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F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate basic life support, including cardiopulmonary resuscitation (CPR, a lifesaving technique that's used in emergencies in which someone's breathing or heartbeat has stopped) for one (Resident #1) of three sampled residents. Resident #1 had physician orders for a full code status. On 2/18/25 shortly before 7:00 A.M., staff removed the resident's oxygen when transferring the resident to bed, placed him/her on the bed in a flat position and as staff turned him/her, the resident was noted not to be breathing. Licensed Practical Nurse (LPN) A got the Nurse Manager (NM), who said the resident died. The NM told LPN A two nurses could verify a resident's death. Staff did not perform CPR. The resident expired. The facility had 89 out of 94 resident who were listed as full code. The census was 94. The administrator was informed on 2/24/25 of an Immediate Jeopardy (IJ), which began on 2/18/25. The IJ was removed on 2/24/25 as confirmed by surveyor on-site verification. Review of the facility's CPR policy, revised 6/5/23, showed: -Policy: It is the policy of this facility to adhere to residents' rights to formulate advance directives.	F 678		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sa De	LNHA	3/17/2025

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.

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In accordance to these rights, this facility will implement guidelines regarding CPR;
-Policy Explanation and Compliance Guidelines:
-1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR;
-2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and:
-a. In accordance with the resident's advance directives, or;
-b. In the absence of advance directives or a Do Not Resuscitate order; and;
-3. CPR certified staff will be available at all times;
-4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable.

Review of the facility's Medical Emergency Response policy, revised 9/1/22, showed:
-Policy: It is the policy of this facility to respond to medical emergencies for residents, staff and visitors.
Policy Explanation and Compliance Guidelines:
-1. The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance;
-2. CPR will continue unless:
-a. There is a Do Not Resuscitate (DNR) order in place;

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-b. There are obvious signs of clinical death (rigor mortis, dependent lividity, decapitation, transection, or decomposition);

-c. Initiating CPR could cause injury or peril to the rescuer;

-3. A nurse will:

-a. Assess the situation and determine the severity of the emergency;

-b. Stay with the resident;

-c. Designate a staff member to announce a Code Blue if necessary, notify the physician and call 911 as needed;

-4. A Code Blue will be announced over the intercom system, if necessary;

-5. All available staff will respond to the emergency accordingly;

-6. The Registered Nurse (RN) supervisor or Charge Nurse of the unit will take the Emergency Cart to the code site, ensure accurate documentation of the event and delegate any other duties or tasks needed;

-7. This will continue until emergency personnel arrive and resident is transported to the Emergency Room (ER) by the Emergency Medical Services (EMS);

-8. If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of emergency medical services, and:

-a. In accordance with the resident's advance directives, or;

-b. In absence of advance directives or a DNR order, and;

-c. If the resident does not show obvious signs of clinical death;

-9. The RN supervisor or designee will ensure emergency medications and equipment are inventoried and restocked;

-10. The night shift supervisor or nurse will

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ensure that all emergency carts and equipment are stocked and ready to use;
-11. The facility will ensure that CPR certified staff are available at all times;
-12. Current certified staff must maintain CPR-Certification for Healthcare Providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills. Online certification is not acceptable;
-13. This facility will not implement a "No CPR" policy.

Review of the facility's Residents' Rights Regarding Treatment and Advance Directives Policy, revised 9/1/22, showed:
-Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive;
-Definitions: "Advance directive" is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated;
-Policy Explanation and Compliance Guidelines:
-1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive;
-2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive;
-3. Upon admission, should the resident have an advance directive, copies will be made and

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placed on the chart as well as communicated to the staff;

-4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities;

-5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions;

-6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate;

-7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives;

-8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions;

-9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care;

-10. The facility will not discharge or transfer a resident should they refuse treatment either through an advance directive or directly unless the criteria for transfer or discharge are otherwise met;

-11. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart:

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F 678	Continued From page 5 -a. What the resident refused; -b. The reason for the refusal; -c. The advice given to the resident about the consequences of refusing; -d. The offering of alternative treatments; -e. The continuation of providing all other services; -12. Any services that would be otherwise required, but are refused, will be documented in the resident's comprehensive care plan; -13. The facility will not initiate or discontinue any other care based on refusal of care by the resident; -14. The facility will use the process as provided by State law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/18/24, showed: -Severe cognitive impairment; -Diagnoses included high blood pressure, seizures, unsteadiness on feet, communication deficit, and muscle weakness. Review of the resident's physician orders active as of 2/18/25, showed an order of full code (in the event of no pulse, initiation of CPR and summoning 911) with an order start date of 7/2/24. Review of the resident's current care plan, dated 6/19/23, showed he/she had a full code status. During an interview on 2/28/25 at 12:42 P.M., the Administrator said the resident did not have an	F 678		

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advanced directive. The resident did not have the mental capacity to do an advanced directive. Residents only have advanced directives if they are admitted to the facility with one or if a resident voices they would like to have one. If a resident has an advanced directive it is reviewed in the care plan meetings to verify they have the same wishes as listed on their advanced directive.

Review of the nurses notes, dated 2/18/25 at 7:33 A.M., showed LPN A and Certified Nurse Aide (CNA) D did a two man transfer of the resident, into bed. CNA D rolled the resident to check his/her brief, and when he/she rolled the resident onto his/her back, the resident did not appear to be breathing. LPN A called for the Nurse Manager (NM). The NM used a stethoscope and verified the resident had no heartbeat or pulse. Two nurses confirmed time of death as 6:58 A.M. Call placed to Nurse Practitioner (NP) C.

During an interview on 2/24/25 at 7:08 A.M., CNA D said the resident was in the common area from approximately 5:00 A.M. to just before 7:00 A.M. The resident was transferred from the recliner into his/her wheelchair and taken to his/her room. The resident was transferred into his/her bed and when the resident was turned over, CNA D asked LPN A if the resident passed. LPN A got the NM, who listened with a stethoscope and said the resident passed away at 6:58 A.M. CNA D heard LPN A tell the NM several times the resident was a full code. No compressions were done.

During an interview on 2/21/25 at 11:22 A.M., LPN A said on 2/18/25, he/she and CNA D transferred the resident from the wheelchair to the bed. The resident was breathing when they transferred him/her. LPN A and CNA D had to

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remove the oxygen so they could transfer him/her, as they didn't want the resident to get caught up in the tube. CNA D transferred the resident onto the bed. Once in bed, CNA D said he/she didn't think the resident was breathing. LPN A assessed the resident by checking for a pulse in his/her neck and arm. LPN A did not feel a pulse. The bed was flat, there was no rise and lowering of the resident's chest to indicate he/she was breathing. LPN A called the NM to confirm no heartbeat. LPN A told the NM the resident was a full code, and the NM said the resident was gone, there was no reason to do CPR, and both nurses could verify the resident expired. CPR was not done.

During an interview on 2/24/25 at 8:30 A.M., the NM said LPN A told him/her he/she didn't think the resident was breathing. The NM checked one side of his/her neck for a pulse and LPN A checked the other side. There was no pulse. LPN A did not say anything to the NM about being a full code. The NM thought the resident was a DNR.

During an interview on 2/21/25 at 12:51 P.M., NP C said she did not tell the NM two nurses could verify a resident's death. Staff reported to her on 2/18/24 at 7:04 A.M., the resident passed in his/her sleep.

During interviews on 2/21/25 at 9:00 A.M., and 2/25/25 at 12:30 P.M., the Administrator said she received a phone call from the NM on 2/18/25 around 7:00 A.M., reporting there was a death in the facility and the resident had expired. The Administrator arrived at the facility around 7:20 A.M. and said LPN A was upset. The NM was calm and on the phone handling things regarding

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the resident's death. LPN A did not report any concerns to the Administrator. CNA D told the Administrator he/she and LPN A took the resident to his/her room to change him/her, put the resident in bed and when CNA D rolled the resident over, the resident was not breathing. LPN A left the room and had the NM come and check on the resident. The NM told the Administrator LPN A did not have any sense of urgency when he/she asked him/her to come to the resident's room, so the NM said he/she assumed the resident was a DNR. The Administrator's expectation is if a resident is found unresponsive, for staff to assess the resident and check the resident's code status. If the resident is a full code, CPR should be initiated, 911 called, and CPR should continue until EMS arrives and takes over care. The expectation is for staff to follow physician orders, and this includes code status. She expected staff to be knowledgeable of and to follow the facility policies.

During an interview on 2/21/25 at 10:05 A.M., the resident's physician, who is also the Medical Director (MD), said staff should have followed the resident's wishes to be a full code. The MD said the odds of resuscitating someone is much higher if staff are there at the time the resident stops breathing. The chances of being revived if CPR was started at the time the resident stopped breathing versus finding a resident that has not been breathing for an unknown amount of time is much greater if CPR is started immediately and 911 is called at that time.

Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level "J". Based on interview and record review

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F 678	Continued From page 9 completed during the on-site visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. Note: At the time of the exit, the severity of the deficiency was lowered to the "D" level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00249747	F 678		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of one resident's (Resident #1) low lab results and to ensure the Medical Director (MD) and other physicians had full access to lab results in the system the physicians use. The MD was not aware of lab results for seizure medications for Resident #1, and the resident sustained seizure activity 18 days later. The facility also failed to ensure the	F 684		

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physician was notified when Resident #1 had a change of condition of new purple discoloration to the resident's fingertips at 8:30 P.M. and did not notify the on call Nurse Practitioner (NP) until approximately 4:30 A.M. after the resident had a fall. The facility failed to document the initial assessment of the change of condition in the medical record. In addition, the facility failed to check gastrostomy tube (g-tube a thin, flexible tube inserted directly into the stomach through a small incision in the abdomen) residuals (the volume of fluid remaining in the stomach) for one of three residents sampled with a g-tube (Resident #13). The sample was 3. The census was 94.

Review of the facility's Notification of Changes Policy, revised 9/1/21, showed:
-Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification;
-Definitions:
-"Life threatening conditions": Examples - Heart attack or stroke;
-"Clinical Complications": Examples - Development of Stage Two (partial thickness loss of dermis (inner layer of the two main layers of the skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough (a layer of dead, non-viable tissue that accumulates on the surface of a wound that is typically yellow, white, or gray in color and may appear moist, stringy, or adherent). May also present as an intact or open/ruptured blister) pressure injury (localized area of skin and underlying tissue damage caused by prolonged pressure, shear, or friction), recurrent episodes of delirium (mental

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state in which a person is confused and has reduced awareness of their surroundings), recurrent urinary tract infection (UTI) or onset of depression;

-"Need to alter treatment significantly": means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction) or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before;

-"Right to privacy": The facility is required to inform the resident of his/her rights upon admission and during the resident's stay including the resident's right to privacy;

-Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification;

-Circumstances requiring notification include:

-1. Accidents;

-a. Resulting in injury;

-b. Potential to require physician intervention;

-2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include:

-a. Life-threatening conditions, or;

-b. Clinical complications;

-3. Circumstances that require a need to alter treatment. This may include:

-a. New treatment;

-b. Discontinuation of current treatment due to:

-i. Adverse consequences;

-ii. Acute condition;

-iii. Exacerbation of a chronic

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condition;
-4. A transfer or discharge of the resident from the facility;
-5. A change of room or roommate assignment;
-6. A change in resident rights;
-Additional considerations:
-1. Competent individuals:
-a. The facility must still contact the resident's physician and notify resident's representative, if known;
-b. A family that wishes to be informed would designate a member to receive calls;
-c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident;
-2. Residents incapable of making decisions:
-a. The representative would make any decisions that have to be made;
-b. The resident should still be told what is happening to him or her;
-3. Death of a resident: The resident's physician is to be notified immediately in accordance with State law;
-4. Notice of room changes:
-5. Contact information of the resident's legal representative or family member must be recorded and periodically updated;
-6. Right to privacy:
-a. The facility is required to inform the resident of his/her rights upon admission and during the resident's stay including the resident's right to privacy;
-b. If a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as

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specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident's interested family member or legal representative, if known;

-c. If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

Review of the facility's Laboratory Services and Reporting Policy, revised 9/1/21, showed:
-Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law;
-Policy Explanation and Compliance Guidelines:
-1. The facility must provide or obtain laboratory services to meet the needs of its residents;
-2. The facility is responsible for the timeliness of the services;
-3. Should the facility provide its own laboratory services, the services must meet the applicable requirement for laboratories;
-4. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements;
-5. Assist the resident in making transportation arrangements to and from the laboratory if necessary;
-6. All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record;
-7. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall

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outside the clinical reference range.

1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/18/24, showed:
-Severe cognitive impairment;
-Diagnoses included high blood pressure, seizures, unsteadiness on feet, communication deficit, and muscle weakness.

Review of the resident's undated care plan, showed:
-Focus: Resident has a seizure disorder;
-Interventions:
-Give medications as ordered. Monitor/document for effectiveness and side effects, initiated 6/19/23;
-Monitor labs and report and sub therapeutic or toxic results to physician, initiated 6/19/23.

Review of the resident's orders, showed:
-Keppra 500 milligrams (mg) give by mouth two times a day for seizures, start date 7/2/24, discontinue (DC) date 12/3/24;
-Keppra 500 mg give one tablet by mouth every morning and at bedtime related to seizures, start date 12/3/24, DC date 2/18/25;
-Dilantin tablet chewable 50 mg give three tablets by mouth two times a day for seizure, start date 7/2/24, DC date 2/18/25;
-Dilantin tablet chewable 50 mg give three tablets by mouth every morning and at bedtime for seizures, start date 12/3/24, DC date 2/18/25;
-Keppra and Dilantin levels every six months starting on the fourth, start date 12/4/24, DC date 2/18/25.

Review of the resident's lab results, showed:

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-Collected: 12/4/24 at 8:19 A.M.;
-Reported 12/6/24 at 1:02 P.M.;
-Dilantin (phenytoin, medication used to treat seizures. Measures the amount of Dilantin in the blood for therapeutic levels for treating seizures, normal therapeutic range 10-20 ug micrograms (ug) /mL);
-Less than (<) 2.5 ug/mL, Low;
-Keppra (levetiracetam, medication used to treat seizures. (levetiracetam, measures the amount of Keppra in the blood for therapeutic levels to treat seizures, normal therapeutic range 6-46 ug/mL);
-< 2 ug/mL, Low.

Review of the resident's progress notes, showed:
-12/6/24 at 11:02 A.M., labs reviewed, see order management;
-12/6/24 at 2:11 P.M., labs reviewed, see order management;
-No documentation the physician was notified of the low Dilantin and Keppra levels.

Review of the resident's orders, showed:
-No new orders entered on 12/6/24.

Review of the resident's progress notes, showed:
-12/24/24 at 10:50 P.M., resident started to have a seizure at 10:50 P.M. lasting for five to six minutes. Emergency Medical Services (EMS) called at 11:00 P.M. EMS arrived at 11:15 P.M. and upon assessment resident was stable;
-12/25/24 at 4:08 A.M., resident was sitting in common area by the nurses station when this nurse noticed the resident having strange behavior. Nurse approached resident and resident was having a seizure at 4:00 A.M. lasting for five to seven minutes. On call NP notified.

Review of the resident's physician progress note

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written by the resident's physician/Medical Director, dated 12/27/24, showed:
-Progress Note Acute Care:
-Chief Complaint: Physical acute visit:
-Interval History: Resident seen and examined at bedside. Resident is reported to have had two seizures overnight earlier this week. Per resident and nursing, resident has been at baseline since seizures occurred and had no proceeding symptoms or signs of illness. Resident had recent bloodwork, but it did not include levels for his/her antiepileptic (medication used to prevent or treat seizures) medications or follow up on his/her hypothyroidism (thyroid does not produce enough thyroid hormone);
-Labs: Labs listed, but did not include TSH 3 UL, Dilantin, Keppra;
-Assessment/Plan: Seizures: Continue current medications and will check therapeutic levels.

During an interview on 2/25/25 at 11:17 A.M., the MD said regarding her progress note on 12/27/25, she was unable to see any labs regarding the resident's Keppra levels, Dilantin levels and TSH levels. The MD said the electronic records system the facility uses, Point Click Care (PCC) and the lab system talk to the system the physicians use and those labs were not in her system. The MD logged onto PCC and went to the resident's medical record, looked under labs and opened the lab results that were collected on 12/4/24 and reported on 12/6/24. When the MD looked at the lab results in PCC, she noticed the lab results for Keppra levels, Dilantin levels and TSH levels. The MD said she could see all the lab results were not pulled over from PCC. The MD said usually the nurse will report any abnormal lab results to the NP or herself. There was no adjustments made on the resident's seizure

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medication by the acting NP at that time and if the results of the Keppra and Dilantin levels were reviewed on 12/6/24, there would have been an adjustment made on the resident's seizure medication and an order to recheck the labs. The NPs also use the same system the MD does for reviewing resident charts. The resident ended up having two seizures after the labs were drawn and the labs showed the seizure medication was not at a therapeutic level for the resident. The resident had labs completed on 5/16/24 and the Keppra and Dilantin levels were in normal range at that time, so the low levels could have been because the resident was not metabolizing the medication well or the resident was not receiving the medication consistently.

During an interview on 2/25/25 at 11:56 A.M., Licensed Practical Nurse (LPN) H said lab results are under the results tab in PCC or the nurse can call the lab to get results. The nurses are responsible for checking the results tab if a resident had labs completed to view the results. The lab will call the facility if there are critical lab results and report those critical lab results to the nurse on duty. The lab does not call if there are abnormal labs. It is the nurse's responsibility to follow up on the lab results and report them to the NP or physician. If a lab has abnormal results, LPN H sends them to the NP through fax or sends them a photo of the labs. LPN H does not look at the specific lab results prior to sending them to the NP or physician. LPN H would document in a progress note if the labs for the resident were sent to the NP or physician.

During an interview on 2/25/25 at 12:04 P.M., LPN I said he/she goes through PCC to get lab results for residents or he/she can log into the lab

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portal and get the results of a resident's labs. If a resident has abnormal labs, the lab will call the facility and inform the nurse of the abnormal labs that are high or low. It does not have to be critical result. LPN I would then immediately call the physician and report the abnormal labs. With abnormal labs, the physician may want to adjust the resident's medication or send the resident to the ER depending on what labs are abnormal. If all lab results were normal, LPN I would still notify the NP or physician the labs were normal and would leave them for them to review. If there were abnormal labs, LPN I would not wait on the NP to come in and review the labs, he/she would call and notify the physician. The notification would be documented in a progress note, including if the physician had any new orders for the resident. If a resident was being checked for Keppra and Dilantin levels and the labs came back low, he/she would call the physician immediately because the physician would probably want to increase the seizure medication or may want to send the resident to the hospital. If the numbers came back low, that would increase the possibility of the resident having seizures and that is why it would be important for report it to the physician.

During an interview on 2/25/25 at 12:30 P.M., the Administrator said the facility gets lab results electronically in PCC by the lab company. The Administrator said the lab will call the facility if there are critical results that need to be reported. It is the nurse's responsibility to look for lab results for residents who have had labs drawn. The Administrator said management also checks the lab and radiology results daily during the week when they have their clinical meetings. If a resident has abnormal labs, the expectation is the

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nurse will report the abnormal labs to the NP or physician. It is expected the nurse will document the notification in a progress note along with any new orders the NP or physician gives. The Administrator expected the physicians and NPs to have access to view all lab results in their system. If lab results came back as low for Keppra <2.5 and Dilantin <2, that would be a concern for that resident. The Administrator would be concerned the resident could have seizures due to the Keppra and Dilantin levels not being in a therapeutic range. The Administrator expected staff to be knowledgeable of and to follow the facility policies.

During an interview on 2/25/25 at 1:02 P.M., the Director of Clinical Intervention (DOCI) said labs are dumped into PCC and the NP, physician, or the MD has to sign off on them. The DOCI said it is the nurse's responsibility to check the dashboard in PCC at least three times each shift and that would notify the nurse as an alert if a resident had new lab results. She expected nurses to review the labs results in PCC as they have been taught and to notify the NP or physician if there are abnormal labs. She also expected the nurse to document the notification in PCC. The DOCI said she expected the MD and NPs to be able to see all residents full lab results in their system. She would be concerned about the resident having seizures if the lab results came back low for Keppra and Dilantin, if the resident was using the medication for seizures. The DOCI expected staff to be knowledgeable of and to follow the facility policies.

Review of the resident's progress notes, dated 2/18/25 at 4:51 A.M., showed the resident was found on the floor unable to explain how he/she

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got there. LPN A did full body assessment, no open areas noted upon getting resident to his/her feet. Resident unable to walk without assistance so nurse placed resident in wheelchair and brought him/her to the nurse's station to check vital signs (VS). Resident blood pressure (BP, normal 120/80) 125/92, pulse rate (P, heart beats per minute (BPM), normal range 60 - 100) 101, oxygen saturation (SpO2), 93% on room air (RA) (normal range, 95% - 100%), respiratory rate (R, breaths per minute, normal range is 12-18) 16, temperature, (T, normal 98.6 degrees Fahrenheit (F)) 98.1. Resident also has some noted blue fingertips when asked if resident was experiencing pain resident denied. Resident was placed on 2 liters (L) of oxygen for comfort resident not showing and signs or symptoms (S/S) of distress. Call placed to on call NP E. NP E stated to continue to monitor resident as normal and he/she will inform in house NP C to round on resident regarding blue fingertips.

During an interview on 2/24/25 at 8:12 A.M., CNA F said the first time he/she worked with the resident was on 2/17/25 day shift (7:00 A.M. to 3:00 P.M.) and evening shift (3:00 P.M. to 11:00 P.M.). CNA F said while working the evening shift, he/she noticed the resident's fingertips were purple and that was the first time CNA F saw this and it scared her because that means no oxygen. CNA F reported the resident had purple fingertips to LPN G.

During an interview on 2/21/25 at 11:22 A.M., LPN A said he/she worked the night shift (7:00 P.M. to 7:00 A.M.) on 2/17/25 and was at the facility from approximately 7:30 P.M. to 9:00 A.M. on 2/18/25. LPN A said CNA F reported to him/her the resident's fingertips were purple at

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the start of shift change, approximately 8:30 P.M. LPN A said he/she and LPN G assessed the resident and gave the resident his/her seizure medication. The resident was in bed. LPN A said the resident was fine except his/her fingertips were purple. LPN A said the assessment he/she completed on the resident was a grip test, asked the resident if he/she was in pain, the resident denied pain, and checked the resident's SpO2 levels. It was 96% on RA. The resident was not using oxygen. LPN A said NP C was going to see the resident the next day. LPN A did not notify the on-call NP E at that time. Around 4:45 A.M., CNA D and LPN A went to the resident's room because the call light was on. When CNA D and LPN A entered the resident's room, the resident was crawling around on the floor on his/her roommate's side of the room. LPN A said he/she performed a full body assessment on the resident and found nothing abnormal. LPN A transferred the resident from the floor into a wheelchair and brought the resident up to the nurse's station in the wheelchair a little before 5:00 A.M. to take the resident's vitals. LPN A said the resident's vitals were alright. His/Her pulse was elevated, the SpO2 was kind of low at 93% and LPN A placed the resident on 2 Liters (L) of oxygen with a nasal cannula. LPN A said the resident's fingertips were still purple. LPN A wanted to send the resident to the hospital at that time to get evaluated, because he/she was a full code (in the event of no pulse, initiation of CPR and summoning 911), fell, his/her SpO2 was low, his/her pulse was elevated, and the resident had purple fingertips. LPN A said the Nurse Manager (NM) who was working the night shift said the resident's vital signs were stable, and they just needed to monitor the resident. LPN A said he/she discussed his/her concerns with NM and told the

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NM the resident was a full code. LPN A called NP E and notified NP E about the fall, resident's vital signs, and the purple fingertips. The NM and CNA D moved the resident to the common area in front of the nurse's station. LPN A was completing vital signs and neurological checks on the resident after the fall, and they were within normal range. The resident continued to wear oxygen during this time. When other residents began coming into the common area, LPN A and CNA D transferred the resident from the recliner into the wheelchair to take the resident back to his/her room to change the resident. The resident was breathing when he/she was transferred into the wheelchair. LPN A removed the oxygen from the resident prior to the transfer because LPN A did not want the resident to get tangled up in the oxygen tubing. The resident was not wearing oxygen when he/she was brought to his/her room. CNA D transferred the resident into his/her bed and when CNA D rolled the resident over, CNA D told LPN A, he/she did not believe the resident was breathing. LPN A assessed the resident by checking for a pulse in the resident's neck and arm, LPN A did not feel a pulse. The resident's bed was in a flat position and LPN A did not see any rising or lowering of the resident's chest. LPN A did not have a stethoscope on him/her so he/she called the NM to the resident's room to assess the resident and confirm there was no heartbeat. NM confirmed there was no heartbeat and told LPN A the resident was gone so there was no reason to perform cardiopulmonary resuscitation (CPR, a lifesaving technique that's used in emergencies in which someone's breathing or heartbeat has stopped) and two nurses could verify death. NM called NP C to report the resident's time of death.

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During an interview on 2/24/25 at 7:08 A.M., CNA D said he/she and LPN A answered the call light on 2/18/25 early in the morning and the resident was on the floor on his/her roommate's side of the room. The roommate said the resident walked to his/her side of the room and fell. CNA D and LPN A picked the resident up and took the resident by wheelchair to the nurse's station. CNA D said the resident's vital signs were stable, but LPN A did not like how the resident looked. CNA D said the resident's eyes were sunken in and the resident had blue fingertips. LPN A wanted to send the resident to the hospital. That was the first time CNA D noticed the resident having purplish/bluish colored fingertips. The pointer finger was discolored from the second bend to the tip and the middle finger was discolored from the first bend to tip on both hands. The resident was responsive while at the nurse's station when he/she would say the resident's name the resident would look at CNA D. When LPN A took the first set of vitals, he/she wanted to send the resident out. LPN A verbalized to NM that he/she wanted to send the resident out and NM said not to send the resident out, because the resident's vitals were stable, and the hospital complains because the facility sends residents out so frequently. NM and CNA D moved the resident onto the couch in the common area in front of the nurse's station. Then NM and CNA D moved the resident to the recliner because the resident did not look comfortable on the couch. The resident was then moved from the recliner to the wheelchair a little before 7:00 A.M. to bring the resident down to his/her room to change him/her. CNA D said the resident's eyes were closed and he/she thought the resident was just sleeping. After transferring the resident into bed, when the resident was turned over, CNA D asked LPN A if

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the resident passed away, because it didn't look like the resident was breathing. LPN A got the NM and the NM listened to the resident and said that the resident passed away at 6:58 A.M. CNA D said LPN A told NM the resident was a full code. The NM said the resident was already gone.

During an interview on 2/24/25 at 8:39 A.M., the NM said he/she came into work the night shift on 2/17/25 around midnight and worked into the morning of 2/18/25. The NM was not aware of any change of condition for the resident until around 4:40 A.M. to 4:45 A.M. when a call came to the nurse's station from the resident's roommate that the resident was on the floor. LPN A and CNA F went down to the resident's room and brought the resident up to the nurse's station in a wheelchair. LPN A used a wrist blood pressure cuff and could not get a reading on the resident, so the NM did a manual blood pressure. The blood pressure was 120/80 or 120/90. LPN A used a pulse oximeter (device that measures the oxygen saturation of the blood) on the resident's finger. The SoO2 reading was 93% on RA and his/her pulse was 101. The resident's fingertips were discolored. LPN A told the NM he/she believed the resident had Raynaud's disease (condition that causes blood vessels in the extremities (usually fingers and toes) to narrow excessively in response to cold temperatures or stress and it is often accompanied by changes in the color of the skin). NM said the resident's three fingertips, pointer finger, middle finger and ring finger on his/her right hand, were a purplish/blue color from the tips to the first bend of the finger. The resident's left hand also had the same purplish/blue discolor on the same three fingers, but it was lighter than the right hand. NM had seen the resident on 2/17/25 during the day with

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	265586	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM PLACE HEALTH AND REHABILITATION	2600 REDMAN ROAD SAINT LOUIS, MO 63136

(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) COMPLETION DATE
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NP C and the resident's fingertips were not like that during the day. NM said the discoloration, which was not normal for the resident and was showing something acute (something that begins suddenly) and new. The NM was concerned why the resident's fingertips would be changing colors. The resident was placed on supplemental oxygen on 2L with a nasal cannula after obtaining vital signs after the resident had the fall, and before the resident was transferred onto the couch in the common area. The NM and CNA D transferred the resident onto the couch and laid him/her down and then transferred the resident into the recliner next to the couch. NM said his/her observation of the resident stopped at that time, around 5:00 A.M., because he/she began passing medications to his/her assigned residents. LPN A did not say anything about wanting to send the resident out to be evaluated at the emergency room (ER) or that the resident was a full code. LPN A was calling his/her name and said "come here I think I need your help". The NM did not feel that there was any urgency when LPN A requested help. When the NM got to the resident's room, LPN A said he/she did not think the resident was breathing. The NM checked one side of the resident's neck and LPN A checked the other side. There was no pulse. LPN A did not say the resident was a full code, so the NM thought the resident was a Do Not Resuscitate (DNR, in the event no pulse no life saving measures to be taken, no CPR) because LPN A did not use any urgency when asking for assistance. LPN A told NM he/she thought the resident died in his/her sleep so the NM called NP C right then and informed NP C the resident expired in his/her sleep. The resident was pronounced expired at 6:58 A.M. NP C gave a death diagnosis of cerebrovascular accident

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(CVA, stroke).

During an interview on 2/24/25 at 7:08 A.M., CNA J said he/she worked the night shift on 2/17/25 but was not assigned to the resident. CNA J said when the resident was brought up to the nurse's station, he/she was alright for a minute then his/her head went back, and the resident went incoherent while sitting in the wheelchair at the nurse's station. CNA J stood in front of the resident when LPN A took the resident's vital signs, and the resident went incoherent. The resident's head went back and he/she wasn't answering the nurses, LPN A and NM. The NM and CNA D transferred the resident to the couch and LPN A put oxygen on the resident. They tried to lay the resident flat on the couch, but the resident didn't look comfortable. The resident was breathing fast at first, but his/her breathing slowed down after a little while. When CNA J saw the resident next, he/she was in the recliner, the resident was on the couch maybe five to ten minutes. The resident was transferred into the wheelchair and taken to his/her room. The oxygen was removed before the resident was transferred. CNA J said the resident did not look good because the resident's jaw looked sunken in.

During an interview on 2/24/25 at 9:38 A.M., NP E said she was on call for the facility and received a call from the facility at 4:39 A.M. on 2/18/25. LPN A reported the resident had an unwitnessed fall, the resident's vital signs were stable. The resident was seen on 2/17/25 during the day at the facility NP C. LPN A reported the resident had purplish colored fingertips since that morning. NP E recommended to monitor and do neuro checks per facility protocol and have facility NP C round

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on the resident to check it out. If LPN A would have reported all the information, as far as the change in color of fingertips that it was new, when it started, fall then placed oxygen on him/her NP E would have said to send the resident out for an evaluation.

During an interview on 2/24/25 at 12:42 P.M., the resident's physician and facility MD said she believed it could have made a difference in the outcome of the resident if the resident was sent out earlier when the change of condition regarding the bluish/purplish fingertips was first identified around 8:30 P.M. The MD said the change was noticed almost seven hours earlier and if the resident was sent out earlier, it could have changed the outcome for the resident in surviving.

During an interview on 2/25/25 at 1:02 P.M., the DOCI said a change in condition is when a resident normally orders two fried eggs and doesn't order it. It should be reported to the nurse then the nurse needs to assess and determine if she needs to notify the resident representative (RR) and physician. The assessment should include a head-to-toe assessment that includes a full set of vital signs, BP, P, R, SpO2, and T. The DOCI said the assessment should be documented somewhere in the resident's active clinical record. The DOCI said she wouldn't say specifically where it should be documented because she didn't have the policy. The facility's Notification of Changes Policy was offered to DOCI to review, and she declined to review it. The DOCI said she would not say it needed to be documented in a progress note. She said it may be documented in a progress note, clinical risk management or assessments. The DOCI said it

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just needed to be documented one time somewhere in the active clinical record. If it was reported that a resident had a new onset of purplish/bluish fingertips, the concerns would be it could maybe a respiratory or a circulatory problem. The DOCI expected the initial assessment regarding the change of condition to be documented. Her expectation is if a change is noticed, to notify the physician and document the assessment if any new information or the resident continues to show signs and symptoms of declining. The change of condition regarding the change in color to the resident's fingertips should have been reported and documented prior to the fall the resident had.

2. Review of the facility's policy, Verifying Placement of Feeding Tube, updated 9/1/21, showed the following:
-Policy: It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube or before administering medications via feeding tube;
-Policy Explanation and Compliance Guidelines:
1. Before beginning a feeding, flushing the tube, or administering medications via the feeding tube, proper placement and functioning will be verified.
4. Procedure for verifying placement of feeding tubes: c. Verify the tube placement: For gastrostomy tubes: check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Flush feeding tube with 30 milliliters (ml) of water after residual measurements to maintain tube patency.
5. The facility will monitor residents for complications related to a resident's feeding tube and tube feeding such as but not limited to signs and symptoms of respiratory distress

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(inconsistent with the resident's baseline) to indicate aspiration or feeding tube dislodgement into the airway. 6. If the resident develops severe respiratory distress or abdomen becomes distended: Immediately stop any feeding oradministration of medication. Notify the immediate supervisor and health care provider.

Review of Resident #13's admission MDS, dated 12/17/24, showed the following:
-Short/Long term memory loss;
-Total dependence on staff for all activities of daily living (ADLs);
-Feeding tube;
-Tracheostomy (an opening surgically created through the neck into the trachea to allow air into the lungs);
-Diagnoses included seizure disorders and disorders of the brain.

Review of the resident's care plan, dated 12/17/25, showed the following:
-Problem: Resident requires a feeding tube;
-Approach: Head of bed (HOB) elevated 45 degrees during and thirty minutes after tube feeding. Check tube placement and gastric content/residual volume per facility protocol and record every shift. Monitor/document/report as needed any signs/symptoms of aspiration, fever, shortness of breath, tube dislodged, infection at the tube site, self-removal of tube, tube malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distention, tenderness, constipation, fecal impaction, diarrhea, nausea, vomiting and dehydration.

Review of the resident's Medication Administration Record (MAR), dated 12/24, showed the following order, dated 12/11/24:

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-Check and record residuals every shift;
-Hold feeding for 1 hour if greater than 100 ml;
-Contact physician if residual exceeds 100 ml times three consecutive checks;
-Flush tube with 30 ml water of water after residual measurement;
-Staff initialed as complete: Day shift: 12/11/24 through 12/26/24 with no documentation of residuals. Evening shift: 12/11/24 through 12/26/24 with no documentation of residuals. Night shift: 12/11/24 through 12/26/24 with no documentation of residuals.

Review of the resident's progress notes, showed:
-1/4/25 at 5:13 P.M.: Readmit to facility. Nonverbal, tracheostomy intact, no signs or symptoms of distress. G-tube intact. Bowel sounds present and active, soft to touch. No further documentation until 1/6/25;
-1/6/25 at 5:36 A.M.: Resident resting in bed. No signs or symptoms of any distress noted. Trach care provided. Suctioned frequently, thick secretions. G-tube patent and intact. No problems with flush or medications, site clean and dry, bowel sounds active in all four quadrants. No further documentation until 1/6/25 at 8:00 P.M.:
-1/6/25 at 8:00 P.M.: Nurse heard feeding machine beeping, entered resident's room, resident covered in coffee ground emesis, noted to be on clothing, around mouth, in g-tube and around trach tube. Trach tube dislodged. Feeding turned off. 911 called, trach at the bedside placed in with new tubing, applied humidity and oxygen connected. Resident suctioned, O2 Sats between 92 and 98%. Respirations 35, with use of intercostal muscles (chest), observed respiratory distress, frequent suctioning, awaiting EMS (Emergency Medical Services);

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-1/6/25 at 8:18 P.M.: EMS arrived at facility, resident transported to the hospital.

Review of the resident's MAR, dated 1/25, showed the following:
-Check and record residuals very shift;
-Hold feeding for 1 hour if greater than 100 ml;
-Contact physician if residual exceeds 100 ml times three consecutive checks;
-Flush tube with 30 ml water of water after residual measurement;
-Staff initialed as complete: Day shift: 1/5/25, with no documentation of residuals. No initials documented on 1/6/25. Evening shift: Initialed on 1/5/25, with no documentation of residuals. 1/6/25: Hospitalized Night shift: Initialed on 1/5/25, with no documentation of residuals, 1/6/25: Hospitalized.

Review of the resident's admission hospital records, dated 1/6/25, showed the following:
-Patient presents to emergency department with a dislodged trach;
-EMS reports coffee ground emesis noted in g-tube;
-Patient intubated upon arrival;
-Paramedics report the patient appeared to have aspirated (the act of drawing in fluid or food into the lungs).

During an interview on 2/13/25 at 10:07 A.M., CNA K said he/she worked the day shift on 1/6/25. The facility was short staffed due to the snow storm. He/She saw the resident several times that day but was not assigned to him/her. CNA K remembered someone said the resident was throwing up. When CNA K entered the room, LPN G was cleaning the resident's face. His/Her trach was in place when CNA K entered the

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room. The resident continued to vomit by the time the EMTs arrived.

During an interview on 2/18/25 at 8:45 A.M., Certified Medication Technician (CMT) L said he/she passed medications on the day shift on 1/6/25. He/She didn't remember who took care of the resident. He/She remembered the resident vomited and LPN G sent him/her to get a trach from central supply. LPN G put the trach back in.

During an interview on 2/18/25 at 9:52 A.M., the NM said he/she worked the day shift on 1/6/25. He/She didn't take care of the resident that day but responded to the resident's room after the Administrator summoned him/her. LPN G and LPN M were at the bedside. LPN G was suctioning the resident. The resident had a large amount of coffee ground emesis coming out of his/her mouth, trach and g-tube. No one reported the resident vomited prior to this time. The Nurse Manager didn't recall who took care of the resident that day.

During an interview on 2/13/25 at 10:18 A.M., LPN G said he/she worked the evening shift on 1/6/25. His/Her shift began at 7:00 P.M. to 7:00 A.M. He/She first saw the resident at approximately 7:30 P.M. LPN G heard the tube feeding machine beeping and entered the resident's room. The resident had vomited coffee ground emesis and appeared to be in respiratory distress. The emesis was around the trach, in the g-tube and on the bed. The resident had a large amount of secretions around his/her trach and the trach was dislodged. LPN G turned off the tube feeding, put in a new trach and called a Stat and 911. EMS asked him/her to deflate the trach so that they could intubate (insert a tube into the

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trachea) the resident. The resident was transported to the hospital.

During an interview on 2/12/25 at 2:02 P.M., the Regional Nurse Consultant said when the nurses sign off on that particular order, it shows acknowledgement and verifies the residual amounts are within acceptable limits of the physician's order. If there was an issue or the amount was not within acceptable limits, there would have been a notification to the physician. There are not any requirements or orders that state there has to be a residual amount recorded. She expected staff to follow orders as written. She was unaware there wasn't a place on the MAR to record residuals.

During an interview on 2/21/25 at 10:44 A.M., the resident's physician, who is also the facility's MD, said she expected staff to follow physician orders and check and record residuals. Coffee ground emesis is a sign of old blood or bleeding. If the resident vomited a large amount, then it probably was there earlier. If staff had checked residuals, the coffee ground emesis would have been seen and should have been reported. If staff had called and reported the coffee ground emesis earlier, the resident would have been sent to the hospital.

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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
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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class I* See the deficiency cited at F678. *The higher classification merited due to the extent of the violation. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level. 2. Class II See the deficiency cited at F684.	A4075		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sara Rea TITLE LNHA (X6) DATE 2/17/25

PLAN OF CORRECTION

Provider Name:	Atrium Place Health and Rehab
Address, City, Zip:	2600 Redman Rd. St. Louis Mo. 63136
Date of Survey:	2/25/2025
Provider number:	265586

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F678	*Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.*	
	1) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** The Facility is unable to make corrective actions for resident T.G.	
	2) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents that are a Full Code have the potential to be affected by this alleged deficient practice. The Director of Nursing/Designee performed 100% audit of all current residents in the facility for correct current code status/wishes for advance directive. -Resident's charts reviewed for physician's order for advanced directive. -The facility conducted an audit on nursing staff to identify CPR certification status. -The nurses involved in the incident were suspended immediately pending investigation. -In-house expiration in the last 30 days were reviewed to identify Residents wishes were honored no concerns identified. -The policy and procedure for "Medical Emergency Response" was reviewed no revision necessary. -Inservicing by the DON/designee began 2/18/2025 and is ongoing to current and future nursing staff including licensed nurses, CMT's, CNA's on the following topics: 1. Emergency Medical Response Policy 2. Following physician orders in relationship to their advanced directive status 3. When to initiate CPR. 4. How to identify a residents advanced directive 5. Where the emergency crash cart is located and how to access it.	

	6. Who is permitted to pronounce death. -As a quality assurance system in place prior to the event, the facility scheduled a BLS (Basic Life Support) CPR class on 2/7/2025, for the scheduled date of 2/21/2025. This course was conducted by the regional nurse consultant, who is an American Heart Association certified BLS instructor. This is an ongoing quality improvement system in an effort to continue to educate and empower our caregivers. -Future admissions will have their code status verified by social service and nursing during the admission process to ensure a physician's order is in place and validated by resident or POA.	
	3) **Measures put into place to ensure that the deficient practice does not recur includes:** The above corrections will be audited during clinical meeting and by DON or Designee weekly x 4 weeks and then monthly 2 months then PRN and on any new order. Findings will be reported during the Monthly QAPI meeting. The DON or designee will ensure compliance.	
	4) **The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** Any variances will be provided to QAA Committee for further follow-up and recommendations.	
	5) **The corrective actions will be completed on or before:**	2/24/25
A4075	See F678	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider Name:	Atrium Place Health and Rehab
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F684	*Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.*	
	6) **The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes:** Resident #1 No longer resides in the facility. Resident #13 No longer resides in the facility. The Nurse Practitioner reviewed Resident #1's laboratory results on 12/6/25 at 11:03 AM from the PCC (point click care) dashboard.	
	7) **The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes:** All residents have the potential to be affected by the alleged practice.	
	8) **Measures put into place to ensure that the deficient practice does not recur includes:** Director of Nursing/designee will provide re-education to Licensed Nurses regarding notification of resident's medical provider when a change of condition is identified, checking residual on residents with gastrostomy tubes, and following of physician's orders concerning these components. The Medical Director will be re-educated on the location of laboratory results in PCC (Point Click Care).	

	Residents with gastrostomy feeding tubes were audited and orders for verification of placement via checking residual are in place. Audits will be conducted to review residents who are receiving anti-epileptic medications for therapeutic level laboratory testing.	
	9) **The facility will monitor its performance to make sure the solutions are sustained by conducting the following:** - Director of Nursing/designee will audit the 24-Hour Report for any changes in condition noted, review anti-epileptic therapeutic range laboratory results and confirm the provider was notified of any adverse findings as appropriate in the morning clinical meeting weekly x 4 weeks, and then monthly x 2 months. - The Director of Nursing/designee will perform random observations of enteral feeding tube administrations to confirm residual is being monitored bi-weekly x4 weeks and monthly x2 months. - Residents who receive anti-epileptic medications will be reviewed weekly x4 weeks and monthly x2 months to confirm orders in place for therapeutic-level testing as appropriate per the provider. Any issues identified while conducting the above audits will have corrective action taken. The results of the audits will be presented to the QAPI committee monthly by the Director of Nursing/designee to determine if additional interventions are needed to maintain compliance and if further monitoring is needed past the 3 months.	
	10) **The corrective actions will be completed on or before:**	2/25/2025