STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACKERT PARK SKILLED NURSING & REHABILITATION CENTE	894 LELAND AVENUE UNIVERSITY CITY, MO 63130

(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
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services to ensure one resident (Resident #1) was free from accident hazards when a Certified Nurse Aide (CNA) failed to secure the resident in bed before leaving to answer the call of another resident in a different room. The resident rolled of the bed and hit his/her head on the floor. The resident suffered two lacerations to the top of his/her head. The sample was four. The census was 44. The Administrator was notified on 1/31/25 at 2:53 P.M., of the past non-compliance, which occurred on 1/16/25. The facility provided training and in-servicing for all staff regarding the facility's resident safety policy. The facility also updated the resident's care plan to ensure the resident's bed is in the lowest position with a mat next to the resident's bed. The deficiency was corrected on 1/20/25. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/21/24, showed the following: -Severe cognitive impairment; -Dependent with activities of daily living;	F 689	Past noncompliance: no plan of correction required.	

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

Administrator 2-10-25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACKERT PARK SKILLED NURSING & REHABILITATION CENTE	894 LELAND AVENUE UNIVERSITY CITY, MO 63130

(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
F 689	Continued From page 1 -Diagnoses of Alzheimer's Disease, depression and high blood pressure; -History of one fall without injury. Review of the resident's care plan, dated 1/20/24, showed the following: -Problem: The resident is at risk for injury regards to fall, unsteady gait/balance, wheelchair bound and poor safety awareness; -Intervention: Keep bed in lowest position with brakes locked. Review of the resident's nurse's note, dated 1/16/25 at 4:57 P.M., showed the nurse was at the desk when the CNA yelled out and said that the resident had fallen out of the bed. The CNA had heard another resident yelling and he/she went to see about this resident and when he/she came back, the resident had fallen. Pressure was applied to the wound and 911 was called. Review of the resident's hospital aftercare medical record, dated 1/16/25, showed the resident has a history of Alzheimer's disease, nonverbal at baseline, congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should), high blood pressure and severe malnutrition, who is coming in from his/her nursing home for a fall out of bed. The resident is unable to participate in gathering history however information from Emergency Medical Services (EMS) said he/she was found out of bed at his/her nursing home with a laceration to his/her head. Observation on 1/27/25 at 10:07 A.M., showed the resident lay in a low bed with a mat on the floor. The resident had six sutures on the top of his/her head which measured approximately 4	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACKERT PARK SKILLED NURSING & REHABILITATION CENTE	894 LELAND AVENUE UNIVERSITY CITY, MO 63130

(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
F 689	Continued From page 2	F 689		

centimeters (cm) by 3 cm.

During an interview on 1/27/25 at 9:45 A.M., CNA A said he/she started his/her rounds. He/She went into the resident's room to give care. CNA A said just as he/she raised the resident's bed to give care, he/she heard another resident screaming out his/her name for help. CNA A went to check on the other resident because he/she did not know if something happened. CNA A found the other resident sitting on the side of his/her bed. CNA A told this other resident he/she would be right back. When CNA A got back to the resident, he/she was on the floor. CNA A said he/she immediately got the charge nurse. CNA A did not secure the resident before leaving and the resident rolled off the bed. CNA A said he/she should have secured the resident before leaving. CNA A said he/she was recently inserviced on the importance of securing a resident before leaving the resident.

During an interview on 2/6/25 at 12:36 P.M., Licensed Practical Nurse (LPN) B said CNA A yelled for him/her to come to the resident's room. The resident had fallen out of bed. When LPN B got to the resident's room, the resident was on the floor bleeding from his/her head. LPN B used a towel stop the bleeding. After he/she got the bleeding under control and the DON arrived, he/she called 911. The resident should have been in a low bed with a mat to the floor. LPN B said when he/she entered the room, the bed was not in a low position and a mat was not on the floor. CNA A should have secured the resident before leaving the resident.

During an interview on 1/27/25 at 10:25 A.M., the Director of Nurses and Administrator said CNA A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACKERT PARK SKILLED NURSING & REHABILITATION CENTE	**894 LELAND AVENUE UNIVERSITY CITY, MO 63130**

(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
F 689	Continued From page 3 should have secured the resident before leaving the resident. The Administrator said all staff have been inserviced and tested with return demonstration on the importance of securing a resident before leaving the resident. MO00248146 MO00248335	F 689		