Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30384	A. BUILDING: _____ B. WING _____	C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERS ASSISTED LIVING, THE	239 KAREN DRIVE HOLTS SUMMIT, MO 65043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, facility staff failed to follow the Code Status, (a medical directive that specifies the type of life-saving measures a patient wishes to receive in the event of a medical emergency) for one resident (Resident #1) with a Do Not Resuscitate (DNR) order, when staff performed cardiopulmonary resuscitation (CPR) to the resident. The facility census was 28. 1. Review of the facility's DNR Order policy, dated April 2017, showed staff are directed to not use CPR and related emergency measures to maintain life functions on a resident when there is a DNR order in effect. A DNR order form must be completed, signed by the Physician and resident, and placed in the front of the resident's medical record. 2. Review of Resident #1's Individual Service Plan, undated, showed an admission date of 06/12/25, and a Do Not Resuscitate code status. Review of the Outside the Hospital Do-Not-Resuscitate (OHDNR) Order form, dated 06/17/25, showed the physician signed the form to consent to withhold CPR in the event of cardiac or respiratory arrest. Review of the residents Physician's Order Sheets (POS), dated 06/17/25, showed a physicain signed order for DNR.	A4777		

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A4777	Continued From page 1 Review of the resident's face sheet, dated 08/21/25, showed staff documented the resident with a code status of DNR. During an interview on 08/21/25 at 12:30 P.M., the Corporate Nurse said Level One Medication Aide (L1MA) A and Personal Care Assistant (PCA) B were assisting the resident onto the toilet when the resident became unresponsive. L1MA A called 911 for assistance and said Family Member B arrived to find personnel performing CPR and told them to stop. The Corporate Nurse said L1MA A was scared and hadn't been in this type of situation before and reacted the best he/she could at the time. During an interview on 08/21/25 at 12:58 P.M., Family Member A said Family Member B witnessed CPR being performed and Family Member B told them to stop because the resident was DNR, but onsite Emergency Medical Services (EMS) personnel said CPR could not be discontinued until evidence of DNR was obtained. Family Member A said CPR was discontinued after Family Member B obtained a copy of the DNR from the medical record. During an interview on 08/21/25 at 1:30 P.M., Family Member B said he/she saw the resident lying on the floor with CPR being performed. Family Member B said he/she told them to stop because the resident had a DNR order. EMS staff told him/her they could not stop until they see the DNR order. Family Member B said a nurse gave him/her a copy from the medical record and then CPR was discontinued. During an interview on 08/21/25 at 2:18 P.M.,	A4777		

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A4777	Continued From page 2	A4777		

PCA B said he/she and L1MA A entered resident's room to administer medications, assisted resident onto the toilet, he/she became unresponsive, and his/her mouth turned blue. L1MA A called 911 and was told by dispatcher to start CPR. PCA B said they were not able to get resident onto the floor, so they were told by dispatcher to start CPR while resident was on the toilet and to hold his/her head up. PCA B said when EMS arrived five to seven minutes later, they moved resident to the floor and EMS personnel instructed L1MA A and PCA B to continue CPR on the resident. PCA B did not recall 911 dispatcher or EMS personnel asking about the resident's code status. The first mention of the resident's code status was from Family Member B who arrived during the episode and told them to stop because the resident had a DNR order.

During an interview on 08/22/25 at 12:08 P.M., the Corporate Nurse said if a resident codes, he/she would expect staff to verify the residents code status by checking the name plate by the resident's bedroom door and/or check the residents medical record. If the resident is a DNR, he/she would not expect CPR to be performed.

During an interview on 08/22/25 at 12:24 P.M., the Director of Nursing (DON) said if a resident codes, he/she would expect staff to verify the residents code status by checking the name plate by the resident's bedroom door and follow the code status orders. If the resident is a DNR, he/she would expect staff to contact the resident's family and physician instead of calling 911.

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A4777	Continued From page 3 During an interview on 08/25/25 at 2:31 P.M., L1MA A said he/she worked on 08/16/25 with PCA B on day shift. L1MA A said he/she was finishing administering morning medications and when he/she went into the resident's room. L1MA A said he/she noticed the resident had some feces on his/her clothes, helped the resident into his/her wheelchair and assisted the resident onto the toilet. L1MA A said the resident started leaning his/her head on the grab bar and the resident became nonresponsive. L1MA A said he/she started "freaking out" and didn't know what to do. L1MA A said he/she called 911. He/She said the 911 dispatcher asked if the resident had a pulse and asked if the resident was a DNR. L1MA A said he/she did not know how to find the code status other than looking in the resident's electronic medical record and said he/she had not been trained on what to do in a situation like that. The 911 dispatcher then told him/her to start performing CPR while the resident was on the toilet. He/She said emergency medical services (EMS) arrived and helped lay the resident on the floor. L1MA A said EMS asked for him/her and PCA B to continue performing CPR. He/She said Family Member B then arrived at the resident's room and said the resident was a DNR and asked them to stop CPR. L1MA A said EMS stated they would need to see documentation of the DNR before CPR stopped. He/She said PCA B took over chest compressions so he/she could print off the DNR documentation. L1MA A said he/she brought the DNR documentation to the resident's room and CPR stopped. MO00258003	A4777		

PLAN OF CORRECTION

Provider/Supplier Name:	The Timbers Assisted Living LLC**
Street Address, City, Zip:	239 Karen Drive Holts Summit MO 65043
Date of Survey:	08/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action. This plan of correction serves as the allegation of substantial compliance.	
Tag ID_A4777	**1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Advanced Directives/Code Status information as been updated. This includes having all doors labeled with red dots for DNR or Green Dots for full code. Binders are placed in easily accessible locations with all resident's face sheets with green dots for full code and red dots with purple sheets for DNR.**	09/17/25
	2. The corrective actions for other residents having potential to be affected by the same deficient practice include: All residents have the potential to be affected.	
	3. Measures put in place to ensure that the deficient practice does not recur includes: Inservice/education will be provided to all staff by DON and or designee on Advanced Directives/Code Status process.	

	4. **The facility will monitor its performance to make sure the solutions are sustained by conducting the following: DON and or designee will audit all Residents Code Status including door labels and information binders once a month for 6 months. All staff upon rehire will receive specific training on Code status. This will be included with Orientation Emergency Preparedness training.**	
	5. The corrective actions will be completed on or before:	9/17/25