STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265838	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409 See Event ID 97R512 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.

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