

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 07/25/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44948</p> <p>Based on interview and record review, the facility failed to obtain physician orders and complete tracheostomy (the presence of a surgical airway placed in the neck to help oxygen reach the lungs) treatment orders for one of four sampled residents (Resident #12) requiring tracheostomy care and maintenance. The census was 106.</p> <p>Review of the facility's Tracheostomy Care Policy, revised 10/2023, showed:</p> <ul style="list-style-type: none"> -The following must be documented in the resident's record: -The procedure completed; -The condition of the stoma and surrounding skin; -The resident's tolerance of the procedure; -Any provider notification of unexpected or abnormal findings. <p>Review of Resident #12's medical record, showed:</p> <ul style="list-style-type: none"> -Diagnoses included anoxic brain damage (damage to the cerebrum caused by a lack of oxygenated blood to the brain), bronchiectasis (a chronic pulmonary disease causing the airways to be inflamed and prone to infection) and tracheostomy status. -The quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/15/24, showed the resident had significant cognitive impairment. <p>Review of the resident's care plan, in use during the onsite investigation process, showed:</p> <ul style="list-style-type: none"> -Focus: Tracheostomy status, resident requires a tracheostomy and is at risk for complications related to accidental decannulation (accidental removal or dislodging of the tracheostomy tubing) and decreased level of consciousness. Interventions included routine changing of suction equipment, the tracheostomy cannula and ties, and to routinely document respiratory status. The care plan goal was to have no signs or symptoms of complication regarding the tracheostomy during admission. <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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's facility admission census section, showed the resident admitted on [DATE] and discharged to the hospital on 4/20/24.</p> <p>Review of the resident's Physician Orders, showed:</p> <p>-An order, dated 4/11/24, for continuous oxygen monitoring, weekly and as needed (PRN) changing of the suction system and tracheostomy equipment, and PRN suctioning of the airway. The end date for this order was 4/24/24;</p> <p>-An order, dated 4/11/24, for a Bivona 6 (a surgical cannula used for tracheostomies measuring 6 millimeters in diameter), and to change the cannula monthly or as needed for complications. The end date for this order was 4/24/24.</p> <p>Review of the resident's Medication and Treatment Administration Record (MAR/TAR) showed:</p> <p>-In April 2024, orders for changing suction equipment weekly and PRN, not documented as completed on any day between 4/11/24 and 4/24/24;</p> <p>-In April 2024, orders for suctioning secretions PRN, not documented as completed on any day between 4/11/24 and 4/24/24;</p> <p>-In April 2024, orders for changing tracheostomy ties twice weekly and PRN, not documented as completed on any day between 4/11/24 and 4/24/24.</p> <p>Review of the resident's progress notes, dated 4/20/24 at 6:02 A.M., showed the resident experienced low oxygenation saturation (SpO2, a measure of the concentrated oxygen in the blood being sent to the body) during activities of daily living (ADL) care. The resident's SpO2 was measured in the low 60s (normal oxygenation levels are 95 and above to support oxygenated blood to the organs), indicating inadequate oxygenated blood in the body. The resident was given 12 liters of high flow oxygen and oxygen saturation was increased to the mid 80s. Suctioning was provided by nursing staff until Emergency Medical Services (EMS) arrived to take the resident to the hospital for evaluation.</p> <p>Review of the resident's facility admission census section, showed the resident was admitted to the facility on [DATE] and discharged to the hospital on 6/22/24.</p> <p>Review of the resident's Physician Orders, showed:</p> <p>-No further orders obtained regarding tracheostomy care for the resident's June and July, 2024 admitted s.</p> <p>Review of the resident's MAR/TAR, showed:</p> <p>-In June 2024, no orders or documentation for changing suction equipment weekly, for suctioning secretions from the resident routinely, or for changing tracheostomy ties entered into the Administration Record.</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>Review of the resident's progress notes, dated 6/22/24 at 7:49 P.M., showed the resident experienced low oxygenation saturation, and was assessed to be short of breath at rest. A call was placed to EMS to send out for hospital evaluation, and staff remained with the resident until EMS arrived. No mention of suctioning the resident's airway noted in the progress note.</p> <p>Review of the resident's facility admission census section, showed the resident was admitted to the facility on [DATE] and discharged to the hospital on 7/6/24.</p> <p>Review of the resident's July 2024 MAR/TAR, showed:</p> <p>-In July 2024 (7/1/24-7/6/24), no orders or documentation for changing suction equipment weekly, for suctioning secretions from the resident routinely, or for changing tracheostomy ties entered into the Administration Record.</p> <p>Review of the resident's progress notes, dated 7/6/24 at 8:23 P.M., showed the resident was noted upon nurse assessment to have a large amount of green sputum at the tracheostomy site, and experienced low oxygenation status measured in the mid 70s. The resident was placed on 8 L of high flow oxygen but adequate and stable oxygenation levels could not be reached. Nursing staff contacted EMS and suctioned the resident until emergency staff arrived to take the resident to the hospital for evaluation.</p> <p>During an interview on 7/25/24 at 11:35 A.M., Registered Nurse (RN) A, an agency nurse at the facility, said nursing staff take direction from the orders placed in the Electronic Medical Record (EMR), and document those treatments and medications on the MAR or TAR for each resident. It is important for tracheostomy patients to have orders noting how often to change equipment, how often to suction the airway, and what size the tracheostomy cuff is, as this information is important for emergent and non-emergent care for tracheostomy patients. Staff are expected by administration to document all completed treatments on the MAR each time they are done.</p> <p>During an interview on 7/25/24 at 10:41 A.M., the Assistant Director of Nursing (ADON) said all nurses in the facility are licensed to care for tracheostomy status residents, but the facility does not schedule nurses who are uncomfortable doing so on the tracheostomy unit unless they have no other staff to do so. The ADON said staff are expected to complete orders as written on the resident's MAR/TAR, and are expected to document those treatments as they are completed.</p> <p>During an interview on 7/25/24 at 1:17 P.M., the Director of Therapy Services said respiratory staff at the facility take primary responsibility for tracheostomy care during the day shift in conjunction with nursing staff, but on night shift, the responsibility falls only on nursing staff. Respiratory staff document treatments in the EMR, and work off of the same order set as reflected on each resident's TAR. The facility has a clinical meeting daily to go over new admissions and to verify order sets for each resident. The facility medical records team provides order audits for these clinical meetings, but does not provide respiratory therapy order audits. Up until a month ago, the facility routinely had a Pulmonary Nurse Practitioner to provide oversight and insight to respiratory residents at clinical meetings, but they have not re-filled that position at this time. The Director of Therapy Services expected tracheostomy orders to be re-ordered or changed per the resident's discharge orders when returning or arriving to the facility.</p> <p>(continued on next page)</p>		

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