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	10/21/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42247 Based on observation, interview and record review, the facility failed to ensure the dignity of one resident (Resident #9). Staff failed to intervene when the resident was sitting in the common area with his/her brief exposed. The sample was 33. The census was 99. Review of the facility's Dignity Policy, dated February 2021, showed: -Policy statement: Each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction with life, and feelings of self -worth and self-esteem. -Residents are treated with dignity and respect at all times. Review of Resident #9's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/14/24, showed: -Severe cognitive impairment; -Upper and lower body dressing: Dependent, helper does all the effort. Resident does none of the effort to complete the activity; -Diagnoses included: heart failure, diabetes, other neurological conditions and aphasia (a language disorder that makes it difficult to understand, speak, read, or write). Review of the care plan, in use at the time of survey, showed: -Focus: resident requires extensive assist with Activities of Daily Living (ADL) care related to impaired balance and incontinence; -Goal: will participate in her care to her highest ability level with assist and support from staff as needed through next review; -Interventions: assist with mobility and ADLs as needed; requires extensive assist with eating, dressing, and hygiene. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/24 at 3:36 P.M., the resident's representative (RR) said approximately twice a month when he/she visited, the resident would be exposed and the RR would notify staff. Observation on 10/16/24 at 7:23 A.M., showed the resident sat up in his/her chair in the common area. The resident's dress was pulled up to the waist exposing the resident's brief. Observation on 10/16/24 at 7:45 A.M., showed the resident remained in the same position in the common area, with his/her dress pulled up to the waist exposing the resident's brief. Observation and interview on 10/16/24 At 7:48 A.M. showed Certified Nurse Aide (CNA) C covered the resident up with a sheet. CNA C said the resident moved his/her legs causing the resident's gown to go up and expose the brief. CNA C covered the resident up so his/her goodies would not be exposed. CNA C tried to tuck the sheet down by the resident's hips so he/she could still move his/her legs. During an interview on 10/17/24 at 10:10 A.M., Licensed Practical Nurse (LPN) NN said if he/she saw a resident exposed he/she would adjust the resident's clothing and/or cover them up with a throw blanket for dignity. The resident's family brought the resident Mumu dresses (loose fitting dresses) with a split in them and the resident kicked his/her legs. Staff covered him/her up and tucked the blanket in at the hips so the resident could still move. During an interview on 10/21/24 at 3:08 P.M., the Administrator said he expected residents to be treated with dignity and respect. MO00243620

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 46970 Based on observation, interview, and record review, facility staff failed to provide reasonable accommodations of individual needs and preferences by failing to ensure call lights were within reach for three sampled residents (Residents #51, #41 and #58). Staff also failed to ensure residents with limited mobility needs and preferences were met when staff did not honor one resident's preference to have his/her head turned (Resident #58). The sample was 33. The census was 99. Review of the facility's Answering the Call Light policy, revised 10/2010, showed: -Purpose: To respond to the resident's requests and needs; -General Guidelines: -Explain the call light to the new resident; -Demonstrate the use of the call light; -Ask the resident to return the demonstration so that you will be sure that the resident can operate the system (Note: Explain to the resident that a call light system was also located in his/her bathroom. Demonstrate how it works); -Be sure that the call light is plugged in at all times; -When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident; -Some residents may not be able to use their call light. Be sure you check these residents frequently; -Report defective call lights to the nurse supervisor promptly; -Answer the resident's call as soon a possible; -Be courteous in answering the resident's call light; -Steps in the Procedure: -Turn off the signal light; -Identify yourself and call the resident by his/her name; -Listen to the resident's request; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Do what the resident asks of you, if permitted. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfil the resident's request, ask the nurse supervisor for assistance. -If you have promised the resident you will return with an item or information, do so promptly; -If assistance is needed when you enter the room, summon help by using the call signal; -Documentation: -The following information should be recorded in the resident's medical record: -Request or complaints made by the resident; -How the request or complaint was satisfied; -If support personnel or family members assisted and how; -If the resident refused the treatment/solution, and the reason(s) why; -The name and title of the individual(s) who performed the procedure. 1. Review of Resident #51's admission Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/3/24, showed: -Moderate cognitive impairment; -Functional limitation in range of motion: Upper extremity (shoulder, elbow, wrist, hand)-Impairment on one side; -Sit to Stand: The ability to safely to a standing position from sitting in a chair or on the side of the bed; -Wheelchair. Observation and interview on 10/6/24 at 10:10 A.M., showed the resident's soft touch and push button call light on the floor on the right side and at the head of his/her bed. The call light was hidden by the privacy curtain. The resident was sitting in his/her wheelchair on the left side of his/her bed, towards the foot. His/Her right hand was contracted (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and he/she wore a brace. The resident said he/she didn't know where his/her call button was. The resident said he/she wanted to use his/her call button but he/she couldn't find it. The resident didn't know his/her call button was on the floor and said he/she would never have found it. The resident said he/she called out for help and sometimes he/she got the attention of staff passing by. The resident said staff helped him/her get dressed and to his/her wheelchair. He/She said staff looked for his/her call light before leaving his/her room but told him/her they couldn't find it. He/She said there had been times when he/she needed staff before and had to yell out because he/she didn't have his/her call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #41's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Mobility: Roll left and Right - Substantial/Maximal assistance. Helper does more than half of the effort; -Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, wash/drying face, and hands - Dependent. Helper does all of the effort; -Diagnosis include heart failure (congestive heart failure (CHF) a chronic condition in which the heart doesn't pump blood as well as it should), pulmonary edema (a condition caused by excess fluid in the lungs), hypertension (a condition in which the force of the blood against the artery walls is too high). During an interview on 10/6/24 at 10:25 A.M., the resident said if he/she needed help from staff, he/she would press his/her call light if he/she could find it. Observation showed the resident's call light clipped onto his/her privacy curtain. The privacy curtain was pushed back towards the wall and out of reach of the resident. The resident said he/she could not reach the call light. He/She beat on the table to get staff attention when he/she could not find his/her call light. The resident said staff clipped his/her call light back there on the privacy curtain. He/She guessed the staff got tired of him/her calling. It took a long time for staff to come when he/she called them and said when staff came, they turned off the call light and would tell him/her they would let his/her aide know or someone would be back to help him/her. The resident said no one came back. 3. Review of Resident #58's medical records, showed: -Moderate cognitive impairment; -Mobility: Roll left and right -substantial/maximal assistance; -Functional limitation in range of motion: Lower extremity (hip, knee, ankle, foot) - Impairment on one side; -Diagnoses included: aphasia (a language disorder that affects a person's ability to communicate), cerebrovascular Accident (CVA, stroke), transient ischemic attack (TIA, a brief disruption of blood flow to the brain that causes stoke-like symptoms), and seizure disorder (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain) or epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). Review of the resident's care plan, showed: -Date initiated, 3/11/24: Focus: Resident is at risk for falls with or without injury related to altered balance while standing and/or walking, history of falls; -Goal: Will minimize risk for falls to extent possible; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions/Task: Educate resident and staff to reposition in bed as needed to ensure fall risk is decreased. Keep call light in reach. Provide verbal reminders/cues to ask for assistance as needed; -date initiated 10/1/24: Focus: Resident is at risk for skin breakdown related to existing skin tear noted on resident's left leg; -Goal: Will be compliant with treatments and intervention measures to prevent skin breakdown; -Interventions/Tasks: Assist to turn and reposition as indicated/tolerated. Observation on 10/6/24 at 10:42 A.M., showed the resident called out for help in his/her room. The resident's call light was illuminated white above the room door but without sound. He/She said I know you hear me. Somebody help me, please help me. The resident was sideways in bed with his/her head just above the folded part of the elevated head of bed. His/Her head leaned against the right bedrail and the resident's legs and feet dangled over the left side of his/her bed. Two staff members passed by the resident's door as he/she yelled, please help me, but did not go into his/her room to help him/her. During an interview on 10/6/24 at 11:16 A.M., the resident said no one came to help him/her turn his/her head. During an interview on 10/6/24 at 11:16 A.M., Licensed Practical Nurse (LPN) K said the resident did not ask him/her for anything when he/she went into his/her room. LPN K said the resident could get the attention of staff by pushing his/her call light. He/She went back into the resident's room and noticed there wasn't a call light for the resident. LPN K said the expectation was for the nurse or aide to answer the resident's call light. He/She said all residents should have a call light in his/her room and it should be in reach. He/She said call lights should not be tied to the privacy curtains, on the floor, underneath resident's beds or tied to the wall. He/She said call lights should be answered within 10 minutes, especially for someone who was bedbound. No one should pass a room where the call light was on, or if a resident was yelling out for help. 4. During an interview on 10/6/24 at 12:08 P.M., Certified Nurse Aide (CNA) L said all residents on the unit belong to all staff and no one should walk pass a resident's room when the call light was on. He/She said the call light should be answered with 5-10 minutes and all residents should have a call light. The call light should be in reach, not on the floor, or clipped to the privacy curtain because that was out of the residents reach. He/She turned the call light off as he/she was doing whatever the resident asked or afterwards. He/She tried to service the resident before leaving his/her room. The call light should not be turned off before the resident was serviced because staff might forget. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/6/24 at 12:13 P.M., CNA M said when the call lights go off, staff were supposed to check the room to see what was going on with the resident. He/She said if there were a lot of lights going off, he/she worked from most important (i.e. wet residents) to getting water. Sometimes it can get hectic but he/she worked the call lights as fast as he/she could. CNA M said call lights should not be on the floor or clipped to the privacy curtain because that was not in reach. All rooms should have call lights and he/she encouraged residents to press the call light when he/she needed help. The call light should not be turned off before the resident is helped and no one should tell a resident he/she was coming back to help him/her and didn't go back. CNA M said it shouldn't take staff a long time to answer the call lights and he/she tried to answer the call light when he/she saw them. 5. During interview on 10/21/24 at 10:32 P.M., the Assistant Director of Nursing said she expected the staff to always place the residents' call lights within reach of the resident and they should be answered in timely manner. She said any staff can answer call lights. 6. During an interview on 10/21/24 at 3:08 P.M., the Administrator said he expected there to be sufficient staffing and call lights to be answered in a timely manner.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to immediately notify a resident's responsible party (RP) after the resident eloped from the facility (Resident #38). The facility also failed to notify two residents' RPs after a change in condition (Resident #196 and #89). In addition, the facility failed to notify the RP after a transfer to the emergency room (Resident #243). The sample size was 33. The census was 99. Review of the facility's change in a resident's condition or status policy, revised November 2015, showed: -Policy statement: The facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, residents rights, etc.); -A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument; -Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status; c. there is a need to change the resident's room assignment; d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center. 1. Review of Resident #38's Fire Protection District report, dated 9/14/24, showed: -Transportation Date: 9/14/24; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Onset Time: 5:00 A.M.; -Emergency Medical Services (EMS) dispatched to a residence with a chief complaint of a confused person. EMS responded with lights and sirens. EMS arrived on scene to find the police standing on the side of the road. Per police, a passerby called 911 of an old man/woman wandering around with no shoes on. Per police, the patient is confused and can't answer questions correctly. Patient is a [AGE] year-old man/woman with a chief complaint of altered mental status. Patient is alert and oriented to self. Patient states he/she was from East St. Louis and did not know how he/she got to the area. Patient sat and secured to stretcher for safety. Patient loaded into hospital and taken to the hospital. Review of the hospital's Health Facility Transfer Chart, showed: -admitted [DATE]; -Expected discharge date of [DATE]; -Oriented to person, disoriented to place, disoriented to situation, disoriented to time; -Final Diagnosis: Altered mental status; -Presenting History: Patient presented to the emergency room from street via police with concern for altered mental status. Patient is resting in bed. He/she says he/she is feeling better. No further history from patient. Per the hospital social worker, patient has a piece of paper with him/her stating the resident's name, identification number, room number, diet order: mechanical soft, regular double portions, thin liquids. -Per fire house staff, the patient was picked up 0.2 miles away from the facility. Review of the resident's progress note, dated 9/18/24 at 3:31 P.M., showed at 1:50 P.M., the resident arrived from the hospital to the facility. Call placed to the nurse practitioner and made her aware the resident has returned to the facility. -No information regarding notification of the RP. During an interview on 10/11/24 at 1:33 P.M., the resident's family member said he/she received a call around 9:00 A.M. or 10:00 A.M. on 9/14/24 from the facility asking if he/she picked up the resident because they could not locate him/her. He/she immediately went to the facility. When he/she arrived, they told him/her the resident was in the hospital. During an interview on 10/11/24 at 2:12 P.M., the Administrator said he was out of town when the incident occurred. The Director of Nursing (DON) received a call and found out the resident was picked up by the police in front of the facility. The family was not notified immediately following the incident because they did not have all of the information. All staff denied knowing anything about the incident and the staff who initially contacted the RP was through a nursing agency and they could not get ahold of him/her to ask questions. The DON should have told the RP the resident was actually missing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #196's medical record, showed: -admitted on [DATE]; -admitted to hospice services on 9/6/24; -Was a full code; -Diagnoses included chronic respiratory failure, anoxic brain injury (occurs when the brain is deprived of oxygen), tracheostomy (opening created in the front of neck to create an air passage), pressure ulcer (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction to sacral region (tailbone), severe protein-calorie malnutrition and dysphagia (difficulty swallowing); -A family member was designated as a #1 emergency contact. Review of the resident's admission Minimum Data Set (MDS), dated a federally mandated assessment instrument completed by facility staff, dated 8/30/24, showed: -The resident was dependent on staff for all activities of daily living; -Had a swallowing disorder; -Had a Gastrostomy (g-tube, a tube surgically inserted through the abdomen into the stomach to provide hydration, nutrition and medications); -Received oxygen therapy; -Received suctioning; -Received tracheotomy (a surgical procedure that creates an opening in the neck to provide an airway and help with breathing) care. Review of a progress note dated 9/11/24, showed -At 7:19 A.M., Registered Nurse (RN) T documented, a change of condition noted during this shift with increased heart rate ranging from 146-165 (normal heart rate 6-100) and shallow breathing. Breathing treatment and comfort medication administered. Hospice notified and advised to keep monitoring and giving comfort medications. Incoming nurse notified and will notify the family. Nurse Practitioner (NP) notified; -At 8:25 A.M., the resident's responsible party was notified; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 5:24 P.M., the nurse on duty was alerted by the aide to come to the resident's room due to a possible code. Upon arriving to the resident's room, the nurse observed two respiratory therapists (RT-a healthcare professional who treats patients with breathing difficulties) at the bedside with the resident's family member. One RT was checking for a pulse the other was preparing the Ambu bag (a medical tool used to force air into the lungs of patients who are not breathing; or are not breathing adequately so still need assistance) that was at the bedside. During an interview on 10/1/04 at 1:46 P.M. Licensed Practical Nurse (LPN) F said on 9/11/24, the day shift nurse did not show for the day shift. At about 7:15 or 7:30 A.M., he/she went over to get report from the night shift nurse. RN T told him/her the resident had a change in condition overnight. When he/she asked RN T if he/she had contacted the family, RN T said no. He/She was going to let the day shift nurse notify the family. LPN F instructed RN T to call the family. RN T called the family around 8:30 A.M. The family was upset and questioning why the resident had not been sent to the hospital for evaluation. During an interview on 10/2/24 at 3:32 P.M., RN T said: -The resident's heart rate kept going up and down all night; -Around midnight the resident's oxygen saturation monitor kept beeping; -The machine showed the resident's heart rate was elevated; -He/She suctioned the resident and provided the resident with a breathing treatment and the resident's heart rate dropped back to normal; -Around 4-4:30 A.M., the resident's oxygen monitor alarmed again, he/she suctioned the resident again and provided a breathing treatment and the resident's heart rate dropped back to normal; -The resident did have shallow breathing; -He/She notified hospice and the Nurse Practitioner (NP) about the resident's change in condition; -Both the hospice nurse and the NP told him/her to keep giving the resident his/her medications and to continue monitor the resident's condition; -When he/she gave report to the oncoming nurse, the oncoming nurse told him/her to notify the family; -Around 7:45 to 8:00 A.M., he/she called the resident's family member; -The resident's other family member called the facility back and wanted to know why the family had not been notified of the change in condition when it happened and why was the resident not sent to the hospital for a change in condition; -He/She should have called the resident's responsible party at the time the change in condition was noted. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/24 at 2:31 P.M., NP U said: -RN T did notify him/her about the resident's change in condition; -He/She expected the nurse to follow the facility policy and call the power of attorney and inform them of the resident's change in condition. During an interview on 10/1/24, at 3:00 P.M., the DON said he would expect nurses to notify the resident's responsible party after change of conditions or an incident and document in the progress notes. 3. Review of Resident #89's admission MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included: heart failure, end stage renal disease (ESRD, chronic irreversible kidney failure), and hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) or hemiparesis (a slight weakness in a leg, arm, or face); -Does this resident have one or more unhealed pressure ulcers at stage one (a reddened, painful area on the skin that does not turn white (blanch) when pressed) or higher? NO. Review of the resident's medication records, showed: -An admission/readmission evaluation assessment, dated 10/8/24, showed: -Skin evaluation, comments: resident noted with a 1 X 0.1 centimeter (cm) open area to right buttocks with 2 smaller area to right buttocks measuring 0.5 x 0.5, foam dressing applied; -No documentation the resident's representative (RR) had been notified. Observation on 10/16/24 at 9:15 A.M., showed the resident was lay in bed. The Wound Nurse assisted the resident onto his/her side. The resident had several open areas on his/her sacrum and right buttocks. The wound nurse described all the areas as stage 3 pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed. Slough (yellow/white material in the wound bed) may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). Review of the progress notes dated 10/8/24 through 10/18/24, showed: -On 10/17/24 at 8:55 A.M., Skin assessment performed on resident 10/16/24. open areas found on sacrum and right buttock. Measurements obtained, Triad paste (barrier) and foam dressing applied. The wound doctor made aware and will see resident today 10/17/24. -There was no progress note showing the resident had wounds prior to 10/17/24 and there was no documentation showing the RP was made aware of the wounds. (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 9:05 A.M., RR XX said on 10/12/24 the nurse was putting the resident into bed and the resident yelled out. The nurse assessed the resident, and the resident had a dressing on his/her buttocks. The RP said they were never notified the resident had wounds. 4. Review of Resident #243's medical record showed: -Initial admitted [DATE]; -Diagnoses included malignant neoplasm (cancerous tumor) of mouth, tracheostomy, gastrostomy, and high blood pressure; -Progress note dated 9/14/2024 7:43 A.M., showed the resident was sent to the hospital via ambulance due to respiratory distress; -Progress note dated 9/14/24 at 6:31 P.M., showed the resident returned to the facility -No documentation staff notified the family or responsible party of the resident's transfer to the hospitalization ; -Progress note dated 9/17 at 4:40 A.M., showed the resident was sent to the hospital due to change of condition; -Progress note dated 9/30/24 at 7:10 P.M., showed the resident was readmitted to the facility; -No documentation staff notified the family or responsible party of the resident's transfer to the hospitalization . During an interview on 10/10/24 at 11:55 A.M., the resident's emergency contact person said the facility did not notify the family of the resident's transfers to the hospital. They just found out when the hospital called. During an interview on 10/18/24 at 3:13 P.M., LPN F said the staff were expected to notify the family or responsible party for any changes of condition or hospitalization and should be documented in the electronic health records (EHR) 5. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nursing (ADON) said she expected the staff to notify the residents' physician and responsible party for any changes of condition and transfers. They should be documented in the EHR under progress notes. 6. During an interview on 10/21/24 at 3:09 P.M., the Administrator expected the staff to notify the family or responsible party to be notified for changes of condition and hospitalization s or transfers. MO00243620 MOO243224 42247 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45083

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 46970 Based on interview and record review, the facility failed to notify the Department of Health and Senior Services (DHSS) as required by state and federal regulations when one resident eloped from the facility and was found by police (Resident #38). In addition the facility failed to notify DHSS when allegations of abuse were made by two residents (Residents #52 and #48). The sample size was 33. The census was 99. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating Policy, dated revised September 2022, showed: - Reporting Allegations to the Administrator and Authorities: - If resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish), neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.), exploitation (taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion), misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law; - The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: -The state licensing/certification agency responsible for surveying/licensing the facility; -The local/state ombudsman; -The resident's representative; -Adult protective services (where state law provides jurisdiction in long-term care); -Law enforcement officials; -The resident's attending physician; and -The facility medical director. -Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone; -Notices include, as appropriate: -the resident's name; -the resident's room number; -the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); -the date and time the alleged incident occurred; -the name(s) of all persons involved in the alleged incident; and -what immediate action was taken by the facility; -Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents; -Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 1. Review of Resident #38's care plan, in use during the time of the investigation, revised 7/16/24, showed: -Focus: Initiated 3/24/24. The resident has been identified as an elopement risk; -Goal: Assist resident with redirection if found wandering to keep him/her aware of his/her surroundings through the next review date; -Interventions: Assess resident risk factors that may trigger wandering behavior. Educate staff where they can find elopement binders. The resident has been placed in the at risk for elopement binder. Music helps the resident relax. Play music for the resident if he/she is actively anxious. Re-orientate resident to his/her room or familiar place as needed; -No information regarding the elopement on 9/14/24. Review of the Fire Protection District report, dated 9/14/24, showed: -Transportation Date: 9/14/24; -Onset Time: 5:00 A.M.; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Emergency Medical Services (EMS) dispatched to a residence with a chief complaint of a confused person. EMS responded with lights and sirens. EMS arrived on scene to find the police standing on the side of the road. Per police, a passerby called 911 of an old man/woman wandering around with no shoes on. Per police, the patient is confused and can't answer questions correctly. Patient is a [AGE] year-old man/woman with a chief complaint of altered mental status. Patient is alert and oriented to self. Patient states he/she was from East St. Louis and did not know how he/she got to the area. Patient sat and secured to stretcher for safety. Patient loaded into hospital and taken to the hospital. Review of the hospital's Health Facility Transfer Chart, showed: -admitted [DATE]; -Expected discharge date of [DATE]; -Oriented to person, disoriented to place, disoriented to situation, disoriented to time; -Final Diagnosis: Altered mental status; -Presenting History: Patient presented to the emergency room from street via police with concern for altered mental status. Patient is resting in bed. He/she says he/she is feeling better. No further history from patient. Per the hospital social worker, patient has a piece of paper with him/her stating the resident's name, identification number, room number, diet order: mechanical soft, regular double portions, thin liquids; -Per the resident's family member, the facility called him/her on 9/14/24 to inform him/her the patient was missing. However, when the Social Worker called the facility on 9/14/24 at 9:59 A.M., the receptionist said the patient was not from their facility. The family member states the facility is working to get the patient transferred to another facility. The family member is aware patient will need to return back to the facility while waiting for the facility to coordinate the transfer if patient is medically ready for discharge; -Per Fire House staff, the patient was picked up 0.2 miles away from the facility; -Social worker called the facility at the listed phone number. The receptionist said the patient was not from their facility; -Social Worker called the assisted living facility associated with the nursing home. The receptionist said the patient is not from their facility. Review of the resident's progress notes, showed no information regarding the resident's elopement on 9/14/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress note, dated 9/18/24 at 3:31 P.M., showed at 1:50 P.M., the resident arrived from the hospital to the facility. No complaints and no respiratory distress noted. Resident was able to make some needs known, and oriented to room, call light, television, bed remote and staff. No edema (swelling) noted and continues to ambulate with slow and steady gait and no use of assist devices. Call placed to the Nurse Practitioner and made her aware the resident has returned to the facility. Review of the resident's physician's progress note, dated 9/20/24 at 7:51 A.M., showed a late entry: Return from hospital. Patient being seen today after being admitted to the hospital with altered mental status. Patient was found on the street by police and was taken to the hospital. Patient improved and was discharged back to the facility with recommendations for patient to be transferred to a memory care accessible facility. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/30/24, showed: -Cognitively impaired; -Wandered four to six days out of seven; -Diagnoses included Alzheimer's Disease and dementia. During an interview on 10/11/24 at 2:52 P.M., Certified Nurse Aide (CNA) B said he/she worked the night shift on 9/13/24 and 9/14/24. He/She was on the hall but not assigned to the resident. He/She thought they did rounds on all residents during the night shift on 9/14/24. He/She saw the resident around 8:00 P.M. on 9/13/24. The resident wandered and was in the dining room and tended to wander throughout the facility. That night, the front doors were broken, and the alarms were not sounding. Apparently, the resident left the facility during the night and was found outside on the facility property and taken to the hospital. He/She did not know the resident was missing until he/she returned on 9/15/24. Licensed Practical Nurse (LPN) R was the nurse on duty and likely did not report the incident. LPN R told CNA B, You didn't see or hear anything regarding the resident's elopement. During an interview on 10/30/24 at 9:13 A.M., LPN UU said he/she worked through an agency and worked during the night shift on 9/14/24 and was assigned to a different hall. He/She did not recall a resident eloping and did not receive any information regarding an elopement. He/She could not recall receiving or providing a report to the on-coming nurse and could not recall who it was. During an interview on 10/11/24 at 2:12 P.M., the Administrator said he was out of town when the incident occurred. The Director of Nursing (DON) received a call and found out the resident was picked up by the police in front of the facility. The police did not come into the facility to find out if the resident belonged at the facility. The resident was a wanderer but not exit-seeking. The resident must have eloped from the facility around 5:00 A.M. Staff discovered he/she was missing around 9:00 A.M. when staff were passing medication. The incident was not reported or investigated thoroughly because the Administrator found out about the incident outside of the time frame and did not have any information. 2. Review of Resident #52's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate cognitive impairment; -Diagnoses included: diabetes, high blood pressure, stroke, and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (weakness in a leg, arm, or face) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 10/16/24 at 7:35 A.M., the resident said a few weeks ago on the night shift, Certified Nurse Aide (CNA) B hit him/her in the head with a closed fist. He/She had provided care, but the resident said he/she did not feel like this was an accident. He/She did not know why the CNA would hit him/her. The CNA was being ignorant. The resident said the incident made him/her feel like he/she was abused, and the facility did not care. The resident said he/she saw the CNA after the incident and he/she felt scared. He/She reported the allegation to the nurse and the Social Worker (SW), and the SW interviewed him/her. During an interview on 10/14/24 at approximately 5:00 P.M. and on 10/16/24 at 3:35 P.M., LPN R said the allegation happened on 9/9/24 around 5:30 A.M. to 6:00 A.M., the nurse was in the resident's bathroom getting warm water to flush the residents feeding tube (a medical device used to provide nutrition). When he/she walked around the curtain and saw the resident and CNA B, both were quiet and just looking. The nurse asked them what was going on. The resident said CNA B slapped him/her in the face. The CNA denied the allegation and left out of the room. The nurse assessed the resident and did not see any redness, bruising or scars on his/her face. The nurse called the on-call phone and spoke with Registered Nurse (RN) W who told him/her to send CNA B home. LPN R sent CNA B home at the same time he/she texted the Director of Nursing (DON) to report the allegation. LPN R said he/she did not document the incident because he/she did not know what the protocol was. When he/she asked what needed to be documented and where to document the allegation, nobody said anything. The next day, the resident told the nurse the facility let the CNA come back to work. The resident never denied the allegation occurred. Review of text messages dated 9/9/24 at 6:18 A.M. and 7:20 A.M., showed: -LPN R: I have a resident who is saying a CNA smacked him/her in the face. The CNA is saying he/she won't get the resident up anymore; -DON: dear lord, what is the name of the CNA; -LPN: CNA B; -DON: ok thank you. During an interview on 10/17/24 at 5:03 P.M., RN W said he/she got a call from LPN R who reported the resident told him/her CNA B had struck him/her. RN W instructed LPN R to immediately send CNA B home and to assess the resident for injuries. RN W reported the allegation to the DON and the Administrator. He/She did not know if the allegation was called in or not. During an interview on 10/16/24 at 11:25 A.M., LPN NN said LPN R reported to him/her CNA B slapped the resident in the face and he/she reported the incident to management. The SW and the Administrator talked with the resident. If an allegation of abuse was made management would tell the nurse what to do and where to document, it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 12:10 P.M., the SW said if a resident had an altercation with an employee, she would redirect to the Administrator. The SW said the incident with the resident happened a little bit ago on the night shift. Nursing reported the incident to the Administrator and the Administrator asked her to talk with the resident. The resident said the young staff member who got him/her up was ugly and when he/she told the staff member, they got mad and was rough with him/her. The CNA denied hitting the resident. The SW reported her findings to the Administrator. The allegation should have been reported to DHSS. She did not know if the allegation was reported to DHSS. During an interview on 10/16/24 at 12:40 P.M., the DON said if something happened, he would expect for staff to document it. If the DON was not in the building when an allegation of abuse was made, he he would expect for staff to call or text to notify him. The resident was not always alert and oriented and had periods of confusion/delusions (a fixed, false belief resistant to change despite conflicting evidence). The resident reported an allegation to the nurse and the nurse notified the DON. The nurse said the resident said CNA B had slapped him/her in the face. The DON was told this was not the first time the resident alleged a staff member had hit him/her. The DON said he talked with the nurse and CNA B. CNA B denied the allegation. When the resident was interviewed, he/she said nothing happened. Once the resident denied the allegation, the CNA was able to come back to work. The DON did not recall seeing any documentation regarding the incident. Allegations of abuse should be reported to DHSS. This allegation was not reported because the resident said it did not happen. During an interview on 10/16/24 at 1:10 P.M., the Administrator said LPN R reported the resident said CNA B slapped him/her. The incident took place a few months ago towards the end of the shift. By the time the Administrator was notified of the incident, CNA B's shift was over. The resident was alert and oriented. When the resident was interviewed, the resident denied CNA B hit him/her. CNA B also denied the allegation. The resident could make things up, but he/she had never said anything like this in the past. The allegation was not reported to DHSS because the facility deemed no abuse, or anything had happened. 3. Review of Resident #48's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included depression and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's care plan, in use during the survey, showed: -Focus: Medication - Anti-Anxiety: Resident requires anti-anxiety medication related to anxiety disorder (Intense, excessive, and persistent worry and fear about everyday situations) date initiated 7/5/23; -Goal: Resident's medication use will result in the maintenance of the resident's functional status; -Interventions/Tasks: -Provide the resident with an activity calendar in room; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Remind the resident the importance of social interaction; -Room visits with the resident, 1:1 for socialization if needed. Review of the resident's progress notes, showed no documentation related to a resident-to-resident abuse allegation. During an interview on 10/15/24 at 9:41 A.M., the resident said he/she was attacked in his/her bed on 7/22/24 by Resident #75. He/She said the resident was no longer in the facility because his/her mental state was worse than other residents in the facility. The resident said Resident #75 was in his/her room when he/she came back from lunch going through his/her packed bags. He/She said Resident #75 took out his/her black dress and held it up. He/She told Resident #75 to put his/her clothes down. The resident said he/she thought Resident #75 wanted sex from him/her because Resident #75 took both his/her hands and grabbed him/her by the head and began pulling the resident towards his/her body. The resident said Resident #75 started to lay back on the bed. The resident's dress flew up, and Resident #75 opened the resident's legs. The resident said Resident #75's vagina was shaved. The resident said he/she didn't know how he/she ended up on top of Resident #75 because the resident was bigger and stronger than him/her. The resident said his/her back was hurting all of the time. He/She said the facility didn't protect him/her from Resident #75. The resident said he/she told Resident #75 not to come back to his/her room and said staff never told Resident #75 to leave his/her room. The resident said he/she had to leave his/her room and yell out for nursing staff to make Resident #75 to leave his/her room. He/She said Resident #75 always challenged him/her when walking down the hall. The resident said he/she told LPN NN and CNA A. The resident said once they came into his/her room, Resident #75 let him/her go. The resident said he/she spoke to the head man, the Administrator. He/She said the Administrator asked him/her a few questions. The Social Worker came and was upset about what happened to him/her. He/She said the Social Worker was beet red and felt bad for him/her. He/She said the Social Worker was tearful, same as him/her. During an interview on 10/16/24 at 11:23 A.M., LPN NN said the resident told him/her about the incident between him/her and the other resident. LPN NN said the other resident was a wander and he/she went into the resident's room. LPN NN said the wandering resident went through Resident #48's things and he/she was trying to get the wandering resident out of his/her room. LPN NN said the resident came out of his/her room into the hallway and told LPN NN the other resident was in his/her room and going through his/her stuff. LPN NN said he/she went into the resident's room and re-directed the wandering resident out of the room. He/She said there was no altercation between the two residents but Resident #48 was really upset with the other resident for being in his/her room. LPN NN said the resident never told him/her he/she had been attacked by the other resident. During an interview on 10/16/24 at 2:16 P.M., CNA A said he/she knew both residents. He/She said the other resident was no longer in the facility but did wander. CNA A said the other resident went into Resident #48's room and went through his/her things. He/She said someone had a bell and asked where it was coming from. He/She said the resident just wanted CNA A to get the other resident from his/her room. CNA A said there was no physical altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:19 P.M., the Social Worker said the resident made it up and had a history of making up things. He/She was bipolar, schizophrenic (a disorder that affects a person's ability to think, feel, and behave clearly), and had anxiety. She said the resident had a history of having sex with people to get money. She said the resident had not had any trauma since coming to the facility that she knew of, and no one reported any abuse allegation to her regarding the resident. She had spoken with the resident about the alleged altercation between the two residents and told the Administrator. She said as far as she knew, there was no physical altercations between the two residents. During an interview on 10/21/24 at 3:08 P.M., the Administrator said he spoke with the resident when the incident had been brought to his attention. He didn't think to document it in that moment. The resident told him what happened with the other resident. He said as far as he could tell, there was no physical altercation, so he dismissed it. He expected allegations of abuse to be reported and investigated. 3. During an interview on 10/21/24 at 3:08 P.M., the Administrator said allegations of abuse and neglect should be investigated and reported to DHSS. MO00243149

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42247 Based on interview and record review, the facility failed to investigate one allegation of staff to resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) (Resident #52). The sample size was 33. The census was 99. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating Policy, revised September 2022, showed: -Policy Statement: All reports of resident abuse, are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -Investigation Allegations: -All allegations are thoroughly investigated. The Administrator initiates investigations; -Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations; -The Administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation; -The Administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation; -Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete; -The individual conducting the investigation as a minimum: -Reviews the documentation and evidence; -Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; -Observes the alleged victim, including his or her interactions with staff and other residents; -Interviews the person(s) reporting the incident; -Interviews any witnesses to the incident; -Interviews the resident (as medically appropriate) or the resident's representative; -Interviews the resident's attending physician as needed to determine the resident's condition; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; -Interviews the resident's roommate, family members, and visitors; -Interviews other residents to whom the accused employee provides care or services; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly; -The following guidelines are used when conducting interviews; -Each interview is conducted separately and in a private location; -The purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process; -Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigator may obtain a statement. -Follow up: - Within five (5) business days of the incident, the Administrator will provide a follow-up investigation report; -The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified; -The follow-up investigation report will provide as much information as possible at the time of submission of the report; -The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation. Review of Resident #52's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/16/24, showed: -Moderate cognitive impairment; -Diagnoses included diabetes, high blood pressure, stroke, and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (weakness in a leg, arm, or face) and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). During an interview on 10/16/24 at 7:35 A.M., the resident said a few weeks ago on the night shift, Certified Nurse Aide (CNA) B hit him/her in the head with a closed fist. He/She had provided care, but the resident said he/she did not feel like this was an accident. He/She did not know why the CNA would hit him/her, the CNA was being ignorant. The resident said the incident made him/her feel like he/she was abused, and the facility did not care. The resident has seen the CNA after the incident and he/she felt scared. He/She reported the allegation to the nurse and the Social Worker (SW), and the SW interviewed him/her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/14/24 at approximately 5:00 P.M. and on 10/16/24 at 3:35 P.M., Licensed Practical Nurse (LPN) R said the allegation happened on 9/9/24 around 5:30 A.M. to 6:00 A.M. The nurse was in the resident's bathroom getting warm water to flush the resident's feeding tube. When he/she walked around the curtain, he/she saw the resident and CNA B both were quiet and just looking. The nurse asked them what was going on. The resident said CNA B slapped him/her in the face. The CNA denied the allegation and left the room. The nurse assessed the resident and did not see any redness, bruising or scars on his/her face. The nurse called the on-call phone and spoke with Registered Nurse (RN) W who told him/her to send CNA B home. The nurse sent CNA B home at the same time he/she texted the Director of Nursing (DON) to report the allegation. The nurse said he/she did not document the incident because he/she did not know what the protocol was. and when he/she asked what needed to be documented and where to document the allegation, nobody said anything. During an interview on 10/16/24 at 12:10 P.M., the SW said if a resident had an altercation with an employee, she would redirect to the Administrator. The SW said the incident with the resident happened a little bit ago on the night shift. Nursing reported the incident to the Administrator and the Administrator asked her to talk with the resident. The resident said the young staff member who got him/her up was ugly and when he/she told the staff member, they got mad and was rough with him/her. The CNA denied hitting the resident. The SW reported her findings to the Administrator. If she wrote a statement, the Administrator would have it. Review of the Resident Grievance Form, located in CNA B's employee file, dated 9/23/24, showed: -Date of grievance or concern: 9/23/24, time 9:11 A.M., -Describe the nature of the grievance: the SW was asked to interview the resident regarding a concern. The SW went to get the resident to ask if he/she had anything to report. The resident said the girl was rough with him/her. The SW asked what does that mean. The girl was rough when turning the resident from side to side. The resident said he/she told the CNA he/she was ugly and he/she turned the resident rough. The SW asked the resident if there was anything else he/she would like to tell the SW. The resident said how did he/she get so ugly. The SW said she could not answer that question; -Investigation: finding, reported interview to the Executive Director; -Resolution: intervention/action: resident did not report any signs of abuse/neglect. CNA denied any abuse/neglect. Other employee denied any signs of abuse/neglect; -Date grievance solved: 9/23/24. Review of the progress notes, dated 9/9/24 through 10/10/24, showed no documentation of an allegation staff slapped the resident or was rough with the resident. During an interview on 10/16/24 at 12:40 P.M., the DON said he talked with the nurse and CNA B. CNA B denied the allegation. When the resident was interviewed, he/she said nothing happened. Once the resident denied the allegation, the CNA was able to come back to work. The DON did not recall seeing any documentation regarding the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 1:10 P.M., the Administrator said the facility did not have an investigation. When the resident was interviewed, he/she denied CNA B hitting him/her and the CNA also denied the allegation. The facility deemed no abuse, or anything had happened. During an interview on 10/21/24 at 3:08 P.M., the Administrator said allegations of abuse and neglect should be investigated and reported to DHSS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37681 45083 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans to address the specific needs of the residents. (Residents #38, #47, #344, #67, and #48). The sample was 33. The census was 99. Review of the facility's Care Plans, Comprehensive Person-Centered policy, dated 2001, showed: -Policy Statement: A comprehensive, person-centered plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; Policy Interpretation and Implementation: -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her pain of care, including the right to: -Receive the services and/or items included in the plan of care; The comprehensive, person-centered care plan: -Includes measurable objectives and timeframes; -Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: -Professional services that are responsible for each element of care; -Builds on the resident's strengths; and -Reflects currently recognized standards of practice for problem areas and conditions. 1. Review of Resident #38's care plan, in use during the time of the investigation, revised 7/16/24, showed: -Focus: Initiated 3/24/24. The resident has been identified as an elopement risk; -Goal: Assist resident with redirection if found wandering to keep him/her aware of his/her surroundings through the next review date; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Assess resident risk factors that may trigger wandering behavior. Educate staff where they can find elopement binders. The resident has been placed in the at risk for elopement binder. Music helps the resident relax. Play music for the resident if he/she is actively anxious. Re-orientate resident to his/her room or familiar place as needed; Review of the resident's hospital's Health Facility Transfer Chart, showed: -admitted [DATE]; -Expected discharge date of [DATE]; -Oriented to person, disoriented to place, disoriented to situation, disoriented to time; -Final Diagnosis: Altered mental status; -Presenting History: Patient presented to the emergency room from street via police with concern for altered mental status. Patient is resting in bed. He/she says he/she is feeling better. No further history from patient. Per the hospital social worker, patient has a piece of paper with him/her stating the resident's name, identification number, room number, diet order. -Per the resident's family member, the facility called him/her on 9/14/24 to inform him/her the patient was missing. However, when the hospital social worker called the facility on 9/14/24 at 9:59 A.M., the receptionist said the patient was not from their facility. The family member states the facility is working to get the patient transferred to another facility. The family member is aware patient will need to return back to the facility while waiting for the facility to coordinate the transfer if patient is medically ready for discharge; -Per fire house staff, the patient was picked up 0.2 miles away from the facility. Review of the resident's Elopement and Wandering Risk Observation/Assessment, dated 9/18/24, showed: -Mobility Status: The resident ambulates independently with or without the use of assistive devices; -Cognitive Status: The resident is disoriented or has periods of confusion and/or impaired attention span but does not wander; -Disease Diagnosis: The resident has two or more diagnoses that may impact cognition; -Mood/Behavior Status: The resident has verbalized a desire to leave the facility, packed their belongings, stood by the exit door or attempted to open an exit door -History of Elopement Attempts: The resident has exhibited unsafe wandering or has made one or more attempts to elope prior to admission or in the last year -Behavior Modification: Exhibits unsafe wandering or elopement attempts but is easily redirected; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Intervention: The care plan has been initiated/updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement. Review of the resident's progress note, dated 9/18/24 at 3:31 P.M., showed at 1:50 P.M., the resident arrived from the hospital to the facility. No complaints and no respiratory distress noted. Resident was able to make some needs known, and oriented to room, call light, television, bed remote and staff. No edema noted and continues to ambulate with slow and steady gait and no use of assist devices. Call placed to the nurse practitioner and made her aware the resident has returned to the facility. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/30/24, showed: -Cognitively impaired; -Wandered four to six days out of seven; -Diagnoses included Alzheimer's Disease and dementia. Review of the care plan, revised 7/16/24, viewed 10/10/24 at 10:51 A.M., showed no information or updated interventions regarding the resident's elopement on 9/14/24. 2. Review of Resident #47's quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -No behaviors; -Diagnoses included heart failure, diabetes and depression; -Bed rails used daily. Observation of the resident on 10/10/24 at approximately 8:03 A.M., 10/11/24 at 8:52 A.M., 10/15/24 at 9:25 A.M. and 10/16/24 at 7:22 A.M., showed the resident lay in bed, with quarter-length side rails raised and in use on both sides of the bed. Review of the resident's care plan, revised 5/16/24, viewed 10/11/24 at 12:56 P.M., in use during the time of the investigation, showed no information regarding the use of side rails. During an interview on 10/15/24 at 6:12 P.M., the resident said he/she used the side rails for repositioning in bed. 3. Review of Resident #344's entry MDS, dated [DATE], showed no information. Review of the resident's medical record, showed: -admitted [DATE]; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included hemiparesis (weakness to one side of the body) following a stroke, respiratory failure, cognitive communication deficit, epilepsy, traumatic brain injury, tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and help with breathing) status and gastrostomy (G-tube, creates an opening into the stomach through the abdomen, allowing a feeding tube to deliver nutrition directly) status. Review of the resident's care plan, revised 8/31/24, reviewed 10/11/24 at 12:59 P.M., showed no information regarding the resident's use of a tracheostomy, gastrostomy or side rail. Review of the resident's physician's orders, dated 10/8/24 through 11/6/24, showed: -An order, dated 8/24/24 for nothing by mouth (NPO) diet ; -An order, dated 9/12/24 for Jevity (provides complete balanced nutrition for tube feeding) at 60 milliliters per hour every shift; -No information regarding tracheostomy status; -No information regarding the use of side rails. Observation on 10/10/24 at approximately 8:03 A.M., showed the resident lay in bed with quarter length side rails raised and in use on both sides of the bed. The resident's G-tube infused at 60 milliliters per hour. The resident had a tracheostomy tube on his/her neck. The resident was non-verbal and nodded his/her head when asked if he/she was okay. Observations on 10/11/24 at 8:55 A.M. and 10/15/24 at 9:48 A.M., showed the resident lay in bed with quarter length side rails raised and in use on both sides of the bed. The resident's G-tube infused at 60 milliliters per hour. The resident had a tracheostomy tube on his/her neck. Observation on 10/16/24 at 7:26 A.M., showed the resident lay in bed on his/her back with quarter length side rails raised on both sides. 4. Review of Resident #67's Bed Rail Observation/Assessment, dated 4/6/24, showed bed rails were used for safety and positioning. Review of the resident's care plan, revised 4/16/24, in use during the time of the investigation and viewed on 10/11/24 at 1:03 P.M., showed no information regarding the use of side rails. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitive impairment; -No behaviors; -Diagnoses included cancer, stroke, seizures and depression; -Bed rails not used. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 10/10/24 at approximately 8:03 A.M., 10/11/24 at 8:48 A.M., 10/15/24 at 6:10 P.M. and 10/16/24 at 7:17 A.M., showed the resident lay in bed on his/her back. with quarter-length bed rails in use and raised on both sides of the bed. 5. Review of Resident # 48's annual MDS, dated [DATE], showed, moderate cognitive impairment, depression, and bipolar disorder (a disorder associated with mood swings from depressive lows to manic highs). Review of the resident's progress notes, dated 8/14/24, showed: -On this date, 8/9/24 at 3:15 P.M., this writer observed the resident attempting to give another resident an oatmeal cream pie that he/she was not supposed to eat due to diet restriction. Director of Nurses (DON) and this writer continued to explain to the resident that it was not safe for him/her to give other residents snacks. He/She again insisted on feeding the resident. Social Services notified the resident was not being complainant when asked not to feed the resident. Review of the resident's physician orders, start date 10/7/24, showed, anti-depressant medication: Prozac; -Side effects: Common- sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia (rapid heart rate), muscle tremor, agitation, headache, skin rash, photosensitivity (skin), excessive weight gain. Special attention for heart disease, glaucoma (eye nerve disease), chronic constipation, seizure disorder, edema (swelling). Monitor; -Directions: Every shift document; -Antipsychotic medication: Haldol and Seroquel; -Side effects: Common- sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal (involuntary movements) reaction, weight gain, edema, postural hypotension (low blood pressure), sweating, loss of appetite, urinary retention. Nursing alert: Tardive dyskinesia (movement disorder that occurs as a result of certain medications), seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice (yellow skin caused by liver disorders). Monitor; -Directions: Every shift document. Review of the resident's care plan in use at the time of the investigation, showed: -No documentation of 8/9/24 behavior or intervention(s) care planned; -No documentation of behaviors or potential side effects related to antipsychotic or antidepressant medications; -No documentation of refusal of care behavior or interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:18 P.M., the Social Worker said it was hard to re-direct the resident, so they needed to call the doctor to get instructions on what to do. The facility staff need more education on people with dementia. When the resident had stressful incidents, he/she would come to the Social Worker's office. The Social Worker said she would report whatever the resident's issues were to the nurse, call the physician, set up a care conference call with the resident's family, and if needed, one-on-one supervision. She calls psychiatry to come out as needed. The resident received psychiatric services once a month. The resident should go out to have his/her medications evaluated/adjusted, but when Emergency Medical Services (EMS) comes, he/she refuses to go. She expected the resident's behaviors, interventions, and services received to be on his/her care plan. 6. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nursing (ADON) said the residents' care plans should be completed and accurate specific to the residents' needs in a timely manner. 7. During an interview on 10/21/24 at 1:56 P.M., the MDS Coordinator said she was responsible for updating care plans, along with nurses and the Social Worker. Care plans were updated quarterly and as needed. Care plans should reflect the resident's specific needs. G-tubes, tracheostomies, side rails, elopements, falls and wounds should be included in a resident's care plan if it reflected the resident's specific need. 8. During an interview on 10/21/24 at 3:18 P.M., the Administrator said he expected the care plans to be accurate and complete, including residents' behaviors and interventions. 46970

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on interview and record review, the facility failed to provide services in accordance with acceptable standards of practice when the facility failed to obtain one resident's labs per physician orders (Resident #27) and when staff failed to complete neurological checks (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological status for the entire 72 hours for one resident (Resident #52). The sample was 33. The census was 99. Review of the facility's Lab and Diagnostic Test Results-Clinical Protocol Policy, dated November 2018, showed: -The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs; -The staff will process test requisitions and arrange for test; -The laboratory, diagnostic radiology provider, other testing source will report test results to the facility. Review of the facility's Neurological Assessment (Routine) Policy, dated October 2023, showed: -Purpose: the purpose of this procedure is to provide guidelines for conducting a routine neurological assessment (neuro checks); -General Guidelines: -Routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury; -Routine neurological exams include assessing: -Mental status and level of consciousness; -Pupillary response; -Motor strength; -Sensation; -Gait. -The Glasgow Coma Scale is used to objectively monitor level of consciousness in patients with neurological damage such as a head injury or cerebrovascular accident (i.e., stroke); -Documentation: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The following information should be recorded in the resident's medical record: -The date and time the procedure was performed; -The name and title of the individual(s) who performed the procedure; -All assessment data obtained during the procedure; -How the resident tolerated the procedure; -If the resident refused the procedure, the reason(s) why and the intervention taken; -The signature and title of the person recording the data. Review of the facility's Neurological Evaluation Flow Sheet, revised 3/10, showed: -Directions: complete neurological evaluations with vital signs initially, then every 30 minutes times four, then every hour times four, then every 8 hours times nine (72 hours). More frequent evaluations may be necessary. Complete episodic charting for at least 72 hours including any pertinent findings related to the neurological evaluation. (unable to read) the most recent evaluation in the medical record and notify the physician of any changes from previous evaluation. 1. Review of Resident #27's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/14/24, showed: -Severe cognitive impairment; -No behaviors or rejection of care; -Diagnoses included: dementia, stroke and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (weakness in a leg, arm or face). Review of the care plan, in use at the time of survey, showed: -Focus: resident has a Stage 4 pressure injury to his/her coccyx related to impaired mobility; -Goal: pressure ulcer will show signs of healing and remain free from infection through review date; -Interventions: administer treatments as ordered and monitor for effectiveness. Review of the Physician Order Sheet (POS), dated last order review: 9/26/24, showed an order for comprehensive metabolic panel (CMP, measurement of blood sugar, electrolytes, fluid balance, kidney and liver function) and Pre-albumin (blood test to assess nutritional status) every month x 2 months, then every 2 months until wound healed, dated 8/10/24. Review of the medical record, showed the labs were not completed until 10/18/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes, dated 8/10/24 through 10/18/24, showed there was no documentation the resident refused to have his/her blood drawn or the physician's order was changed. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nursing (ADON) said when an order for a lab is received, the nurse should enter the order into the computer and enter the information in the lab book located at the nurse's station. The nurses are responsible for completing the lab requisitions. The phlebotomist comes to the facility Monday through Friday and as needed. Labs results are uploaded into the computer. The physician should be notified of the results. During an interview on 10/21/24 at 3:09 P.M., the Administrator said he expected lab orders to be completed as ordered. 2. Review of Resident #52's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included other neurological condition, stroke and hemiparesis or hemiplegia. Review of the care plan, in use at the time of survey, showed: -Focus: resident was at risk for fall related to impaired mobility; -Goal: will be free of injury related to fall through the review date; -Interventions: follow facility fall protocol. Review of the progress notes, dated 8/27/24 through 8/31/24, showed: -On 8/27/24 at 10:43 P.M., the nurse was notified by staff that the resident was laying on the fall mat in front of his/her bed. Assessment completed, no signs and symptoms of distress noted. Range of motion (ROM) performed without pain and limitation. No injury noted. Message was left for the resident representative to call the facility. Neuro checks noted; -On 8/28/24 at 8:39 A.M., physician progress note: Blood Pressure (BP, normal is 90/60 through 130/80) 138/80, Temperature (T, normal is 97.9 through 99.1), Pulse (P, normal is 60 through 100) 68, Respirations (R, normal is 12 through 18) 20, Oxygen saturation (02, normal is 95% through 100%) 96%; -On 8/28/24 at 8:08 P.M., P 90-R 20- B/P 138/79- O2 97% on room air (RA). Resident remained on close observation; -On 8/29/24 at 8:25 P.M., Resident remained on close observation, P 77-R 20-B/P 142/82- O2 98% RA; -On 8/30/24 at 7:10 P.M., T 98.0-P 77-R 18-B/P 142/79- O2 99% RA. Resident remained on close observation; -On 8/31/24 at 4:42 P.M., resident on incident follow up (IFU) day 3 for fall. T 98.0 P 75, BP 138/82, 02 99 RA, R 18 even and unlabored. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the neurological evaluation flow sheet, dated 8/27, showed 10 out of 12 opportunities were blank. During an interview on 10/17/24 at 10:10 A.M., Licensed Practical Nurse (LPN) NN said if a resident fell and hit their head or the fall was unwitnessed, he/she would assess the resident, notify the family and the physician and do neuro checks. Neuro checks should be completed on the paper form per the directions on the form. During an interview on 10/18/24 at 3:13 P.M., LPN F said neuro checks were done on paper form. The form should be completed for the whole 72 hours. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nursing (ADON) said neuro checks should be done after a fall, with head injury and with unwitnessed falls. If a resident was sent out, the neuro checks should continue upon return to the facility and follow the 72-hour neuro check assessment. Fall follow-up notes should be documented in the progress notes. During an interview on 10/21/24 at 3:09 P.M., the Administrator said he expected staff to follow the schedule on the neuro check form and he expected the form to be completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 42247 Based on observation, interview and record review, the facility failed to follow acceptable nursing standards when the facility failed to enter one resident's (Resident #343) treatment order into the computer for nine days resulting in the wound treatment not being administered per physician orders. In addition, one resident was observed to not have an ordered treatment in place (Resident #89). The sample was 33. The census was 99. Review of the facility's Wound Care Policy, revised [DATE], showed: -Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing; -Preparation: -Verify that there is a physician's order for this procedure; -Review the resident's care plan to assess for any special needs of the resident; -Documentation: The following information should be recorded in the resident's medical record; -The type of wound care given; -The date and time the wound care was given; -The position in which the resident was placed; -The name and title of the individual performing wound care; -Any changes in the resident's condition; -All assessment data obtained when inspecting the wound; -How the resident tolerated the procedure; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and why; -The signature and title of the person recording the data; -Reporting; -Notify the supervisor if the resident refuses the wound care; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Medication and Treatment Orders Policy, dated [DATE], showed: -Policy statement: orders for medications and treatments will be consistent with principles of safe and effective order writing; -Drug and biological orders must be recorded on the physician's order sheet in the resident's chart; -The signing of orders shall be by signature or a personal computer key; -Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order. Review of the facility's Charting and Documentation Policy, dated [DATE], showed: -Documentation in the medical record may be electronic, manual or a combination; -The following information is to be documented in the resident medical record; -Treatments or services performed; -To ensure consistency in charting and documentation of the resident's clinical record. Documentation of procedures and treatments will include care-specific details, including: -the date and time the procedure/treatment was provided; -the name and title of the individual(s) who provided the care; -the assessment data and/or any unusual findings obtained during the procedure/treatment; -how the resident tolerated the procedure/treatment; -whether the resident refused the procedure/treatment; -notification of family, physician, or other staff, if indicated; and -the signature and title of the individual documenting. 1. Review of Resident #343's Inpatient Hospital Discharge Summary, dated [DATE], showed: -admitted [DATE]; -discharge date of [DATE]; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reason for hospitalization : Patient with a history including quadriplegia (medical condition characterized by the partial or total loss of function in all four limbs and the torso) and chronic decubitus (pressure ulcer/wound, injury to the skin and/or underlying tissue, as a result of pressure or friction) wounds; -Wound Care Instructions: Wound Excoriation (a mechanical injury to the skin) buttocks, coccyx (tailbone area), gluteal cleft (vertical crease between the buttocks). Bilateral (both sides), active; -Discharge to skilled nursing facility. Review of the resident's Admission/Readmission Evaluation/Assessment, showed: -admitted [DATE]; -Cognitively intact; -Extremities: Paralysis; -Non-weight bearing; -Assistance with bathing, grooming, toileting and bed mobility; -Resident has wound on buttock; -Unstageable (pressure ulcer where the actual base and condition of the ulcer cannot be determined due to dead tissue obscuring the wound depth) coccyx. Review of the resident's Comprehensive Skin Evaluation/Assessment, dated [DATE], showed: -Admission Assessment; -Resident has one or more newly identified or existing wounds or skin care integrity concerns; -Coccyx, pressure, stage III (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough (moist dead tissue) may be present but does not obscure the depth of tissue loss); -Right buttock, pressure, stage III; -Left buttock, pressure, stage III; -Sacrum, pressure, stage III; Review of the resident's Comprehensive Certified Nursing Assistant (CNA) Shower Review, dated [DATE], showed the resident's buttock was circled. Review of the resident's progress notes, showed no documentation regarding wounds from [DATE] through [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Comprehensive CNA Shower Review, dated [DATE], showed the resident's buttock was circled. A circle was noted on the resident's left upper back and an X was noted on the right, above the resident's buttock. Review of the resident's Nurse Practitioner's progress note, dated [DATE] at 7:17 A.M., showed pressure ulcers of unspecified site, unspecified stage. Short Wave Diathermy (SWD, a physical therapy treatment that uses electromagnetic waves to generate heat and treat soft tissues and joints) to sacral/buttock wounds to increase local blood flow and reduce pain. Review of the resident's Nurse Practitioner's progress note, dated [DATE] at 6:48 A.M., showed a follow up. Current level of function. SWD to sacral/buttock wounds to increase local blood flow to reduce pain. Patent is to perform rolling for positioning. Patient verbalizes his/her dislike for the treatment however is agreeable to treatment this session. Registered Nurse (RN) noted patient was uncomfortable and requested to be removed from SWD and repositioned on his/her back. Patient has high risk for developing contractures (muscle and joint rigidity), pressure ulcers, poor healing, or fall if not receiving adequate therapy and pain control. Quadriplegia, unspecified, pressure ulcer of unspecified site, pressure ulcer of left buttock, stage III, pressure ulcer of right buttock, stage III. Review of the resident's Comprehensive CNA Shower Review, dated [DATE], showed the resident's buttock was circled. A circle was noted on the resident's left upper back and an X was noted on the right, above the resident's buttock. Review of the resident's Comprehensive Skin Evaluation/Assessment, dated [DATE], showed: -Assessment type: weekly; -Resident has one or more newly identified or existing wounds or skin integrity concerns; -Right buttock, other, stage N/A; -Left buttock, other, stage N/A; -Right gluteal fold, other, stage N/A; -Wound treatment in place. Review of the resident's electronic physician's order sheet (ePOS), dated [DATE] through [DATE], showed: -Start date [DATE]. Coccyx/bilaterally buttock: cleanse with wound cleanser/normal saline (WC/NS), pat dry, apply collagen (used to aid in wound healing) and cover with Zetuvit (a soft absorbent dressing that can be used to treat a variety of wounds) bordered dressing daily and as needed. Large area multiple dressings needed; -No treatment ordered to the pressure ulcers prior to [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, in use during the time of the investigation, initiated and revised [DATE], showed: -Focus: The resident has a stage III pressure ulcer to left and right buttock and is at risk for further breakdown; -Goal: Will be compliant with treatments and intervention measures to prevent skin breakdown; -Interventions: Administer medication as ordered. Administer treatment as ordered, refer to physical therapy and wound consult as indicated. Review of the resident's Treatment Administration Record (TAR), dated [DATE] and reviewed on [DATE] at 8:23 A.M., showed: -Coccyx/Bilaterally buttock: Cleanse with WC/NS, pat dry, apply collagen and cover with Zetuvit bordered dressing daily and as needed. (Large area multiple dressings needed) every day shift. Start date [DATE]; -Treatments completed ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE]; -No documentation of treatments ordered or completed prior to [DATE]. Review of the resident's Comprehensive CNA Shower Review, dated [DATE], showed the resident's buttock was circled. An X was noted on the resident's left upper back and an X was noted on the right, above the resident's buttock. Review of the resident's Skin and Wound Evaluation, dated [DATE], showed: -Type: Pressure; -Stage III-full-thickness skin loss; -Present on admission; -Wound measurements: Area 118.1 Centimeter (cm), Length 27.1 cm, width 17.2 cm, depth 0.2 cm, undermining (describes when the wound extends underneath the edges of the wound) not applicable, tunneling (wound that forms a narrow channel or passageway that extends from the wound's surface into deeper tissue) not applicable; -Goal of care: Healable; -Progress: Deteriorating. Review of the resident's Comprehensive CNA Shower Review, dated [DATE], showed the resident's buttock was circled. A circle was noted on the resident's left upper back and on the right, above the resident's buttock. Review of the resident's Comprehensive Skin Evaluation/Assessment, dated [DATE], showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Numeric Pain Scale: where 0 is no pain and 10 is the worst pain possible. Seven for severe pain; -Resident has one or more newly identified or existing wounds or skin integrity concerns; -Site: Sacrum (triangular bone located above the coccyx), pressure, length 27.1, width 17.2, depth 0.2, unstageable; -Resident sacrum area declined in healing process. Open areas deep cavity like wounds with visible fat tissue but no bone exposed. Area beefy red with some granulation (new tissue growth) and heavy bloody drainage. No odor, no tunneling and no undermining. Left gluteal deep purple/blue. Area measuring 27.1x17.2x0.2 cm. Sacrum: Cleanse area with wound cleanser/normal saline, pat dry then apply collagen and cover with bordered foam dressing daily and as needed. Resident seen weekly by wound clinic and physician. Review of the resident's progress notes, showed: -[DATE] at 9:44 A.M., Resident sacrum area declined in healing process. Open areas deep cavity like wounds with visible fat tissue but no bone exposed. Area beefy red with some granulation and heavy bloody drainage. No odor, no tunneling and no undermining. Left gluteal area deep purple/blue. Area measuring 27.1x17.2x0.2 cm. Sacrum: Cleanse areas with wound cleanser/normal saline, pat dry then apply collagen and cover with bordered foam dressing daily and as needed. Resident seen weekly by wound clinic and physician. Resident own responsible party made aware of decline in wound with no wound care changes at this time; -[DATE] at 11:08 A.M., Writer administered routine wound care treatment to right and left buttocks. Wound declined since last treatment. Beefy red blood noted 27.1x17.2x0.2, no tunneling, no undermining, blue and purple area noted on lateral lower gluteal. Writer will continue daily treatment as ordered. During an interview on [DATE] at 7:28 A.M., the resident lay in bed and watched television. He/She said he/she arrived at the facility on a Tuesday and remembered receiving treatment on his/her wound the following day. He/She could not recall receiving wound care daily but said he/she has received some since being admitted to the facility. Observation on [DATE] at 10:40 A.M., showed the resident lay in bed. The wound nurse assisted the resident to roll over towards the door. The resident had a dressing that covered both buttocks and sacrum. The nurse removed the dressing and there were several open areas covering the buttocks that bled, and a dark area on the left upper thigh/buttocks area that was not open. The wound doctor said the dark area was new this week. The nurse provided wound care and applied a new dressing to the area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:30 A.M., the Wound Nurse said currently the floor nurses were responsible for completing the skin assessments. She was responsible for completing all the wound treatments Monday through Friday. On the weekends the floor nurses were responsible for completing their own treatments. When a treatment was completed, staff should click on the treatment to document it was completed. If there was a hole on the TAR that would mean it was not documented or it was not done. The wound doctor did the weekly wound documentation and sends the report to the facility. The wound nurse transferred the information into the facility's computer system. The wound doctor was responsible for entering the treatment orders into the computer, the facility nurse was responsible for confirming the orders. There were some orders on the order sheets waiting to be confirmed for weeks. Any nurse can confirm the order. If the orders were not confirmed they would not show up on the TAR to show a treatment needed to be completed. During an interview on [DATE] at approximately 11:00 A.M., the wound doctor said the areas on the resident's buttocks and sacrum were pressure ulcers. The resident was non-compliant with his/her care and the resident would rather have the consequences of the wounds because he/she wanted to sit up in the chair when he/she wanted to. The wounds have declined this week because there was an extension of one the wounds. During an interview on [DATE] at 3:21 P.M., CNA II said he/she was familiar with the resident and worked with him/her frequently. The resident received bed baths/showers during the evening shift but he/she would change the resident during the day shift. The resident has a huge wound on his/her coccyx. CNA II works day shifts and on weekends. He/She has seen some wound treatment done during the weekdays but none on the weekends. They do not have a wound nurse working the weekend. If the resident was supposed to receive wound treatment on the weekend, it was probably not completed. During an interview on [DATE] at 8:10 A.M., Licensed Practical Nurse (LPN) U said the resident had wounds. If his/her dressing came off, he/she would replace it but he/she did not routinely provide wound care. During an interview on [DATE] at 11:43 A.M., the Assistant Director of Nursing (ADON) said she started at the facility on [DATE]. Skin assessments were completed upon admission. Wounds were documented on the initial assessment. The wound nurse would then measure the wounds if they were discovered upon admission. She would at least describe the wound. If a resident was admitted from the hospital with wounds, the facility would verify the wounds with the physician and inform the wound nurse. The facility does not have a wound nurse 24 hours so if a resident was admitted after hours, the wound nurse would assess the resident the following day. There were no standing orders for wound care. If there was no wound order in the hospital discharge paperwork, she would get the orders from the facility physician as soon as possible. The ADON assessed the resident upon admission on [DATE] and he/she had a huge sacral wound. She informed the wound nurse. The wound nurse would inform the physician and the physician would write the order. She was not sure how the resident's wound treatment did not start until [DATE]. The physician was supposed to put in the order and the nurse would confirm the orders. She was not sure how it was not communicated. She expected the nurses to look at the admission paperwork. There is a system within the facility for communicating orders, but it was broken. There was a delay in the resident's wound care and the wound got worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:13 P.M., LPN G said he/she was the wound nurse and started at the facility at the end of [DATE]. When a resident was admitted , the nurse does a full head to toe assessment. If a resident had skin issues, they would notify him/her. If there were any skin issues, the physician would be notified. This communication could be verbal or in writing. Sometimes it will take more than 24 hours for the information to be communicated. Once the information regarding the wound was communicated, he/she would inform the physician. The physician saw the resident on [DATE] and put an order in for treatment. He/She was not sure why it did not carry over to the ePOS or TAR. He/She had been treating the wound since ,d+[DATE]. He/she treated the wounds Monday through Friday, but not on the weekends because they have no wound nurse on the weekend. He/She had documentation of his/her treatment of the wound and would find it. At 1:12 P.M., LPN G returned and said he/she did not have any documentation regarding wound treatment. He/She had handwritten notes on personal paper but nothing in the clinical record. The resident was admitted to the facility late on [DATE]. He/she saw the resident on [DATE] and measured the wound at 26x7.5x0.3 on the left buttock and called it unstageable. The right buttock measured at 22.0x5.5x0.3 and was unstageable. On [DATE], he/she treated the resident with Revive and a foam dressing. After [DATE], the resident was treated with collagen and foam dressing. There was no documentation to indicate this. Since the orders were not placed on the POS and MAR, the treatments were not completed on the weekend because they would have not known what the treatments were since they were not listed. During an interview on [DATE] at 10:58 A.M., the wound physician said the resident was admitted to the facility on [DATE]. A skin assessment should have been done upon admission and treated for wounds. The first time he saw the resident, he took pictures. He wrote orders on [DATE] but they did not carry over. He was not sure why it wasn't put into the POS and TAR until the 10th. The resident had a quite sizable wound from the hospital. Review of the physician's notes, viewed on his computer, showed: -[DATE]. Area 28.07 cm, length 12.46 cm, width 8.27 cm and deepest point 0.2 cm. -[DATE]. Area 228.61 cm with a 714 percent increase in size, length 21.81 cm with a 75% increase in size, width 16.59 % with a 101% increase in size. Deepest point 0.1 cm.; -[DATE]. Area 118.14 cm with a 48% decrease in size, length 27.07 cm with a 24% decrease in size, width 17.2 cm with a 4% increase in size. Deepest point 0.2 cm. The physician said he put the orders and recommendations in on [DATE], The nurse should have followed up. It would have helped to have another staff ensure orders were carried over. Not sure why it didn't carry over and it wound likely got worse from not having consistent treatment. However, patient factor outweighed treatment factor. The patient was to be turned and repositioned at least every two hours but could be noncompliant. The resident was alert and oriented and could make his/her needs known. Some patients who are quadriplegic may not feel what was going on with their wounds. 2. Review of Resident #89's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Moderately impaired cognition; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included: heart failure, end stage renal disease (ESRD, chronic irreversible kidney failure), and hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) or hemiparesis (a slight weakness in a leg, arm, or face); -At risk for developing a pressure ulcer? Yes; -Does the resident have one or more unhealed pressure ulcers at stage I (intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area) or higher? No. Review of the resident's care plan in use at the time of survey, did not show the resident had an alteration in his/her skin integrity. Review of the resident's progress notes, dated [DATE] at 8:30 P.M., showed the resident readmitted to the facility. The note did not show the resident had wounds. Review of the resident's admission/readmission evaluation assessment, dated [DATE], showed: -Skin evaluation, comments: resident noted with a 1 X 0.1 cm open area to right buttocks with 2 smaller area to right buttocks measuring 0.5 x 0.5, foam dressing applied; -Site: right buttocks, Type: pressure, Length: 1, Width: 0.1, Depth: 0, Stage: 1; -Site: right buttocks, Type: pressure, Length: 0.5, Width: 0.5, Depth: 0, stage 1; -Site: right buttocks, Type: pressure, Length: 0.5, Width: 0.5, Depth: 0, stage 1. Review of the resident's TAR, dated [DATE] through [DATE], showed: -An order for: Cleanse area to right buttocks with NS or WC and apply foam dressing daily and as needed till healed, at bedtime for pressure area to right buttocks, start date was [DATE]. During an interview and observation on [DATE] at 9:15 A.M., showed the resident was lying in bed. The wound nurse loosened the resident's brief, inside the brief was toilet paper with bowel movement on it, stuffed between the resident's legs. The wound nurse provided incontinence care and rolled the resident over. The resident did not have a foam dressing on his/her buttocks. The resident had several open areas on his/her sacrum and right buttocks. The wound nurse described all the areas as stage 3 pressure ulcers and gave approximate measurements as he/she observed the wounds. The sacrum had two wounds, the top wound was 1.2 cm X 0.8 cm X 0.2 cm and the bottom wound 0.2 cm x 0.2 cm X 0.1 cm. The right buttocks had three open wounds, the approximate measurements for the top wound were 0.3 cm X 0.3 cm X 0.1 cm, the middle was 0.2 cm X 0.2 cm X 0.1 cm and the bottom wound was 0.5 cm X 2.0 cm X 0.2 cm. The wound nurse said she did not know why toilet paper would be left in the resident's brief, probably the night shift was rushing. The possible consequence of leaving soiled tissue in a brief could be skin breakdown. The wound nurse was not aware the resident had wounds and today was the first time she saw the resident. She would have expected staff to have reported to her the resident had wounds. The wound doctor would be at facility today and she was going to ask him to see the resident. (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

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Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes dated [DATE], through [DATE], showed: -On [DATE] at 8:55 A.M., Skin assessment performed on resident [DATE]. Open areas found on sacrum and right buttock. Measurements obtained, Triad paste (barrier) and foam dressing applied. The wound doctor made aware and will see resident today [DATE]. Review of the resident's Comprehensive Skin Evaluation/Assessment, dated [DATE], showed: -Resident has one or more newly identified or existing wounds or skin integrity concerns. Yes; -Site: sacrum, type, length, width, depth, and stage were blank; -Site: right buttocks, type, length, width, depth, and stage were blank; -Site: right buttocks, type, length, width, depth, and stage were blank. Review of the resident's TAR, dated [DATE] through [DATE], showed: -An order for: Cleanse sacrum/right buttocks with wound cleanser/normal saline, pat dry then apply Triad paste and cover with bordered foam dressing daily and as needed, start date was [DATE]. During an interview on [DATE] at 11:00 A.M., the wound doctor said he did not see the resident, and he did not have access to his/her medical record. The nurse told him yesterday the resident had wounds, but he did not have time to see the resident yesterday and the resident was out today. During an interview on [DATE] at 10:00 A.M., CNA C said if a resident had a redden or open area, he/she would notify the nurse and if the residents dressing came off, he/she would notified the nurse. 3. During an interview on [DATE] at 3:08 P.M., the Administrator said he would expect physician orders to be entered into the computer timely and he would expect for staff to follow the physician orders and the facility's policies and procedures. MO00242993

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview, and record review, the facility failed to ensure safety and adequate monitoring for one resident (Resident #38), whom the facility identified as an elopement risk, and failed to prevent the resident from eloping from the facility. The facility failed to document the elopement in the resident's medical record and in the resident's plan of care. The sample size was 33. The census was 99. Review of the facility's Elopement policy, revised December 2007, showed; -Policy Statement: -Staff shall investigate and report all cases of missing residents; -Policy Interpretation and Implementation; -Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. -When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: -Examine the resident for injuries; -Notify the Attending Physician; -Notify the resident's legal representative (sponsor) of the incident; -Complete and file Report of Incident/Accident; and; -Document the event in the resident's medical record. Review of the Resident #38's Elopement and Wandering Risk Observation/Assessment, dated 6/30/24, signed 9/16/24, showed: -Mobility Status: The resident ambulates independently with or without the use of assistive devices; -Cognitive Status: The resident wanders aimlessly or displays wandering behavior without a sense of purpose; -Disease Diagnosis: The resident has two or more diagnoses that may impact cognition; -History of Elopement Attempts: The resident has not expressed a desire to leave and has not attempted to leave the facility; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Behavior Modification: Exhibits unsafe wandering or elopement attempts but is easily redirected; -Intervention: The resident is identified as an elopement risk and is in the elopement binder. Review of the resident's care plan, in use during the time of the investigation, revised 7/16/24, showed: -Focus: Initiated 3/24/24. The resident has been identified as an elopement risk; -Goal: Assist resident with redirection if found wandering to keep him/her aware of his/her surroundings through the next review date; -Interventions: Assess resident risk factors that may trigger wandering behavior. Educate staff where they can find elopement binders. The resident has been placed in the at risk for elopement binder. Music helps the resident relax. Play music for the resident if he/she is actively anxious. Re-orientate resident to his/her room or familiar place as needed; -No information regarding the elopement on 9/14/24. Review of the Fire Protection District report, dated 9/14/24, showed: -Transportation Date: 9/14/24; -Onset Time: 5:00 A.M.; -Emergency Medical Services (EMS) dispatched to a residence with a chief complaint of a confused person. EMS responded with lights and sirens. EMS arrived on scene to find the police standing on the side of the road. Per police, a passerby called 911 of an old man/woman wandering around with no shoes on. Per police, the patient is confused and can't answer questions correctly. Patient is a [AGE] year-old man/woman with a chief complaint of altered mental status. Patient is alert and oriented to self. Patient states he/she was from East St. Louis and did not know how he/she got to the area. Patient sat and secured to stretcher for safety. Patient loaded into hospital and taken to the hospital. Review of the hospital's Health Facility Transfer Chart, showed: -admitted [DATE]; -Expected discharge date of [DATE]; -Oriented to person, disoriented to place, disoriented to situation, disoriented to time; -Final Diagnosis: Altered mental status; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Presenting History: Patient presented to the emergency room from street via police with concern for altered mental status. Patient is resting in bed. He/she says he/she is feeling better. No further history from patient. Per the hospital social worker, patient has a piece of paper with him/her stating the resident's name, identification number, room number, diet order: mechanical soft, regular double portions, thin liquids; -Per the resident's family member, the facility called him/her on 9/14/24 to inform him/her the patient was missing. However, when the Social Worker called the facility on 9/14/24 at 9:59 A.M., the receptionist said the patient was not from their facility. The family member states the facility is working to get the patient transferred to another facility. The family member is aware patient will need to return back to the facility while waiting for the facility to coordinate the transfer if patient is medically ready for discharge; -Per Fire House staff, the patient was picked up 0.2 miles away from the facility; -Social worker called the facility at the listed phone number. The receptionist said the patient was not from their facility; -Social Worker called the assisted living facility associated with the nursing home. The receptionist said the patient is not from their facility. Review of the resident's progress note, dated 9/18/24 at 3:31 P.M., showed at 1:50 P.M., the resident arrived from the hospital to the facility. No complaints and no respiratory distress noted. Resident was able to make some needs known, and oriented to room, call light, television, bed remote and staff. No edema (swelling) noted and continues to ambulate with slow and steady gait and no use of assist devices. Call placed to the Nurse Practitioner and made her aware the resident has returned to the facility. Review of the resident's Elopement and Wandering Risk Observation/Assessment, dated 9/18/24, showed: -Mobility Status: The resident ambulates independently with or without the use of assistive devices; -Cognitive Status: The resident is disoriented or has periods of confusion and/or impaired attention span but does not wander; -Disease Diagnosis: The resident has two or more diagnoses that may impact cognition; -Mood/Behavior Status: The resident has verbalized a desire to leave the facility, packed their belongings, stood by the exit door or attempted to open an exit door -History of Elopement Attempts: The resident has exhibited unsafe wandering or has made one or more attempts to elope prior to admission or in the last year -Behavior Modification: Exhibits unsafe wandering or elopement attempts but is easily redirected; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Intervention: The car plan has been initiated/updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement. Review of the resident's physician's progress note, dated 9/20/24 at 7:51 A.M., showed a late entry: Return from hospital. Patient being seen today after being admitted to the hospital with altered mental status. Patient was found on the street by police and was taken to the hospital. Patient improved and was discharged back to the facility with recommendations for patient to be transferred to a memory care accessible facility. Review of the resident's progress notes, showed no information regarding the resident's elopement. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/30/24, showed: -Cognitively impaired; -Wandered four to six days out of seven; -Diagnoses included Alzheimer's Disease and dementia. During an interview on 10/11/24 at 10:28 A.M., Certified Nursing Assistant (CNA) QQ said he/she arrived to work on 9/14/24 for the day shift. He/she was not assigned to the resident. Staff approached him/her around 7:15 A.M. and asked if he/she saw the resident. Staff began looking for the resident. During an interview on 10/11/24 at 11:09 A.M., Certified Medication Technician (CMT) OO said he/she arrived at the facility at 6:45 A.M. on 9/14/24 and started passing medication. No night shift staff were available when he/she arrived. No report was given to the day shift nurse as the night nurse had already left that morning. They could not locate any aides either, so no report was given. He/She started on the resident's hall and did not see him/her. The resident wandered and spent most of his/her time in the dining room so he/she kept passing medication on the hall. After about an hour and a half, he/she went to the dining room and did not see the resident. An agency nurse (unidentified) was working and CMT OO asked the nurse if he/she saw the resident. They began to look and could not find the resident. The agency nurse called the family and asked if they took the resident out of the facility. After finding out the family did not have the resident, the code was called. Around 10:30 A.M., the nurse informed him/her the resident was located and was at the hospital. This was the first time he/she heard the resident eloped. The facility never had an in-service following the resident's elopement. During an interview on 10/11/24 at 12:03 P.M., CNA PP said when he/she arrived for his/her shift on 9/14/24, they began looking for the resident. He/She later found out the resident was found by the police and brought to the hospital. No in-service was completed following the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/24 at 2:52 P.M., CNA B said he/she worked the night shift on 9/13/24 and 9/14/24. He/She was on the hall but not assigned to the resident. He/She thought they did rounds on all residents during the night shift on 9/14/24. He/She saw the resident around 8:00 P.M. on 9/13/24. The resident wandered and was in the dining room and tended to wander throughout the facility. That night, the front doors were broken, and the alarms were not sounding. Apparently, the resident left the facility during the night and was found outside on the facility property and taken to the hospital. He/She did not know the resident was missing until he/she returned on 9/15/24. Licensed Practical Nurse (LPN) R was the nurse on duty and likely did not report the incident. LPN R told CNA B, You didn't see or hear anything regarding the resident's elopement. During an interview on 10/15/24 at 5:07 P.M., LPN R said he/she no longer worked at the facility. He/She recalled the incident with the resident eloping but was not working the night the resident eloped. However, he/she worked night shift and the resident wandered but could be redirected. He/She was not aware of the doors not working. During an interview on 10/30/24 at 9:13 A.M., LPN UU said he/she worked through an agency and worked during the night shift on 9/14/24 and was assigned to a different hall. He/She did not recall a resident eloping and did not receive any information regarding an elopement. He/She could not recall receiving or providing a report to the on-coming nurse and could not recall who it was. During an interview on 10/11/24 at 1:33 P.M., the resident's family member said he/she received a call around 9:00 A.M. or 10:00 A.M. on 9/14/24 from the facility asking if he/she picked up the resident because they could not locate him/her. He/She immediately went to the facility. When he/she arrived, staff told him/her the resident was in the hospital. He/She could not recall who the nurse was, but they could not provide him/her with any additional information. Only that the resident was in the hospital. The family member went to the hospital and spoke with the Social Worker. The Social Worker told the family member the resident was discovered in the early morning walking the streets with no shoes on. The family member returned to the facility and again asked what happened. The Administrator told him/her they viewed the camera system and the resident walked out behind a staff member. During an interview on 10/11/24 at 2:12 P.M., the Administrator said he was out of town when the incident occurred. The Director of Nursing (DON) received a call and found out the resident was picked up by the police in front of the facility. The police did not come into the facility to find out if the resident belonged at the facility. The resident was a wanderer but not exit-seeking. The resident must have eloped from the facility around 5:00 A.M. Staff discovered he/she was missing around 9:00 A.M. when the CMT was passing medication. They were not sure how the resident got out because the camera system was not working, and they could not view the elopement. The doors were functioning during that time and there were no issues with the alarms. He thought the resident may have walked out behind a staff. The Administrator was not able to obtain information from staff because staff assigned that night denied being assigned to the resident and did not see anything. LPN UU was the nurse assigned during the night shift and could not provide any information. The resident was last seen around 10:00 P.M. by the CMT from what he was able to gather from staff. After the incident, they in-serviced staff and obtained an elopement bracelet and placed the resident in the elopement binder. The incident was not reported or investigated thoroughly because the Administrator found out about the incident outside of the time frame and did not have any information. The resident was a wanderer and elopement risk so staff should have monitored him/her to prevent the resident from leaving the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00239413 MO00242535

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on observation, interview and record review, the facility failed to provide appropriate administration of enteral (passing through the intestine) nutrition for a resident who was dependent on a gastrostomy tube (g-tube, a tube inserted through the abdomen that brings nutrition directly to the stomach) (Resident #245). The resident did not receive the continuous order of the tube feeding for approximately five hours. The facility identified 19 residents who received tube feedings. The census was 99. Review of the facility's Enteral Nutrition Policy, revised in November 2018, showed: -Policy Statement: Adequate nutritional support through enteral nutrition is provided to residents as ordered; -The interdisciplinary team, including the dietitian, conducts a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings; -Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. If a feeding tube is ordered, the provider and interdisciplinary team document why enteral nutrition is medically necessary; -The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypoglycemia (low blood sugar levels) or hyperglycemia (high blood sugar levels), and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk; -Enteral feedings are scheduled to try to optimize resident independence whenever possible (e.g., at night or during hours that do not interfere with the resident's ability to participate in facility activities); -The nurse confirms that orders for enteral nutrition are complete. Complete orders include: -The enteral nutrition product; -Delivery site (tip placement); -The specific enteral access device; -Administration method (continuous, bolus, intermittent); -Volume and rate of administration; the volume/rate goals and recommendations for advancement toward these; -Instructions for flushing (solution, volume, frequency, timing and 24-hour volume); (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff caring for residents with feeding tubes are trained on how to recognize and report complications relating to the administration of enteral nutrition products, such as: -nausea, vomiting, diarrhea and abdominal cramping; -inadequate nutrition; -metabolic abnormalities; -interactions between feeding formula and medications; and -aspiration. Review of Resident #245's medical record, showed: -admitted to the facility on [DATE]; -Diagnoses included cerebral infarction (stroke), hemiplegia (muscle weakness or partial paralysis on one side of the body), acute respiratory failure (enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood), and dysphagia (difficulty swallowing), unspecified protein-calorie malnutrition; -Physician's order for NPO (nothing by mouth) diet; -Physician's order of Jevity 1.5 Cal (high protein and fiber supplement) for enteral feed (tube feeding, method of providing nutrition to patients who are unable to eat or swallow safely), 70 milliliters per hour (ml/hr), with 150 ml/hour of water every 4 hours. Review of the resident's care plan, revised on 10/1/24, showed: -Focus: has a g-tube and is at risk for enteral nutrition complications; -Goal: Will be able to tolerate enteral support without pulling at tube and causing trauma to nares (openings of the nose) or stoma (a small opening in the abdomen that is used to remove body waste (feces and urine) into a collection bag), no gastric distress, diarrhea, abdominal distention; -Interventions: Check for tube placement as ordered, notify Physician if unable to tolerate tube feeding, observe for abdominal distention, regurgitation, nausea, abdominal pain, diarrhea, congestion, change in level of consciousness (LOC), fever, and notify Physician of occurrence, observe for signs and symptoms of infection and report any findings to Physician. Observations on 10/16/24 at 7:04 A.M. and 10:49 A.M., showed the resident lay in bed. His/Her tube feeding pump was off. An empty 1000 ml bottle hung on the pole. The bottle was dated 10/15/24, at 4:00 P.M. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 11:02 A.M., Licensed Practical Nurse (LPN) D said he/she was assigned to Hall 400 and there was supposed to be another nurse on Hall 300 where the resident resided. LPN D said the resident had an order of Jevity 1.5 Cal and was supposed to be a continuous infusion. He/She was not notified there was not a nurse on Hall 300 and was not aware the resident's tube feeding was not infusing. LPN D hung and started the tube feeding infusion as ordered at 11:15 A.M. During an interview on 10/18/24 3:13 P.M., LPN F said tube feeding should be administered per physician's order. The staff were supposed to check the residents throughout the day to know if a new bag needed to be hung. He/She said the tube feeding pump beeped when the bottle was empty. LPN F added that there should be more staff on Halls 300 and 400 for the safety of the residents. During interview on 10/21/24 at 10:32 P.M., the Assistant Director of Nursing said that tube feedings should be administered as ordered by the physician. The midnight shift nurse was responsible for changing the tubing every 24 hours. During an interview on 10/21/24 3:09 P.M., the Administrator expected the staff to administer tube feedings per physician's order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, facility staff failed to ensure physician orders for tracheostomy and ventilation machines (a machine that provides positive pressure ventilation) were compete with all pertinent information to care for residents and failed to have orders for continuous oxygen monitoring for residents with a tracheostomy (Residents #13, #25, and #245). Additionally, the facility failed to have staff trained on how to set and monitor the functioning of ventilation machines and continuous oxygen monitoring devices. Review of the facility's Oxygen Administration policy, revised October 2010, showed: -Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration; -Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol; Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: -Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); -Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); -Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); -Vital signs; -Lung sounds; -Arterial blood gases and oxygen saturation. During an interview on 10/16/24 at 12:55 P.M., Registered Respiratory Therapist (RRT) Z said the facility utilized a [NAME] closed suction system on the 200, 300, and 400 halls. Review of the facility's Suction Policy, revised August 2014, showed: -The policy did not address the facility's use of a [NAME] Closed Suction System (a closed-circuit method for tracheal suctioning that uses a catheter (tube) that can be reused) for residents with a tracheotomy and did not provide manufacturers guidelines for any of the suction equipment used in the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 8:18 A.M., the Director of Nursing (DON) said the facility used a continuous oxygen monitoring system on the 300 and 400 hall for residents that have a tracheostomy and require continuous oxygen. The device was attached to a resident by way of a sensor attached to the resident's fingernail or toenail. The machine monitored the resident's oxygen saturation levels and heart rate. The monitors would alarm if a residents' oxygen saturation was too low, the resident's heart rate was too high or too low and/or if the sensor was dislodged. The continuous oxygen monitoring machine would alarm in the resident's room with sound and flash in red the room number. 1. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/25/24, showed: -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; -Cognitively intact; -Rejection of Care: Behavior not exhibited; -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; -Respiratory Treatments: Oxygen therapy, suctioning, tracheostomy care and non-invasive mechanical ventilator. Review of the resident's care plan, located in the electronic health record (EHR), showed: -Date Initiated 6/9/23, revised on 3/8/24 : -Focus: Diagnosis of CHF. At risk for respiratory complication as evidenced by shortness of breath (SOB), tachypnea (rapid breathing), and dyspnea (difficult breathing).; -Goal: Will not have complications related to CHF which requires outside interventions; -Interventions/Tasks: Administer medication as ordered. Monitor for signs of respiratory distress. Monitor oxygen saturation; -Date Initiated 6/9/23, revised on 3/8/24: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Uses oxygen continuously; -Goal: Will not have complications requiring outside interventions related to tracheostomy/ventilator; -Interventions/Tasks: Change oxygen tubing as ordered. Change suction system as ordered. Monitor and respond to ventilator alarms as ordered; -Date Initiated 2/24/24 and Revised On 3/8/24: -Focus: Requires an invasive mechanical ventilator and is at risk for respiratory distress; -Goal (revised on 10/1/24): Secretions are mobilized and airway remains patent; -Interventions/Tasks: Assess tracheal tube, checking whether it is secure. Assess rate and quality of respiratory pattern. Assess vital signs. Call light in reach and answered promptly. Resident has a chronic ventilator (vent) and likes to hook himself/herself up to the ventilator nightly. It has been determined that the resident is not safe for himself/herself off of the vent although he/she continues to take his/her vent off at his/her own will. Resident has been educated that doing this puts him/her at harm for respiratory failure. Monitor oxygen saturation through pulse oximetry and atrial blood gases as appropriate and notify physician if below 92% (normal 95-100%). Review of the resident's physician's orders (POS) on 10/16/24 showed: -An order dated 10/10/24 for High Humidity Trach Collar (HHTC) @28% for Sats (saturations) greater than 90% oxygen (O2). No directions specified for order; -An order dated 10/14/24 for Tracheostomy showed: Trach care, cleanse site with ( ) sterile water or normal saline (H202/NS) and change trach dressing. Type: _____, Size:_____, Cuffed:_____, Uncuffed:_____, Fenestrated (A fenestrated tube is a tracheostomy tube with a hole or holes in the outer cannula that allow air to pass through the patient's upper airway and mouth):__yes__no , Disposable Inner Cannula:__yes__no, Passy-Muir Valve:__yes, # of hours use__, __no___. Cuff must be deflated while a Passy Muir speaking valve is in place (a medical device that allows patients with tracheotomies or ventilators to speak and communicate) every 8 hours; -The tracheostomy order did not include the specific information staff needed to care for the resident's tracheostomy. -It did not contain orders for the resident's ventilator or ventilator settings; -It did not contain an order for continuous oxygen monitoring. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/16/24 at 6:38 A.M., showed unknown certified nursing assistant (CNA) alerted Licensed Practical Nurse (LPN) BB the resident needed to be suctioned. The oxygen monitoring screen at the nurse's station and on the resident hallways were not sounding to indicate if the resident was having trouble with his/her oxygen levels. LPN BB entered the resident's room and attempted to suction the resident and RR Z came in and took over. Observation at that time showed, the resident's continuous oxygen monitor had been turned off. RRT Z looked at the resident's continuous oxygen monitoring machine and turned it on. The screen showed a malfunction error. RRT Z left the room and brought in a replacement machine. During interviews on 10/15/24 at 7:15 A.M., and on 10/16/24 at 7:08 A.M., 8:15 A.M. and 11:15 A.M., RRT Z said the facility used a continuous oxygen monitoring system for residents with a tracheotomy. The monitoring system alerted with an alarm if something was wrong. He/She did not know who was responsible for maintaining the equipment and making sure it was in working order. Staff that were working should assess the equipment daily. Staff should ensure equipment was plugged in and working, sensors were intact and in place on the residents. During an interview on 10/2/24 at 12:25 P.M., Registered Nurse (RN) W said the continuous oxygen monitoring system malfunctioned all the time. At times the machine would alarm in a resident's room, but not at the nurse's station and/or on the monitoring screens in the hallways. Only the respiratory therapy department knew how to set and maintain the ventilators on the hallways. 2. Review of Resident #25's medical record showed: -Diagnosis included Chronic Obstructive Pulmonary Disease (COPD, lung disease), dysphagia (difficulty swallowing), and unspecified intracranial injury (brain injury). Review of the resident's quarterly MDS, dated [DATE], showed: -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 cognitively impaired; -Rejection of Care: Behavior not exhibited; -Respiratory Treatments: Oxygen therapy, suctioning, and tracheostomy care. Review of the resident's care plan, revised on 10/16/24, showed: -Focus: Tracheostomy. Resident requires a tracheostomy; -Goal: Will have no signs of complications with tracheostomy to the extent possible; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Auscultate lung sounds (listen to) lung sounds, assessing for decreased or adventitious lung sounds (refer to sounds that are heard in addition to the expected breath sounds mentioned above. The most commonly heard adventitious sounds include crackles, rhonchi, and wheezes), change suction system as ordered/indicated, change trach ties (helps stabilize and keep the tracheal cannula (a tube within the outer tube which can be removed) in place) as ordered and as needed, provide means of communication, reassure help is available immediately; -Focus: Requires the use of oxygen continuous related to acute respiratory failure; -Goal: Will be complaint with oxygen therapy. Will be maintained at their respiratory baseline with a patent (open) airway and unlabored respirations; -Interventions: Maintain head of bed elevated to level of comfort to promote oxygenation. Provide calm environment free of stimuli to reduce/prevent anxiety, respiratory therapy as indicated, monitor for signs and symptoms of respiratory distress and report to physician, pulse oximetry. Review of the resident's POS, dated 10/16/24, showed the following: -Oxygen at 6 liters/minute continuously per trach collar; -Suction tracheostomy tube as needed to clear airway; -The orders did not include: -Type or size of tracheostomy; -Use of continuous oxygen monitoring. Observation on 10/16/24 at 7:04 A.M., showed the resident lay in bed. His/Her HHTC was not attached to any oxygen source and the mask was lying on the foot of the bed. There was no continuous oxygen monitoring machine in his/her room to alert staff the resident was not receiving oxygen. During an interview on 10/16/24 at 7:43 A.M., the DON said he did not know why Resident #25 did not have a continuous oxygen monitoring machine in his/her room. 3. Review of Resident #245's medical record physicians order sheet showed: -An order dated 7/26/24, to suction secretions as needed orally (by mouth) using a catheter; -An order dated 7/26/24, for continuous oxygen saturation monitoring; -An order dated 7/26/24, for oxygen at 5 L /minute continuous per nasal cannula; -It did not contain orders for HHTC; -It did not contain orders for tracheostomy cannula, including brand or size. Review of the resident's care plan, revised on 10/1/24, showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident requires a tracheostomy and is at risk for complications; -Goal: Will have no signs or symptoms of complications with tracheostomy tube to the extent possible; -Interventions: Administer humidified oxygen as ordered, administer medications as ordered, encourage to cough out secretions, monitor and report signs of respiratory distress or hypoxia (body not getting enough oxygen), provide trach care as indicated, resident has a #6 [NAME] trach (a tube used to bypass upper airway obstructions) and make sure the resident is in a comfortable position; -Focus: Resident requires the use of oxygen continuous 5L/min per nasal cannula related to respiratory failure; -Goal: Will be compliant with oxygen therapy; -Interventions: Change humidification and oxygen tubing as indicated, educate the resident on the importance of keeping the oxygen on and at the prescribed setting, and monitor and report signs of hypoxia to physician. -The care plan did not address the resident used a HHTC and utilized a continuous oxygen monitoring system. Review of the resident's progress note, dated 10/8/24, showed: -Trach care done; -Patient remains on 28% (nothing noted); -5L trach collar set up (no mention of oxygen). Observation on 10/16/24 at 7:04 A.M., showed the resident lay in bed. His/Her HHTC mask was at the nape (back) of his/her neck and not over his/her tracheostomy stoma (surgically created opening in the neck that leads to the windpipe). 4. During interviews on 10/15/24 at 7:15 A.M., and on 10/16/24 at 7:08 A.M., 8:15 A.M. and 11:15 A.M., RRT Z said the respiratory therapist was responsible for setting the ventilators. There should be orders in the resident's medical records to include settings of the ventilators, brand and size of tracheostomy equipment, levels of high humidity and oxygen flow rates. The respiratory therapy staff had not inserviced the nurses at the facility on the use of the facility's specific equipment and policies. During an interview on 10/17/24 at 11:13 A.M., LPN FF said he/she had not been provided any additional training by the facility for using their specific equipment and or policies and procedures regarding caring for residents with a tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 7:58 A.M., RRT EE said the facility had approximately 12 to 15 residents with a tracheostomy. All of the residents with a tracheostomy used the piped in wall oxygen and suctioning equipment. All residents with a tracheostomy should have continuous oxygen monitoring equipment. During an interview on 10/16/24 at 7:43 A.M., the DON said all residents with orders for oxygen and HHTC should have their equipment placed correctly and monitored by staff. During an interview on 10/21/24 at 2:00 P.M., the Administrator said he would expect residents' medical records to contain complete and accurate orders. During a telephone interview on 10/16/24 at 3:40 P.M., the facility's medical director said all residents' physician's orders should address the residents' tracheostomy care, including the brand name and size of the equipment. Ventilator orders should be on the physician's order sheets. All residents with a tracheotomy should be on continuous oxygen monitoring.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 42247 Based on interview and record review, the facility failed to ensure residents receiving dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) had documented assessments and monitoring related to dialysis and ongoing documented communication with the dialysis center. The facility identified 10 residents as receiving dialysis, of which one was sampled (Residents #89). The sample was 33. The census was 99. Review of the facility's Care of a Resident with End-Stage Renal Disease, Policy, dated September 2010, showed: -Policy Statement: residents with end-stage renal disease (ESRD, kidneys no longer work as they should to meet the body's needs) will be cared for according to currently recognized standards of care; -Policy interpretation and implementation: -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents; -Education and training of staff includes, specifically: -The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; -Signs and symptoms of worsening condition and/or complications of ESRD; -How to recognize and intervene in medical emergencies such as hemorrhages (bleeding) and septic infections (a life-threatening condition that occurs when the body has an extreme response to an infection); -Timing and administration of medications, particularly those before and after dialysis; -The care of grafts (an access made by using a piece of soft tube to join an artery and vein in the arm) and fistulas (an access made by joining an artery and vein in your arm); -Education and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care; -Agreements between this facility and the contracted ESRD facility include all aspects of how the residents care will be managed, including: -How information will be exchanged between the facilities; -The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #89's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/20/24, showed: -Moderately impaired cognition; -Diagnoses included ESRD; -Received dialysis on admission and while a resident. Review of the care plan, in use at the time of survey, showed: -Focus: requires hemodialysis and was at risk for weight fluctuations; -Goal: will be free of signs or symptoms of complications related to hemodialysis to extent possible; -Interventions: avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity or applying restrictive clothing or restraints on the arteriovenous (AV, surgical connection made between an artery and a vein) site extremity; dialysis center to provide dialysis catheter access site care including changing the caps; dietary consult to meal planning as indicated; -The care plan failed to show when the resident received dialysis, how the resident would get to and from dialysis and what monitoring the staff would provide. During an interview on 10/14/24 at 6:10 P.M., the resident said he/she went out today for dialysis. His/Her dialysis access site was in his/her upper chest on the right side. The resident did not know if staff checked his/her vital signs or weight before he/she went to dialysis but he/she took a paper with him/her to dialysis whenever the staff gave it to him/her. Observation and interview on 10/18/24 at 7:10 A.M., showed the resident seated in his/her wheelchair in the 200-hall dining room. The resident said he/she was getting ready to out for dialysis, no one had checked his/her vital signs or weight this morning. They will do it at dialysis. Review of the Physician Order Sheet, dated 10/11/24, showed there was no physician order for dialysis. Review of the progress notes, dated 9/14/24 through 10/18/24, showed: -On 9/16/24 at 4:20 P.M., the Social Worker was informed by family that the resident had dialysis. Patient will be attending dialysis at an outside facility. Review of the vital signs, showed: -Temperature, pulse, respiration and blood pressure was completed on 9/13, 9/14 and 9/26/24, and one weight was documented. Review of the resident's medical record, showed there was one hemodialysis communication observation/assessment facility post dialysis, dated 10/14/24. The assessment was blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 10/1/24 through 10/11/24, showed no monitoring documented for dialysis. During observation and interview on 10/16/24 at 9:55 A.M., Licensed Practical Nurse (LPN) H said there was a blue folder with the dialysis assessments at the nurse's station for residents who go out for dialysis. LPN H looked inside the resident's folder and said there was only his/her face sheet. The nurse should complete the top of the dialysis communication form and send it with the resident when they go out for dialysis. Residents who receive dialysis should have their vitals and weight monitored along with the bruit and thrill (physical signs that indicate good blood flow in a dialysis fistula or other vascular system), and they should be assessed for pain. The only place this was documented was on the dialysis form. During an interview on 10/17/24 at 10:10 A.M., LPN NN said the nurse completes the dialysis form and the form was sent with the resident when they go to dialysis. In addition, staff should check the resident's bruit and thrill and document it in the computer. On 10/17/24, the resident's dialysis communication sheets were requested. On 10/21/24 at 10:30 A.M., the Administrator said if they did not provide the information, they did not have it. The facility was working on a new form for dialysis. During an interview on 10/18/24 at 3:13 P.M., LPN F said there should have physician's order for dialysis. The nurse checks the resident's vital signs, bruit and thrill before the resident leaves for dialysis and when the resident returns to the facility. These were all documented in the resident's electronic health records. LPN F said the residents would take a communication sheet and will bring it back upon their return to the facility, but the residents do not bring the sheets back at times. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nurses (ADON) said the residents on dialysis were to be monitored and assessed. The staff documents in the TAR. The ADON expected staff to provide a communication sheet when the residents leave for dialysis. The communication sheets should include the resident's weight, and their vital signs before and after the dialysis treatment. The ADON was not sure if dialysis required a physician's order. During an interview on 10/21/24 at 3:09 P.M., the Administrator said he expected staff to have a monitoring tool for residents who are on dialysis and it should be documented. He expected to have a physician's order for dialysis.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to provide services by sufficient numbers of nursing personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care needs. The facility did not have a system in place to ensure the required coverage was provided. As a result one resident, who experienced acute shortness of breath had to call 911 for intervention. (Resident #35). Another resident called 911 on one occasion because he/she could not get staff to answer his/her call light to help reposition a tube and on another occasion because he/she had a soiled brief and had waited 10 hours for staff to clean him/her. (Resident #46). In addition, one resident, who was dependent on staff for nutrition, went over 5 hours without receiving his/her physician ordered tube feeding (a method of providing nutrition, fluids, and medication to someone who is unable to eat or drink safely by mouth). (Resident #245). In addition, during the survey, one resident's light was observed to be on for almost two hours while staff walked past the resident's room. (Resident #20). The facility also failed to have adequate awake employees prepared to provide care and safely monitor residents on the night shift. The census was 99. Review of the facility's Facility Assessment Tool, not dated showed: -Number of residents licensed to provide care for: 120; -Average daily census: 90; -Number (enter average or range) of persons admitted : -Weekday: ,d+[DATE]; -Weekend: ,d+[DATE]; -Number (enter average or range) of persons discharged : -Weekday: ,d+[DATE]; -Weekend: ,d+[DATE]; -Acuity: -Special treatments and conditions: number/average or range of residents: -Oxygen therapy: ,d+[DATE] -Suctioning (a device used to extract fluids/secretions such as saliva and mucus from body cavities): , d+[DATE]; -Tracheostomy care: ,d+[DATE]; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ventilator or respirator: 1; -IV medications: ,d+[DATE]; -Dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly): ,d+[DATE]; -Advanced wound care needs: ,d+[DATE] -Assistance with activities of daily living (ADL): -Transfer: -Independent: 14; -Assist of ,d+[DATE] staff: 49; -Dependent: 19; -Toilet use: -Independent: 8; -Assist of ,d+[DATE] staff: 52; -Dependent: 22; -Eating -Independent: 62 -Assist of ,d+[DATE] staff: 11; -Dependent on staff: 9; -Respiratory/Ventilator : -Not addressed -Licensed Nurses Licensed Practical Nurse (LPN), Registered Nurse (RN), based on the facility's budgeted staffing plan. Staff will be adjusted based on resident needs and the skill levels of available staff. -Director of Nursing (DON) RN full-time; -Days (7:00 A.M. to 7:00 P.M.) -LPN (Licensed Practical Nurse) Assistant Director of Nursing (ADON) (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4 LPN/RN Charge Nurses; -1 LPN Wound Care Nurse; -1 LPN MDS Nurse (Minimum Data Set, a federally mandated assessment completed by facility staff): -Nights (7:00 P.M. to 7:00 A.M.); Certified Nursing Assistant (CNA): -Days 1:15 residents; -Nights 1:18 residents; Other (e.g., Department Heads, Nurse Educator, Quality Assurance, Ancillary staff in maintenance, housekeeping, dietary and laundry); -Admissions Coordinator -Marketing Director -Social Services Director -Social Services Assistant - Medical Records Director -Activities Director -Director of Environmental Services -Business Office Manager -Dietary Supervisor -Director of Rehab -Central Supply -Housekeeping -Laundry -Dietary Aides -Cooks (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Individual staff assignment: Facility determines, and reviews individual staff assignments based on the acuity of current resident needs. The nurses and CNAs are generally assigned to the same area to promote consistency and continuity of care. Information provided by the facility on [DATE], showed the following: -80 residents were designated as full code; -29 residents had pressure ulcers (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction); -19 residents received tube feedings through a gastrostomy tube (g-tube, a tube inserted through the abdomen that brings nutrition directly to the stomach); -15 residents had a tracheotomy (tube surgically inserted into the trachea for the purpose of breathing) and required oxygen by way of a high humidity trach collar, (HHTC-a soft plastic mask that provides extra humidity to a tracheostomy by delivering humidified air or oxygen directly to the trach); -10 residents received dialysis (helps filter waste, excess fluid and toxins from the blood); -Six residents required intravenous (IV) antibiotics; -Two residents used a ventilator (machine used to assist with breathing); -Two residents used continuous positive airway pressure machine (CPAP, a machine that uses mild air pressure to keep breathing airways open while you sleep). 1. Review of Resident #35's care plan, revised on [DATE], showed: -Focus: Uses nasal Bilevel Positive Airway Pressure machine (BiPAP, a noninvasive machine that helps people breathe by delivering pressurized air into the airways through a mask or nasal canula (a device that delivers extra oxygen through a tube and into the nose)) while in bed during the night and sometimes during the day; -Goal: Absence of complications from the noninvasive mechanical ventilation; -Interventions: Observe for changes in the level of consciousness, assess respiratory rate, depth and [NAME], assess heart rate, blood pressure and breath sounds. Review of the resident's quarterly MDS, dated [DATE], showed: -Clear speech, understood, understands, clear comprehension; -Cognitively intact; -Behavior: Rejection of care: Behavior not exhibited; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Prognosis: Does the resident have a condition or chronic disease that may result in a life expectancy of less than six months: no; -No dyspnea (shortness of breath); -No specialized treatments including oxygen therapy and/or use of BiPAP. Review of the resident's physician's order sheets (POS) dated [DATE], showed; -Full code; -Continuous BiPap every shift. Review of the facility's Daily Assignment Sheet, dated [DATE], showed: -One nurse, and three CNAs scheduled for the night shift 7:00 P.M. through 7:00 A.M., on the 100 hall. Review of the Florissant Valley Fire Protection District (FVFPD) EMS run sheet, dated [DATE] at 1:01 A.M., showed: -EMS responded to the facility for a resident with ineffective breathing; -Found the resident lying in bed, unresponsive; -Staff was performing CPR (Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating); -The resident was nonverbal and was in respiratory arrest with a palatable pulse noted to his/her carotid (neck) and radial (wrist) region; -Staff was unable to report any notable history of the patient; -Implied consent was used to treat and transfer the resident. Review of the resident's progress notes showed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], at 1:40 A.M., this nurse responded to a phone call from 911 stating they were on their way to a resident calling and saying he/she can't breathe. The nurse immediately stopped what they were doing and found nursing personnel. The CNA from 200 hall went to check on the resident and the nurse went to find the resident's nurse which took about one minute. The nurse informed the 100 hall nurse, which was the resident's nurse, about the call. That nurse walked in the room while this nurse was walking back towards 200 hall getting coded status. This nurse was called to the resident's room by the other nurse, so he/she did not make it to check the code status. CNA noticed green dot near door which means full code. As he/she entered the room the resident was unresponsive and was pale/grey. The nurse checked carotid and radial pulse which was very faint. He/She did not start CPR. The nurse asked the CNAs to raise the bed and make it as flat as possible and he/she continued to assess the resident. He/She grabbed oxygen and placed it on the resident. As he/she was placing the oxygen EMS arrived and took over. This nurse provided EMS the face sheet and medication list; -On [DATE] at 3:29 A.M., writer made aware by staff that resident called 911 himself/herself due to difficulty breathing. The writer along with staff nurse entered the resident's room and found resident not responsive to verbal stimuli or sternal rub. Weak radial and carotid pulse were found. Staff applied oxygen from crash cart when paramedics arrived and transported resident to the emergency room (ER). Responsible party called, no answer, voice mail inbox full. Nurse Practitioner and nursing management made aware; -On [DATE] at 7:43 A.M., Late entry: Spoke with nurse, resident's vitals were not indicative of starting CPR. EMS arrived and did not see necessity to start CPR while in the building. EMS then transported the resident to the hospital. During an interview on [DATE] at 7:20 A.M., LPN X said, he/she was working the night the resident was sent to the hospital. EMS called the facility to report the resident had called 911 and they were in route to the facility. He/She was not working on the resident's hall. The agency nurse who was assigned to work the hall was outside in his/her car on break. The agency nurse came back inside after LPN X sent a CNA out to get him/her. LPN X was originally scheduled to work on the 100 hall, but the 200 hall nurse called in and he/she was pulled to the 100 hall. There was usually one nurse on each hall during the night shift. At times the 300 and 400 halls would have two nurses but that was rare. It was very difficult to care for ,d+[DATE] residents for 12 hours by yourself. The facility didn't have enough staff to adequately care for the number of residents they have. During an interview on [DATE] at 5:01 P.M. Paramedic I said the resident called 911 himself/herself. He/She reported his/her call light had been on an extended period of time and no staff would respond. He/She was having difficulty breathing. The resident sounded like he/she was in respiratory distress. An ambulance was immediately dispatched to the facility. In the meantime, EMS attempted to contact the facility and make them aware of what was going on. It took a long time for any staff to answer the phone and receive report. When EMS arrived at the facility the resident was lying in bed with his/her phone still on the bed. Staff were attempting CPR. The resident was transported to the nearest hospital. This particular facility did not have enough staff and not enough trained staff. EMS had been called to the facility 126 times in the past 90 days. Most of the time, staff were calling because they didn't know how to operate the equipment at the facility. Or, residents called because there was not enough staff to meet their basic care needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:00 A.M., CNA C said call bells should be answered timely. If a call light went off and he/she was with a resident, he/she would finish with that resident then go to the resident who was ringing. 3. Review of Resident #245's medical record, showed: -admitted to the facility on [DATE]; -Diagnoses included cerebral infarction (stroke), hemiplegia (muscle weakness or partial paralysis on one side of the body), acute respiratory failure (enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood), and dysphagia (difficulty swallowing), unspecified protein-calorie malnutrition; -Physician's order for NPO (nothing by mouth) diet; -Physician's order of Jevity 1.5 Cal (high protein and fiber supplement) for enteral feed (tube feeding, method of providing nutrition to patients who are unable to eat or swallow safely), 70 milliliters per hour (ml/hr), with 150 ml/hour of water every 4 hours. Review of the resident's care plan, revised on [DATE], showed: -Focus: has a g-tube and is at risk for enteral nutrition complications; -Goal: Will be able to tolerate enteral support without pulling at tube and causing trauma to nares (openings of the nose) or stoma (a small opening in the abdomen that is used to remove body waste (feces and urine) into a collection bag), no gastric distress, diarrhea, abdominal distention; -Interventions: Check for tube placement as ordered, notify Physician if unable to tolerate tube feeding, observe for abdominal distention, regurgitation, nausea, abdominal pain, diarrhea, congestion, change in level of consciousness (LOC), fever, and notify Physician of occurrence, observe for signs and symptoms of infection and report any findings to Physician. Observations on [DATE] at 7:04 A.M. and 10:49 A.M., showed the resident lay in bed. His/Her tube feeding pump was off. An empty 1000 ml bottle hung on the pole. The bottle was dated [DATE], at 4:00 P.M. During an interview on [DATE] at 11:02 A.M., LPN D said he/she was assigned to Hall 400 and there was supposed to be another nurse on Hall 300 where the resident resided. LPN D said the resident had an order of Jevity 1.5 Cal and was supposed to be a continuous infusion. He/She was not notified there was not a nurse on Hall 300 and was not aware the resident's tube feeding was not infusing. LPN D hung and started the tube feeding infusion as ordered at 11:15 A.M. During an interview on [DATE] 3:13 P.M., LPN F said tube feeding should be administered per physician's order. The staff were supposed to check the residents throughout the day to know if a new bag needed to be hung. He/She said the tube feeding pump beeped when the bottle was empty. LPN F added that there should be more staff on Halls 300 and 400 for the safety of the residents. He/She said there would only be one nurse at times. He/She said there were a lot of oversight, and the residents' care should be taken seriously, and the facility should provide sufficient and competent staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:49 P.M., CNA AA said Halls 300 and 400 were supposed to have two nurses on day shift but sometimes there was only one. He/She said it would be difficult for one nurse to work on those halls. 4. Review of Resident #20's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Always incontinent of bowel and bladder; -Diagnoses included: high blood pressure, diabetes, chronic lung disease, and hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) or hemiparesis (a slight weakness in a leg, arm, or face). Observations on [DATE] of the resident's call light, showed: -At 5:45 A.M. the call light was on; -At 5:58 A.M., the call light remained on. Staff walked down the same hall as the resident's room and went into another resident's room whose call light was not on; -At 6:13 A.M., the call remained on. During an interview at 6:15 A.M., the resident said he/she turned the call light on 30 minutes ago and no one had come to answer it. He/She put the call light on for staff to dry him/her. The resident said staff did not routinely come in and check on him/her during the night. The resident had to ring the call light if he/she needed anything. Observation on [DATE] of the resident's call light, showed: -At 6:25 A.M., the call light was on; -At 6:31 A.M., the call light was on; -At 6:42 A.M., the call light remained on, the nurse was at the nurse's station; -At 6:50 A.M., the call light was on; -At 6:55 A.M., call light remained on. During observation and interview on [DATE] at 7:03 A.M., LPN Q said he/she personally did not know why the light was on and said call lights should be answered expeditiously. Observation on [DATE] at 7:15 A.M., showed the resident's call light remained on. Observation and interview on [DATE] at 7:38 A.M., showed the call light remained on. The resident said staff had not come to check on him/her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN R: I'm at work, I keep going through the same things with the same aide, he/she left on break with multiple lights on and people needing to be changed; -DON: I hate you're (message cut off). Review of a text message sent from LPN R to the on-call phone, dated [DATE] at 2:03 A.M., showed: We have two aides that been gone and unable to be found since 12 tonight this is the second time this happened during a shift. During an interview on [DATE] at 3:09 P.M., the Administrator said he expected the facility to have sufficient staffing. The staff should not be sleeping during their shift. 8. During Resident Council interviews on [DATE] at 2:00 P.M., residents said the longest wait time for call lights was between four and six hours. One resident said he/she saw six staff walk past call lights. During an interview on [DATE] at 12:08 P.M., CNA L said he/she answered the call light within five to ten minutes. He/She said no one should pass a room with the call light on. All of the residents belong to all of the staff so anyone passing by can answer the call light. He/She turned the call light off in the resident's room while he/she was completing whatever the resident asked him/her to do. He/She said the call light should not be turned off before completing the task because staff may get distracted and forget what the resident wanted. During an interview on [DATE] at 12:13 P.M., CNA M said when the call lights go off, they are supposed to check the room to see what's going on. He/She said if a lot of call lights were going off, he/she worked them from most important, such as resident being wet, to getting water. Sometimes it could get hectic but he/she answered the call lights as fast as he/she could. He/She encouraged residents to use his/her call light instead of yelling out for help. He/She said the call light should not be turned off before the resident was helped and no one should tell a resident they would be back and not go back. CNA M said if he/she could help the resident right then, he/she would. During an interview on [DATE] at approximately 12:30 P.M., CMT N said the call lights should be answered within five minutes and all staff should make sure the resident had his/her call light in reach before leaving the room. CMT N said the call light should not be turned off before the resident's request had been completed because staff might forget what the resident needed. He/She said anyone could answer the call light and no one should walk past a room if the call light was on. 9. During interview on [DATE] at 10:32 P.M., the ADON said residents' call lights should be answered in timely manner. She said any staff can answer to call lights. Not answering a call lights for one to two hours was unacceptable. 10. During an interview on [DATE] 3:09 P.M., the Administrator said call he would expect for the facility to have sufficient staff and he would expect for call lights to be answered timely. MO00239413 MO00241263 (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00241307 MO00242176 MO00242993 MO00243224 MO00243620 MO00243010 MO00242979 MO00243149 42247 45083 46970

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 42247 Based on interview and record review, the facility failed to ensure their licensed staff were competent in their knowledge of the facility policy and procedures for how to provide tracheostomy (tube surgically inserted into the trachea for the purpose of breathing) care and suctioning to residents. In addition, the facility failed to train their licensed nursing staff on the use of the facility's continuous oxygen monitoring system, piped in oxygen system, and the wall suctioning equipment. This had the potential to affect the 15 residents at the facility who had a tracheostomy and required frequent suctioning and oxygen saturation monitoring. The facility census was 99. Review of the facility's Suction Policy, revised [DATE], showed: Purpose: The purpose of this procedure is to help prevent nosocomial (facility acquired) infections associated with suctioning and to prevent transmission of such infections to residents and staff; General Guidelines: -Wash hands before and after suctioning and before and after manipulating any respiratory therapy equipment. -Wear sterile gloves on both hands when performing care of a tracheostomy and during endotracheal (in the trachea/windpipe) suctioning of residents, whether through the oropharynx (throat), endotracheal tube or tracheostomy; -Suction machines must be available at the bedside of residents who require suctioning because they cannot clear nasal, oral and/or respiratory secretions by themselves and also at the bedside of all tracheostomy and ventilator residents; -When disconnecting ventilator residents from ventilator breathing circuits to provide suctioning, direct the mist from the ventilator away from the resident's and the employee's faces, to prevent conjunctivitis. -A portable suction machine filter must be inspected weekly and changed as necessary. -The policy did not address the facility's use of a [NAME] Closed Suction System (a closed-circuit method for tracheal suctioning that uses a catheter (tube) that can be reused) for residents with a tracheotomy. The facility should have a policy for each specific type of suction machine used in the facility. The facility did not provide any manufactures guidelines to any of their equipment. The facility did not have a policy and or procedure guide for the use of their continuous oxygen monitoring system. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not have a policy and or procedure guide for the use of piped in oxygen or suction system. During an interview on [DATE] at 12:55 P.M., Registered Respiratory Therapist (RRT) Z said the facility utilized a [NAME] closed suction system on the 200, 300, and 400 halls. Review of the [NAME] Closed Suction System for adults manufacturers guidelines, showed: The [NAME] Closed Suction System is a closed-circuit method for tracheal suctioning that uses a catheter that can be reused. Here are some steps for performing a [NAME] suction: -Prepare: Wash your hands, open the package, and remove all caps from the catheter. -Attach the catheter: Slide the catheter into the sleeve to the correct depth. -Suction: -Squeeze the thumb valve to create a vacuum; -Slowly remove the catheter while continuing to squeeze the thumb valve; -Do not leave the catheter in for more than 5 seconds; -Repeat until patient breathes easily or their lungs sound clear; -Slide the catheter in the sleeve to the color or number as you were told or measured. This is the suction depth. 1. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -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; -Cognitively intact; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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; -Respiratory Treatments: Oxygen therapy, suctioning, tracheostomy care, and non-invasive mechanical ventilator. Review of the resident's care plan, located in the electronic health record (EHR), showed: -Date Initiated [DATE] and Revised On [DATE]: -Focus: Requires an invasive mechanical ventilator and is at risk for respiratory distress; -Goal (revised on [DATE]): Secretions are mobilized and airway remains patent; -Interventions/Tasks: Assess tracheal tube, checking whether it is secure. Assess rate and quality of respiratory pattern. Assess vital signs. Call light in reach and answered promptly. Resident has a chronic ventilator and likes to hook himself/herself up to the ventilator (vent) nightly. It has been determined that the resident is not safe to take him/herself off of the vent although he/she continues to take his/her vent off at his/her own will. Resident has been educated that doing this puts him/her at harm for respiratory failure. Monitor oxygen saturation. Observation on [DATE] at 6:38 A.M., showed an unknown certified nursing assistant (CNA) alerted Licensed Practical Nurse (LPN) BB the resident needed to be suctioned. The LPN entered the resident's room and attempted to suction the resident. The resident told LPN BB he/she was not doing it correctly. LPN BB continued to attempt to suction the resident, but said he/she did not know what he/she was doing wrong. At 6:40 A.M. RRT Z entered the room and began to provide the needed suctioning. RRT Z said the resident's electronic oxygen saturation machine had been turned off when he/she entered the room with LPN BB. During an interview on [DATE] at 6:35 A.M., LPN BB said he/she learned tracheostomy care in nursing school, but did not have any experience at this facility. He/She was not provided any training or information specific to the facility's equipment and or policies and procedures. There were no training materials at the nurse's station. When he/she accepted the assignment to the facility he/she was not informed he/she would be responsible for ,d+[DATE] residents with a tracheostomy or residents on ventilators. He/She thought the monitoring board at the nurse's station and on the hallways was the facility's call light system. He/She was not given report about the residents when he/she arrived at the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on [DATE] at 7:15 A.M., and on [DATE] at 7:08 A.M., 8:15 A.M. and 11:15 A.M., RRT Z said he/she assisted to suction the resident (on [DATE]). The facility used a continuous oxygen monitoring system for residents with a tracheotomy. The monitoring system alerted with an alarm if something was wrong and it could not read a resident's oxygen level. He/She did not know who was responsible for maintaining the equipment and making sure it was in working order. Staff that were working should assess the equipment on a daily basis. Staff should ensure equipment was plugged in and working, sensors were intact and in place on the residents. The respiratory therapy staff had not inserviced the nurses at the facility on the use of the facility's specific equipment and policies. He/She was not aware of any competency training provided to nursing staff prior to working with residents who had a tracheostomy. During an interview on [DATE] at 11:20 A.M., the resident said he/she almost died this morning. The LPN did not know what he/she was doing. He/She was using the wrong tubing to try and suction the resident's trach. Residents called 911 themselves because staff were not trained how to deal with tracheostomy residents and ventilators. During an interview on [DATE] at 7:58 A.M., RRT EE said the facility had approximately 12 to 15 residents with a tracheostomy. All of the residents with a tracheostomy used the piped in wall oxygen and suctioning equipment. All RRT staff worked the day shift, (7:00 A.M. to 7:00 P.M.). The facility was in the process of training nursing staff on the facility's equipment and policies. During an interview on [DATE] at 12:25 P.M., Registered Nurse (RN) W said the facility staff were not trained on the facility's specific oxygen system, suctioning system or continuous oxygen monitoring system. The facility did not have enough trained staff to care for the amount of residents with a tracheostomy and or residents that require a ventilator. The facility did not have any respiratory therapists that worked on the evening/night shift and/or weekends and holidays. The continuous oxygen monitoring system malfunctioned all the time. At times the machine would alarm in a resident's room, but not at the nurse's station and/or on the monitoring screens in the hallways. Only the respiratory therapy department knew how to set and maintain the ventilators on the hallways. During interviews on [DATE] and [DATE] at 3:00 P.M. and 7:00 A.M., RN T said on the 7:00 P.M. to 7:00 A. M. shift, he/she is the only nurse working on the ,d+[DATE] hall. Respiratory therapists did not work after 5:00 P.M. He/she didn't know what the monitor screen at the nurses' station or on the hallways was used for. He/she knew how to do tracheostomy care. The facility did not provide any training regarding their policies on tracheostomy care or the how to use the equipment the facility utilizes. During an interview on [DATE] at 6:29 A.M., LPN GG said he/she had not been provided any additional training or inservicing on the specific equipment the facility used. When the facility asked agency staff to come to the facility, they asked if the nurse had any experience with tracheostomy care. During an interview on [DATE] at 11:10 A.M., the Administrator said the facility had hired some new respiratory therapists. He was hoping they could get them to stagger their shifts, so at least someone would be in the facility until 11:00 P.M. Facility nurses and agency nurses were not provided additional training for tracheostomy care. Staff were not provided competency education. Nurses should know how to provide tracheostomy care and ventilator care because, they are nurses. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:40 P.M., the facility's Medical Director said she thought the facility had a respiratory therapist on duty 24 hours a day, 7 days a week. She was unaware respiratory therapy staff were not in the facility on the evening/night shift. The facility should only put fully trained and competent nurses on the respiratory hall. Staff should be inserviced on the facility's policies and procedures prior to working. MO00241263 MO00242176 MO00242776 MO00242834 MO00242862 MO00242993 MO00242979 45083

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42247 Based on interview and record review, the facility failed to establish a system of record for all controlled drugs (drug or chemical that is regulated by the government in terms of its manufacture, possession, and use) with sufficient detail to enable an accurate reconciliation for two out of three medication carts reviewed. This had the potential to affect all residents with controlled substance orders. The census was 99. Review of the facility's Controlled Substances Policy, dated November 2022, showed: -The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. Review of the facility's Controlled Substance Shift Change Count-Check Sheet, dated 10/1/24 through 10/14/24, showed: -On the 100 hall: Oncoming shift, six out of 28 opportunities were blank and off going shift, nine out of 28 opportunities were blank; -On the 300-400 hall: Oncoming shift, three out of 28 opportunities were blank and off going shift, five out of 28 opportunities were blank. During an interview on 10/14/24 at approximately 10:30 A.M., Licensed Practical Nurse (LPN) F said controlled substances should be counted every shift. The oncoming nurse counts with the off going nurse. The number of packages is counted along with the number of pills. If the count was correct, both staff members sign the controlled substance shift count sheet (log). If there was a blank on the log, it would mean someone forgot to sign because the nurses are counting controlled substances and doing report at the same time. During an interview on 10/14/24 at 11:00 A.M., LPN H said the number of packages and the number of pills is counted with the oncoming staff and the off going staff every shift. If the count was correct, both staff members sign the log. If there was a blank on the log, that would mean the nurse did not sign the log. He/She did not know why someone would not sign the log. During an interview on 10/17/24 at 10:10 A.M., LPN NN said the oncoming and off going nurse count the controlled substances. If the count was correct, they both would sign on the log. If the log was not signed, that would mean the nurse did not sign. If the log was not signed, you would not know if they did the count or not. During an interview on 10/16/24 at 2:33 P.M., the Director of Nursing said controlled substances should be counted with two nurses, the on coming and the off going, every shift and documented in the controlled substance binder. If there was a hole on the control log, that would mean the nurse was not doing their job. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/24 at 3:08 P.M., the Administrator said he expected staff to follow the facility's policies and procedures.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to ensure the monthly drug regimen review (DRR) recommendations were followed timely. The requirements associated with the medication regimen review (MRR) apply to all residents, whether short or long stay. The facility failed to complete the timelines and responsibilities for the MRR by the consultant pharmacist when they failed to address MRR irregularities for two residents investigated for the MRR (Residents #48 and #14). The facility census was 99. Review of the facility's Pharmacy Services Role of the Consultant Pharmacist, dated 2001, showed: -The consultant pharmacist will provide specific activities related to medication regimen review including: -A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; -Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated; -Provident the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. 1. Review of Resident # 48's Annual Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 6/29/24, showed moderate cognitive impairment, depression, and bipolar disorder (mental health disorder characterized by manic highs and depressed lows). Review of the resident's physician order sheet, showed: -Advair Diskus Aerosol Powder Breath Activated 250-50 micrograms (mcg)/Dose (Fluticasone-Salmeterol, used to treat lung disease) Give 1 puff by mouth two times daily; -Carvedilol (treats high blood pressure) 3.125 milligram (mg). Give 1 tablet by mouth two times a day. Review of the resident's Consultant Pharmacist's MRR, dated 7/10/24, showed: -Category: Medication administration recommendation; -Routing: Nursing; -Recommendation: ***Resending from May 2024; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Please add the following instructions to Advair Diskus inhaler: Rinse mouth with water after use and spit to reduce risk of oral candidiasis (yeast infection). Review of the resident's physician order sheet, reviewed on 10/1/24, showed no new physician order related to Advair Diskus inhaler instructions and/or the pharmacy recommendation dated 7/10/24. Review of the pharmacist Note to Attending Physician/Prescriber, dated 12/12/23, showed: -This resident has orders for the following medications: Carvedilol 3.125 mg by mouth twice daily. This medication is recommended to be taken with food to slow absorption to prevent sudden changes in blood pressure. As a fall precaution, please consider add to the order to take this medication with food/with morning and evening meals; -Physician/Prescriber Response: -Agree - Accept the recommendation(s) above, please write a new order to implement. Review of the resident's physician order sheet, reviewed on 10/21/24, showed no new physician order instructions added related the pharmacy recommendation, dated 12/12/23. 2. Review of Resident #14's Annual MDS, dated [DATE], showed moderate cognitive impairment, thyroid disorder, and anxiety disorder. Review of the resident's physician order sheet, showed: -Levothyroxine Sodium (used to treat thyroid disorder) 75 mcg. Give 1 tablet by mouth in the morning; -Atorvastatin Calcium (used to treat high cholesterol) 40 mg. Give 1 tablet by mouth at bedtime. Review of the pharmacist Note to Attending Physician/Prescriber, dated 9/10/24, showed: -MRR; -Please consider ordering the following labs for this resident: -TSH (Thyroid-stimulating hormone, blood test measures the amount of thyroid-stimulating hormone in your blood) and FLP (Fasting Lipid Panel, a blood test that measures the levels of cholesterol and other fats in your blood after fasting for about 12 hours) now and at least once yearly to evaluate current levothyroxine and atorvastatin therapy; -Physician/Prescriber Response: -Agree, order labs. Review of the resident's progress note, reviewed on 10/21/24, showed no new orders and/or documentation related to the MRR recommendations of TSH or FLP blood test. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 10/21/24 at 3:18 P.M., the Administrator said he expected the pharmacy recommendations to be followed and/or there to be documentation with rationale for not following the recommendation(s) in the residents' medical records.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on interview and record review, the facility failed to follow through with the pharmacist's recommendations regarding gradual dose reductions and documentation of behavior monitoring, side effects and related diagnoses for the use of the antipsychotic medications, for two residents (Resident #48 and #68). The sample was 33. The census was 99. Review of the facility's Pharmacy Services Role of the Consultant Pharmacist, dated 2001, showed: -The consultant pharmacist will provide specific activities related to medication regimen review including: -A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; -Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated; -Provides the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. Review of the facility's Administering Medications policy, dated 2001, showed: -As required or indicated for a medication, the individual administering the medication records in the resident's medical record: -Any complaints or symptoms for which the drug is administered. 1. Review of Resident #48's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/29/24, showed moderate cognitive impairment, depression, and bipolar disorder (a disorder associated with mood swings from depressive lows to manic highs). Review of the resident's Consultant Pharmacist's Medication Regimen Review (MRR), dated 8/9/24, showed: -Recommendation: This resident has an order for the following antipsychotic medications: Haldol (antipsychotic) and Seroquel (atypical antipsychotic drug used to treat depression and bipolar disorder); -An Abnormal Involuntary Movement Scale (AIMS) assessment is recommended to be performed every three months due to the risk of side effects associated with long-term use of antipsychotic. Please perform an AIMS assessment now and quarterly and place in the resident's chart; (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Recommendation: Annual Gradual Dose Reduction (GDR) review documentation; -This resident has orders for the following psychotropic medications: -Prozac (anti-depressant) 20 mg (milligram) QD (once a day); -Order date: 6/25/23; -Seroquel (Quetiapine Fumarate), 50 mg HS (hours of sleep); -Order date: 6/24/23; -Haldol Decanoate (also known as haloperidol) inject 75 mg IM (intramuscular) Q (each or every) 28 days; -Order date: 9/22/23; -Guidelines require all residents residing in long-term care facility have a GDR attempted at least twice in the first year of admittance and then annually thereafter, unless does reduction is clinically contraindicated. This recommendation is a reminder to conduct an evaluation in an attempt to establish the lowest effective dose with the fewest number of medications through period reduction and/or discontinuation, and does not necessarily reflect my clinical judgement or opinion regarding the discontinuation or reduction; -Please evaluate the current dose and consider a GDR to ensure this resident is using the lowest possible effective/optimal dose; -Condition stable. Attempt dose reduction of one agent New Order - no documented response; -Or the following are acceptable clinical contraindications (check if applicable) -Residents symptoms returned or worsened after the most recent GDR attempt - no documented response; -Attempted GDR would likely impair the resident's function - no documented response; -GDR would cause psychiatric instability by exacerbating underlying psychiatric disorder - no documented response; -Other (please document) - no documented response. Review of the resident's physician orders, start date 10/7/24, showed anti-depressant medication: Prozac; -Side effects: Common- sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia (rapid heart rate), muscle tremor, agitation, headache, skin rash, photosensitivity (skin), excessive weight gain. Special attention for heart disease, glaucoma (eye nerve disease), chronic constipation, seizure disorder, edema (swelling). Monitor; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Directions: Every shift document; -Antipsychotic medication: Haldol and Seroquel; -Side effects: Common- sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal (involuntary movements) reaction, weight gain, edema postural hypotension (low blood pressure), sweating, loss of appetite, urinary retention. Nursing alert: Tardive dyskinesia (movement disorder caused by certain medications), seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice (yellow skin caused by liver disorders). Monitor; -Directions: Every shift document; Review of the resident's Consultant Pharmacist's MRR, dated 10/9/24, showed: -Documentation/Charting issues. As this resident receives psychotropic therapy, please ensure that behavior monitoring, and side effect monitoring is routinely done by staff. Be sure to associate the drug with the behavior that is being monitored; -Resident is on the following psychotropic medications: Prozac, Haldol, Seroquel. Review of the resident's care plan in use at the time of the investigation, showed: -No documentation related to psychotropic therapy, behavior monitoring, or side effect monitoring as recommended by MRR; -No documentation of pharmacy recommended GDR, dated 8/9/24, related to psychotropic medications (Prozac, Seroquel, Haldol Decanoate injection). Review of the resident's October 2024 medication administration record, dated 10/17/24 at 7 P.M., showed anti-depressant medication: Prozac; -Side effects: Common- sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity (skin), excessive weight gain. Special attention for heart disease, glaucoma, chronic constipation, seizure disorder, edema. -Monitor every shift. Document (+) if side effects present and with progress note, (-) side effects not present; -No documentation of (+) or (-) on 10/17/24 from 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/18/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/19/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/20/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M. Review of the resident's October 2024 medication administration record, dated 10/17/24 at 7:00 P.M., showed antipsychotic medication Haldol and Seroquel (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Side effects: Common- sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction, weight gain, edema postural hypotension, sweating, loss of appetite, urinary retention. Nursing alert: Tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice. -Monitor every shift. Document (+) if side effects present and with progress note, (-) side effects not present; -No documentation of (+) or (-) on 10/17/24 from 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/18/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/19/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M.; -No documentation of (+) or (-) on 10/20/24 from 7 A.M. to 7 P.M. or 7 P.M. to 7 A.M. Review of the resident's medication administration record (MAR): Psychotropic MAR (Behavior and Side Effect (SE) monitoring only), dated 10/1/24 thru 10/31/24, showed no documentation of side effects related to anti-depressant and/or antipsychotic medication. 2. Review of Resident #68's admission MDS, dated [DATE], showed: -Adequate hearing and vision; -Unclear speech, makes self understood and understands; -No behavioral symptoms; -Diagnoses included heart failure, high blood pressure, asthma, respiratory failure; -Neurological (affects the brain) or psychiatric (mental, emotional, and behavioral) disorders not marked. Review of the resident's Admission Record sheet, showed: -Initial admitted [DATE]; -Diagnosis of cognitive communication deficit (difficulty with communication that's caused by a disruption in cognitive processes). Review of the resident's electronic care plan, revised 8/16/23, showed: -Focus: The resident at risk for psychosocial well-being concerns related to anxiety; -Goal: Will increase social involvement and report decreased feelings of loneliness, will have psychosocial needs met; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions/Tasks: Encourage family and friends to maintain contact through alternative means during visitor restrictions, encourage friends and family to visit, report as needed for any signs and symptoms of decline in social well-being. Review of the resident's electronic Physician's Order, with start date of 8/24/24, showed Quetiapine Fumarate (Seroquel, can treat schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), bipolar disorder), oral tablet 25 mg two times a day for anxiety. Review of the resident's MRR, dated 9/9/24 and 10/11/24, showed: -Medication: Quetiapine 25 mg BID (twice a day) for anxiety; -Recommendation: Requiring clarification and addition appropriate diagnosis supporting antipsychotic use. -No documentation showed the recommendation was acted upon. Review of the resident's electronic MAR, dated 10/1/24 through 10/10/24, showed Quetiapine 25 mg was administered two times daily. During an interview on 10/18/24 at 9:22 A.M., the Administrator said the resident's pharmacy recommendations were not reviewed by the physician, and he expected staff to have the recommendations reviewed or addressed, and signed by the physician. 3. During an interview on 10/21/24 at 3:18 P.M., the Administrator said he expected the pharmacy recommendations to be followed or acted upon, and to have documentation with rationale for not following the recommendations. 46970

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 42247 Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors when staff failed to administer medications per physician orders for three residents (Residents #246, #47 and #195). The sample was 33. The census was 99. Review of the facility's Administering Medications Policy, dated revision April 2019, showed: -Policy statement: medications are administered in a safe and timely manner, and as prescribed; -Medications are administered in accordance with prescriber orders, including any required time frame; -If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record (MAR) space provided for that drug and dose; -The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones; -As required or indicated for a medication, the individual administering the medication records in the resident's medical record: -The date and time the medication was administered; -The signature and title of the person administering the drug; -The policy failed to show staff what to do if a medication was unavailable. Review of the facility's Adverse Consequences and Medication Errors Policy, dated February 2023, showed: - A medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services; - Examples of medications errors include omission - a drug is ordered but not administered; -A significant medication-related error is defined as: -Requiring medication discontinuation or dose modification that should not be abruptly discontinued; -Requiring treatment with a prescription medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Med Bank Inventory List (e-kit, automated medication dispensing system), undated showed the following medications was available: -Bupropion (antidepressant) 75 milligrams (mg); -Clopidogrel (Plavix, blood thinner) 75 mg; -Nifedipine ER (Procardia, used to treat high blood pressure) 300 mg; -Carvedilol (used to treat high blood pressure) 6.25 mg; -The list did not show how many of each medication was available. 1. Review of Resident #246's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 9/10/24, showed: -Cognitively intact; -Diagnoses included: chronic respiratory failure with hypoxia (too little oxygen and too much carbon dioxide in the blood for a long time); morbid (severe) obesity due to excessive calorie; obstructive sleep apnea (OSA, sleep disorder that causes shallow breathing or pauses in breathing during sleep). Observation and interview on 10/11/24 at 8:05 A.M., showed Licensed Practical Nurse (LPN) RR prepared the residents medications. The medication Modafinil was not administered. The nurse said the medication was unavailable, he/she had to call the pharmacy. The nurse believed the pharmacy was waiting on a prescription and a Prior Authorization (PA, a health plan cost-control process by which physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage) and the physician also need to be called, regarding the PA. The nurse said the resident had not had the medication since he/she had been at the facility. Review of the MAR, dated 8/1/24 through 8/31/24, showed: -An order for: Modafinil tablet 100 mg, give 1 tablet by mouth two times a day for sleep apnea (a sleep disorder that causes people to stop breathing or to breathe shallowly while they sleep), start date was 8/29/24 and discontinue date was 8/29/24; -Documentation showed: at 8:00 A.M., an eight (nauseated or resident preference) was documented; -An order for: Modafinil tablet 100 mg, give 1 tablet by mouth two times a day for OSA start date was 8/29/24: -Documentation showed: At 8:00 A.M., on 8/30 and 8/31/24 a 9 (other: see nurse notes or sleeping) was documented; -Documentation showed at 8:00 P.M. on 8/29/24 a 5 (absent from facility without meds or hold/see nurse notes) was documented; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/30 and 8/31/24 a 9 was documented. Review of the progress notes dated 8/29/24 through 8/31/24, showed: -On 8/29/24 at 12:09 A.M., This order is outside of the recommended dose or frequency. Modafinil tablet 100 mg, give 1 tablet by mouth two times a day for sleep apnea. The frequency of two times per day exceeds the usual frequency of daily; -There was no documentation showing the physician was notified Modafinil was not administered, or the frequency exceeded the usual frequency. During an interview on 10/16/24 at 4:20 P.M., Pharmacist SS said Modafinil and Ozempic were not covered by the resident's insurance. Both medications needed a PA. The pharmacy notified the facility by fax or messaging system 14 times over a 3-month span for the Modafinil and four times for the Ozempic. The medications were never filled, and neither medication was available in the facility's e-kit. Review of the MAR, dated 9/1/24 through 9/30/24, showed: -An order for: Ozempic (1 mg/dose) injects 1 mg subcutaneously (under the skin) in the morning every Wednesday for diabetes, state date was 9/4/24: -Documentation showed: On 9/4, 9/11, 9/18 and 9/25 a 9 was documented; -An order for: Modafinil tablet 100 mg, give 1 tablet by mouth two times a day for OSA: -Documentation showed at 8:00 A.M., -On 9/1, 9/4, 9/6 through 9/13, 9/17, 9/20 through 9/24, 9/26 and 9/30 a 9 was documented; -On 9/2, 9/3, 9/14, 9/15, 9/18, 9/19, 9/28 and 9/29 was documented as administrated; -On 9/5 a 2 (drug refused) was documented; -On 9/27 was blank; -Documentation showed at 8:00 P.M., -On 9/1, 9/2, 9/4 through 9/12, 9/14 through 9/17, 9/20, 9/23, 9/25 and 9/30 a 9 was documented; -On 9/3, 9/18, 9/19, 9/21 and 9/22, 9/24, 9/26 through 9/29 was administrated. Review of the progress notes dated 9/1/24 through 9/30/24, showed: -On 9/9/24 at 11:19 A.M., physician progress note, OSA/Chronic Obstructive Pulmonary Disease (COPD, chronic lung disease) modafinil daily, obesity continue Ozempic; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/23/24 at 8:06 A.M., physician progress note, OSA/Chronic Obstructive Pulmonary Disease (COPD, chronic lung disease) modafinil daily, obesity continue Ozempic; -There was no documentation showing the resident refused his/her medications nor was there documentation showing the physician was aware the medications were not administered, or the medications required a PA. Review of the MAR, dated 10/1/24 through 10/11/24, showed: -An order for: Ozempic (1 mg/dose)-inject 1 mg subcutaneously in the morning every Wednesday for diabetes: -Documentation showed: On 10/2 was blank and on 10/9 a nine was documented; -An order for: Modafinil tablet 100 mg, give 1 tablet by mouth two times a day for OSA: -Documentation showed at 8:00 A.M., -On 10/1, 10/4, 10/5, 10/9 and 10/11 a 9 was documented; -On 10/2, 10/3, 10/6 through 10/8 and 10/10 was documented as administered; -Documentation showed at 8:00 P.M., -On 10/1, 10/2, 10/5, 10/6, 10/8 through 10/10 a 9 was documented; -On 10/3, 10/4, 10/7 was documented as administered. Review of the progress notes dated 10/1/24 through 10/11/24 showed there was no documentation showing the resident refused the medications, the MD was notified the resident did not receive his/her medications or the facility was waiting on a PA. During an interview on 10/17/24 at 5:03 P.M. Registered Nurse (RN) W said if a medication was not available, he/she would look to see if the medication was available in the e-kit, notify the physician to see what they wanted to do, call the resident representative and document it. The physician should be notified if one dose of medication was missed. The pharmacy would fax the facility if a PA was needed. The Director of Nursing (DON) handled the PA. He/She did not have full access to the messaging system and he/she did not recall seeing a PA for resident's Ozempic or Modafinil and he/she did not recall if the resident received these medications. 2. Review of Resident #47's quarterly MDS dated [DATE], showed: -Moderate cognitively impairment; -No behaviors or refusal of care; -Diagnoses included: diabetes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR, dated 9/1/24 through 9/30/24, showed: -An order for: Ozempic (0.25 or 0.5 mg/dose) inject 0.5 mg subcutaneously one time a day every Friday for diabetes; -Documentation showed: on 9/13/24 a 9 was documented and on 9/ 27/24 it was blank. Review of the progress notes dated 9/13/24 through 9/27/24, showed no documentation showing why the medication was not administered and no documentation showing the physician was made aware the medication was not administered. During an interview on 10/17/24 at 1:45 P.M., Pharmacist TT said the pharmacy sent out one box of Ozempic on 9/13/24. 3. Review of Resident #195's medical record, showed: -admitted on [DATE]; -Alert and oriented to person, place, time and situation; -Diagnoses included: transient ischemic attack (TIA, also known as a mini stroke, a brief episode of reduced blood flow to the brain that causes stroke-like symptoms); high blood pressure, bipolar (a mental illness that causes extreme mood swings, or shifts in mood energy and activity levels) and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Review of the MAR, dated 10/1/24 through 10/10/24, showed: -An order for bupropion extended release 24-hour 300 mg tablet, give one time a day for depression: -Documentation showed: on 10/1, and 10/4/24 a 9 was documented; -An order for: folic acid 1 mg, give one time a day for supplement: -Documentation showed: 10/2 through 10/5/24 was blank; -An order for: Plavix 75 mg, give one time a day for anticoagulant (blood thinner): -Documentation showed: On 10/1, 10/3, 10/4/24 a 9 was documented; -An order for: Procardia XL Extended Release 24-hour 90 mg tablet, give one time daily related to hypertension (high blood pressure). -Documentation showed: 10/2 through 10/5/24 was blank; -An order for Zyprexa 2.5 mg gives one time a day related to bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior, and sleep); -Documentation showed: 10/2 through 10/5/24 was blank; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order for: carvedilol 25 mg, give one twice a day related to hypertension; -Documentation showed at 8:00 A.M.,10/2 through 10/5/24 was blank and at 5:00 P.M., 10/1 through 10/5/24 was blank. During an interview on 10/16/24 at 4:20 P.M., Pharmacist SS said the pharmacy sent bupropion, folic acid, Procardia and Zyprexa to the facility on [DATE]. 4. During an interview on 10/17/24 at 3:00 P.M., Certified Medication Technician (CMT) I said if a medication was not available he/she would look in the medical record to see if the medication was reordered. If it needed to be ordered he/she would do it, plus he/she would report it to the nurse and document see progress note and he/she would tell the resident the medication was reordered. 5. During an interview on 10/16/24 at 9:55 A.M., LPN H said if a medication was unavailable, he/she would reorder the medication from the pharmacy. He/She would follow up with the pharmacy. Also, he/she would notify the physician and document it on the MAR. The MAR will automatically generate a progress note. 6. During an interview on 10/21/24 at 10:32 A.M. the Assistant Director of Nursing (ADON) said if a medication was not available, she would expect for staff to check to see if the medication was available in the e-kit and for staff to use the key code on the MAR to document if the medication was not administered. If a MAR code showed See progress notes she would expect a corresponding progress note to document why the medication was not administered. She would expect there to be a progress note if the medication was not administered. The physician needed to be notified if three doses of the medication were missed. If a medication required a PA, the facility would be notified when the pharmacy delivered the routine medications to the facility. The ADON was not aware of a messaging service the pharmacy used. If there was a blank on the MAR that meant either the medication was missed, not given or the medication was not signed out. The ADON would expect staff to administer medications appropriately and she would have expected staff to follow up on the Ozempic and modafinil. 7. During an interview on 10/21/24 at 3:09 A.M., the Administrator said he would expect for staff to administer medications per physician orders. If a medication was not available or if a medication needed a PA, he would expect for staff to notify the physician. If there was a blank on the MAR it meant the medication was not given. If the MAR code showed See progress notes, he would expect a corresponding note. MO00242993 MO00237547 MO00242546 MO00241307

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42247 Based on observation, interview and record review, the facility failed to label and store medications according to acceptable standards of practice, when staff failed to lock the medication carts on one hall, date medications when opened, failed to store an unopened insulin pen in the refrigerator, and date an opened vial of a purified protein derivative (PPD, used to diagnose tuberculosis (TB) infection). For three of three medication carts reviewed and one of two medication storage rooms reviewed. The facility identified six medication/treatment carts and three medication rooms. The census was 99. Review of the facility's Medication Labeling and Storage Policy, dated 2001, showed: -Policy statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys; -Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location; -Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial, -The policy failed to show if and when medications should be dated. Review of the facility's Security of Medication Cart, dated April 2007, showed medication carts must be securely locked at all times when out of the nurse's view. 1. Observation on 10/10/24, of the 100 hall medication carts, showed: -At 5:45 A.M., one medication cart located across from the nurse's station, unlocked. There was no staff at the nurse's station or in view of the cart; -At 5:47 A.M., Licensed Practical Nurse (LPN) Q stood at the medication cart; -At 5:53 A.M., LPN Q walked away from the medication cart, leaving the cart unlocked. The second medication cart located in the hall in front of the common area, unlocked and not in view of staff; -At 5:55 A.M., LPN Q returned to second medication cart; -At 5:57 A.M., LPN Q walked away from the second medication cart, the lock on the medication cart partially pushed in; -At 5:58 A.M., LPN Q returned to the second medication cart and unlocked the cart by pulling the lock out (no key used), the first medication cart remains unlocked and unsupervised; (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 6:02 A.M., LPN Q returned to the second medication cart and unlocked it by pulling the lock out (no key used); -At 6:25 A.M., both medication carts were unlocked, no staff present at the nurse's station or in view of the carts; -At 6:31 A.M., staff locked the second medication cart, the first medication remained was unlocked. During an interview on 10/16/24 at 9:55 A.M., LPN H said when the medication cart was not in use the medication cart should be locked. During an interview on 10/17/24 at 10:10 A.M., LPN NN said the medication cart should be locked when it is not in use. 2. Review of the package insert for Novolog insulin (short acting) recommended storage, showed store unused Novolog in a refrigerator between 36 Fahrenheit (F) to 46 F. Review of the insulin lispro pen (short acting insulin) manufacturers instructions for use, showed: -In-use Pen: Store the Pen you are currently using at room temperature. Keep away from heat and light; -Throw away the Insulin Lispro Pen you are using after 28 days, even if it still has insulin left in it. Observation on 10/14/24 at 9:55 A.M., the 200 hall nurse's cart, showed: -One Novolog insulin pen stored on the medication cart that was unopened; -One insulin Lispro pen opened and undated. During an interview on 10/14/24 at 9:55 A.M., LPN E said unopened insulin pens should be stored in the refrigerator until they are opened. The insulin lispro was started the end of last month or it was started on the first of this month. 3. Review of the Food and Drug Administration (FDA) website, showed purified protein derivative (PPD) solution should be discarded 30 days after opening or if the solution becomes cloudy. Observation on 10/14/24 at approximately 10:30 A.M., of the 300-400 hall medication room, showed one vial of a PPD, opened and undated. During an interview on 10/14/24 at approximately 10:30 A.M., LPN F said the PPD was opened 10/5/24. Observation at this time showed LPN F wrote the date of 10/5/24 on the PPD solution at this time. 4. During an interview on 10/16/24 at 9:55 A.M., LPN H said injectable medications should be dated when they are opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 10/16/24 at 2:33 P.M., the Director of Nursing (DON) said the medication cart should be locked when it is stored. Insulin and PPD solution should be dated when opened. Insulin should be discarded after 28 days for all insulins. Unopened insulin should be stored in the refrigerator. 6. During an interview on 10/21/24 at 3:09 P.M., the Administrator said the medication cart should be locked when not in use. Injectables should be dated when opened and unopened insulin should be stored in the refrigerator.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 42247 Based on interview and record review, the facility failed to have a complete and thorough facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. The facility assessment did not address complete staffing needs to include respiratory therapists, restorative therapy, social services, and dietary service staff. In addition, the facility assessment failed to address staff competencies to meet the needs of residents. The census was 99. Review of the facility's undated Facility Assessment, showed: -No names and/or titles of staff involved in completing assessment; -Average daily census: 90; -Special treatments and conditions: -Oxygen therapy: 14-20 on average; -Suctioning: 7-10 on average; -Tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing) care: 7-10 on average; -Ventilator (provides mechanical ventilation/breathing) or respirator (an apparatus used to induce artificial respiration): 1; -Bilevel positive airway pressure (BIPAP, non-invasive breathing device that helps people breath)/continuous positive airway pressure(CPAP, a machine that delivers positive airway pressure to aide in breathing): 5-8 average; -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 (Certified Nurse's Aides) to residents: 1:15 ratio on days, and 1:18 on nights; -Residents independent for dressing 7, bathing: 5, transfers: 14, eating: 62, toileting: 8; -Residents requiring assist of 1-2 staff for dressing 52, bathing: 58, transfers: 49, eating:11, toileting: 52; -Residents dependent for: Dressing: 23, bathing: 19, transfers: 19, eating: 9, toileting: 15; -No documentation of ratios of direct care staff, for tracheostomy care, restorative therapy staff, Social Services staff, dietary staff, housekeeping and laundry staff necessary on each shift to ensure the needs of residents are met; (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation of the need for a Registered Respiratory Therapist, or the need for respiratory therapy 24 hours a day, seven days a week; -No information regarding staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. During the course of the survey process, problems were identified which included: -Insufficient nursing staff available to meet the needs of residents, as evidenced by staff interviews, residents with missed treatments, and residents with inappropriate tracheostomy care; -Respiratory therapy was not scheduled 24 hours a day, seven days a week. During an interview on 10/21/24 at 2:27 P.M., the Administrator said the facility assessment is developed by the Administrator and reviewed by the facility's Regional office and facility's interdisciplinary team. The facility assessment is updated annually unless needed otherwise. He expects the facility assessment to accurately reflect the facility's general staffing needs, including staff ratios. The facility assessment should include all of the facility's resources as they pertain resident care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to follow acceptable infection control standards when staff failed to perform hand hygiene between glove changes and failed to wear appropriate personnel protective equipment (PPE) for four residents (Residents #243, #82, #73 and #52) who required Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs, bacteria or fungi resistant to multiple antimicrobials (an agent that kills microorganisms or stops their growth)); that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS). In addition, the facility failed to assure a resident's Foley catheter (or indwelling catheter, a thin and hollow tube that's inserted into the bladder to drain urine) bag was off the floor for one resident (Resident #244). The sample was 33. The census was 99. Review of the facility's Enhanced Barrier Precautions Policy, dated 2001, showed: -Policy statement: enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents; -Gloves and gown are applied prior to performing the high contact resident care activity; -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: -Dressing; -Bathing/showering; -Transferring; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of [NAME] colonization; -Wounds generally include chronic wounds (wound that doesn't heal; heal slowly or heals but tends to recur); -Indwelling medical devices include urinary catheters (a sterile tube inserted into the bladder through the urinary tract to drain urine) and feeding tubes. Review of the EBP sign, undated, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Everyone must: clean their hand including before entering and before leaving the room; -Providers and staff must wear gown and gloves for the following high contact resident care activities: -Dressing; -Transferring; -Changing linens; -Providing hygiene; -Changing brief; -Device care or use: urinary catheter. 1. Review of Resident #243's entry Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/30/24, showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record, showed: -Diagnoses included malignant neoplasm (cancerous tumor) of mouth, tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and help with breathing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) and high blood pressure. Review of the care plan, in use at the time of survey, showed: -Focus: The resident requires a tracheostomy and is at risk for complications related to accidental decannulation (removal of a tracheostomy tube); -Goal: Will have no signs or symptoms of complications with tracheostomy tube to the extent possible; -Interventions: Administer medications as ordered, change trach ties as ordered and as needed, ensure ties are secure, encourage to cough out secretions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 8:32 A.M., showed Registered Respiratory Therapist (RRT) CC entered the resident's room, applied gloves, gown, surgical mask and eye goggles. He/She placed a trash liner into a trash bin, then removed his/her gloves and replaced with clean ones, with no hand hygiene in between. He/She then removed the old tracheostomy dressing with light blood drainage stained on the dressing and placed it in the trash bin. He/She proceeded to clean the resident's tracheostomy area with cotton swabs, cleaning each side of the stoma (opening), wearing the same gloves. He/She removed the gloves after throwing the cotton swabs away and applied a pair of clean gloves. No hand hygiene was performed. He/She lowered the head of bed with a gloved hand, touching the bed controls. Using the same gloves, RRT CC applied a clean dressing to the tracheostomy site and adjusted it to fit. He/She removed the gloves and elevated the head of the bed. He/She applied clean gloves with no hand hygiene performed. He/She obtained a suction tool (Yankauer, suction tip is an oral suctioning tool used in medical procedures), and suctioned the resident's mouth, then placed the suction tool into its original packaging and in a plastic bag, then hung it unto the wall. 2. Review of Resident #82's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included high blood pressure, anemia (decrease in number of red blood cells) and spinal stenosis (narrowing of the spinal canal); -Number of unstageable (unable to visualize wound bed) pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction) with suspected deep tissue injury (when a deep pressure injury is suspected but can't be confirmed) in evolution: eight. Observation on 10/10/24 at 4:30 A.M., showed an EBP sign outside the resident's room. The resident lay in bed. Certified Nurse Aide (CNA) V emptied 1200 milliliters (mL) of urine from the resident's catheter bag. The CNA did not wear a gown. The CNA unfastened the resident's brief and rolled the resident towards the door. The resident had a bowel movement. The CNA removed the dressing from the coccyx (a small triangular bone at the base of the spinal column) and said the Wound Nurse would do the dressing in the morning. He/She used a disposable wipe to clean the resident's back side and folded a clean pad and sheet halfway under the resident, applied an antifungal cream to his/her bottom, rolled the resident towards the window, positioned the sheet and brief under the resident and rolled the resident onto his/her back. CNA V used a disposable wipe to clean the resident from front to back, and fastened the brief. The CNA did not wear a gown or change his/her gloves when going from dirty to clean areas while providing care. 3. Review of Resident #73's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included cancer, anemia and high blood pressure; -Number of unstageable pressure ulcers with suspected deep tissue injury in evolution: one. (continued on next page)

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 10/21/2024

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Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 4:45 A.M., showed a sign for EBP on the wall outside the room. The resident lay in bed. CNA O performed hand hygiene and put on gloves, unfastened the resident's brief, used a disposable wipe, and performed peri care (cleansing between the legs and buttocks area). The resident rolled over and the CNA wiped the resident's back side. There was no dressing on the open wound on the resident's coccyx. CNA O rolled the resident onto his/her back and fastened the brief, put a gown on the resident, adjusted his/her socks and covered he resident up then he/she removed his/her gloves. The CNA did not wear a gown while providing personal care and did not change his/her gloves when going from dirty to clean areas while providing care. 4. Review of Resident #52's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included diabetes, high blood pressure, stroke and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm, or face). Review of the care plan, in use at the time of survey, showed: -Focus: resident had a gastronomy tube (g-tube, feeding tube) and is to be flushed for patency; -Interventions: flush g-tube per doctor's orders. Observation on 10/10/24 at 7:15 A.M., showed no EBP sign outside the resident's door. The resident lay in bed. CNA C provided peri care and placed a clean brief on the resident. When the resident was rolled onto his/her side, a g-tube was observed. The mechanical lift pad was placed under the resident. CNA C and CNA A used the mechanical lift to transfer the resident into the chair. Neither CNA wore a gown while providing personal care or while transferring the resident. 5. During an interview on 10/21/24 at 9:25 A.M., the Infection Control Preventionist (ICP) Nurse said residents who have wounds, urinary catheters and g-tubes required EBP and staff should wear a gown and gloves while providing direct resident care. Staff know which residents require EBP because they have a sign outside their door. Staff should perform hand hygiene when they enter the resident's room and apply gloves, they should clean the peri area from front to back, remove the gloves and perform hand hygiene and apply new gloves when they go from a dirty to clean area. Hand hygiene should also be performed after they finish providing care. The packages of disposable wipes are for single resident use. 6. During an interview on 10/21/24 at 10:32 A.M., the Assistant Director of Nursing (ADON) said she expected staff to perform hand hygiene in between glove changes. Staff are expected to use hand sanitizers or wash with soap and water. She also expected staff to wear the required PPE for residents on EBP. 7. Review of Resident #244's admission MDS, dated [DATE], showed: -Adequate hearing, unclear speech, usually understood, usually understands; -Impairment of both sides of upper and lower extremities; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on self-care. Review of the resident's medical record, showed diagnoses included anoxic (deficient in oxygen) brain damage, chronic respiratory failure, tracheostomy, gastrostomy and cognitive communication deficit. Review of the care plan, in use at the time of survey, showed: -Focus: The resident was at risk for complications with urinary system related to indwelling catheter; -Goal: Will have no complications of infections related to the urinary device; -Interventions: Administer medications as ordered, notify physician of signs and symptoms of urinary tract infection (UTI) such as mental status changes, foul smelling urine, color change in urine, hematuria (blood in the urine), sedimentation, burning with urination, increased temperature, privacy cover to catheter bag as indicated to promote dignity. Review of the resident's physician's orders, started on 9/29/24, showed Meropenem Solution Reconstituted (used to treat infections caused by bacteria) 1 gram (GM), intravenously (IV, fluids or medications administered within the veins) every 12 hours for bacterial infection, for 7 days. Review of the resident's progress notes, showed documentation, dated on 9/24/24 at 6:41 P.M., 9/27/24 at 3:27 P.M., and 10/13/24 at 5:16 P.M., of abdominal distention and blockage in his/her Foley catheter. Observation on 10/10/24 at 8:13 A.M., showed the resident's Foley bag lay on the floor, on top of the floor mat. The bag was not placed in a privacy bag and was behind the privacy curtain. During an interview on 10/18/24 at 3:13 P.M., Licensed Practical Nurse (LPN) F said Foley bags should be off the floor at all times to prevent infection. 8. During an interview on 10/21/24 at 9:25 A.M., the ICP Nurse said the residents' Foley bags should be off the ground. The bag should be changed when observed contact to the ground. The staff were expected to apply PPE when providing care to residents with Foley catheter. 9. During an interview on 10/21/24 at 3:08 P.M., the Administrator said he expected staff to follow the facility's infection control policies and procedures. 45083

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on interview and record review, the facility failed to offer and/or provide vaccinations as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines. Two of five sampled residents (Residents #89 and #245), did not receive vaccines for influenza (a vaccine that can protect against the flu) and pneumococcal (a vaccine that can protect against pneumonia). In addition, these two residents, and another resident (Resident #47) did not receive the COVID-19 (an infectious disease caused by the SARS-CoV-2 or corona virus) vaccines. Furthermore, these three sampled residents and another resident (Resident #68), four out of five residents, did not receive a completed purified protein derivative skin test (PPD skin test, a method for diagnosing latent tuberculosis (TB, a bacterial infection that can affect the lungs and other parts of the body)). The census was 99. Review of the facility's Infection Prevention and Control Program Policy (IPCP), revised October 2018, showed: -An IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; -Immunization is a form of primary prevention; -Widespread use of influenza vaccine in the nursing facility is strongly encouraged; -Policies and procedures for immunization include the following: -The process for administering the vaccines; -Who should be vaccinated; -Contraindications to vaccination; -Potential facility liability and release from liability; -Obtaining direct and proxy consent, and how often; -Monitoring for side effects of vaccination; -Availability of the vaccine, and who pays for it. Review of the facility's Vaccination of Residents Policy, undated, showed: -All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated; -Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provision of such education shall be documented in the resident's medical record; -All new residents shall be assessed for current vaccination status upon admission; -The resident or the resident's legal representative may refuse vaccines for any reasons; -If vaccines are refused, the refusal shall be documented in the resident's medical record; -If the resident receives a vaccine, at least the following information shall be documented in the residents' medical record: -Site of administration; -Date of administration; -Lot number of the vaccine (located on the vial); -Expiration date (located on the vial); -Name of person administering the vaccine; -Certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine; -The resident's attending physician must provide a separate written order for any other vaccination, and such orders shall be recorded in the resident's medical record; -Inquiries concerning this policy should be referred to the infection preventionist or the administrator. 1. Review of Resident #89's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/20/24, showed: -Moderate cognitive impairment; -Diagnoses included heart failure, kidney failure and arthritis; -Did the resident receive the influenza vaccine: No; -If not received, state reason: Not offered; -Is the resident's pneumococcal vaccination up to date? No; -If not received, state reason: Not offered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident's medical record, showed no documentation influenza, pneumococcal and COVID-19 vaccines were administered. No documentation showing PPD skin test were provided. No informed consent or proof of refusal was provided. 2. Review of Resident #245's entry MDS, dated [DATE], showed he/she was admitted to the facility on [DATE]. Review of the resident's medical record, showed no documentation influenza, pneumococcal and COVID-19 vaccines were administered. No informed consent or proof of refusal was provided. Review of the PPD skin test, showed step 1 was provided on 7/26/24, with negative result read on 7/28/24. No documentation of step 2 was provided. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Moderate cognitive impairment; -Diagnoses included heart failure, high blood pressure, diabetes and high cholesterol; -Did the resident receive the influenza vaccine: No; -If not received, state reason: Resident not in the facility during this year's influenza vaccination season; -Is the resident's pneumococcal vaccination up to date? No; -If not received, state reason: Not offered. Review of the resident's medical record, showed: -Informed consent for influenza vaccine, signed on 1/27/24, the resident opted to decline the vaccine; -Informed consent for pneumococcal vaccine, signed on 1/27/24, the resident opted to decline the vaccine; -No documentation of COVID-19 vaccines was administered; -No documentation showing PPD skin tests were provided; -No informed consent or proof of refusal to COVID-19 vaccines and PPD skin tests were provided. 4. Review of Resident #68's admission MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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	265838	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included blood clot, heart failure, high blood pressure, malnutrition, asthma; -Did the resident receive the influenza vaccine: No; -If not received, state reason: Resident not in the facility during this year's influenza vaccination season; -Is the resident's pneumococcal vaccination up to date? No; -If not received, state reason: Offered and declined. Review of the resident's medical record, showed: -Informed consent for influenza vaccine, signed on 8/15/23, the resident opted to decline the vaccine; -Informed consent for pneumococcal vaccine, signed on 8/15/23, the resident opted to decline the vaccine; -Declination Form for COVID-19 vaccine, signed on 8/15/23; -No documentation showing PPD skin tests were provided; -No informed consent or proof of refusal of PPD skin test was provided. 5. During an interview on 10/21/24 at 9:25 A.M., the Infection Control Preventionist (ICP) Nurse said the admitting nurse was responsible for assuring the required immunizations were completed. The nurse requests the physician's order, then will obtain consents from the resident or responsible party. The facility had supplies for influenza, pneumococcal, COVID-19 vaccinations, and the PPD skin test. If not available, staff will order from the pharmacy. The PPD skin tests were to be documented in the Treatment Administration Record (TAR) and any additional vaccinations were to be documented in the electronic health record (EHR) under progress notes. The consents were to be documented and/or scanned and saved in the EHR. 6. During an interview on 10/21/24 at 9:25 A.M., the ICP Nurse said if they did not provide the vaccinations or immunization records of the residents, they were not completed or administered. She expected the immunizations and skin tests to be completed per policy. 7. During an interview on 10/21/24 at 3:09 P.M., the Administrator said he expected staff to have the immunizations administered and/or completed.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 42247 Based on observation, interview and record review, the facility failed to ensure staff completed routine inspections of bed/side rails as part of a regular maintenance program to identify possible areas of entrapment to reduce the risk of accidents for three residents (Residents #47, #27 and #344). The sample was 33. The census was 99. Review of the FDA (Federal Drug Administration) guidance, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, showed: -It is suggested that facilities and manufacturers determine the level of risk for entrapment and take steps to mitigate the risk. Evaluating the dimensional limits of the gaps in hospital beds is one component of an overall assessment and mitigation strategy to reduce entrapment; -The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement; -Bed rails (commonly used synonymous terms are side rails, bed side rails, grab bars and safety rails), may be an integral part of the bed frame or they may be removable and at times are used either as a restraint, a reminder or an assistive device; -There are seven potential entrapment zones in hospital beds. Review of the facility's Bed Safety and Bed Rails Policy, dated revised August 2022, showed: - Policy statement: resident beds meet the safety specifications established by the hospital bed safety workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met; -Policy interpretation and implementation: - Bed frames, mattresses and bed rails are checked for compatibility and size prior to use; -Bed dimensions are appropriate for the resident's size; -Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA; -Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The maintenance department provides a copy of inspections to the administrator and report results to the Quality Assurance and Performance Improvement (QAPI) committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee; - Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.). 1. Review of Resident #47's medical record, showed a Nursing Bed Rail Observation/Assessment, dated 2/6/24, showed: -Cognitive impairment: Yes; -Does not use bed rails; -Remainder of observation/assessment left blank. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 8/4/24, showed: -Moderate cognitively impairment; -No behaviors or refusal of care; -Diagnoses included: diabetes, heart failure and depression. Review of the resident's physician order sheet, showed no order for side rails. Review of the resident's care plan, showed staff did not address the resident's use of side rails. Observations of the resident on 10/10/24 at approximately 8:30 A.M., 10/15/24 at 9:25 A.M., 10/15/24 at 6:12 P.M., 10/17/25 at 3:01 P.M. and 10/18/24 at 7:18 A.M. showed the resident lay in bed with bilateral side rails raised. During an interview on 10/15/24 at 6:12 P.M., the resident said he/she used the side rails for positioning. 2. Review of Resident #27's annual MDS, dated [DATE], showed: -Severe cognitive impairment; -Roll left to right: substantial/maximal assistance; -Sit to lying dependent, helper does all the effort. Resident does none of the effort to complete the activity; -Personal hygiene, upper and lower body dressing: dependent; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eating: supervision or touching assistance helper provides verbal cues or touching/steady assistance as resident completes activity; -Diagnoses included: dementia, stroke and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm or face) Review of the care plan in use at the time of survey, showed: -Focus: has full 1/4 bilateral siderails to increase independence in bed mobility; -Goal: will not suffer any injuries related to side rails; -Interventions: complete side rail assessment, monitor resident safety while in bed, use side rails as indicated (increase in bed mobility). Review of the Bedrail Observation, dated effective 2/10/23, showed: - Why is the use of bed rail(s) being considered? Resident/ family requested for safety and position enabler; - Medical Symptoms: identify all that contribute to the resident's need to use bed rail(s), physical symptoms: weakness, balance deficit and unable to support trunk in upright position; - Recommended: quarter siderail for right and left upper; - Evaluation of entrapment risk: -Right side, Left side, Headboard, Footboard: are there gaps between mattress and side/bed rail, headboard or footboard? No; - Evaluation of resident's size and weight: are the bed dimensions appropriate for the resident's size and weight, based on visual inspection of the resident in bed, and the resident's verbalized comfort level? Yes; - The evaluation did not include measurements. Observation on 10/10/24 at 6:50 A.M. and on 10/16/24 at 7:20 A.M., the resident lay in bed with the top quarter rails up. 3. Review of Resident #344's medical record, showed: -Alert with limited speech; -Diagnoses included acute kidney failure, high blood pressure, traumatic brain injury, stroke and hemiplegia (paralysis on one side of the body); -Use of gastrostomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of the Nursing Bed Rail Observation/Assessment. Review of the resident's physician order sheet, showed no order for side rails. Review of the resident's care plan, showed staff did not address the resident's use of side rails. Observations of the resident on 10/10/24 at approximately 8:30 A.M., 10/11/24 at 8:55 A.M., 10/15/24 at 9:48 A.M., and 6:33 P.M., 10/16/24 at 7:26 A.M., 10/17/24 at 3:26 P.M. and 10/18/24 at 7:22 A.M., showed the resident lay in bed with bilateral quarter side rails raised. 4. During an interview on 10/18/24 at 3:13 P.M., Licensed Practical Nurse F said the maintenance department was responsible for safety checks. 5. During an interview on 10/21/24 at 12:46 P.M., the Maintenance Director said therapy assessed the residents for siderails and he installed the siderails on the beds. He was aware of the risk for entrapment with side rails and he had the tools to do the measurements. However, he did not have any documentation showing the siderail measurements were completed. 6. During an interview on 10/21/24 at 3:09 P.M., the Administrator said he expected the residents' siderails to be measured, checked for entrapment and to be documented. He expected this to be done quarterly.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 37681 Based on observation, interview and record review the facility failed to ensure all call lights in the facility were in working order including audible notification at the nurse station on the 100 and 200 halls. The census was 99. Review of the facility's Answering the Call Light Policy, dated October 2010, showed: -Purpose: The purpose of this procedure is to respond to the resident's requests and needs; -Report all defective call lights to the nurse supervisor promptly. Observation on 10/10/24 at 6:13 A.M. showed Resident #20's call light was illuminated outside the resident's room with a red light light up on the wall inside the resident's room. There was no audible sound in the hall. During an interview on 10/10/24 at 5:05 A.M., Licensed Practical Nurse (LPN) P said call lights did not sound on the 100 and 200 halls, they just illuminated. The white light was for the room and a red light was the bathroom. Staff must look up to see which call lights were on. During an interview on 10/10/24 at 7:00 A.M., Certified Nurse Aide (CNA) S said when a resident pushed the call light, the call light should light up in the hall outside the resident's room and sound at the nurse's station. During an interview on 10/10/24 at 7:03 A.M., LPN Q said the call lights on the 300 and 400 halls sounded when they were on. The only way for staff to know the call lights were on in the 100 and 200 halls was for staff to look at the call light. On the 100 hall, there was one resident whose call light would light up for no reason. He/She did not know if anyone had investigated the issue or not. LPN Q said there was not a board at the nurses station to show which call lights were on. There was a light on the ceiling at the nurse's station that would light up white to indicate a call light on that hall was on. During an interview on 10/14/24 at approximately 5:00 P.M., LPN R said when residents turned on their lights on his/her shift, the light would light up, but it did not sound. Frequently, the call lights would malfunction, and the resident would be given a bell. But the bells did not work because if staff were down the hall with the door shut, they could not hear the bells ring. During an interview on 10/21/24 at 12:46 P.M., the Maintenance Director said he was made aware when an item needed to be repaired by staff completing a work order, through the TELS (a building management platform that helps manage maintenance tasks and emergencies) system or by word of mouth. He was aware of two call lights, one on the 100 hall and one on the 200 hall, that needed to be rewired. If the call lights were not functioning properly, the residents were given a bell to ring. The call lights on the 100 and 200 halls would light up but they did not sound. There was a digital screen at the nurse's station that would light up and show which call light was on.