemiplegia (paralysis on one side of the body)/hemiparesis (muscle weakness on one side of the body) and depression;</p> <p>-Surgical wound;</p> <p>-Surgical wound care.</p> <p>Review of the resident's care plan, located in the electronic medical record (EMR), showed:</p> <p>-4/10/24: Focus: Resident is at risk for skin breakdown related to existing other skin problems, midline abdomen incision. Goal: Will prevent or delay skin breakdown to the extent possible. Interventions: Administer treatments as ordered. Keep skin as clean and dry as possible.</p> <p>Review of the resident's Physician's Order Sheet (POS), located in the EMR, showed:</p> <p>4/25/24: Midline abdominal surgical site. Cleanse with wound cleanser or normal saline. Apply silver (antimicrobial) alginate (an absorbant fiber) rope and cover with a dry dressing daily and PRN.</p> <p>Review of the resident's wound company weekly report completed by the wound company Nurse Practitioner (NP), dated 4/29/24, showed:</p> <p>-Wound/Ulcer #1:</p> <p>-Location: Midline abdomen;</p> <p>-Type: Surgical;</p> <p>-Wound Bed Description: 60% granulation (new/healing tissue) and 40% hypergranulation (excessive growth of granulation tissue);</p> <p>-Measurements: 0.5 centimeters (cm) length x 0.5 cm width x 0.4 cm depth;</p> <p>-Peri-wound (the area surrounding the wound): Normal - No infection noted;</p> <p>-Exudate (drainage): Small;</p> <p>-Color: Serosanguineous (thin, clear or pink fluid from a wound);</p> <p>-Debridement (removal of dead/necrotic/nonviable tissue) that has been completed at this site: Mechanical (removal of nonviable tissue with wet to dry dressings changed regularly) completed via normal saline (water/salt solution) and 4 x 4s (gauze);</p> <p>-Goal: Obtain a reduction in the wound size every two weeks;</p> <p>-Wound Status: Stable - continue current treatment;</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Additional Notes: Site was silver nitrated (used to cauterize (close) wounds);</p> <p>-Treatment: Cleanse with wound cleanser or normal saline, apply silver alginate rope, cover with dry bordered gauze dressing, change daily and PRN (as necessary).</p> <p>Review of the resident's Treatment Administration Record (TAR), dated 5/1/24 through 5/6/24, showed:</p> <p>-Midline abdominal surgical site. Cleanse with wound cleanser or normal saline. Apply silver alginate rope and cover with a dry dressing daily and PRN. There was no nurse's initial (an indication a treatment has been completed as ordered) for Saturday, 5/4/24. Licensed Practical Nurse (LPN) C initialed the treatment had been completed on Sunday, 5/5/24.</p> <p>Observation on 5/6/24 at 9:18 A.M., showed the resident lay in bed. The wound company NP and facility Wound Nurse (WN) raised the resident's gown to assess the surgical incision on the resident's mid abdomen. The dressing covering the incision was dated 5/3/24. The incision site was open, and red with a moderate amount of drainage. The facility WN said that was the same dressing she applied on 5/3/24. The dressing should be changed daily. The resident said no one had changed the dressing since last Friday (5/3/24). If staff had wanted to change his/her dressing, he/she would not have stopped them.</p> <p>Review of the resident's wound company weekly report completed by the wound company Nurse Practitioner (NP), dated 5/6/24, showed:</p> <p>-Wound/Ulcer #1:</p> <p>-Location: Midline abdomen;</p> <p>-Type: Surgical;</p> <p>-Wound Bed Description: 60% granulation and 40% hypergranulation;</p> <p>-Measurements: 0.7 cm x 0.6 cm x 0.5 cm depth;</p> <p>-Peri-wound: Normal - No infection noted;</p> <p>-Exudate (drainage): Moderate;</p> <p>-Color: Yellow;</p> <p>-Debridement that has been completed at this site: Mechanical completed via normal saline and 4x4's;</p> <p>-Goal: Obtain a reduction in the wound size every two weeks;</p> <p>-Wound Status: Stable;</p> <p>-Additional Notes: Site was silver nitrated (used to cauterize (close) wounds);</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Treatment: Cleanse with wound cleanser or normal saline, apply silver alginate rope, cover with dry bordered gauze dressing, change daily and PRN.</p> <p>2. Review of Resident #28's annual MDS, dated [DATE], showed:</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Clear speech - distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands - clear comprehension;</p> <p>-Moderately impaired cognition;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment on one side;</p> <p>-Diagnoses of septicemia (infection of the blood), wound infection, stroke, hemiplegia/hemiparesis, anxiety and depression;</p> <p>-Surgical wound;</p> <p>-Surgical wound care.</p> <p>Review of the resident's care plan, located in the EMR, showed:</p> <p>-4/16/24: Focus: Resident has impaired skin integrity present on admission as evidenced by surgical wound. Goal: Surgical wound will heal without complications. Interventions: Administer treatments as ordered and monitor for effectiveness. Educate on avoiding skin injuries.</p> <p>Review of the resident's POS, located in the EMR, showed:</p> <p>-4/24/24: Left abdomen. Cleanse with wound cleanser or normal saline and apply antibiotic ointment. Cover with dry dressing and changed daily and PRN.</p> <p>Review of the resident's TAR, dated 5/1/24 through 5/6/24, showed:</p> <p>-4/25/24: Left abdomen. Cleanse with wound cleanser or normal saline and apply antibiotic ointment. Cover with dry dressing and changed daily and PRN. There was no nurse's initial showing the treatment had been completed on Saturday, 5/4/24. LPN C initialed the treatment had been completed on Sunday, 5/5/24.</p> <p>Review of the facility weekly wound report, dated 4/29/24, showed:</p> <p>-Left lower abdomen. Skin tear. Acquired at facility. 1.3 cm x 1.5 cm x 2.0 cm. Cleanse with wound cleanser, apply antibiotic ointment, cover with dressing, daily and PRN.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/6/24 at 8:28 A.M., the resident lay in bed. He/She said he/she had one wound treatment that was on his/her stomach. He/She had an incision that had healed, but the tape staff used caused his/her skin around the healed incision to become sore and raw. He/She lifted up his/her gown at that time, showing a small dressing dated 5/3/24, on his/her abdomen. He/She said no one had changed the dressing since last Friday, 5/3/24. He/She said he/she would not have prevented anyone from changing the dressing had they wanted to.</p> <p>3. During observation and interview on 5/6/24 at 8:40 A.M., the WN said she works Monday through Friday. The NP and WN both said it is not uncommon for the treatments not to be completed on the weekends. They both said they had spoken to the Administrator in the past about the treatments frequently not being done on the weekends, but it is still a problem. The NP said she is in the facility one time a week, on Mondays. One of the reasons she schedules her visits on Mondays is because 95% of the time, several of the residents' treatments are not done on the weekends and she wants to assess them as soon as possible after the weekend. She measures and assesses the wounds and pressure ulcers and writes any new orders as necessary. The WN said she can't be here every day to make sure the nurses are completing the treatments as ordered.</p> <p>4. During an interview on 5/6/24 at 10:36 A.M., the wound company NP said it is important for the treatments to be completed as ordered. If the treatments are not being completed as ordered, there is a risk of deterioration or infection.</p> <p>5. During an interview on 5/6/24 at 12:36 P.M., LPN B said he/she worked 7:00 A.M. to 7:00 P.M. on Saturday, 5/4/24. He/She did not work Sunday 5/5/24. Normally there are two nurses working that hall, but that day, he/she was the only nurse. A Certified Medication Technician (CMT) came in later that day, but he/she was still the only nurse. That hall has some very heavy treatments that take time to complete. Since he/she was the only nurse, he/she did not have time to do all the treatments. He/She left the TARs blank of the residents he/she could not get done. He/She did not get Resident #29's treatment completed, but he/she did get Resident #30's treatment completed. He/She would have done all of them had he/she had the time.</p> <p>6. During an interview on 5/6/24 at 12:57 P.M., LPN C said he/she worked 7:00 A.M. to 7:00 P.M. on Sunday, 5/5/24. He/She had the back hall. He/She did not do any of the treatments he/she was assigned to because the facility did not have any supplies on the treatment cart. There was no wound cleanser or dressings. Additional supplies are locked up in the WN's office and he/she does not have a key to her office. This is not the first time this has happened and he/she has spoken to the WN about making sure the treatment cart is stocked. He/She did not check the treatment carts from the other sides. There is a manager on-call, but he/she did not call the manger to see if they could get the supplies. He/She initialed all of the treatments as being completed, but he/she did not do any of the treatments he/she was assigned to that day.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. During an interview on 5/6/24 at 3:00 P.M., the facility WN said it's been a problem on the weekends in regards to the treatments not getting done. It depends on who is working though. Some nurses are not doing them, but not all. She stocked all the treatment cart before she left on Friday, 5/3/24. She does keep the treatment supplies locked in her office because if she doesn't, staff just run through the supplies. Even if Nurse C ran out of supplies, there is a manager on duty with the key to her office. If Nurse C needed supplies, he/she could have asked the manager on duty to open her office. Completing the treatments as ordered is very important. If they are not getting done consistently, the wound or pressure ulcer may get worse or infected. She has discussed the treatments not getting done on the weekends with the Administrator in the past.</p> <p>8. During an interview on 5/7/24 at 7:25 A.M., the Administrator said he expected the treatments to be completed as ordered. The nurse who worked Sunday 5/5/24 initialed the treatments had been completed, but they had not been. That nurse should not have initialed the treatments were completed. He/She should have followed protocol and documented they had not been completed with an explanation as to why. He/She should have informed the on-coming 7:00 P.M. to 7:00 A.M. shift the treatments were not completed so that nurse could have completed them. The facility is open 24/7 and the next shift should be able to complete anything that was missed from the prior shift. He recalled the NP and WN speaking to him a few months ago about treatments not being completed on the weekends, but that was a few months ago and he had not heard that was still a problem. He was under the impression the problem had been resolved.</p> <p>9. During an interview on 5/10/24 at 1:40 P.M., the Director of Nurses said the wound care policy is current and what she expected staff to follow. She expected treatments to be completed as ordered. If they cannot be completed as ordered, staff should document the reason why in the resident's progress notes.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to report one resident's (Resident #1) excoriated buttocks identified upon admission to the physician for a treatment order and failed to monitor the excoriation until 2/15/24, when a nurse identified two abrasions on the buttocks, the physician was notified, and a treatment order was started. On 2/16/24, a nurse documented the resident had what appeared to be a stage 2 pressure ulcer (Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) on the buttocks and a new order for Santyl (an ointment used to aid in wound healing by removing dead skin tissue) and a consult with the wound care company was ordered by the Nurse Practitioner (NP). The facility also failed to ensure one resident (Resident #3) with known pressure ulcers on the right foot wore bilateral heel protectors (pressure relieving boots) as ordered, and with known pressure ulcers on the buttocks and sacrum was turned and repositioned timely. In addition, three of the four residents sampled had did not have care plans that identified their pressure ulcers and all three of those residents said they did not always get their treatments completed as often as ordered (Residents #1, #3 and #7). One other resident (Resident #4) with an order to wear multipodus boots (protective boots used to prevent and/or aide in healing of pressure ulcers/wounds) was observed on two separate days not wearing the multipodus boots as ordered. The facility identified 19 residents with pressure ulcers. Four were sampled and problems were found with all four. The census was 90.</p> <p>Review of the facility Wound Care policy, undated, showed:</p> <p>-Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing;</p> <p>-Preparation:</p> <p>-Verify that there is a physician's order for the procedure;</p> <p>-Review the resident's care plan to assess for any special needs of the resident.</p> <p>1. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/19/24, showed:</p> <p>-admitted [DATE];</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Unclear speech - slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognitively intact;</p> <p>-Rejection of Care - Presence and Frequency: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment of the lower extremity;</p> <p>-Mobility Devices: [NAME] and wheelchair;</p> <p>-Toileting and personal hygiene: Dependent - Helper does all of the effort;</p> <p>-Roll left and right, sit to lying, toilet transfer and tub/shower transfer: Partial/moderate assistance;</p> <p>-Always continent of bowel and bladder;</p> <p>-Diagnosis of right hip fracture;</p> <p>-Risk of Pressure Ulcers (also known as bed sores, are localized damage to the skin and/or underlying tissue that usually occur over a bony prominence usually as the result of long-term pressure): Yes;</p> <p>-Unhealed Pressure Ulcers: No;</p> <p>-Surgical Wounds: Yes;</p> <p>-Applications of ointments/medications other than feet: Yes.</p> <p>Review of the resident's care plan, located in the electronic health record (EHR), showed no focus/problem documented for the amount of assistance required for activities of daily living (ADLs: dressing, bathing, transfers, positioning, eating, toileting), and no focus/problem documented for excoriation (skin injury) and/or pressure ulcers.</p> <p>Review of the resident's progress note, dated 2/12/24 at 6:19 P.M. showed: Admission note. Resident arrived via emergency medical services. Resident is alert and oriented to person, place, time, and situation. Resident is toe touch weight bearing (the amount of weight the resident is able to bear is limited) related to a right hip fracture. Resident is continent of bowel and bladder, but due to condition wears an incontinent brief. All assessments that were due upon arrival were completed and documented in appropriate sections of the EHR.</p> <p>Review of the resident's Comprehensive Skin Evaluation Assessment, dated 2/12/24, showed: -Presence of Wounds: Resident has one or more newly identified or existing wounds or skin integrity concerns: Yes;</p> <p>-Right trochanter (hip): Surgical incision;</p> <p>-Right and Left Buttock: Excoriation;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Additional Care options included: Moisture barrier, moisture control, positioning wedge, and turning and repositioning program. All options were left blank.</p> <p>Review of the resident's Nursing Comprehensive Skin Evaluation/Assessment, completed on 2/12/24, showed:</p> <p>-Resident has one or more newly identified or existing wounds or skin integrity concerns: Yes; -Note all skin issues:</p> <p>-Right trochanter: Surgical incision;</p> <p>-Right and Left Buttock: Excoriation;</p> <p>-Additional Care: None.</p> <p>Review of the resident's Braden Scale (an assessment used to determine a resident's risk for developing pressure ulcers), dated 2/12/24, showed the resident was not at risk to develop pressure ulcers.</p> <p>Review of the resident's progress notes, dated 2/12/24 through 2/14/24, showed no documentation regarding excoriation to the resident's right/left buttocks as noted on the skin assessments or if the physician had been notified about excoriation to the resident's buttocks.</p> <p>Review of a Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review (a form completed by CNA's and co-signed by Nurses showing if the CNA had identified any skin problems during a shower or bath), dated 2/14/24, showed:</p> <p>-A mark on the lower right buttock of an anatomical figure;</p> <p>-No explanation of what the mark meant;</p> <p>-The form was co-signed by a Nurse.</p> <p>Review of the resident's progress notes, showed:</p> <p>-2/15/24 at 7:11 P.M., Nurse was called into the resident's room. Resident noted having two abrasions to the coccyx (tailbone) and right buttock. Coccyx measures 1.5 centimeters (cm, length) by 0.5 cm (width) by 0.1 cm (depth) and right inner buttock measures 1.8 cm by 1.7 cm by 0.1 cm. New treatment orders are in place;</p> <p>-2/15/24 at 7:15 P.M.: Physician updated.</p> <p>Review of the resident's treatment administration record (TAR), dated 2/1/24 through 2/29/24, showed:</p> <p>-2/12/24 through 2/15/24: No documentation about the resident's excoriated buttocks, and no treatment order for the excoriated buttocks;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Start Date 2/16/24: Cleanse coccyx (tailbone) and right buttock with wound cleanser, apply Calmoseptine (an ointment used to protect skin from wetness, urine, stool, minor cuts/burns) three times a day for abrasions. Discontinue Date: 2/21/24;</p> <p>-Review of the TAR showed a blank space with no nurse's initials (nurses initials indicate the treatment was completed as ordered) on 2/16/24;</p> <p>-Start Date 2/17/24: Santyl apply to the right buttock every evening shift for wound care. Discontinue Date 2/20/24;</p> <p>-Start Date 2/20/24: Santyl ointment. Apply to the right buttock every day shift. Cover with dry bordered dressing daily, and PRN. Discontinue Date 3/4/24;</p> <p>-Review of the TAR showed a blank space with no nurse's initials on 2/22/24, 2/24/24, 2/27/24, and 2/28/24.</p> <p>Review of the resident's progress note, dated 2/17/24 at 3:11 P.M., showed: This nurse observed what appeared to be a stage 2 open area to resident's right buttock. NP notified and ordered Santyl every day and a consult with the wound care company.</p> <p>Review of the resident's physicians order sheet (POS), located in the resident's electronic health records (EHR) showed an order dated 2/17/24 for the wound care company to evaluate and treat the resident.</p> <p>Review of the facility weekly wound reports, showed:</p> <p>2/19/24: Right buttock. Acquired (began at facility). Type of wound: Pressure. Stage: Stage? To be assessed. Current Measurement: 0.5 cm by 1.0 cm by 0.1 cm. Treatment: Cleanse with wound cleanser and apply Santyl, cover with bordered dressing and change daily and PRN (as necessary);</p> <p>2/26/24: Right buttock. Type of wound: Pressure. Stage: Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Current Measurement: 1.1 cm by 1.1 cm by 0.2 cm. Treatment: Cleanse with wound cleanser, apply Santyl to wound bed, cover with dry bordered dressing and change daily and PRN;</p> <p>-3/4/24: Right buttock. Type of wound: Pressure. Stage: Stage 3. Current Measurement: 1.0 cm by 1.1 cm by 0.2 cm. Treatment: Cleanse with wound cleanser, apply Santyl to wound bed, cover with dry bordered dressing and change daily and PRN;</p> <p>Review of the resident's TAR, dated 3/1/24 through 3/31/24, showed:</p> <p>-Start Date 2/20/24: Santyl ointment. Apply to right buttock every day shift and cove with dry bordered dressing. Discontinue Date 3/4/24;</p> <p>-Start Date 3/5/24: Santyl ointment. Apply to right buttock daily and apply collagen powder (a protein that helps to stimulate new tissue growth) and cover with dry bordered dressing daily and PRN. No Discontinue Date.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Braden Scale assessment, dated 3/4/24, showed the resident was at risk to develop pressure ulcers.</p> <p>Observation on 3/5/24 at 8:00 A.M., showed the resident lay in bed as the facility Wound Nurse (WN) and Director of Nurses (DON) completed the resident's skin assessment. The resident had a dressing on his/her right buttock dated 3/4/24. The WN said the wound care company saw the resident yesterday on 3/4/24. She had not yet documented the wound company assessment from 3/4/24, but would provide that information to the surveyor. No other wounds or pressure ulcers were noted. During an interview at 8:23 A.M., the resident said his/her treatment was supposed to be done daily, but sometimes it was not done daily.</p> <p>During an interview on 3/5/24 at 9:00 A.M., the facility WN said she made rounds with the wound care company every week on Mondays. Her weekly pressure ulcer report was based on the wound company's assessment.</p> <p>During an interview on 3/5/24 at 2:30 P.M., the DON said the nurse completing the admission skin assessment was responsible to notify the physician if there are any areas of concern. The resident's physician should have been notified about the excoriation on the resident's buttocks. Any skin problem should be noted on the TAR so nurses are routinely monitoring and assessing. Treatment orders should be completed as ordered. If a treatment can't be completed as ordered, the nurse should document a code that shows why the treatment was not completed and/or the nurse should document the reason in the progress note. If the TAR was blank, she can't assume a treatment was done. The care plan should have been updated to identify the resident's pressure ulcer.</p> <p>2. Review of Resident #3's admission MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing; -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Moderately impaired cognition; -Rejection of Care - Presence and Frequency: Behavior not exhibited; -Dependent - Helper does all of the effort: Toileting hygiene, shower/bathing; -Mobility Device: Wheelchair; -Frequently incontinent of bowel; -Diagnoses of hemiplegia (paralysis affecting one side of the body) or hemiparesis (muscular weakness affecting one side of the body) , and multiple sclerosis (a potentially disabling disease of the brain and spinal cord); <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: Yes; -Number of unstageable (Unstageable - Deep tissue: Suspected deep tissue injury in evolution.): One;</p> <p>-Other Problems: Moisture associated skin damage (inflammation or skin erosion by a prolonged exposure to moisture such as urine, stool, sweat, sound drainage, saliva, or mucus);</p> <p>-Pressure Ulcer Care: Yes.</p> <p>Review of the resident's Braden Scale, dated 1/12/24, showed the resident was at risk to develop pressure ulcers.</p> <p>Review of the resident's care plan, located in the EHR, showed no focus/problem documented for the amount of assistance required for ADLs, and no focus/problem documented for pressure ulcers.</p> <p>Review of the resident's POS, located in the EHR, showed:</p> <p>-Start Date Blank Revision Date: 1/29/24: Resident to have bilateral heel protectors on while in bed and up in wheelchair as tolerated to promote skin integrity;</p> <p>-Start Date 2/13/24 No Discontinue Date: Right heel medial (middle). Cleanse with wound cleanser, apply Medihoney (a gel used to treat pressure ulcers/wounds and/or burns) and calcium alginate (an absorbent dressing made from seaweed and used to absorb drainage). Cover with a dry dressing and change daily and PRN;</p> <p>-Start Date 2/13/24 No Discontinue Date: Left buttock. Cleanse with wound cleanser, apply Medihoney and calcium alginate with a dry dressing daily and PRN;</p> <p>-Start Date 2/13/24 No Discontinue Date: Right buttock. Cleanse with wound cleanser, apply Medihoney and calcium alginate with a dry dressing daily and PRN;</p> <p>-Start Date 2/19/23 No Discontinue Date: Right heel lateral (on the side). Paint with betadine (an antiseptic solution used to prevent skin infection) daily;</p> <p>Start Date: 2/28/24 No Discontinue Date: Sacrum (the area between the lower back and upper buttocks). Cleanse with wound cleanser, apply Medihoney and calcium alginate with a dry dressing daily and PRN.</p> <p>Review of the resident's TAR, dated 2/1/24 through 2/29/24, showed:</p> <p>-Start Date: 1/30/24 Discontinue Date: 2/13/24: Left Buttock. Cleanse with wound cleanser, apply betadine dampened gauze and cover with dry bordered dressing daily and PRN. The TAR showed no nurses initials on 2/1/24, 2/2/24, 2/6/24, and 2/11/24;</p> <p>-Start Date: 2/13/24 No Discontinue Date: Left Buttock. Cleanse with wound cleanser, apply Medihoney and calcium alginate, cover with a dry dressing and change daily and PRN. The TAR showed no nurses initials on 2/14/24 and 2/24/24;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Start Date: 1/30/24 Discontinue Date: 2/13/24: Right Buttock. Cleanse with wound cleanser, apply betadine dampened gauze and cover with dry bordered dressing daily and PRN. The TAR showed no nurses initials on 2/1/24, 2/2/24, 2/6/24, and 2/11/24;</p> <p>-Start Date: 2/13/24 No Discontinue Date: Right Buttock. Cleanse with wound cleanser, apply Medihoney and calcium alginate, cover with a dry dressing and change daily and PRN. The TAR showed no nurses initials on 2/14/24 and 2/24/24;</p> <p>-Start Date: 1/30/24 Discontinue Date: 2/19/24: Right heel lateral. Cleanse with wound cleanser, paint with betadine daily and PRN. The TAR showed no nurses initials on 2/1/24, 2/2/24, 2/6/24, and 2/11/24;</p> <p>-Start Date: 2/20/24 No Discontinue Date: Right heel lateral. Apply betadine, paint daily. The TAR showed no nurses initials on 2/24/24;</p> <p>-Start Date: 1/30/24 Discontinue Date: 2/13/24: Right heel medial. Cleanse with wound cleanser, apply silver alginate, cover with dry border dressing daily and PRN. The TAR showed no nurses initials on 2/1/24, 2/2/24, 2/6/24, and 2/11/24;</p> <p>-Start Date 2/13/24 No Discontinue Date: Right heel medial. Apply Medihoney and calcium alginate, and cover with a dry dressing daily and PRN. The TAR showed no nurses initials on 2/14/24 and 2/24/24;</p> <p>-Start Date: 2/28/24 No Discontinue Date: Sacrum. Cleanse with wound cleanser, apply Medihoney and calcium alginate , cover with a dry dressing daily and PRN. The TAR showed the treatment had been completed as ordered.</p> <p>Review of the resident's Braden Scale, dated 2/22/24, showed the resident remained at risk to develop pressure ulcers.</p> <p>Review of the facility weekly wound report, dated 2/26/24, showed:</p> <p>-Location of Wound: Right Buttock. Type of Wound: Pressure. Stage: Unstageable (Slough and or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). Current Measurement: 5.0 cm by 2.7 cm by 1.1 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Left Buttock. Type of Wound: Pressure. Stage: Unstageable. Current Measurement: 3.0 cm by 3.0 cm by unable to determine. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Sacrum. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 6.5 cm by 5.0 cm by 0.3 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Right heel medial. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 0.8 cm by 0.8 cm by 0.3 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Location of Wound: Right heel lateral. Type of Wound: Pressure-Deep Tissue Injury (DTI). Stage: Stage 3. Current Measurement: 1.0 cm by 1.3 cm by DTI Treatment: Paint with betadine daily and PRN.</p> <p>Review of the resident's TAR, dated 3/1/24 through 3/5/24, showed the treatments had been administered as ordered.</p> <p>Review of the facility weekly wound report, dated 3/4/24, showed:</p> <p>-Location of Wound: Right Buttock. Type of Wound: Pressure. Stage: Unstageable. Current Measurement: 5.0 cm by 2.1 cm by 1.0 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Left Buttock. Type of Wound: Pressure. Stage: Unstageable. Current Measurement: 4.0 cm by 3.5 cm by unable to determine. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Sacrum. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 6.2 cm by 4.8 cm by 0.3 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Right heel medial. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 0.6 cm by 0.3 cm. Treatment: Cleanse with wound cleanser and apply Medihoney and calcium alginate, cover with dry dressing daily and PRN;</p> <p>-Location of Wound: Right heel lateral. Type of Wound: Pressure-DTI. Stage: Stage 3. Current Measurement: 1.4 cm by 1.5 cm by DTI Treatment: Paint with betadine daily and PRN.</p> <p>Observations and interviews on 3/5/24: showed:</p> <p>-7:40 A.M.: The resident lay in bed as the DON and WN completed a skin assessment. Two protective boots sat underneath the mirror in the room next to the closet. The closet had a picture of the resident up in a wheelchair wearing the boots. There were no instructions on the picture. The resident had dressings dated 3/4/24, on right foot, sacrum, and left and right buttock. After the skin assessment was completed, the DON and WN left the room without placing the protective boots on the resident;</p> <p>-9:57 A.M.: The resident lay in bed. He/She said no one had been in the room to clean or turn and reposition him/her since the skin assessment at 7:40 A.M. The protective boots remained underneath the mirror by the closet. The resident said he/she can't put the protective boots on by himself/herself. Most of the time, staff do not put the protective boots on him/her. He/She did not mind wearing the protective boots. The resident turned on his/her call light at that time to request turning and repositioning;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-12:21 P.M.: The resident lay in bed in the same position as he/she was in at 7:40 A.M., and his/her protective boots remained under the mirror next to the closet. He/She said a staff member turned off the call light he/she turned on at 9:57 A.M., and said they would be back, but no one returned. CNA A entered the room at that time. The CNA said he/she had taken care of the resident before today. He/She came to work today at 7:00 A.M. He/She had not had time to clean, turn and reposition the resident yet. He/She felt horrible about not being able to get to the resident until now. He/She was aware the resident had pressure ulcers and should be turned and repositioned every two hours, but he/she just had not had time. He/She was going to clean, and turn and reposition the resident now. He/She did not know there was an order for the resident to wear the protective boots while in bed. He/She thought they were to be worn when the resident is up in the wheelchair because that is what the picture showed.</p> <p>-1:10 P.M.: The resident said sometimes his/her treatments do not get done on a daily basis.</p> <p>During an interview on 3/5/24 at 2:30 P.M., the DON said she expected the resident's protective boots to be worn as ordered. Treatment orders should be completed as ordered. If a treatment can't be completed as ordered, the nurse should document a code that shows why the treatment was not completed, and/or the nurse should document the reason in the progress note. If the TAR is blank, she can't assume a treatment was done. The care plan should have been updated to identify the resident's pressure ulcers.</p> <p>3. Review of Resident #7's admission MDS dated [DATE], showed:</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Clear speech - distinct intelligible words;</p> <p>-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Shower/bathe: Independent;</p> <p>-Always continent of bowel;</p> <p>-Diagnoses of arthritis, multiple sclerosis and depression;</p> <p>-Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: Yes;</p> <p>-Number of unstageable (Unstageable - Deep tissue: Suspected deep tissue injury in evolution.): One.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, located in the EHR, showed no focus/problem documented for the amount of assistance required for ADLs, and no focus/problem documented for pressure ulcers.</p> <p>Review of the resident's POS, located in the EHR, showed and order with Start Date: 2/23/24, No Discontinue Date: Right lateral ankle. Cleanse with wound cleanser, apply silver alginate (an absorbent antimicrobial dressing), cover with with dry bordered dressing and change daily and PRN.</p> <p>Review of the resident's TAR, dated 2/1/24 through 2/29/24, showed:</p> <p>-Start Date 1/17/24 Discontinue Date 2/6/24: Right lateral ankle. Cleanse with wound cleanser and apply Drawtex (an absorbent wound dressing) and foam dressing daily. The TAR showed no nurses initials on 2/3/24 and 2/6/24;</p> <p>-Start Date 2/8/24 Discontinue Date 2/19/24: Right lateral ankle. Cleanse with sound cleanser, apply collagen (a natural fibrous protein that facilitates wound healing) and Drawtex, cover with dry bordered foam dressing, and change every 3 days and PRN. The TAR showed no nurses initials on 2/11/24 and 2/14/24;</p> <p>-Start Date 2/20/24 Discontinue Date 2/23/24: Right lateral ankle. Cleanse with wound cleanser, apply silver alginate, cover with a dry dressing and change daily and PRN. The TAR showed no nurses initials on 2/21/24;</p> <p>-Start Date 2/24/23 No Discontinue Date: Right lateral ankle. Cleanse with wound cleanser, apply silver alginate, cover with a dry bordered dressing and change daily and PRN. The TAR showed the treatment was completed as scheduled.</p> <p>Review of the resident's Braden Scale dated 2/15/24, showed the resident was at risk to develop pressure ulcers.</p> <p>Review of the facility weekly wound report, dated 2/26/24, showed:</p> <p>2/6/24:</p> <p>-Location of Wound: Right lateral ankle. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 3.8 cm by 3.5 cm by 0.3 cm. Treatment: Cleanse with wound cleanser, apply silver alginate, cover with dry bordered dressing and change daily and PRN;</p> <p>3/4/24:</p> <p>-Location of Wound: Right lateral ankle. Type of Wound: Pressure. Stage: Stage 3. Current Measurement: 4.0 cm cm by 3.2 cm by 0.2 cm. Treatment: Cleanse with wound cleanser, apply silver alginate, cover with dry bordered dressing and change daily and PRN.</p> <p>During observation and interview on 3/5/24 at 9:35 A.M., the resident lay in bed. There was a dressing on his/her right foot. The resident said staff do the daily treatment on his/her right foot most of the time. Once in a while it was every other day, but not too often.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's TAR, dated 3/1/24 through 3/5/24, showed the resident's treatment had been administered as ordered.</p> <p>4. Review of Resident #2's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Persistent vegetative state/no discernible consciousness: Yes. <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Dependent-Helper does all of the effort: Toileting hygiene, shower/bathe self, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfers; -Always incontinent of bowel/bladder; -Diagnoses of seizure disorder or Epilepsy (a brain disorder that cause recurring, unprovoked seizures, traumatic brain injury (usually caused by a blow or traumatic injury to the head or body), and respiratory failure; -Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: Yes; -Number of Pressure Ulcers: One Stage 3. <p>Review of the resident's POS, showed an order dated 2/22/24, no discontinue date, for bilateral multipodus boots while in bed as tolerated.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <ul style="list-style-type: none"> -Date Initiated 10/6/22: Focus: Impaired cognitive ability related to traumatic brain injury with loss of consciousness; -Date Initiated 10/26/22: Focus: Dependent upon staff with all ADLs. Interventions/Tasks: Assist with all ADLs as needed; -Date Initiated 10/26/23: Focus: Impaired skin integrity. Interventions/Tasks: Clean and dry skin after each incontinent episode. Pressure reducing mattress. Treatments as ordered. Weekly skin assessments; -The care plan did not identify the resident's multipodus boots while in bed as an intervention. <p>Observation on 3/4/24 at 11:00 A.M., showed the resident lay in bed with his/her eyes closed and unresponsive. The resident did not wear multipodus boots and none were seen in the resident's room or his/her closet.</p> <p>Observation on 3/5/24 at 7:50 A.M., showed the resident lay in bed with his/her eyes closed and unresponsive. He/She did not have on multipodus boots. The facility WN and DON completed a skin assessment. No areas of pressure ulcers/wounds were noted on the resident's feet.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an interview on 3/5/24 at 2:30 P.M., the DON said if a resident has an order for pressure relieving boots, she expected staff to follow the orders and ensure the boots are applied. Treatment orders should be completed as ordered. If a treatment can't be completed as ordered, the nurse should document a code that shows why the treatment was not completed and/or the nurse should document the reason in the progress note. If the TAR is blank, she can't assume a treatment was done. The care plans should be updated to identify resident's pressure ulcers.</p> <p>MO00231775</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to follow their policy and failed to implement and/or promptly implement the Registered Dietician's (RD) dietary recommendations for residents that experienced severe three month weight loss (greater than 7.5%) and severe six month weight loss (greater than 10%), and failed to ensure residents' heights were readily available to the RD so resident's body mass index (BMI, used to determine if a person is underweight or overweight) and ideal body weights (IBW, the ideal weight for men/women based on height and weight) could be calculated. The facility also failed to develop care plan interventions for residents experiencing severe weight loss. In addition, the facility failed to ensure residents received adaptive utensils, plate guards, and cups as ordered during meals. Four residents with severe weight loss were sampled and problems were found with three (Residents #39, #40 and #42). The census was 94.</p> <p>Review of the facility Weight Assessment and Intervention policy, undated, showed:</p> <p>-Policy Statement: Resident weights are monitored for undesirable or unintended weight loss or gain;</p> <p>-Weight Assessment:</p> <p>-1. Residents are weighed upon admission and at intervals established by the interdisciplinary team;</p> <p>-2. Weights are recorded in each unit's weight record chart and in the individual's medical record;</p> <p>-3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing;</p> <p>-4. Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time;</p> <p>-5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month: 5% weight loss is significant; greater than 5% is severe. 3 month: 7.5% weight loss is significant; greater than 7.5% is severe. 6 month: 10% weight loss is significant; greater than 10% is severe;</p> <p>-6. If the weight change is desirable, this is documented;</p> <p>-Evaluation:</p> <p>-1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes:</p> <p>-a. The resident's target weight range (including rationale if different from ideal body weight);</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -b. The resident's calorie, protein, and other nutrient needs compared with the resident's current intake; -c. The relationship between current medical condition or clinical situation and recent fluctuations in weight; -d. Whether and to what extent weight stabilizations or improvement can be anticipated; <p>-2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example:</p> <ul style="list-style-type: none"> -a. Cognitive or functional decline; -b. Chewing or swallowing abnormalities; -c. Pain; -d. Medication-related adverse consequences; -e. Environmental factors (such as noise or distractions related to dining); -f. Increased need for calories and/or protein; -g. Poor digestion or absorption; -h. Fluid and nutrient loss; -i. Inadequate availability of food or fluids; <p>-Care Planning:</p> <ul style="list-style-type: none"> -1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or resident's legal surrogate; -2. Individualized care plans shall address, to the extent possible: <ul style="list-style-type: none"> -a. The identified causes of weight loss; -b. Goals and benchmarks for improvement; -c. Time frames and parameters for monitoring and reassessment; <p>-Interventions:</p> <ul style="list-style-type: none"> -1. Interventions for undesirable weight loss are based on careful consideration of the following: <ul style="list-style-type: none"> -a. Resident choice and preferences; <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-b. Nutrition and hydration needs of the resident;</p> <p>-c. Functional factors that may inhibit independent eating;</p> <p>-d. Environmental factors that may inhibit appetite or desire to participate in meals;</p> <p>-e. Chewing and swallowing abnormalities and the need for diet modifications;</p> <p>-f. Medications that may interfere with appetite, chewing, swallowing, or digestion;</p> <p>-g. The use of supplementation and/or feeding tubes;</p> <p>-h. End of life decisions and advance directives;</p> <p>-2. Interventions for undesired weight gain consider resident preferences and rights. A weight loss regimen will not be initiated for a cognitively capable resident without his/her approval and involvement;</p> <p>-3. If a resident declines to participate in a weight loss goal, the dietician will document the resident's wishes, and those wishes will be respected.</p> <p>1. Review of Resident #39's Physician's Order Sheet (POS), located in the electronic medical record (EMR), showed:</p> <p>-6/19/23: Resident to utilize built up curved spoon and fork (adaptive utensils used to allow the resident to eat independently), cup with handles and lid and a straw;</p> <p>-10/3/23: Regular diet. Mechanical soft texture;</p> <p>-11/8/23: Resident to utilize plate guard (used to prevent food from sliding off the plate) on plate for all meals.</p> <p>Review of the resident's weight summary, located in the electronic medical record (EMR), showed:</p> <p>-1/8/24 at 1:19 P.M.: 142.6 pounds (lbs);</p> <p>-2/3/24 at 6:37 P.M.: 135.6 lbs.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/24, showed:</p> <p>-Makes Self Understood: Unclear speech - slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability to Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Severely impaired cognition;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment of one upper and one lower extremity;</p> <p>-Eating: Blank;</p> <p>-Diagnoses: diabetes mellitus (high blood sugar levels), stroke, hemiplegia/hemiparesis, malnutrition (protein or calorie) or at risk for malnutrition, anxiety and depression;</p> <p>-Height of 5'8;</p> <p>-Weight of 136 lbs;</p> <p>-Loss of 5% or more in the last month, or loss of 10% in last 6 months: Yes, not on physician prescribed weight loss regimen.</p> <p>Review of the resident's dietary note located in the EMR progress notes, and documented by the RD on 2/20/24 at 5:36 P.M., showed:</p> <p>-Resident on Hospice since 11/6/23;</p> <p>-Resident eats with aide and is dependent on staff members for help with meals - uses plate guard, built up left curve spoon, and cup with two handles;</p> <p>-Resident is on a regular-mechanical soft diet (soft food items) with super cereal (high calorie/fat oatmeal) at breakfast. Aide reports resident has on/off appetite but eats 50-100% of meals with encouragement. Resident's ability to feed self changes day-to-day. Resident prefers finger foods;</p> <p>-Weight 135.6 lbs. Resident with significant weight loss of 5% (7 lbs) x 1 month. Resident's previous weight 142.6 taken 1/8/24;</p> <p>-Recommendations: Resident prefers finger foods, offer when able. House supplement (high calorie drink similar to Ensure/Boost) with all meals.</p> <p>Review of the resident's POS, located in the EMR, and reviewed on 5/7/24, showed:</p> <p>-2/21/24: House supplements with meals.</p> <p>Review of the resident's weight summary, located in the EMR, showed:</p> <p>-3/18/24 at 11:41 A.M.: 132.0 lbs.</p> <p>Review of the resident's dietary note located in the EMR progress notes, and documented by the RD on 3/28/24 at 12:20 P.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident on regular mechanical soft diet and is to receive house supplements at all meals. Resident drinks supplements when offered. Resident reports good appetite often presenting with confusion limiting intakes. Resident's ability to feed self changes day-to-day;</p> <p>-Height 68 (inches). Weight 132 lbs. Resident with significant weight loss of 13.8% (21.2 lbs) x 6 months, and insidious (gradual) weight loss of 7.3% (10.4 lbs) x 3 months. Resident goal is weight gain. Multiple nutrition interventions in place;</p> <p>-Recommendations: Fortify food (high calorie) on tray three times a day. Mighty cup (supplement) with lunch/dinner. Resident may benefit from appetite stimulant for increased intakes.</p> <p>Review of the resident's POS and progress notes, showed no order and no documentation the facility contacted the resident's physician to request an appetite stimulant to increase appetite.</p> <p>Review of the resident's weight summary, located in the EMR, showed:</p> <p>-4/10/24 at 1:20 P.M.: 128.7 lbs.</p> <p>Review of the resident's care plan located in the EMR, showed:</p> <p>-4/29/23: Focus: Mechanical soft diet related to recent stroke. Diagnoses of malnutrition and diabetes mellitus. Goal: Nutritional needs will be met and his/her weight will remain stable through next review. Interventions/Tasks: Assess nutritional status of resident at least quarterly and as necessary. Assist with meals as needed. Diet per physician order. Need for adaptive equipment. Refer to Occupational Therapy as appropriate. Refer to RD as appropriate. Weight per facility protocol;</p> <p>4/29/23: History of stroke. Usually able to understand others and understand others. Goal: Needs will be met and communication with staff will be effective through next review. Interventions/Tasks: Ask yes/no questions. Encourage resident to speak slowly and take his/her time;</p> <p>-The care plan did not identify the resident's preference for finger foods.</p> <p>Review of the resident's Dining RD Nutritional Care Form, dated 4/30/24 and completed by the RD, showed:</p> <p>-Resident on regular-mechanical soft diet and is to receive a house supplement at all meals. Resident drinks supplements when offered. Aide reports resident has on/off appetite, but eats 50-100% of meals with encouragement. Resident reports good appetite - occasionally presenting with increased confusion limiting intakes. Resident eats with aid and is dependent on staff members for help with meals - uses plate guard, built up left curve spoon, and cup with two handles at meals;</p> <p>-Weight 128.7 lbs. Ideal body weight 154 lbs. Resident with significant weight loss of 9.7% (13.9 lbs) x 3 months. Resident goal weight gain. Multiple nutrition interventions in place;</p> <p>-Recommendations: Fortify food (additional calories/fats are added to promote weight gain) on tray three times a day and mighty cup with lunch and dinner.</p> <p>Review of the resident's POS, located in the EMR, and reviewed on 5/7/24, showed:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No order for fortified foods three times a day;</p> <p>-No order for a might cup;</p> <p>-No order for an appetite stimulant.</p> <p>Review of the resident's progress notes, located in the EMR, showed no documentation the facility contacted the RD to clarify her recommendation for mighty cup at lunch and dinner.</p> <p>Observation on 5/7/24 at 12:26 P.M., showed the resident sat at a dining room table with Certified Nursing Assistant (CNA) E sitting next to him/her, providing cues and at times feeding the resident. The resident received a regular mechanical soft diet for lunch with one glass of flavored drink. The resident's plate had a plate guard, but the resident had regular utensils and was drinking from a regular cup and no straw. Review of the resident's menu slip that laid on the table showed: Mechanical soft diet, regular. Adaptive equipment: 2 handled cup with lid, curved build-up fork and spoon, plate guard, and straw. The menu slip did not show an order for fortified foods, house supplements or a mighty cup. During an interview at that time, CNA E said if a resident received fortified foods, it would be printed on the menu slip, and served by dietary. The resident ate approximately 80% of the meal.</p> <p>Observation on 5/9/24 at 8:08 A.M., showed the resident sat at a dining room table with CNA E next to him/her providing cues and at times feeding the resident. The resident received a mechanical soft breakfast with one glass of orange juice and regular utensils. The resident did not have fortified food. The resident's plate had a plate guard, but the resident had regular utensils and was drinking from a regular cup and no straw. Review of the resident's menu slip that laid on the table showed: Mechanical soft diet, regular. Adaptive equipment: 2 handled cup with lid, curved build-up fork and spoon, plate guard, and straw. The menu slip did not show an order for fortified foods or mighty cups. CNA E said the Certified Medication Technicians (CMTs) give the house supplements and mighty cups. He/She was not aware the resident was supposed to be given fortified foods. The resident's breakfast is not fortified foods. The dietary department would be responsible to serve fortified food. The resident did not have super cereal. The resident did not have his/her adaptive utensils, two handled cup with a lid because the dietary is responsible to bring that out with the plate. Dietary has not been bringing those items out very often. The resident ate approximately 70% of the meal.</p> <p>During an interview on 5/9/24 at 9:15 A.M., the Dietary Manager (DM) said she is not sure what the RD meant when she recommended mighty cups. The facility has mighty shakes (similar to a milk shake) and magic cups (similar to ice cream). It is her job to clarify what the RD meant, which she had not done. The facility has been out of magic cups for quite some time now, a couple of months at least. If fortified foods is not on the resident's menu slip, then the resident is not receiving fortified foods because dietary staff would not know to add it to the resident's plate.</p> <p>During an interview on 5/15/24 at 9:05 A.M., the RD said she saw the resident on 4/29/24, and the facility received her recommendations on 4/29/24. She recommended fortified foods and magic cups (an ice cream supplement). She did not mean to write mighty cup on the recommendation. No one from the facility contacted her to clarify mighty cups. She was aware the magic cup was on back order, but did not write to start the magic cup when available. She did not recommend a substitute, although ice cream could substitute. She was not aware the resident was not receiving fortified foods per her recommendation on 3/28/24 at 12:20 P.M. The resident should be receiving fortified foods.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/10/24 at 10:27 A.M., showed the resident weighed 132.8 lbs.</p> <p>Review of an e-mail dated 5/20/24 from the Administrator, showed no one contacted the resident's physician to inquire about an appetite stimulant as documented by the RD on 3/28/24.</p> <p>2. Review of Resident #40's care plan, located in the EMR, showed:</p> <p>-12/21/23: Focus: Cognitive Impairment. Resident is alert and requires assistance with decision making. Interventions: Anticipate needs and meet promptly. 12/21/23: Focus: Potential for impaired communication with dysphasia (difficulty speaking) related to stroke. Interventions: Give ample time for resident to communicate. Use simple direct communication such as yes questions as needed. 12/21/23: Focus: Malnutrition. Resident is on a mechanical soft diet (soft foods/ground meats) and has a diagnosis of malnutrition. Interventions: Administer nutrition related medications per physician's orders. Allow adequate time for meal consumption. Assist with meals/fluids. Monitor weight per protocol.</p> <p>Review of the resident's weight summary, located in the EMR, showed:</p> <p>-1/8/24: 126.2 lbs.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Speech Clarity: No speech - absence of spoken words;</p> <p>-Makes Self Understood: Rarely/never understood;</p> <p>-Ability to Understand Others: Rarely/never understands;</p> <p>-Rejection of Care: Behavior of this type occurred 1 to 3 days;</p> <p>-Eating: Independent - Resident completes the activity by him/herself with no assistance from helper;</p> <p>-Diagnoses: Cancer (with or without metastasis (spread of a disease), stroke, aphasia (partial or total loss of language skills), hemiplegia (paralysis affecting one side of the body)/hemiparesis (muscular weakness that affects one side of the body), malnutrition (protein or calorie) or at risk for malnutrition,</p> <p>-Height of 5'6;</p> <p>-Weight of 126 lbs;</p> <p>-Weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months: No or unknown.</p> <p>Review of the resident's weight summary, located in the EMR, showed:</p> <p>-2/3/24: 127.9 lbs;</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-2/8/24: 124.3 lbs;</p> <p>-3/18/24: 120.4 lbs;</p> <p>-4/8/24: 115.9 lbs.</p> <p>Review of the resident's Dining RD Nutritional Care Form, dated 4/30/24, and completed by the RD, showed:</p> <p>-Resident on regular mechanical soft diet with thin liquids and fortified foods three times a day. Resident independent with staff assist/supervision needed at meals. Resident uses adaptive feeding equipment to increase independence at meals. Plate guard/built up utensils/2 handle mug;</p> <p>-Height: none. Weight 115.9 lbs. Unable to calculate IBW without height. Resident is significant weight loss of 8.2% (10.3 lbs) x 3 months and insidious weight loss of 3.7% (4.5 lbs) x 1 month;</p> <p>-Recommendations: Double portions at meals three times a day.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Speech Clarity: No speech - absence of spoken words;</p> <p>-Makes Self Understood: Rarely/never understood;</p> <p>-Ability to Understand Others: Rarely/never understands;</p> <p>-Rejection of Care: Behavior of this type occurred 1 to 3 days;</p> <p>-Eating: Independent - Resident completes the activity by him/herself with no assistance from helper;</p> <p>-Height: 5'6;</p> <p>-Weight: 126 lbs.</p> <p>Review of the resident's weight summary, located in the EMR, showed:</p> <p>-5/6/24: 132.6 lbs.</p> <p>Review of the resident's current POS, located in the EMR on 5/7/24, showed:</p> <p>-3/26/24: Fortified diet mechanical soft texture;</p> <p>-4/2/24: Adaptive feeding equipment: Plate guard, built up utensils, two handled mug to be provided during all meals to facilitate independence with self-feeding;</p> <p>-No order for double portions at meals three times a day.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/7/24 at 1:10 P.M., showed the resident sat in a wheelchair in his/her room feeding himself/herself a mechanical soft diet. The resident received two pork sandwiches, a bowl of beans (regular serving), corn (regular serving), a cup of pudding and a glass of a flavored drink. The resident had eaten most of one sandwich, and a few bites of the other food items. The resident did not have any adaptive utensils, plate guard or 2 handled mug. Review of the resident's menu slip showed: Diet order - mechanical soft fortified. 2 handled cup and built up utensils. The menu slip did not show double portions.</p> <p>Observation on 5/9/24 at 8:19 A.M., showed the resident's breakfast tray sat on a small serving cart in the hall. The resident's tray contained scrambled eggs with cheese, a dark brown oatmeal and a half slice of toast. CNA J walked by the cart at that time. The CNA was asked if portion sizes on the resident's plate looked any different than the other resident trays (the resident's breakfast tray was compared to 5 other residents' plates). The CNA said he/she could not tell any difference in the portion sizes. He/She did not know the resident should have double portions because it is not on the menu slip. If it were on the menu slip and the resident's portion size were no different than the rest, he/she would let the kitchen know so the resident could receive the double portions.</p> <p>Review of the diet orders for the 5 residents whose plates were used for comparison on 5/19/24 at 8:19 A.M., showed 4 of the 5 had orders for regular portion sizes, and one (Resident #42) had an order for double portions.</p> <p>Observation on 5/9/24 at 8:33 A.M., showed the resident lay in bed, feeding himself/herself breakfast. The resident's breakfast plate was the same as when it was observed on the small cart at 8:19 A.M. The resident did not answer questions when asked.</p> <p>During an interview on 5/9/24 at 9:15 A.M., the DM said if double portions is not printed on the resident's menu slip, then the resident is not receiving double portions as dietary staff would not know to add double portions on the resident's plate.</p> <p>During an interview on 5/15/24 at 9:05 A.M., the RD said she saw the resident on 4/29/24, and the facility received her recommendations for double portions at all meals on 4/30/24. She recommended the double portions to promote weight gain.</p> <p>Observation on 5/10/24 at 10:30 A.M., showed the resident weighed 116.3 lbs.</p> <p>3. Review of Resident #42's dietary note located in the EMR progress notes, and documented by the RD on 3/28/24 at 11:05 A.M., showed:</p> <ul style="list-style-type: none"> -Resident is on a regular mechanical soft diet with Ensure three times a day. Resident reports good appetite eating 75-100% of meals. Resident independent at meals with staff assist/supervision; -Height: none. Weight of 156.2 lbs. Unable to calculate BMI/IBW without height in EMR. Resident with significant weight loss of 10.5% (18.3 lbs) x 6 months; -Recommendations: Fortify food on tray at all meals; -Double portions at all meals; <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Need height in EMR.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability to Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>-Moderately impaired cognition;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Eating: Blank;</p> <p>-Diagnoses of anemia, renal (kidney) insufficiency, malnutrition, anxiety and depression;</p> <p>-Height: 5'7;</p> <p>-Weight: 156 lbs;</p> <p>-Weight Loss of 5% or more in the last month or loss of 10% or more in the last 6 months: No or unknown.</p> <p>Review of the resident's care plan located in the EMR, showed no focus areas or interventions for malnutrition, or weight loss.</p> <p>Review of the resident's Dining RD Nutritional Care Form, dated 4/26/24 and completed by the RD, showed:</p> <p>-Resident is on a regular mechanical soft diet and is to receive fortified foods, double portions and Ensure or equivalent three times a day. Resident reports good appetite eating 75-100% of meals;</p> <p>-Height: None. Weight of 154.9 lbs. Resident with significant weight loss of 13.1% (23.4 lbs) x 6 months;</p> <p>-Recommendations: Continue all other current plan of care.</p> <p>Observation on 5/7/24 at 12:31 P.M., showed the resident sat at a table in the dining room feeding himself/herself lunch. The resident received regular portions of food which included one pork sandwich, corn, and beans. Review of the resident's menu slip that sat next to his/her plate, showed: Mechanical soft regular, fortified. The menu slip did not show double portions.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/9/24 at 8:19 A.M., showed the resident's breakfast tray sat on a small serving cart in the hall. The resident's tray contained scrambled eggs with cheese, a dark brown oatmeal and a half slice of toast. CNA J walked by at that time. CNA J was asked if portion sizes on the resident's plate looked any different than the other resident trays (the resident's breakfast tray was compared to 5 other plates). The CNA said he/she could not tell any difference in the portion sizes. He/She did not know the resident should have double portions because it is not on the menu slip. If it were on the menu slip and the resident's portion size was no different than the rest, he/she would let the kitchen know so the resident could receive the double portions.</p> <p>Review of the diet orders for the 5 residents whose plates were used for comparison on 5/19/24 at 8:19 A.M., showed 4 of the 5 had orders for regular portion sizes and 1 (Resident #40) had an order for double portions, which had the same portion sizes as all of the residents observed.</p> <p>During an interview on 5/15/24 at 9:05 A.M., the RD said she recommended double portions for the resident on 3/28/24, and the facility received that recommendation on 3/28/24. She was not aware the resident had not been receiving double portions at all meals.</p> <p>On 5/10/24, the resident weighed 182.7 lbs.</p> <p>On 5/20/24 at 12:31 P.M., via an e-mail, the Administrator documented the resident weighed 185.8 lbs. on 5/20/24. The Administrator offered no explanation for the discrepancy between the RD's documented weight of 156.2 lbs documented on 3/28/24 at 11:05 A.M., and the 156 lbs as documented on quarterly MDS dated [DATE].</p> <p>4. During an interview on 5/9/24 at 8:40 A.M., Cook F said he/she cooks the foods and sometimes he/she places the food on the plates. When he/she places food on the plates, he/she will use the resident's menu slips to know what type of food the resident should receive. If fortified foods or double portions are not on the resident's menu slip, then he/she would not know to serve fortified foods or add double portions. When a resident receives double portions, the larger portion size should be obvious when compared to a plate without double portions.</p> <p>5. During an interview on 5/9/24 at 9:15 A.M., the DM said the RD will usually touch base with her before she leaves the facility, but they do not discuss any new orders. She gets the RD's recommendations at the same time as the DON. She will review any new RD recommendations and add them to the menu slip the following Monday. She was not aware of any RD recommendations that had not been added to the menu slips until today. If she does not add a new order like fortified foods or double portions to the menu slip, the dietary staff will not add it to the resident's plates when they are serving. She should have had the new RD's recommendations from 4/30/24, added to the menu slips by now. Fortified foods are foods with extra fats/calories added, typically for residents experiencing weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. During an interview on 5/9/24 at 9:15 A.M., the Director of Nurses (DON) said the RD is in the facility every Tuesday, and usually touches base with her prior to leaving, but the RD does not discuss any new recommendations with her that day. The RD will send her report via e-mail to her, the Administrator, the DM, and facility wound care nurse usually a few days later, usually by Thursday. She will obtain any new orders based on the RD's recommendations Sunday or Monday, and add the new orders to the POS and MAR. She was not aware of any previous missed RD recommendations. She could not explain why the RD recommendations from 4/30/24, had not been added to the resident's POS or MARs as of today, She said they should have been added by now. Admission heights and weights should be obtained upon admission or no later than the next day. Heights are normally obtained by reviewing the hospital records that came in with the resident or asking the resident. If they can't determine the resident's height, then the nurse should use a measuring tape to get the height and document it in the resident's EHR. The RD used the resident's height to determine the resident's IBW, which is important information for the RD to have. Residents with significant/severe weight loss should have the weight loss added to the care plan with interventions. The facility Weight Assessment and Intervention policy is the current policy and she expected it to be followed.</p> <p>7. During an interview on 5/15/24 at 9:05 A.M., the RD said she is usually at the facility once a week on Tuesdays. She does not see all the residents every time she is there. Adaptive utensils are important. Without adaptive equipment, the resident's intake might be affected. She needs a resident's height so she can calculate the resident's IBW which is used to calculate a resident's nutritional needs.</p> <p>MO00234970</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>22409</p> <p>Based on interview and record review, the facility failed to ensure nurses received training for one resident's non-invasive mechanical ventilator (a machine that provides respiratory support), and failed to ensure nurses were aware the facility had back-up ventilators to use. The resident said his/her ventilator had repeatedly alarmed during the course of two or three nights, and facility nurses did not know why it was alarming or how to fix it. He/She eventually turned the ventilator off because the alarms prevented him/her from sleeping. In addition, the facility failed to obtain orders for the use of the non-invasive mechanical ventilator. The facility identified one resident with a non-invasive mechanical ventilator. (Resident #14). The census was 90.</p> <p>Review of the ventilator manufacturer's instruction manual provided by the facility, showed:</p> <p>-Possible Alarm Causes and Actions:</p> <p>-Low minute ventilation alarm, low inspiratory pressure alarm, low expiratory pressure alarm, circuit disconnection alarm may indicate a leak/disconnection: Accidental decannulation (the trach tube comes out) immediately insert tracheostomy (a surgical procedure creating an opening in the neck to place a tube into the trachea allowing air to enter the lungs). Leaks around tracheostomy: Some leak may be tolerated and may be due to position, so try repositioning. Assess equipment disconnection within circuit: Reconnect any loose connections and re-assess. Is the alarm set appropriately: Check alarm settings are prescribed and re-set if any discrepancies;</p> <p>-High minute ventilation alarm, high expiratory pressure alarm, high inspiratory pressure alarm, low Vti (tidal volume of inspiration/the amount of air moved in and out during breathing) alarm, check circuit may indicate a blockage or obstruction. Increased work of breathing: Suction, consider need for nebulisers (aerosol mist medications). Assess retained secretions/increased pulmonary (lungs) resistance. assess equipment circuit blockage: Follow circuit from resident through to ventilator and ensure it is not kinked or obstructed. Is the alarm set appropriately: Check alarm settings are prescribed and re-set if any discrepancies.</p> <p>Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/25/23, showed:</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Unclear speech, slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Rejection of Care: Behavior not exhibited;</p> <p>-Diagnoses of heart failure (e.g., congestive heart failure (CHF, a long term condition that occurs when the heart cannot pump blood well enough to provide the body with a normal supply) and pulmonary edema (excessive fluid accumulation in the tissue or air spaces of the lungs), pneumonia (an inflammatory condition of the lungs), anxiety, depression, schizophrenia (a mental disorder characterized by recurring episodes of psychosis (a mental state marked by loss of contact with reality)), asthma (long-term inflammatory disease of the airways/lungs), and respiratory failure;</p> <p>-Respiratory Treatments: Oxygen therapy, suctioning (a device used to extract fluids/secretions such as saliva and mucus from body cavities), tracheostomy care and non-invasive mechanical ventilator.</p> <p>Review of the resident's care plan, located in the electronic health record (EHR), showed:</p> <p>-Date Initiated 6/9/23:</p> <p>-Focus: Diagnosis of CHF. At risk for respiratory complication as evidenced by: shortness of breath, tachypnea (rapid breathing), and dyspnea (difficult breathing).;</p> <p>-Goal: Will not have complications related to CHF which requires outside interventions through next review;</p> <p>-Interventions/Tasks: Administer medication as ordered. Monitor for signs of respiratory distress. Monitor oxygen saturation;</p> <p>-Date Initiated 6/9/23:</p> <p>-Focus: Uses oxygen continuously;</p> <p>-Goal: Will not have complications requiring outside interventions related to tracheostomy/ventilator through next review;</p> <p>-Interventions/Tasks: Change oxygen tubing as ordered. Change suction system as ordered. Monitor and respond to ventilator alarms as ordered;</p> <p>-Date Initiated 2/24/24 and Revised On 3/8/24:</p> <p>-Focus: Requires an invasive mechanical ventilator and is at risk for respiratory distress;</p> <p>-Goal: Secretions are mobilized and airway remains patent;</p> <p>-Interventions/Tasks: Assess tracheal tube, checking whether it is secure. Assess rate and quality of respiratory pattern. Resident has a chronic ventilator and likes to hook himself/herself up to the ventilator nightly. Resident has been educated by Respiratory Therapy on how to do so.</p> <p>Review of the resident's physician's order sheet, located in the resident's EHR, showed:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Start Date 7/6/23: IPRAT (ipratropium)-albuterol (adrenergic bronchodilator (used to control symptoms of asthma) inhale one puff every 6 hours for shortness of breath;</p> <p>-Start Date 7/22/23: Five liters of oxygen during the day and ventilator at night;</p> <p>-Start Date 7/22/23: Check primary ventilator settings every shift;</p> <p>-Start Date 7/24/23: Advair Diskus (contains a combination of fluticasone (a steroid that prevents inflammation) and Salmeterol (a bronchodilator that relaxes the muscles in the airways) 1 puff orally two times a day;</p> <p>-Start Date 8/21/23: Every 4 hours oxygen spot check for poor perfusion (inadequate circulation);</p> <p>-Start Date 9/3/23: Modafinil (a medication used to treat excessive sleepiness caused by sleep apnea (a condition that causes you to stop breathing for seconds or minutes at night)</p> <p>200 milligrams (mg) daily;</p> <p>-Start Date 11/7/23: Respiratory Therapy (RT) to provide Flutter (a device used to improve mucus clearance) therapy every 24 hours as needed related to chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues);</p> <p>-No order for a non-invasive mechanical ventilator noted.</p> <p>During an interview on 3/5/24 at 1:30 P.M., the resident said he/she used a ventilator at night. About a week and a half ago, the ventilator kept alarming/beeping. It was like that for a couple of days. He/She had to turn the ventilator off because he/she couldn't sleep. The nurses did not know what was wrong or how to fix it. RT E finally fixed it so he/she could use it.</p> <p>During an interview on 3/6/24 at 9:25 A.M., RT F said the resident did not use the ventilator during the day, only at night during sleep. The ventilator supported the resident's lungs at night by blowing off CO₂ (Carbon dioxide. Too much CO₂ can cause shortness of breath and fatigue). A sign of high CO₂ was lethargy. When there was a problem with a ventilator there was an alarm sounded. The ventilator had numeric range on the screen from 10 to 70. If that parameter was exceeded high or low, an alarm sounded. If the parameter was below 10 there may be a leak in the system or the ventilator/tracheostomy tubing may need repositioned. If the ventilator screen showed above 70, the resident may need suctioned or there may be some sort of a blockage. If everything seemed to be alright and the ventilator continued to alarm, there were two back-up ventilators in the storage area located on the same hall where the resident resided. The nurses should know what the alarms meant and what high and low numbers meant. They should know where the extra ventilators were located. He/She did not know if all the nurse's had been inserviced to the ventilator alarms, what to look for when the alarms sounded or where the back-up ventilators were located. He/She had not inserviced the nurses and there were several agency nurses that worked at the facility as well. Currently there were no instructions at the nurse's station on what should be done if the ventilator alarm sounded.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/6/24 at 9:35 A.M., Licensed Practical Nurse C, who was assigned to the resident, said he/she had worked at the facility for a couple of months. The resident never told him/her about the ventilator not working. He/She had not been inserviced about the ventilator since starting. He/She did not know what the numbers on the ventilator screen meant or what to do if the numbers were below 10 or above 70. He/She did not know the facility had two back-up ventilators in storage. He/She felt like he/she should be aware of those things.</p> <p>During an interview on 3/6/24 at 2:30 P.M., the Director of Nurses said the nurses should know what to do if the resident's ventilator began to alarm. They should also know the facility had back-up ventilators and where they were located. She was not sure if the nurses had been inserviced or not.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to consistently ensure a ratio of no more than 12 residents assigned per Certified Nursing Assistant (CNA) on the day shift per the Facility Assessment (used to determine what resources are needed to provide adequate care, including staffing) necessary to meet the needs of the residents including their activities of daily living (ADLS, dressing, bathing, transfers, eating, and toileting). Eight residents were sampled (Resident #3, #2, #1, #7, #5, #9, #10 and #11) and all 8 did not receive showers as scheduled, and one (Resident #3) with pressure ulcers (also known as bedsores are localized damage to the skin and/or underlying tissue) was unclean and turned and repositioned timely. The census was 90.</p> <p>Review of the Facility Assessment, dated 9/20/23, and completed by the Administrator, Director of Nurses (DON), Assistant Director of Nurses (ADON), Director of Rehabilitation, Maintenance Supervisor, Dietary Supervisor, and Medical Director, showed:</p> <ul style="list-style-type: none"> -Average daily census: 90; -Residents independent for dressing, bathing, transfers, eating, toileting: 5; -Residents requiring assist of 1-2 staff for dressing, bathing, transfers, eating, toileting: 70; -Residents dependent for: Dressing: 9, bathing: 14, transfers: 12, eating: 7, toileting: 15; -Staff Type/Plan: The following contains the facility's budgeted staffing plan. Staff will be adjusted based on resident needs and the skill levels of available staff. CNAs to residents: 1:12 ratio on days, and 1:15 on nights. <p>1. Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/19/24, showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Moderately impaired cognition; -Rejection of Care/Presence and Frequency: Behavior not exhibited; -Dependent/Helper does all of the effort: Toileting hygiene, shower/bathing; -Mobility Device: Wheelchair; <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Frequently incontinent of bowel;</p> <p>-Indwelling urinary catheter (inserted through the urethra into the bladder to drain urine);</p> <p>-Diagnoses of hemiplegia (paralysis affecting one side of the body) or hemiparesis (muscular weakness affecting one side of the body), and multiple sclerosis (a potentially disabling disease of the brain and spinal cord);</p> <p>-Risk of Pressure Ulcers: Yes;</p> <p>-Unhealed Pressure Ulcers: Yes;</p> <p>-Number of unstageable (Unstageable Deep tissue: Suspected deep tissue injury in evolution): One;</p> <p>-Other Problems: Moisture associated skin damage (inflammation or skin erosion by a prolonged exposure to moisture such as urine, stool, sweat, sound drainage, saliva, or mucus);</p> <p>-Pressure Ulcer Care: Yes.</p> <p>Review of the resident's care plan, located in the electronic healthcare record (EHR), showed:</p> <p>-Focus: Date Initiated 1/14/24: Psychosocial/Daily Routine. Resident perceives that daily routine is very different from prior pattern in the community. Resident prefers to choose clothing to wear, doing things with groups, and receiving shower;</p> <p>-Goal: Will express satisfaction with the routines of daily living;</p> <p>-Interventions/Tasks: Allow to express feelings. Allow to make decisions, set schedules, and to participate in self-care to the extent possible.</p> <p>Observations and interviews on 3/5/24: showed:</p> <p>-7:40 A.M.: The resident lay in bed as the DON and facility Wound Nurse (WN) completed a skin assessment. The WN unfastened the resident's incontinent brief and showed a small amount of bowel movement in the brief. After the skin assessment the resident's brief was refastened and the DON and WN left the room;</p> <p>-9:57 A.M.: The resident lay in bed. He/She said no one had been in the room to clean or turn and reposition him/her since the last observation at 7:40 A.M. The resident turned on his/her call light at that time to request cleaning and turning and repositioning;</p> <p>-10:00 A.M.: CNA A said there were about 44 residents on the unit. The facility tried to schedule three CNAs, but a lot of the time they didn't end up with three CNAs. When there were just two CNAs, that was over 20 residents apiece. Something had to give, which was the showers. His/Her shift began at 7:00 A.M. Today there were just two CNAs. CNA A and an orientee (CNA in training) were the only ones until a few minutes ago when a third CNA came in. He/She was able to get complete two showers, but that was only because those residents really needed them. He/She did not know if he/she would be able to get any more showers done today;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-12:21 P.M.: The resident lay in the same position. He/She said a staff member turned off the call light and said they would be back, but no one returned. CNA A entered the room at that time. He/She had not had time to clean, turn and reposition the resident yet. CNA A felt horrible about not being able to get to the resident until now. Residents were supposed to be turned and repositioned every two hours, but he/she just had not had time. He/She was getting ready clean. turn and reposition the resident now.</p> <p>During an interview on 3/5/24 at 8:05 A.M., the resident said he/she preferred showers as opposed to bed baths. He/She felt so much cleaner after a shower. He/She did not recall the last time he/she received a shower. The CNAs told him/her they did not have enough staff to give him/her a shower.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Wednesday and Saturday on the day shift.</p> <p>Review of the resident's Skin Monitoring: CNA Shower Review Forms (completed by CNAs and reviewed by Nurses when a resident receives a shower), from 1/12/24 (admitted) through 3/5/24, showed:</p> <p>-The resident received 9 of 15 scheduled showers;</p> <p>-The last shower the resident received was on 2/26/24.</p> <p>2. Review of Resident #2's annual MDS, dated [DATE], showed persistent vegetative state/no discernible consciousness: Yes.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Dependent/Helper does all of the effort: Toileting hygiene, shower/bathe self, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfers;</p> <p>-Always incontinent of bowel/bladder;</p> <p>-Diagnoses of seizure disorder or epilepsy (a brain disorder that cause recurring, unprovoked seizures, traumatic brain injury, usually caused by a blow or traumatic injury to the head or body), and respiratory failure.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>-Focus: Date Initiated 10/25/22: Impaired cognitive ability related to traumatic brain injury (usually caused by a blow or other traumatic injury to the head or body);</p> <p>-Focus: Sate Initiated 10/25/22: Bowel incontinence;</p> <p>-Goal: Resident will have no skin breakdown related to bowel incontinence;</p> <p>-Interventions/Tasks: Assist with perineal care (washing the buttocks/genitalia) with each incontinence episode;</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Focus: Date Initiated 10/26/22: Resident is dependent on staff with all activities of daily living (ADLs, cleaning, turning and repositioning, grooming, hygiene, etc.);</p> <p>-Interventions/Tasks: Assist with mobility and ADLs as needed.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Tuesday and Friday on the day shift.</p> <p>Review of the resident's progress notes, showed the resident was hospitalized from 2/6/24 through 2/21/24.</p> <p>Review of the resident's Skin Monitoring Comprehensive CNA Shower Review forms from 2/1/24 through 3/5/24, showed the resident received four of six scheduled showers.</p> <p>3. Review of Resident #1's admission MDS, dated [DATE], showed:</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands, misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care/Presence and Frequency: Behavior not exhibited;</p> <p>-Functional Limitation in Range of Motion: Impairment of the lower extremity;</p> <p>-Mobility Devices: [NAME] and wheelchair;</p> <p>-Dependent/Helper does all of the effort: Toileting and personal hygiene;</p> <p>-Partial/moderate assistance: Roll left and right, sit to lying, toilet transfer and tub/shower transfer;</p> <p>-Always continent of bowel and bladder;</p> <p>-Diagnosis of hip fracture.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>-Focus: Date Initiated 2/21/24, Psychosocial Daily Routine: Resident perceives that daily routine is very different from prior pattern in the community. Resident prefers choosing clothes to wear, keeping up with the news, listening to music and receiving showers.</p> <p>During an interview on 3/5/24 at 8:23 A.M., the resident said he/she preferred showers over bed baths. Showers made him/her feel better and cleaner.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's shower schedule, showed he/she should receive a shower every Monday and Thursday on the day shift.</p> <p>Review of the resident's Skin Monitoring Comprehensive CNA Shower Review forms from 2/12/24 (admitted) through 3/5/24, showed the resident received five of six scheduled showers.</p> <p>4. Review of Resident #7's admission MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability To understand Others: Usually understands, misses some part/intent of message but comprehends most conversation; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -Shower/bathe: Independent; -Always continent of bowel; -Diagnoses of arthritis, multiple sclerosis and depression. <p>During observation and interview on 3/5/24 at 9:35 A.M., the resident lay in bed. His/Her hair appeared oily. The resident said he/she did not receive two showers a week. Most of the time the staff did not offer him/her a shower. He/She said his/her hair felt like someone sprayed WD-40 on it. He/She would like to have his/her showers as scheduled.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Monday and Thursday on the evening shift.</p> <p>5. Review of Resident #5's quarterly MDS dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability To Understand Others: Understands; -Cognitively intact; <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Rejection of Care: Behavior not exhibited;</p> <p>-Ability to shower/bathe self: Blank;</p> <p>-Occasionally incontinent of bowel and bladder;</p> <p>-Diagnoses of anxiety and depression.</p> <p>During an interview on 3/5/24 at 10:40 A.M., the resident said he/she did not receive two showers weekly most of the time. He/She did not receive his/her shower last Tuesday, but did receive one last Thursday because he/she kept asking for one. When only two staff worked on the unit, which happened frequently, he/she never asked for a shower because they would tell him/her they did not have enough staff. He/She would prefer to have his/her showers. He/She said, When you get a shower you feel cleaner, especially when you get hair washed.</p> <p>Review of the resident's shower schedule, showed he/she should receive a shower every Tuesday and Friday on the night shift.</p> <p>6. Review of Resident #9's annual MDS dated [DATE], showed:</p> <p>-Adequate hearing and vision;</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands;</p> <p>-BIMS Score: Blank;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Substantial/maximal assistance required for bathing;</p> <p>-Frequently incontinent of bowel;</p> <p>-Diagnoses of arthritis, dementia and asthma (a condition that causes inflammation and narrowing of the airways/lungs).</p> <p>During an interview on 3/5/24 at 9:40 A.M., the resident said there were weeks he/she did not get two showers. The CNAs told him/her they couldn't give showers because there were not enough staff.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday on the day shift.</p> <p>7. Review of Resident #10's annual MDS dated [DATE], showed:</p> <p>-Adequate hearing and vision;</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands;</p> <p>-Moderately impaired cognition;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Physical impairment of one upper and one lower extremity;</p> <p>-Ability to shower/bathe self: Blank;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Diagnoses of stroke and dementia.</p> <p>During an interview on 3/5/24 at 9:42 A.M., the resident said he/she was supposed to get a shower yesterday (Monday 3/4/24) but he/she did not get one. The CNAs did not ask him/her if he/she wanted a shower yesterday. If they had, he/she would have told them yes. He/She felt better after a shower.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday.</p> <p>8. Review of Resident #11's quarterly MDS dated [DATE], showed:</p> <p>-Adequate hearing;</p> <p>-Vision impaired, sees large print, but not regular print in newspapers/books;</p> <p>-Speech Clarity: Unclear speech, slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood;</p> <p>-Ability To Understand Others: Usually understands;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Ability to shower/bathe self: Blank;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Diagnoses of hemiplegia or hemiparesis, and depression.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/5/24 at 9:44 A.M., the resident said he/she was supposed to get a shower yesterday, but he/she did not get one. Yesterday, the CNAs did not ask if he/she wanted a shower. He/She preferred a shower. He/She felt nasty when he/she does not receive a shower.</p> <p>Review of the resident's shower schedule, showed the resident should receive a shower every Monday and Thursday on the day shift.</p> <p>9. During an interview on 3/5/24 at 10:08 A.M., Licensed Practical Nurse (LPN) B said today there were 42 residents on the unit. When there were two CNAs the residents would not get their showers. He/She tried to help the CNAs when he/she could, but he/she had his/her own responsibilities as well. More often than not, the unit ended up with two CNAs.</p> <p>10. During an interview on 3/5/24 at 12:10 P.M., the facility Staffing Coordinator/CNA said the 100 hall had over 40 residents. She scheduled three CNAs on the 100 hall, but it was not uncommon for someone to call in or not show up. Yesterday she had three CNAs scheduled. One called off and one went home sick shortly after coming in. That left one CNA until about 11:00 A.M., when she went to the 100 hall and worked as a CNA. She did not give any assigned showers yesterday because she did not have time. She did not think the other CNA was able to give any showers yesterday.</p> <p>11. During an interview on 3/6/24 at 2:30 P.M., the DON said she expected residents to receive their showers as scheduled. Two CNAs with 20 plus residents each would not be enough to get everything done. The Administrator said the facility tried to schedule three CNAs on the 100 hall, but it didn't always work out.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received adaptive equipment at meals as ordered, to assist with resident eating independence and increase food/fluid intake. Four residents with orders for adaptive eating equipment were sampled and problems were found with three (Residents #39, #40 and #41). The census was 94.</p> <p>Review of the facility Assistance with Meals policy, undated, included:</p> <p>Policy Statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident;</p> <p>Policy Interpretation and Implementation:</p> <p>Residents Who May Benefit from Assistive Devices:</p> <ol style="list-style-type: none"> Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups; Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils; Resident may choose not to use adaptive devices. <ol style="list-style-type: none"> Review of Resident #39's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/24, showed: <ul style="list-style-type: none"> -Makes Self Understood: Unclear speech - slurred or mumbled words; -Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability to Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation; -Severely impaired cognition; -Rejection of Care: Behavior not exhibited; -Functional Limitation in Range of Motion: Impairment of one upper and one lower extremity; -Eating: Blank; <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses: diabetes mellitus (high blood sugar levels), stroke, hemiplegia (paralysis of one side of the body)/hemiparesis (muscle weakness of one side of the body), malnutrition (protein or calorie) or at risk for malnutrition, anxiety and depression.</p> <p>Review of the resident's care plan located in the electronic medical record (EMR), showed:</p> <p>-4/29/23: Focus: Mechanical soft diet related to recent stroke. Diagnoses of malnutrition and diabetes mellitus. Goal: Nutritional needs will be met and his/her weight will remain stable through next review. Interventions/Tasks: Assess nutritional status of resident at least quarterly and as necessary. Assist with meals as needed. Diet per physician order. Need for adaptive equipment. Refer to Occupational Therapy as appropriate. Refer to Registered Dietician (RD) as appropriate. Weight per facility protocol;</p> <p>4/29/23: History of stroke. Usually able to make his/her needs known and usually is able to understand others. Goal: Needs will be met and communication with staff will be effective through next review. Interventions/Tasks: Ask yes/no questions. Encourage resident to speak slowly and take his/her time.</p> <p>Review of the resident's physician's order sheet (POS), located in the EMR, showed:</p> <p>-6/19/23: Resident to utilize built up curved spoon and fork (adaptive utensils used to allow the resident to eat independently), cup with handles and lid and a straw;</p> <p>-11/8/23: Resident to utilize plate guard (used to prevent food from sliding off the plate) on plate for all meals.</p> <p>Review of the resident's dietary note located in the EMR progress notes, and documented by the RD on 2/20/24 at 5:36 P.M., showed:</p> <p>-Resident eats with aide and is dependent on staff members for help with meals - uses plate guard, built up left curve spoon, and cup with two handles.</p> <p>Review of the resident's Dining RD Nutritional Care Form, dated 4/30/24 and completed by the RD, showed:</p> <p>-Resident eats with aide and is dependent on staff members for help with meals - uses plate guard, built up left curve spoon, and cup with two handles at meals</p> <p>Observation on 5/7/24 at 12:26 P.M., showed the resident sat at a dining room table with Certified Nursing Assistant (CNA) E sitting next to him/her. The resident had been served lunch. His/Her plate had a plate guard, but he/she had regular utensils and was drinking from a regular cup and no straw. The resident's menu, slip located on the table, showed: Adaptive equipment: Two-handed cup with lid, curved build-up fork and spoon, plate guard, and straw.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 5/9/24 at 8:08 A.M., showed the resident sat at a dining room table with CNA E next to him/her. The resident's plate had a plate guard, but he/she had not been given a two-handled cup with lid, curved build-up fork and spoon, or a straw. CNA E said the resident did not have his/her adaptive utensils or two handled cup with a lid because dietary staff are responsible to bring those items out with the plate. Dietary staff have not brought those items out very often.</p> <p>During an interview on 5/9/24 at 9:15 A.M., the Dietary Manager (DM) said if the resident's menu slip showed two-handled cup with straw, plate guard, and build-up spoon and fork, then dietary staff were responsible to ensure it was on the tray when it went to the dining room.</p> <p>2. Review of Resident #40's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Speech Clarity: No speech - absence of spoken words; -Makes Self Understood: Rarely/never understood; -Ability to Understand Others: Rarely/never understands; -Rejection of Care: Behavior of this type occurred one to three days; -Eating: Independent - Resident completes the activity by him/herself with no assistance from helper; -Diagnoses: Cancer (with or without metastasis (spread of a disease)), stroke, aphasia (partial or total loss of language skills), hemiplegia/hemiparesis, malnutrition (protein or calorie) or at risk for malnutrition. <p>Review of the resident's care plan, located in the EMR, showed:</p> <p>-12/21/23: Focus: Cognitive Impairment. Resident is alert and requires assistance with decision making. Interventions: Anticipate needs and meet promptly. 12/21/23: Focus: Potential for impaired communication with dysphasia (difficulty speaking) related to stroke. Interventions: Give ample time for resident to communicate. Use simple direct communication such as yes questions as needed.</p> <p>-12/21/23: Focus: Malnutrition. Resident is on a mechanical soft diet (soft foods/ground meats) and has a diagnosis of malnutrition. Interventions: Administer nutrition related medications per physician's orders. Allow adequate time for meal consumption. Assist with meals/fluids;</p> <p>-The care plan did not identify the resident's adaptive feeding equipment (plate guard/built-up utensils(the handles of the utensil is either bent to accommodate the resident's needs or the handles may have thick foam allowing the resident to grip the utensils)/two-handled mug).</p> <p>Review of the resident's POS located in the EMR on 5/7/24, showed:</p> <p>-4/2/24: Adaptive feeding equipment: Plate guard, built-up utensils, two-handled mug to be provided during all meals to facilitate independence with self-feeding.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Dining RD Nutritional Care Form, dated 4/30/24, and completed by the RD, showed:</p> <ul style="list-style-type: none"> -Resident independent with staff assist/supervision needed at meals. Resident uses adaptive feeding equipment to increase independence at meals. Plate guard/built-up utensils/two-handed mug. <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Speech Clarity: No speech - absence of spoken words; -Makes Self Understood: Rarely/never understood; -Ability to Understand Others: Rarely/never understands; -Rejection of Care: Behavior of this type occurred one to three days; -Eating: Independent - Resident completes the activity by him/herself with no assistance from helper. <p>Observation on 5/7/24 at 1:10 P.M., showed the resident sat in a wheelchair alone in his/her room, feeding himself/herself lunch. The resident did not have adaptive utensils, plate guard or two-handed mug. The resident's menu slip showed the resident should have the following: Two-handed cup and built-up utensils.</p> <p>Observation on 5/9/24 at 8:33 A.M., showed the resident lay in bed feeding himself/herself breakfast. The resident had not received a plate guard, built-up utensils, or a two-handed cup. The resident did not answer questions when asked.</p> <p>3. Review of Resident #41's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands - clear comprehension; -Moderately impaired cognition; -Rejection of Care: Behavior not exhibited; -Eating: Partial/moderate assistance - Helper does less than half the effort; <p>-Diagnoses of gastroesophageal reflux disease (heartburn), malnutrition (protein or calories) or at risk for malnutrition, depression, and psychotic disorder (other than schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis).</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Nutritional Risk assessment dated [DATE], completed by the RD and located in the EMR, showed:</p> <ul style="list-style-type: none"> -Resident currently on a regular diet. Resident reports good appetite and is eating 50-100% of meals. Resident reports difficulties with eating related to limited mobility hands/arms, and he/she prefers finger foods. Resident cannot open foods on own and has a hard time feeding self certain foods. <p>Review of the resident's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Speech Clarity: Clear speech - distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands - clear comprehension; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -Eating: Partial/moderate assistance - Helper does less than half the effort. <p>Review of the resident's POS, located in the EMR, showed:</p> <ul style="list-style-type: none"> -4/12/24: Adaptive feeding equipment. Angled, built-up and weighted utensils, plateguard, Dycem (a non-slip mat used to keep the plate from sliding), and two-handled cups provided during all meals. <p>Review of the resident's care plan, located in the EMR, showed:</p> <ul style="list-style-type: none"> -4/15/24: Focus: Malnutrition. Resident is at risk for malnutrition due to needing assistance with eating. Goal: Will maintain adequate nutritional status as evidenced by stable weight. Interventions: Allow adequate time for meal consumption. Notify physician of significant weight gain. Plate guard per orders. Refer to RD as needed; -The care plan did not address: Angled built-up and weighted utensils, two-handled cups, Dycem, or the resident's preference to be served finger foods. <p>Observation on 5/7/24 at 12:53 P.M., the resident sat in his/her room on the side of the bed. Staff brought the resident a regular lunch tray (pork sandwich, a bowl of beans, and corn). The resident did not receive built-up and weighted utensils, plateguard, Dycem, or a two-handled cup. The resident sent the lunch back and requested a cheeseburger.</p> <p>During an interview on 5/7/24 at 12:523 P.M., the resident said staff never bring him/her the adaptive equipment. He/She pointed to a weighted spoon on his/her bed table and said he/she kept it and cleaned it himself/herself because it won't come back if he/she let them take it. He/She could use the two-handled cup because he/she frequently spilled liquids served in a regular cup. It was difficult for him/her to use regular utensils/cup because he/she has numbness in his/her hands and arms. He/She has asked for finger foods in the past, but always gets a regular tray he/she has to send back. Most of the time he/she would request a hamburger in place of the first tray they send.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/9/24 at 9:15 A.M., the DM said she was aware the resident requested finger foods, but she was under the impression she had to send a regular tray and if it was refused, then send the cheeseburger. The resident did send the first tray back frequently and requested a lot of cheeseburgers. She had not discussed finger food alternatives with the resident or RD.</p> <p>During an interview on 5/10/24 at 9:50 A.M., the resident sat in his/her room. The resident said when he/she sends his/her tray back, sometimes staff would forget to bring a replacement tray, which made him/her angry. Observation at that time showed a fork, knife and spoon with built-up handles on the bed table. The resident said when he/she first admitted, staff would [NAME] the special utensils, but it's been a long time since he/she received any. Yesterday they provided it. He/She can use a regular fork, but has to stab food to get it on the fork. Most of the food is softer and had to be scooped, which he/she cannot do with a regular fork.</p> <p>4. Observation on 5/9/24 at 8:20 A.M., showed Certified Occupational Therapy Assistant (COTA) K stood at the door of the kitchen with two or three unopened plastic bags containing adaptive utensils.</p> <p>During an interview on 5/9/24 at 8:52 A.M., COTA K said he/she was getting the adaptive utensils earlier this morning for a couple of residents (two not included in the sample) that did not have it on their breakfast trays. It was not uncommon for residents not to receive adaptive feeding equipment during meals. Therapy assesses residents for adaptive equipment that can assist them with eating and drinking more independently. A physician's order is obtained for the adaptive equipment and the dietary department gets a copy of those orders which are added to the menu slips. He/She had discussed this problem with management several times in the past, but it doesn't seem to make a difference.</p> <p>5. During an interview on 5/9/24 at 9:15 A.M., the DM said her staff should be reading the menu slips when they are serving and ensure each resident is getting the adaptive equipment printed on the menu slip. Any adaptive equipment should be sent on the meal tray to the resident by the dietary staff. A lot of the time, adaptive equipment that was sent out did not return and she ended up not having enough adaptive equipment for the residents. She had recently ordered more. The Director of Nurses said she expected nursing staff to read the menu slips and notify dietary if adaptive equipment has not been sent on the meal tray.</p> <p>6. During a telephone interview on 5/15/24 at 9:05 A.M., the RD said she was usually at the facility once a week on Tuesdays. She does not see all the residents every time she is there. Adaptive utensils are important. Without adaptive equipment, residents may not eat/drink as much as possible.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had comfortable water temperatures for bathing. Residents #14, #15, #16 and #17 complained the facility water temperatures for the sinks and showers in their rooms were too cold to comfortably take showers and/or bed baths. Review of the facility's water temperature logs from October 6, 2023 through February 26, 2024, showed water temperatures in multiple resident rooms as well as community shower rooms were below the acceptable threshold of 105 Fahrenheit (F) to 120 F. In addition, water temperatures in the sampled residents' rooms on 3/6/24, showed the water temperatures remained below the acceptable water temperature range. The census was 90.</p> <p>Review of the facility Water Temperatures, Safety policy, dated 2002 and revised on 2009, showed:</p> <ul style="list-style-type: none"> -Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents; -Policy Interpretation and Implementation: <ul style="list-style-type: none"> -Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than blank Fahrenheit (F), or the maximum allowable temperature per state regulation; -Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log; -Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. <p>Review of the facility Test and Log the Hot Water Temperatures policy dated 3/6/24, showed:</p> <ul style="list-style-type: none"> -For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit (F), although this temperature can still cause burns if exposure reaches five minutes. 100 degrees F is considered a safe water temperature for bathing; -Test temperature in shower area; -Test temperature at mixing valve (a device that mixes cold and hot water to deliver tempered water from the water heater); -Check resident rooms at the end of each wing on a rotating basis or per facility policy; -Common area bathrooms, public bathrooms and any other areas having sinks should be checked and recorded as well; <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Record results in the water temperature log. Note any discrepancies. Adjust water heater settings as required. Retest as necessary.</p> <p>1. Review of the facility water temperature logs, from 10/1/23 through 1/25/24, showed:</p> <p>-10/6/23: 100 Hall shower room - 97.1 F, room [ROOM NUMBER] - 87.4 F, 200 Hall Shower room - 93.4 F, room [ROOM NUMBER] - 90.1 F, 300 Hall shower room - 99.1 F, and room [ROOM NUMBER] - 91.2 F;</p> <p>-10/12/23: 100 Hall shower room - 97.1 F, room [ROOM NUMBER] - 87.4 F, 200 Hall shower room - 93.4, room [ROOM NUMBER] - 90.1 F, 300 Hall shower room - 99.1 F, and room [ROOM NUMBER] - 91.2 F;</p> <p>-10/16/23: room [ROOM NUMBER] - 82 F, room [ROOM NUMBER] - 73 F, room [ROOM NUMBER] - 81 F, room [ROOM NUMBER] - 71 F, and room [ROOM NUMBER] - 95 F;</p> <p>-11/27/23: room [ROOM NUMBER] - 87 F, rooms [ROOM NUMBERS] - 75 F, room [ROOM NUMBER] - 71 F, room [ROOM NUMBER] - 79 F, and room [ROOM NUMBER] - 78 F;</p> <p>-12/4/23: room [ROOM NUMBER] - 82 F, room [ROOM NUMBER] - 76 F, and room [ROOM NUMBER] - 77 F;</p> <p>-12/15/23: rooms [ROOM NUMBERS] 79 F, room [ROOM NUMBER] 76 F, and room [ROOM NUMBER] 77 F;</p> <p>-12/25/23: room [ROOM NUMBER] - 81 F, room [ROOM NUMBER] - 74 F, room [ROOM NUMBER] - 79 F, and room [ROOM NUMBER] - 87 F;</p> <p>-1/1/24: room [ROOM NUMBER] - 75 F, room [ROOM NUMBER] - 74 F, room [ROOM NUMBER] - 86, and room [ROOM NUMBER] - 87 F;</p> <p>-1/16/24: room [ROOM NUMBER] - 83 F, room [ROOM NUMBER] - 74 F, room [ROOM NUMBER] - 75 F, room [ROOM NUMBER] - 79 F, room [ROOM NUMBER] 86 F, and room [ROOM NUMBER] - 95 F;</p> <p>-1/25/24: room [ROOM NUMBER] - 79 F, room [ROOM NUMBER] - 84 F, room [ROOM NUMBER] - 67 F, Room - 218 - 61 F, room [ROOM NUMBER] - 54 F, and room [ROOM NUMBER] - 61 F.</p> <p>2. Review of the Resident Council minutes, dated 1/29/24, showed:</p> <p>-Council members said the hot water isn't working in some bathrooms;</p> <p>-Performance Improvement Plan: Hot water tanks were replaced;</p> <p>-Person Responsible: Maintenance Director;</p> <p>-Goal Date: 1/28/24.</p> <p>3. Review of the facility water temperature logs, from 2/2/24 through 2/26/24, showed:</p> <p>-2/2/24: room [ROOM NUMBER] - 76, room [ROOM NUMBER] - 89 F, room [ROOM NUMBER] - 87 F, room [ROOM NUMBER] - 76 F, room [ROOM NUMBER] - 78 F, room [ROOM NUMBER] - 62, room [ROOM NUMBER] - 71, room [ROOM NUMBER] - 50 F, room [ROOM NUMBER] - 51 F, room [ROOM NUMBER] - 65, and room [ROOM NUMBER] - 56.</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garden Plaza Drive Florissant, MO 63033	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-2/7/24: room [ROOM NUMBER] - 76 F, room [ROOM NUMBER] - 75, room [ROOM NUMBER] - 72 F, room [ROOM NUMBER] - 71, room [ROOM NUMBER] - 74 F, room [ROOM NUMBER] - 76 F, room [ROOM NUMBER] - 72 F, room [ROOM NUMBER] - 65 F, room [ROOM NUMBER] - 63, room [ROOM NUMBER] - 74, room [ROOM NUMBER] - 64 F, and room [ROOM NUMBER] 82 F;</p> <p>-2/15/24: room [ROOM NUMBER] - 82 F, room [ROOM NUMBER] - 79 F, room [ROOM NUMBER] - 81 F, room [ROOM NUMBER] - 79 F, room [ROOM NUMBER] - 80 F, room [ROOM NUMBER] - 83 F, room [ROOM NUMBER] - 75 F; rooms [ROOM NUMBERS] - 75 F, room [ROOM NUMBER] - 84 F, room [ROOM NUMBER] - 82 F, room [ROOM NUMBER] - 75 F, and room [ROOM NUMBER] - 89 F;</p> <p>-2/26/24: room [ROOM NUMBER] - 76 F, room [ROOM NUMBER] - 77 F, room [ROOM NUMBER] - 75 F, room [ROOM NUMBER] - 75 F, room [ROOM NUMBER] - 79 F, room [ROOM NUMBER] - 90 F, room [ROOM NUMBER] - 80 F, room [ROOM NUMBER] - 78 F, room [ROOM NUMBER] - 78 F, room [ROOM NUMBER] - 93 F, room [ROOM NUMBER] - 86 F, room [ROOM NUMBER] - 83 F, and room [ROOM NUMBER] - 89 F.</p> <p>4. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/25/23, showed:</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Unclear speech, slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;</p> <p>-Cognitively intact;</p> <p>-Diagnoses of heart failure (e.g., congestive heart failure (a long term condition that occurs when the heart cannot pump blood well enough to provide the body with a normal supply) and pulmonary edema (excessive fluid accumulation in the tissue or air spaces of the lungs), pneumonia (an inflammatory condition of the lungs), anxiety, depression, schizophrenia (a mental disorder characterized by recurring episodes of psychosis (a mental state marked by loss of contact with reality)), asthma (long-term inflammatory disease of the airways/lungs), and respiratory failure.</p> <p>During an interview on 3/5/24 at 1:30 P.M., the resident said there was no hot water in his/her bathroom. He/She had a shower in his/her bathroom, but he/she wouldn't take showers because the water was too cold. The water in the shower room on his/her unit was too cold as well. The water temperatures had been cold for months. He/She told several staff the water was too cold.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 3/6/24 at 10:29 A.M. showed the surveyor ran the sink water for several minutes. The water remained cool to the touch. The water temperature was tested with a thermometer and showed 75 F. The facility Maintenance Director (MD) entered the bathroom with his/her thermometer, and tested the water in the sink and the shower. The thermometer showed 74 F. He felt the water and said it was cool, and would not want to bathe or shower in it. He checked the water temperatures of a few rooms on every unit weekly. The facility just had a new water heater installed on the 300 Hall a week or two ago.</p> <p>5. Observation on 3/6/24 at 10:36 A.M., showed the MD tested the water in the shared resident 300/400 Hall shower room. The water temperature showed 75 F.</p> <p>6. Review of Resident #15's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Adequate hearing; -Speech Clarity: Unclear speech, slurred or mumbled words; -Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time; -Ability To Understand Others: Usually understands, misses some part/intent of message but comprehends most conversation; -Moderately impaired cognition; -Rejection of Care: Behavior not exhibited; -Shower/bathe self: Setup or clean-up assistance, Helper sets up or cleans up, resident completes activity; -Diagnoses of stroke, and hemiplegia or hemiparesis. <p>During an interview on 3/6/24 at 10:42 A.M., the resident said he/she took showers in his/her room. It was uncomfortable because the water was too cold. It had been that way for months. The surveyor tested the water from the resident's shower. The thermometer showed a temperature of 78 F.</p> <p>7. During an interview on 3/6/24 at 10:45 A.M., Licensed Practical Nurse (LPN) C said the water temperatures were cold on the 300/400 Halls. The residents often complained about the water being cold. It had been that way for quite a while. He/She had told the Director of Nurses (DON), Administrator and the MD in the past. The residents still complained the water was cold.</p> <p>8. During an interview on 3/6/24 at 10:50 A.M., Certified Nurse Aide D said the water was too cold in many of the resident rooms and the shower room. He/She used a kettle to heat water up so he/she could give the residents a comfortable bed bath. Residents had been complaining about the water temperatures being too cold for a long time.</p> <p>9. Review of Resident #16's admission MDS, dated [DATE], showed:</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Adequate hearing;</p> <p>-Speech Clarity: Unclear speech, slurred or mumbled words;</p> <p>-Makes Self Understood: Usually understood, difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Ability To Understand Others: Usually understands, misses some part/intent of message but comprehends most conversation;</p> <p>-Moderate cognitive impairment;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Shower/bathe self: Independent;</p> <p>-Diagnosis of other fracture.</p> <p>During an interview on 3/6/24 at 11:00 A.M., the resident said he/she had been at the facility for about three weeks. There had not been warm water to take a shower. He/She refused to take a shower because the water was too cold. He/She told everyone the water was too cold. The surveyor tested the water from the resident's bathroom sink. The thermometer showed a temperature of 78 F at the sink, and shower temperature of 80 F.</p> <p>10. Review of Resident #17's admission MDS dated [DATE], showed:</p> <p>-Adequate hearing;</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands;</p> <p>-Cognitively intact;</p> <p>-Rejection of Care: Behavior not exhibited;</p> <p>-Shower/bathe: Substantial/maximal assistance;</p> <p>-Diagnoses of cancer and dementia.</p> <p>During an interview on 3/6/24 at 11:11 A.M. the resident said he/she had been at the facility for a month. The water had been cold since he/she had been there. He/She did not take showers because it was too cold. The surveyor tested the water from the resident's bathroom sink and the thermometer showed a temperature of 82 F. The shower in the resident's room was also tested and the thermometer showed a temperature of 78 F.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11. During an interview on 3/6/24 at 12:05 P.M., the MD said he had worked at the facility for about one year. He said normal ranges for water temperature was 99 F to 100 F. He was not aware water temperatures should range from 105 F to 120 F. The Administrator said he was not aware of the cold water temperatures until a few weeks ago after a resident complained in the 1/29/24 resident council meeting. He was not aware the water temperatures were still low after the facility replaced one of the hot water heaters.</p> <p>MO00232883</p> <p>MO00233050</p>		